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The ACA's Choice Problem

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Abstract

The Affordable Care Act (ACA) is in many ways a success. Millions more Americans now have access to health care, and the ACA catalyzed advances in health care delivery reform. Simultaneously, it has reinforced and bolstered a problem at the heart of American health policy and regulation: a love affair with choice. The ACA's insurance reforms doubled down on the particularly American obsession with choice. This article describes three ways in which that doubling down is problematic for the future of US health policy. First, pragmatically, health policy theory predicts that choice among health plans will produce tangible benefits that it does not actually produce. Most people do not like choosing among health plan options, and many people—even if well educated and knowledgeable—do not make good choices. Second, creating the regulatory structures to support these choices built and reinforced a massive market bureaucracy. Finally, and most important, philosophically and sociologically the ACA reinforces the idea that the goal of health regulation should be to preserve choice, even when that choice is empty. This vicious cycle seems likely to persist, based on the Democratic debates leading up to the 2020 presidential election.

Keywords Affordable Care Act, ACA, choice, managed competition, health insurance

The Affordable Care Act (ACA) is in many ways a success. Millions more Americans now have access to health care, and it catalyzed advances in delivery reform. Simultaneously, the ACA has reinforced and bolstered a problem at the heart of American health policy and regulation: a love affair with choice. More specifically, the problem is sanctifying the idea that choice of health insurance plans is valuable. When it comes to some aspects of their health care, people may genuinely appreciate options and being able to make choices that leave them better off. Some people care about selecting a doctor they like and trust or who is convenient to their home or work. Many people care about reproductive choice. Most of us value the ability to decline care we don't want. But very few people value choosing a health plan, in and of itself.

The ACA's insurance reforms doubled down on the particularly American obsession with choice. This article describes three ways in which that doubling down is problematic for the future of US health policy. First, pragmatically, health policy theory predicts that choice among health plans will produce tangible benefits that it does not in fact produce. Most people do not like choosing among health plan options, and many people—even if well educated and knowledgeable—do not make good choices. Second, creating the regulatory structures to support choices has built and reinforced a massive market bureaucracy, which I describe in detail elsewhere (Hoffman 2019b). Finally, and most important, philosophically and sociologically the ACA reinforces the idea that the goal of health regulation should be to preserve choice, even when that choice is empty. This vicious cycle seems likely to persist, based on the Democratic debates leading up to the 2020 presidential election.

The Pragmatic Problem with Choice of Health Plan

Mostly simply, the problem of choice of health plan is that it does not—and cannot—work in practice as anticipated in theory. The primary goal of the ACA was to reduce the number of uninsured and underinsured Americans through two main pathways: a Medicaid expansion and making individual (nongroup) health insurance more accessible and affordable.

The policy design that motivated the latter—the expansion of the individual market—was modeled off of a similar reform in Massachusetts in 2006 and based loosely on the theory of managed competition, most often associated with Stanford economist Alain C. Enthoven (1978a, 1978b, 1993). The oversimplified idea is that when consumers choose among health plans in a marketplace that is carefully regulated, they will make choices based on their preferences. Since most people will presumably choose plans where they get better care at lower costs, insurers will design and offer higher-value plans to compete for their business.

Enthoven (1978b: 718) initially called the idea “Consumer-Choice Health Plan” and explained, “What distinguishes [this plan] from the others is that it seeks to give the consumer a choice from among alternative systems for organizing and financing care, and to allow him to benefit from his economizing choices.” For example, Enthoven (1978a: 652) stated that if people wanted a plan that prioritized better access to home health care or ambulatory care over, for example, hospitalization, they could choose it.

Enthoven’s implicit assumption was that a tightly managed plan with an integrated delivery system, like a staff-model health maintenance organization, would prevail. He imagined plans where primary care providers would benefit financially if they reduced their patients’ excessive use of expensive specialty and inpatient care. If this reduction lowered plan spending but not quality, people would increasingly want these plans. Enthoven (1978b: 715) sought to mobilize choice in part to correct the thorny problems of overreliance on specialists and fee-for-service medicine.

Managed competition has influenced nearly every major health financing reform effort of the past decades. It graduated to the policy main stage in the early 1990s, when it was incorporated into the blueprint for President Clinton’s attempt at health reform, the Health Security Act (H.R. 3600, 103d Cong. [1993–94]). Although that reform failed, the idea lived on in the design of the Medicare Part D prescription drug coverage and Medicare Advantage, where Medicare beneficiaries can choose among plans administered by private health insurance companies.

Most recently, managed competition emerged in the ACA’s health insurance exchanges, or Marketplace, where people could shop for plans. The ground rules for insurers were similar to what Enthoven (1978b: 713–14) described in his first blueprint, mandating that they accept any

applicant during an open enrollment period (guaranteed issue), requiring “community-rated” premiums that do not vary based on health status, and placing limits on out-of-pocket spending. Like Enthoven’s vision, the ACA was designed with the idea that consumers’ choices would drive value in a managed, competitive insurance marketplace.

The problem for the ACA, and with all of the versions of managed competition prior, is that it does not work as imagined. The reasons are many. The first problem is a flawed market, where choices do not resound as clearly as Enthoven envisioned. He imagined consumers’ signals to insurers would prompt insurers to transform health care financing and delivery. Although less true when Enthoven first wrote, providers have accreted substantial market power through consolidation, undermining insurers’ negotiating power.¹

The ACA, as designed, only exacerbates this power imbalance. Managed competition relies on having multiple insurers competing for customers, but the more insurers there are in the Marketplace, the less any one of them enrolls enough subscribers to gain bargaining power. Furthermore, the ACA’s exchanges reach a small slice of the population: initial best-case scenario estimates were about 24.7 million people enrolled by 2019 (CBO 2010). Actual annual enrollment to date is less than half that number (Kaiser Family Foundation 2019). With enrollees

¹ Vogt and Town (2006: 1, 6) document changes in concentration during the 1990s. Gaynor and Town (2012) report that hospital consolidation increased the price of hospital care and sometimes decreases quality. Dafny (2014: 198) states that “the last hospital-merger wave (in the 1990s) led to substantial price increases with little or no countervailing benefit.”

divided among 50 states, insurers gain little leverage to negotiate with behemoth hospital systems.

Even without faulty markets, the second major problem would be fatal: Enthoven's idealized consumer, who chooses smartly among plans, does not—and will never—exist (Glied 2007). This problem is multilayered. First, neoclassical economics assumes that consumers have well-ordered preferences, or “tastes,” that are genuinely aligned with their interests. Yet, people do not have exogenous preferences among systems of financing and organizing care. Most people have never experienced home health care or ambulatory care versus hospitalization. It is difficult to get a sense of willingness to pay for something that is intangible.

Second, if people did have well-ordered preferences, most would struggle to translate them into plan choice. Most people do not understand the basic and defining features of health insurance plans, such as how much a plan costs and what benefits are covered (Garnick et al. 1993: 206). In a survey of insured adults, only 14% correctly answered four simple multiple-choice questions about cost-sharing features, such as a deductible, that are central to understanding the value of the plan (Loewenstein et al. 2013: 855). Yet, people overestimated their understanding, which suggests many would not seek help or education even if offered.

Third, choosing a health plan requires making calculations regarding deductibles, cost sharing, premiums, and probability that exceed many Americans' literacy and numeracy skills (Nelson et al. 2008; Peters and Levin 2008; Reyna et al. 2009: 945–46). Even college-educated Americans show surprisingly high levels of error on simple arithmetic tests (Nelson et al. 2008: 263).

Fourth, even without these fundamental problems, choosing health insurance has all of the telltale characteristics that impair rational decision making, sometimes referred to as

cognitive biases. For example, people are overly optimistic about their own health (Weinstein 1980), which could prompt them to underinvest in health insurance. People also struggle to factor risk into decision making, an element central, of course, to health insurance choices.² This explains in part why young, healthy people may forgo buying health insurance, even when it's cheap.

Not surprisingly, a volume of empirical work documents that people, regardless of education, income, or smarts, routinely make poor choices among health plans. These poor choices persist even when options are simplified. And they persist even in the face of substantial choice architecture and simplification to improve decision making, which caused Bhargava and Loewenstein (2015: 2506) to conclude that “the main barrier to financially efficient choice was not the number of options confronting employees, nor the transparency of their presentation, but rather the . . . lack of basic understanding of health insurance.”

A few representative studies, among the many dozens documenting this unyielding failure, illustrate the problem. One study simulated the purchase of an ACA plan using only participants who passed a screening test for basic insurance literacy (Johnson et al. 2013). These more-literate-than-average subjects still selected the best choice only about half of the time. Wharton business school students got it wrong over one-quarter of the time. Short of defaulting people into the right option, choice architecture tools, like just-in-time calculators and tutorials, produced little improvement.

² Kahneman and Tversky (1979: 264) indicate that people make choices inconsistent with their own expected utility when navigating risky options.

As another example, in the University of Michigan employee plan, over one-third of enrollees selected a plan that was identical to another option in every way except that it had a more restricted provider network (Sinaiko and Hirth 2011: 453). There was no scenario in which a worker would be better off enrolled in this plan, yet a large number of employees selected it. Another study of a large US firm found that most employees chose a worse option and, as a result, paid on average 24% more than they should have on premiums (Bhargava, Loewenstein, and Sydnor 2017: 1325). Lower-income employees were more likely to make a bad choice.

Similar results occur in the Medicare market, where beneficiaries choose among private prescription drug plans. One study revealed that 73% of enrollees could have chosen a plan with lower premiums with no risk of spending more on prescription drugs during the year (Abaluck and Gruber 2011: 379). Another estimated that less than 10% of enrollees in Medicare drug plans choose their least-expensive option (Heiss et al. 2012). Once Medicare beneficiaries choose plans, they usually do not switch during subsequent open enrollment periods (Koma et al. 2019), even when they would be made better off by doing so (Afendulis, Sinaiko, and Frank 2017).

People choose ACA plans that will cost them more in the long run (Avalere Health 2015; Fung et al. 2017). As many as one-third of people enroll in a plan with the lowest monthly premiums but that make them ineligible for significant cost-sharing reductions that would limit their out-of-pocket spending when they use care. Others choose health plans that are not aligned with their own stated medical needs and preferences. One simulation of an ACA exchange found that 40% of respondents chose a plan that would cost them at least \$500 more than another option based on their self-reported health needs (Barnes, Hanoch, and Rice 2014: 67). In a different simulated study, only one-third of respondents chose the cost-minimizing plan, based on their own anticipated medical care need (Bhargava, Loewenstein, and Benartzi 2017). Forty-

three percent of people overinsured, on average overspending by 24% or \$1324 on premiums, and nearly a quarter underinsured. The authors estimated that if all people buying plans on the ACA exchanges had similar error rates as the study population, “the result would be roughly \$7.1 billion of excess spending each year, borne by a population with low to moderate incomes” (10).

Thus, managed competition, in practice, is not fostering meaningful choice or making people better off.

The Bureaucratic Problem with Choice of Health Plan

These choice-venerating policies, in turn, create larger institutional problems, what I call health care’s market bureaucracy (Hoffman 2019b). Markets do not exist in isolation (Vogel 2018). Regulations determine the bounds of competition (Marone 1994). Establishing these bounds for the ACA exchanges was a major lift, guided by no less than 100 pages of the ACA and Herculean regulatory efforts interpreting these pages. To set up and run the ACA exchanges, the federal government has spent tens of billions of dollars (Mach and Redhead 2014), and states have spent additional billions of dollars; California estimates annual costs of \$350 million to run its exchange (Covered California 2018).

When exchanges falter or ground rules change, updates have required armies of health regulators, reams of regulation, and seemingly endless evaluation and adjustment by technocratic experts (Hoffman 2019a). Under the Obama administration alone, the Department of Health and

Human Services issued 24 new rules and 64 guidance documents on the exchanges,³ with parallel efforts in many states. The Trump administration continues apace, undoing much of what the Obama administration put in place.

Even more, health care's market bureaucracy amasses equally within the walls of private industry (McMaken 2015). The exchanges rely on private insurer participation, and their costs of operating, including high profits and salaries, is part of the cost of the market-based bureaucracy. It is unsurprising that the administrative costs of the US health care system well outpace those of its peers (Frakt 2018).

Furthermore, the exchanges have commanded oversized technocratic analysis of their successes and shortcomings, consuming the time and energy of talented researchers and think tanks. Scholars, news outlets, and policy makers obsess over every twist and turn, from an insurer joining or dropping out to the ups and downs of premium prices. The *New York Times* alone published over 300 articles on the ACA exchanges from 2010 to 2016 (Hoffman 2019b).

{Au: 2019 or in press?}

The result is a market-lubricating regulatory scaffold—a bureaucracy perhaps larger than what a direct regulatory approach would produce, and equally vulnerable to capture, or perhaps even more so because, by definition, private industry holds the reins to success. Yet, this expensive tinkering provides insurance for a mere 3% of the population and sets them up to make poor plan choices.

³ CMS n.d. counts listings under “Health Insurance Marketplaces” through calendar year 2016.

The ACA perpetuates health care's market bureaucracy, yet it is only a small part of it. Managed competition has equally informed the design of the Medicare supplemental market, including Medicare Advantage, Medigap, and the Medicare Part D market. Beyond insurance, an equally futile market bureaucracy grew from consumer-driven approaches to medical care choices. There regulatory scaffolding supports policies attempting with little success to incentivize patients to make good choices to reduce their use of low-value care or to find lower-priced providers (Hoffman 2019b). Likewise, modern antitrust regulation attempts, also with little success, to generate market dynamics that will drive higher-value health care. As antitrust expert Thomas Greaney (2009: 225) described, "Properly applied, antitrust law should promote decentralized decision-making by market participants while encouraging efficient combinations that serve consumer welfare." These policies all privilege market choice and dynamics to achieve larger health policy goals. In turn, regulatory structures focus on scaffolding, lubricating, and repairing markets that in theory will enable people to choose what they value most, even though this theory repeatedly falls short in application.

The ACA has continued to build the market bureaucracy. Although 20 million more Americans now have health insurance, about half through the exchanges, the ACA arguably paved a painful and expensive path to this end.

The Sociological Problem with Choice of Health Plan

The market bureaucracy, in turn, feeds a modern American obsession with choice. Pouring effort into regulatory structures aimed at bolstering choice perpetuates the idea that choice should be the ultimate goal.

This veneration of choice as *the* American value has been building since at least the 1960s. Early kernels in health care might be traced to reproductive and civil rights activists, and

legal cases like *Griswold v. Connecticut* in 1965 (381 U.S. 479, 483) and *Roe v. Wade* in 1973 (410 U.S. 113, 170), which favored individual control through a language prohibiting government intrusion over individual reproductive choices. Choice defined the early disability rights movement and demands for independent living and self-direction instead of institutionalization (Administration for Community Living, n.d.). It echoes in works like *Our Bodies Ourselves*, published in 1970 by the Boston Women's Health Collaborative, seeking to help women find self-empowerment over their bodies (Our Bodies, Our Selves, n.d.).

In health care, the sanctification of choice is in part a reaction to a system in which what patients wanted long came second. For most of the twentieth century, doctors controlled medical care decisions. Then, central planning and managed care emerged to address high spending in the 1970s and 1980s, and regulators and insurers gained decisional control. When those efforts fell short, consumer choice grew as something of a "sacred value" (Tetlock 2003). Informed consent evolved and aimed to put medical decisions back in the hands of patients. Market-based policies grew up in parallel, which elevated individual choice, defined by buying power.

Yet, this veneration of choice has arguably gone too far. A world of increasing market choices is actively making people worse off (Schwartz 2004). Not only do people often make poor choices, but people also dread making choices. Thirty percent of respondents to one survey reported they would rather prepare their taxes than navigate health insurance (eHealthinsurance 2008). The very existence of a market-based system can be contrary to what makes people, at least some people, feel better off. One study revealed that, although the idea of choice was associated with positive attributes for middle-class respondents, working-class respondents associated it with negative attributes and difficulty (Stephens, Fryberg, and Markus 2011).

Choice can also obfuscate what people collectively value and impede productive policies. Studies show that activating the idea of choice can decrease support for policies promoting equality and societal benefits (Savani, Stephens, and Markus 2011). The ACA offers an illustration of this idea. Although it might have been otherwise (Hoffman 2011), the downfall of the ACA's individual mandate came in part because it sought to achieve a collective goal through individual action. It prompted Americans to focus on their own bottom line—exactly how much an insurance policy cost and what it provided in return—instead of on the goal of universal access to health care. Choice centered the policy discussion in the wrong ideological place. The ACA's health insurance reforms make this same mistake more broadly. They elevate the idea that choice of health plan is in and of itself an important goal. In turn, regulatory efforts futilely attempt to achieve this goal, without question.

Yet, at the end of the day, most Americans do not care if their insurance comes from Aetna or Blue Cross. Many people do not know their own plan deductible—if they know what a deductible is—and many would struggle to weigh a choice between a plan with a \$10 copay or 10% coinsurance. Most people do, however, care about access to good doctors and hospitals. And Americans do care that they and others can get access to necessary health care without going broke. The most important collective goals may have very little to do with choice, and it will be necessary to move choice aside to understand this reality.

The Post-ACA Horizon for Choice

As the ACA turns 10, we can celebrate that it brought deep national attention to the goal of universal coverage, even if it has not yet achieved it. It also provides a moment to reflect on whether choice should remain the guiding light going forward.

As candidates gear up for the 2020 election, they risk perpetuating the reverence of choice. Candidates who want to build on the ACA's infrastructure sell choice, advocating for a public option for more choice. Perhaps most evident, Pete Buttigieg calls for "Medicare for all who want it." He asserts that if Medicare is the best option, people will choose it, and it will slowly displace inferior private plans. Vice President Joe Biden calls for "giving Americans a new choice, a public health insurance option like Medicare." (Biden for President 2019).

Part of why these candidates sell choice is to differentiate themselves from advocates for a single-payer plan. Choice serves as a euphemistic promise to enfranchised Americans with gold-plated health insurance to let them keep their plans, as well as a balm to others who are loyal to their plans, whether their plans deserve such loyalty or not, or who are fearful of change. Candidates know and bank on the resonance of choice among voters—a resonance crafted through years of careful public-relations campaigns by opponents to single-payer health care (Potter 2020)—even among candidates who understand that choice is a largely empty promise. Proponents of Medicare for All also reinforce the centrality of choice, either by selling these plans based on choice of doctor, which Medicare for All would enhance for many people, or by crafting transition plans that look like opting into Medicare for All.

Choice keeps its stronghold in part based on the narrative that what Americans want is too heterogeneous to be captured by any one solution. Yet, even at this moment when democracy limps along, democratic deliberation over health care priorities is vibrant, and sometimes reveals shared ground. Without overemphasizing the extent of such shared ground because Americans are clearly divided on many critical aspects of health policy, the places of shared commitments could suggest a basis for policy making priorities. For example, widespread outrage over exorbitant drug pricing and the bind in which it has put many American families is clear.

Americans identified lowering drug prices as a top 2017 congressional priority (Council of Economic Advisers 2018). Likewise, in the summer of 2017, public outcry arose against the newly elected Republican Congress's effort to repeal the ACA (Sessions, Cassidy, and Goodman 2017), suggesting at least high-level support for greater access.

The fight over Medicaid expansion reinforces this theme. The ACA intended to require states to expand Medicaid access to anyone earning up to 138% of the federal poverty level, but the ACA's first major legal challenge, *NFIB v. Sebelius*, effectively made this expansion optional. As of September 2018, 34 states and the District of Columbia had expanded (Kaiser Family Foundation 2018).

In the more conservative opt-out states, voters have begun to directly override their representatives' decision not to expand Medicaid in these states through ballot initiatives (Antoinisse and Rudowitz 2019). Maine passed a ballot initiative to expand Medicaid in November 2017 and voters in Idaho, Nebraska, and Utah followed in November 2018. These ballot initiatives suggest that voters value access to medical care in their communities, especially for lower-income community members. For these initiatives to pass required people who would not directly benefit personally to vote in favor. When the populace expresses shared commitments, whether in abstract terms like valuing access or concrete terms like lower drug prices, it is the job of elected representatives to overcome political barriers to respond. Yet, to the contrary and reflective of deep political dysfunction, legislatures and governors in Medicaid ballot-initiative states dig in their heels deeper to resist expansion, and Congress stalls out again and again on drug pricing reforms. We then turn futilely back to markets with hope that they will fix the things that our politicians are increasingly unable and unwilling to fix.

Bureaucracy is inevitable, but it should bolster a health care system that can fulfill, rather than frustrate, what people and communities genuinely care about. Looking slightly under the surface suggests that what people really care most about is not always choice and that it is time to refocus health regulation on realizing other shared values.

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