Title: Keeping up with the Cadillacs: What Health Insurance Disparities, Moral Hazard, and the Cadillac Tax Mean to The Patient Protection and Affordable Care Act
Author: Rebecca Adkins Fletcher
*Medical Anthropology Quarterly* 2014.
This is the author’s post-print. Please cite the final version of the article, available at [http://dx.doi.org/10.1111/maq.12120](http://dx.doi.org/10.1111/maq.12120).
Keeping up with the Cadillacs: What Health Insurance Disparities, Moral Hazard, and the Cadillac Tax Mean to The Patient Protection and Affordable Care Act

A major goal of The Patient Protection and Affordable Care Act is to broaden health care access through the extension of insurance coverage. However, little attention has been given to growing disparities in access to health care among the insured, as trends to reduce benefits and increase cost sharing (deductibles, co-pays) reduce affordability and access. Through a political economic perspective that critiques moral hazard, this article draws from ethnographic research with the United Steelworkers (USW) at a steel mill and the Retail, Wholesale and Department Store Union (RWDSU) at a food-processing plant in urban Central Appalachia. In so doing, this article describes difficulties of health care affordability on the eve of reform for differentially insured working families with employer-sponsored health insurance. Additionally, this article argues that the proposed Cadillac tax on high-cost health plans will increase problems with appropriate health care access and medical financial burden for many families. [Cadillac tax, cost sharing, employer-sponsored insurance (ESI), moral hazard, Patient Protection and Affordable Care Act (PPACA)]

Something that always bugs me is that you call and make you an appointment and that’s the first thing they want to know is what type of insurance do you have? It’s not like, “Are you afraid you’re dying of cervical cancer?” It’s like, “Do you have insurance? … Where is your wallet? Give me your card; we’re going to make a copy before we do anything” … But you think they could ask you how you’re doing before they just ask you for your health insurance card.

—Crissy, USW

Complaints about the quality of health care available in Meridian (pseudonym), an urban Central Appalachian area, are seldom heard. However, as Crissy’s sentiments attest, a commonly held belief that health care is dependent on health insurance as a measure of ability to pay for services is reinforced by health care facility gatekeepers (often receptionists and office administrators). Crissy reminds us that having health insurance is a vital first step in gaining access to health care, and this is a founding principle behind the Patient Protection and Affordability Act (PPACA). However, Crissy also calls attention to the complexity of accessing health care, as concerns over payments (provider side) and affordability (consumer side) can take priority over attending to health care needs, even for the insured. Crissy’s words resonate with the concerns of many insured families in Meridian for whom the complexities of managing basic necessities, including health care, in an uncertain and shifting economy are clearly visible.

Commonly referred to as “health care reform” or more critically as “Obamacare,” the Patient Protection and Affordable Care Act (ACA) (H.R. 3590) was signed into law by President Barack Obama in March 2010. The two hallmarks of the ACA are the extension of health
insurance coverage to reduce the number of the uninsured and efforts to make health care affordable. As the lack of universal health coverage for millions of Americans has been described as the “single greatest barrier to ensuring equitable access to health care” (Davis 2001:46), the ACA will greatly reduce the number of people without health insurance. However, little attention has been given to the disparities in health care among those with health insurance, and the ability of the reform measures to effectively address gaps in affordability for the insured is unclear. As Stone asserts, “under the persuasive aura of moral hazard, the impact of cost sharing on people with insurance has escaped intense political ire” (2011:891). Because of the range of available health insurance plans and costs, including exclusions, premium rates, deductibles, co-pays, prescription coverage, and spending caps, the insured are anything but a monolithic group. Yet, because health insurance is often equated with having health care, these factors are under-addressed in terms of health care access and affordability among the insured. A look into the concept of moral hazard provides some perspective on recent health insurance reform and policy transformation.

Moral hazard is an analytical tool employed in economics and political policy regarding social responsibility. The implication of moral hazard is basic: If a person (or group) is protected from risk, their behavior will become riskier (more socially unacceptable). Moral hazard, however, fails to account for other cultural and structural influences on behavior. In relation to health insurance, moral hazard gained popularity in policy circles through the writings of Kenneth Arrow (1963, 1968) and Mark Pauly (1968). While Arrow (1963) argued for the need for social insurance, Pauly’s (1968) argument against social insurance through the logic of moral hazard and economics became a guiding principal in U.S. health policy (Stone 2011:886).

Specifically, moral hazard refers to the overuse of health care due to the lowering (or hidden total) of the cost of health services for those with health insurance. Hence, the basic assumption of moral hazard is that an individual will seek health care that they would not have sought without insurance to cover part of the cost, thus overusing or obtaining unnecessary health care. The economics of moral hazard assumes that the uninsured seek medical care when it is really necessary (efficient consumers), while the insured, because they only pay a portion of the costs, irresponsibly overuse health care (inefficient consumers) (Gladwell 2005). In essence, the well insured use more than their fair share (“unnecessary”) of health care, and this inefficiency must be controlled through disincentives (cost). From this perspective, insurance increases inefficiency and health care costs because the insured obtain unnecessary care and drive up overall costs. Hence, increasing the number of people with health insurance will increase health resource waste and inefficiency, leaving society worse off (Stone 2011:888–889).

Moral hazard has had great influence in recent decades on health policy economics, as it is the logic behind the promotion of Health Savings Accounts (HSAs) and consumer-driven health care (CDHC). If the purpose of health insurance is to “make access to health care independent of the ability to pay” (Stone 2011:890; see also Hoffman 2006:503), then the negative effects of cost sharing not only reduce access to health care but also reduce financial security for individuals and working families. Arguments against cost sharing are not new, as similar denouncements were levied against major medical (high deductible) coverage beginning in the late 1940s. As Hoffman (2006) asserts, the lessons of cost sharing in the form of major medical coverage have been ignored in the current push for high deductible plans (e.g., HSAs). Rather than a panacea for controlling rising health care costs, cost sharing in the form of major medical coverage contributed to health care inflation and chronic underinsurance conditions (Hoffman 2006:502). More recent applications of moral hazard’s “blunt tools” (Heimer 1985) to
influence health behavior have increased patient cost sharing, most notably in higher deductibles and co-pays to discourage the use of health care and, thus, insurer payout. This is realized in reduced health care utilization, including preventive, elective, and necessary health care due to cost (Mariner 2004; Woolhandler and Himmelstein 2007) and is a means of inducing self-rationing all health care.

This article draws from a broader ethnographic investigation of the intersections of access to health care, health insurance status, and labor union membership amid economic transformation in Meridian. Once an industrial hub in the region, industrial decline coupled with an expanding service sector has yielded fewer jobs that provide a living wage and employer-sponsored insurance (ESI). I conducted ethnographic research within the community and with the Retail, Wholesale, and Department Store Union (RWDSU) at a food-processing plant and United Steelworkers (USW) at a steel mill for more than 18 months in 2007–2008. This included 74 semi-structured interviews and extensive participant–observation at union- and community-sponsored events, such as rallies, festivals, parades, health fairs, and political events.

The CAGH (Critical Anthropology of Global Health Study Group) Take a Stand Statement: Health Insurance Reform encourages critical dialogue about equitability and efficiency of health care delivery. In so doing, medical anthropologists are tasked with providing on-the-ground analyses and contextualization of the ACA. Providing a view on the eve of reform, this article engages the CAGH statement through both empirical analysis of cost sharing for the insured (on-the-ground) and analysis of moral hazard as a financial tool of health policy (studying up), with an eye toward what these mean for ACA’s effectiveness. Herein, I critically evaluate the economic tenet of moral hazard through ethnographic engagement, calling attention to the problems of cost shifting for access to health care (underinsurance) and the potential of the ACA’s proposed Cadillac tax on high-cost health plans to undermine access to health care for those with more generous ESI. In so doing, this article provides a critical “anthropology of policy” perspective of the ACA to address the intended and unintended consequences of health policy (Singer and Castro 2004; Van Willigen 1986). To evaluate the implications of moral hazard and problems of underinsurance due to cost sharing, I turn now to the RWDSU and USW as they describe their experiences with accessing and affording health care under different levels of ESI coverage and expendable incomes.

Translating Health Insurance into Health Care: Issues of Affordability among the Insured

Historically, health insurance in the United States has been primarily employment based (Davis 2001; Glied and Borzi 2004), and labor unions incorporated health benefits into collective bargaining following the failure of the Wagner-Murray-Dingell bill for national health insurance in 1942 (n 1994; Gottschalk 2000). ESI plans remain popular among workers because they are often more generous (fewer exclusions, higher actuarial value, lower deductibles and co-pays) and more affordable than non-group private plans. In addition, employee premium shares are not counted as taxable income for employees or toward employer payroll taxes (Hyman 2010:4; Swartz 2006:47; Thomasson 2003), making ESI part of the hidden “shadow welfare state” (Gottschalk 2000), where workers do not see their untaxed health premiums as a government subsidy.

Health is strongly linked to socioeconomic status, especially in urban areas where economic restructuring from a manufacturing to a service economy results in a loss of good paying union jobs with benefits (Geronimus 2000:868). Despite these losses, union members
remain among the most protected American workers because they are more likely to have health benefits than non-union workers (AFL-CIO 2012). Indeed, 99% of companies with union workers offer ESI, compared with 60% of non-union companies (Rowland et al. 2009:6). This reflects the strength of collective bargaining and labor’s long history of involvement with health insurance policy. It also makes ethnographic research with unions a critical site for analysis of neoliberal processes that destabilize job and resource (including health care) security. Union families are particularly well situated to offer insights into the dynamics and workings of ESI regarding access to health care, as different unions and job sites offer different health benefit packages relating to industry type, company size, and union strength.

By today’s standards, RWDSU\(^2\) and USW members in Meridian have very reasonable insurance coverage. RWDSU’s\(^3\) insurance in 2007 had biweekly premiums of $19 for an employee (single) and $41 for family coverage. Deductibles were $300 (individual) and $600 family; co-pay rates were $15. In contrast, USW members refer to their “Cadillac” coverage. Members have zero premiums (individual and family coverage), and the insurance pays 100% of medical costs following a $10 co-pay and a $250 individual or $500 family deductible. Incidentally, USW members had no deductible requirements prior to 2005. RWDSU members pay more for health insurance premiums and have larger co-pays and deductibles than the Steelworkers, thus reducing their already smaller take-home wages.

With wages estimated to range between $25,000 and $35,000 depending on overtime (approximately half those of the Steelworkers), RWDSU members have less expendable finances with which to pay premium, co-pay, deductibles, and uncovered costs. Median household income in Meridian is at about $35,000, so RWDSU members are representative of many households in the community. Most insured RWDSU members had few complaints about accessing health care, but it is notable that some of them had postponed health care due to difficulties paying uncovered costs. This is in contrast to the relative ease of accessing and paying for health care described by the Steelworkers, and it leads us to look more closely at the condition of underinsurance.

Underinsurance, a relative concept and one difficult to quantify, is measured and understood in diverse ways that often include an understanding of economic, structural, and attitudinal dimensions of underinsurance (Bashshur et al. 1993). For example, measures of underinsurance account for inadequacy of coverage in the event of a high-cost illness (Farley 1985; Kuttner 1999; Short and Banthin 1995), plan benefits relative to income (Schoen et al. 2005), or actuarial value of the plan (Gabel et al. 2006). Yet the most common determinant of underinsurance is a threshold measure, where a percentage of household spending on medical expenses is understood as the maximum out-of-pocket affordability rate (e.g., Banthin et al. 2008; Schoen et al. 2005; Shoem et al. 2008; Short and Banthin 1995). This maximum threshold of affordability varies between 5% and 10% of income in several studies (Merlis 2002; Schoen et al. 2005; Shearer 2000) and is set at 9.5% in the ACA. Nevertheless, being underinsured is reasonably understood as having inadequate health insurance coverage for health care needs that result in forgone care or high out-of-pocket medical costs relative to income (Bartlett 2000; Blewett et al. 2006:667). This becomes all the more important amid estimates that 20% of those with insurance in 2007 were underinsured, an increase of 60% from 2003 estimates (Schoen et al. 2008:w300).
**RWDSU and Underinsurance**

RWDSU participants were largely satisfied with their ESI coverage, and most reported few problems accessing health care. However, for some insured RWDSU families, affordability sometimes limits the use of needed health care. Lance describes the reasons he postponed seeking medical care:

As a matter of fact, in this area I would say that people that do have healthcare and have insurance is the most likely not to use it, because we know we’re going to have to pay the difference. So to give you an example, I went two to three years of really feeling bad [unexplained], and I thought it was night shift and absolutely wouldn’t go to the doctor until it hit me in the face. … Somebody that actually has insurance is sitting there thinking I can wait this out because I’ve got to pay my half, so actually the people that have insurance is probably the least likely to use it unless it’s an absolutely emergency. The facilities are here. I can drive 15 minutes in any direction and get the best care you could want. It’s the paying for it [that’s the problem]. (Lance, RWDSU)

In this case, although Lance is insured, wages and the cost of health care are an undeniable part of his health care equation, and he is unlikely to seek health care in the absence of a medical emergency. Like many other people in the community, his frustration lies in the fact that he is working, has health insurance, and still finds payment for medical care sometimes beyond his reach. His statements also underscore how increased out-of-pocket costs reduce appropriate use of health care for the insured (Woolhandler and Himmelstein 2007:879).

It was not uncommon among RWDSU participants for them (or their children) to have received public insurance (Medicaid or Children’s Health Insurance Program [CHIP]). Some RWDSU members shared their concerns regarding health insurance coverage and affordable medical care for their children. For example, Phillip put his wife and children on his ESI plan when it became available to him. Prior to that, his children were on Medicaid. They have since regretted putting the children on the ESI because of the numerous exclusions. For example, while Medicaid paid 100% of the children’s medical bills, their ESI does not cover all childhood vaccinations and has limits on well-child visits. Because of the increased out-of-pocket expenses, they signed up for CHIP to defray costs. Phillip describes a conversation with the Department of Health and Human Resources about taking the kids off his ESI and putting them back on Medicaid:

But I talked to somebody about getting help and they said well where they’re on your insurance, if you take them off your insurance there could be a six-month penalty because you’ve had them on there and you knowingly had them on there and knowingly took them off to get this insurance. … They [DHHR official] said you have a chance of you know losing out on insurance for six months until we put them on it, and that—that got me. I was like well if I had known that I would have never put them on my insurance to begin with. Penalized, yeah; like I’m in the wrong for dropping my insurance because they [Medicaid] pay better. [Laughs] That don’t make much sense you know. You’d think they’d want something better for your family. (Phillip, RWDSU)
Although Phillip and Beth regret taking the children off Medicaid and putting them on the insurance, they may have had little choice in the matter. Indeed, it is likely that the state would have reduced the children from full Medicaid coverage to CHIP as part of benefit phase-out (Boushey 2005). The six-month waiting period, where a child must be without private health insurance for a state-determined length of time before returning to CHIP is a policy intended to prevent private insurance “crowd-out” as a way to limit the substitution of private insurance for public coverage (Lee et al. 2008:388). As it turns out, the couple’s private insurance also limits pregnancy coverage, so Beth’s current pregnancy is covered by Medicaid. Thus, to gain access to affordable care, some families turn to public assistance (Medicaid) to fill in the gaps in their insurance coverage. Indeed, this is akin to job outsourcing, as private health insurance companies allay coverage for certain health care needs (mostly of women and children) to taxpayer-funded programs, especially Medicaid and CHIP. As Phillip and Beth are quick to point out, they pay for insurance coverage that pays very little for the health care their family needs.

Phillip and Beth’s concerns were echoed by another RWDSU member, a single father, who lamented that he cannot afford for his daughter to have the tonsillectomy that would rid her of chronic infections. Because he is employed “parttime” (but works more than 40 hours per week) and earns a wage of nine dollars/hour, he does not qualify for ESI. This family is caught in a bind: The father makes too much money for his daughter to qualify for full Medicaid benefits and only qualifies for reduced CHIP benefits (15%), but his income is insufficient to purchase a private non-group plan or to pay the balance uncovered by CHIP. This makes the tonsillectomy unaffordable, and his daughter suffers the consequences of ill health and frequently missing school.

However, not everyone described access problems or inferior medical treatment as a result of their public insurance status. Kelly (RWDSU) asserted, “It’s still the same—just that the medical card pays for everything. No matter what it was, prescriptions and all that good stuff, the medical card did [pay]. In the union, you have to pay for some of your services. That’s expected I guess, if you work. ”Two points are important in Kelly’s statement. First, she did not experience the negativity described by many other public insurance recipients, either regarding the attitudes of medical professionals or staff or in terms of proffered medical treatment. She also acknowledged that Medicaid paid for more services than her current ESI plan. While Kelly notes that “in the union” she has to pay for some of her medical services, this statement does not appear to be a negative perception of union membership. Rather, this reflects a community-wide understanding that if you work, you are expected to pay more for health care.

Significant in these examples from RWDSU families are concerns with paying for health care, even for those with ESI or public insurance. Meridian families reflect many insured working and middle-class families throughout the United States for whom cost remains a barrier to health care due to cost (Banthin et al. 2008; Schoen et al. 2008). As indicated by their experiences, simply being enrolled in an insurance program did not necessarily give them or their children access to medically appropriate health care. Problems with insurance exclusions (a type of underinsurance) create access barriers for many, especially children and pregnant women. Ironically, while some women and children have fewer benefits under some public plans than under some private ones (Lambrew 2007; Star 2011:156), other families must supplement private coverage with public forms of insurance to make necessary health care more affordable.

These examples lend perspective to the “metal” (bronze, silver, gold, and platinum) levels of insurance coverage offered through the ACA insurance exchanges. Even at their “platinum” level of coverage, some RWDSU families earning the median income in Meridian
(1.5 times the poverty rate) clearly had difficulty affording health care. Low-income families purchasing insurance on the exchanges must buy at least a silver plan (70% actuarial value) to gain limit protections on co-pay and deductibles. Silver plans, with premiums costing approximately $118/month, are more expensive than the current RWDSU plan and provide less coverage. This will place many low-income families in the “bronze trap,” where increased cost sharing (premiums, high co-pays, and deductibles) increase delayed and forgone care (Heilman 2013). This serves as a caution that policies that extend health insurance coverage without careful attention to both quality of coverage and overall affordability of care will only partially address health care disparities.

Anthropological analysis of neoliberal frameworks behind market-based medicine and policy reforms (e.g., Horton 2001; Morgen and Maskovsky 2003; Rylko-Bauer and Farmer 2002) reveal increased problems with access and affordability. This is demonstrated in examples of Medicaid managed care (MMC), where the extension of coverage to low-wage (working poor) individuals/families, such as Tennessee’s TennCare program, resulted in diminished benefits for those in the program (Kuttner 1999:167). New Mexico’s MMC program (Salud!), which emphasizes competition, efficiency, and individual choice, has been critiqued for increasing complexity and creating additional barriers to health care for already disadvantaged patients. Such actions include cutting prescription drug benefits, restricting eligibility, complicating application procedures, increasing co-payments, and reducing or delaying provider reimbursement, which, in turn, results in some providers reducing their Medicaid case-loads (Horton et al. 2001; Lamphere 2005; Lopez 2005; Rylko-Bauer and Farmer 2002).

Maskovsky argues that ideologies that promote choice for those on Medicaid and support policy shifts to a private consumer model also hide the negative effects for those relying on those programs (2000). By disguising the social and health care access costs of policy shifts behind moral hazard logic of efficiency and personal responsibility, the detrimental effects of neoliberal shifts that reduce the safety-net and transfer increased health costs to individuals (as with MMC and recent trends in ESI)are hidden from plain sight. The claims of MMC to provide low-cost and high-quality health care to the poor are similar to the claims that ACA will increase access and make health care affordable in that both are premised from plans to keep costs down and use the savings to pay for expanding coverage. Although Stone asserts that the ACA rejects moral hazard (2011:894), this abandonment is incomplete as evidenced by the proposed Cadillac tax as a means to pay for expanding health insurance coverage to the uninsured.

**USW “Cadillac” Coverage**

A striking theme in the interviews among the Steelworkers was their descriptions of their “good” health insurance, their “Cadillac” plan. But what exactly is meant by having good health insurance? As used by the Steelworkers, good health insurance allows first, the bearer access to their choice of health care by, second, assuring the health care provider that they will not only get paid but that they will receive a good rate for their services. Additionally, the good insurance may also reduce the amount or percentage of services to be paid by the patient (as with 100% coverage that the Steelworkers have, which is better than the platinum plans offered on the exchange), hence reducing the service provider’s billing expenses and the likelihood of nonpayment for services. This includes lower co-pays and deductibles, more extensive coverage, higher reimbursement rates for health services, and a higher (or no) lifetime expenditure limit.
This is well understood by people in the community, as they describe the “business” of health care.

For example, I routinely asked participants if they had any trouble (barriers) getting health care when they needed or wanted it. Answers from Steelworkers often included a mention of their health insurance card, such as one laughing reply of, “Not as long as you show that insurance card” (Lowell, USW). Other union members talked about their health insurance in similarly telling ways; they described their health insurance card as their pass to getting health care. Dean described it as “It’s like flashing a gold card. Oh, he’s got good insurance, we’ll take care of him; we really will” (Dean, USW). Steelworkers often imbued their health insurance cards with authority that signified their health care purchasing power. For Joan, the good health insurance she had was equated with having “unlimited freedom” (class privilege) to access health care (Joan, USW). Henry described the great lengths to which he relies on his insurance status to be assured a medical appointment.

If I have to go to somebody I always tell them my name and I tell them where I work and I tell them [name of health insurance company]—before they ask me anything. That’s just part of my hello to them and it kind of opens doors you know. …Yeah; and there’s probably some kind of law somewhere that says they can’t absolutely refuse somebody so I don’t even put them in the predicament or the position to have to guess whether I have good health care. I tell them. So that’s probably helped my chances; it hasn’t hurt anything. … I’ve always told them that; I just kind of thought it was a door opener, because they know that they’re going to get their money and might be a little more—little more ready to take care of me. So I just do that for selfish reasons. … I want them to see me. I want to give myself the best chance possible of them seeing me, or I wouldn’t be wasting my time. … I always tell them I have a good insurance, and in other words, you will get paid. Will you please see me? (Henry, USW)

Henry’s account is significant for several reasons. By assuring the provider that there will be no problems with payment for services, Henry actively works to reduce the chance he will be refused access to the health care system. By stating that he does not want the provider to have to guess if he has “good healthcare,” he conflates good healthcare with “good health insurance,” where his insurance status and quality entitle him to their services. Implicit in his statement is an understanding that without his good insurance he might be turned away.

Even with good health insurance, there are limits to accessing health care, and some acknowledge that even a well-insured patient may not get the best health care possible. This is clearly understood by Quentin (USW), as he explained health care in terms of the larger American economic system:

Well it may not be the best [health care] there is, but it’s as good as a working person could afford. I’m not Rockefeller; you know Rockefeller is going to get the best you know. When you make a quarter of a million dollars a day, every day, seven days a week, you can afford the best. But see like I said, we have a limit on our [insurance]. He don’t have a limit on his. That’s your difference between a working person and a rich person. A working person eats when he can; the rich person eats when he wants to. As long as you understand, you know, the economics of the United States of America you can pretty well
understand why this is done this way and why that is done this way. It’s who, you know—the haves and the have-nots. (Quentin, USW)

While health insurance benefit packages buffer the costs and increase the likelihood of accessing health care services for most people, Quentin implies that there are differential levels of health care, with access to better health care being related to health insurance status. Quentin’s words provide a political–economic understanding that health care is a business, an industry, and access to it may be limited and tenuous, depending on one’s combination of employment, health insurance benefits, and personal wealth. In this manner, the ability to access and utilize health care services cannot be fully separated from income and wages.

Although the judgmental gaze of moral hazard almost exclusively pinions health care waste on the insured patient for “overusing” health care, this unfairly represents how health care delivery and treatment decisions are made (Stone 2011:893). For example, trepidation about unnecessary medical testing and visits was expressed by two USW members in the following manner:

And sometimes it’s even been a problem for people to have insurance that good. Well, I’m going to get you in here and I’m going to do every test—this hasn’t happened to me—but I’m going to do every test I can do to get money. (Joan, USW)

No; when you work at the steel mill and you got [insurance company name], they don’t mind getting you in because they know they’re going to get big bucks. Yeah, when you got good insurance, they don’t hesitate because they know they’re going to get paid. … They’re in the business [to] make you well or halfway make you well and continue on having you come back. And every time you go through the door it’s $75 bucks. (Matt, USW)

As related in Joan’s statement, she sees the possibility that because she has good health insurance that doctors will order unnecessary testing or procedures simply because they are covered by the health insurance and are “easy money.” However, Joan also offered that unnecessary treatment may be reduced by the patient’s willingness to speak up and ask questions. Matt draws attention to the routine need for follow-up appointments and referrals that are endemic of the fee-for-service system. Both of these participants are suspicious of doctors’ motivations (or the structure of the health care system) and make clear the double-edged sword of having good health insurance. Importantly, this is also an indictment on a missing aspect of the moral hazard debate: the moral hazard of physician’s and health care system’s financial motivations (Baker 1996:283). Drawing from the Dartmouth studies of geographic variations on health care expenditures, Stone points out that doctors, not patients, determine the type and duration of care necessary (2011:891). This includes decisions on diagnostic testing, medications, therapy, hospitalization, and referrals.

Although most medical expenses are tied to doctors’ decisions regarding medical treatment, policy and cost-sharing disincentives discourage health care utilization by individuals at the initial point of health care service (Stone 2011:892). Savvy patients may question or refuse specific proffered services, despite insurance coverage. However, it is difficult for a sick patient to judge whether a referral for an MRI or other expensive diagnostic test is necessary or is related to the “culture of money” (Gwande 2009:41), a conflict of interest where physicians are
more likely to order imaging testing when they have a financial stake in the imaging services (see Appleby 2008; Rodwin 1993; Sirovich et al. 2008). Ultimately, cost disincentives do not account for the power structure and knowledge differential of the doctor–patient relationship and do not distinguish between “necessary” and “unnecessary” care (Doran and Robertson 2009:235).

**Falling Off the Cliff: The Cadillac Tax and Underinsurance**

Responses to health care reform from organized labor have been overwhelmingly positive. On a national scale, the RWDSU encouraged their members to contact their representatives about passing the ACA (RWDSU 2009). The USW remains engaged with the reform efforts, updating their website with news and press releases regarding the ACA. For example, the USW promises that “Our union will fight for three principles of health care: universal coverage, cost control, and comprehensive coverage” (USW 2012). The USW also touts the importance of the ACA for members, including extending coverage for vulnerable populations, such as young adults and children, as well as the end to rescinding coverage, lifetime maximums, pre-existing condition exclusions, an end to gender bias in insurance rates, free preventive services, and access to affordable coverage in the event of job loss (USW 2010, n.d.a, n.d.b).

However, the Cadillac tax does not get union support (Norman 2009). A particular concern in the health reform debates relevant to many union workers is the excise tax, popularly known as the Cadillac tax, on high-cost ESI health plans. While a tax exemption loophole exists for all ESI premiums, only the most high-cost plans (the Cadillacs) are currently targeted for taxation to begin in 2018. The purpose of this tax is twofold. First, it discourages the offering and uptake of high-cost plans by making them less affordable for businesses and workers (Lee 2011:584) as they are blamed for much of the rise in health care costs in the form of moral hazard (Leonhardt 2009). Second, the tax also provides an important source of income to help cover the costs of expanding insurance coverage to the uninsured. This revenue is possible, even if fewer high-cost plans are offered, because this tax is tied to general consumer inflation plus 1%, so as health insurance premium rates increase faster than the general inflation rate, more insurance plans will be subject to the tax (Lee 2011:583).

Steelworkers in Meridian described their good insurance as an earned and chosen benefit, because they have bargained for it in lieu of higher wages and other benefits. Because the purpose of the Cadillac tax is to reduce the offering and uptake of high-cost plans, less-comprehensive coverage plans may be chosen to reduce premium costs (Gruber 2010; Herbert 2009). As the tax would shift a greater portion of health care costs onto families, eventually taxing the “Chevys” as well as the “Cadillacs” (Abelson 2009), it conflates high-cost and high-value plans (Bivens and Gould 2009:4–6; Gabel et al. 2010). Ultimately, what the Cadillac tax does is reduce the number of people with high-cost health insurance. However, the tax does not distinguish between plans that are high cost because they are benefit generous and those that are high-cost because they have “sicker, older enrollees” (Oberlander 2011:480).

The potential that cost shifting and insurance plans with lower actuarial values will lead to increasing levels of underinsurance and medical financial burden is quite real, as some companies are already reducing the generosity of health plans offered to remain below the excise tax threshold (Abelson 2013). This is further supported by hospital rates of bad debt, which are rising faster among the insured than the uninsured in some hospitals (Pellathy and Singhal 2010), and the fact that half of all bankruptcies are attributed to medical debt (Kinney 2010:413).
Lee states that “Market-based insurance is not designed to help people buy things they could otherwise not afford; it is meant to make their finances predictable” (2011:576; emphasis in the original). For many families in Meridian, because health care needs and costs are not always readily predictable or affordable regardless of insurance status, the importance of good insurance is allowing access to affordable care without having to forgo other basic necessities or to incur insurmountable debt. Union membership appears to provide greater levels of control over access to health care for certain wage earners and their dependents than experienced by many (but not all) non-union workers. As seen here, union strength and company size also affect collective bargaining ability regarding ESI, as the clout of the USW and the size of the steel corporation make more generous ESI possible for workers.

As the USW examples detail the benefits of having good health insurance as related to ease of access to health care and affordability, other examples from the RWDSU of access difficulties offer a counter-balance that is, unfortunately, increasingly representing the norm in the United States. While RWSU members have above-average insurance coverage, their descriptions of affordability of health care exemplify the problems in accessing health care for increasing numbers of insured working and middle-class families. The comparison between the experiences of RWDSU and USW families shows clearly that it is the ability to obtain the medical “procedures that are too expensive to afford without insurance” (Nyman 1999:823) that makes good health insurance not only valuable but necessary. This counters broader ideological and economic arguments that blame “overly generous benefits” and personal (patient) irresponsibility for the high cost of health care and as excessive burdens for corporations, as evidenced in the debates over the auto industry bailouts (see Feulner 2012).

Of great concern with the ACA and the Cadillac tax is the potential to undermine good health insurance, thus increasing rates of chronic underinsurance. The ACA sets the minimum standard of coverage at 60% actuarial value, well below the coverage level many families with ESI currently have. A realistic worry is that this bar for health insurance coverage is too low and may lead to increased levels of underinsurance (Schoen 2005, 2008). For example, actuarial values of ESI plans are almost always above 80% (Gabel et al. 2006), so if families, such as those among the RWDSU, making median wages with health insurance coverage well above minimum 60% actuarial value, are having difficulty affording health care, then the ACA runs the risk of leaving more families underinsured. Given the problems of cost sharing and underinsurance, Cadillac tax disincentives intended to reduce the offering and uptake of high-cost plans in the name of cost effectiveness may undermine access to health care for some families.

Using moral hazard as the argument for ultimately reducing the offering of good health insurance places the responsibility of unnecessary treatment on the shoulders of individuals at the moment they feel they need health care and asking them to self-ration. This seems highly ironic considering the onslaught of advertisements through various media outlets encouraging listeners to “ask your doctor if this pill or treatment is right for you.” It is also unlikely to control costs (Gusmano 2011; Oberlander 2011), a primary incentive for the measures in the first place. Baker attributes this one-sided view to the problem of equating insurance and redistribution, resulting in an unfair focus on moral hazard and too little focus on the indirect social benefits (e.g., disease control, increased productivity) that Zeckhauser (1973) called “positive externalities” (Baker 1996:283, 289; Nyman 2004).

It is with this understanding that this article argues that the ACA appears to take for granted that having health insurance grants access to health care, and it does not account for
disparities in health care access and affordability among the insured. While health insurance is a vital first step, attention must be paid to quality of insurance (benefit coverage, actuarial value), out-of-pocket costs, reimbursement rates to health care providers, and cultural factors (stereotyping, gender, racial, and class inequalities) if the ACA is to effectively address health disparities, avoid reducing health care accessibility for the insured, and not compete with other necessities. The Cadillac tax, based in moral hazard, has the potential to undermine the availability and affordability of good insurance and may increase rates of underinsurance and medical financial burden for working and middle-class families.

Future ethnographic unpacking of the language of “unnecessary” and “overuse” of health care (patient-centered focus) from “overtreatment” (Brownlee 2007) (physician- and health-system focus) is needed. At the very least, eliminating one-sided discussions of moral hazard (if not the concept itself) or acknowledging that welfare gains from the income transfers (insurance payouts) may outweigh moral hazard losses (Nyman 1999:822–823) would permit a more holistic analysis of the various social and economic costs and consequences (lived realities) of health policy. This is in keeping with the notions of “informed critique of policy” (Singer and Castro 2004:xiii) and the “anthropology of policy” (Van Willigen 1986), where critical medical anthropology can situate shifting patterns in resource (health insurance) distribution as well as the intended and unintended consequences of policy implementation.

Notes

Acknowledgments. This research was supported by the National Science Foundation Doctoral Improvement Grant [PI, Mary K. Anglin; Co-PI, Rebecca Adkins Fletcher, #0646390] and the James S. Brown Graduate Student Award for Research on Appalachia, University of Kentucky. An earlier version of this article was presented at the Tobin Workshop: Behavioral/Institutional Research and Regulation of the New Health Insurance Market, Cornell Law School, April 28–29, 2011.

The author thanks Jessica Mulligan, Amy Dao, Lance Gravlee and the anonymous MAQ reviewers, and Alyson O’Daniel for their insightful comments and suggestions.

1. Actuarial value is understood as “The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, you would be responsible for 30% of the costs of all covered benefits” (Healthcare.gov n.d.).
2. RWDSU insurance is fully-insured funding, where the employer shifts the entire risk to the insurer. USW insurance is self-insured funding, where the employer pays the insurer only for administrative functions and retains full responsibility for paying claims.
3. At the time of the interviews in 2007, the part-time workers at the food-processing plant did not qualify for ESI, and the ESI information presented here is for full-time workers in the RWDSU only. The RWDSU organized the part-time workers in 2005, bringing them into the union, earning them access to the union’s grievance and seniority system and a 50% wage increase in contract bargaining. In the 2008 contract negotiations (after interviews were complete), the union bargained for (and won) ESI for part-time union workers in the contract.
4. This is a 40% excise tax on insurance benefit premium values above $10,200 for single or $27,500 for family coverage ESI plans (Oberlander 2011:480). At present, the USW insurance plan cost is just below the threshold for the excise tax.
References Cited

Abelson, R.


AFL-CIO


Appleby, J.


Arrow, K. J.


Baker, T.


Banthin, J. S., P. Cunningham, and D. M. Bernard


Bartlett, D., III


Bashshur, R., D. G. Smith, and R. A Stiles


Bivens, J., and E. Gould


Boushey, H.


Brownlee, S.


Davis, K.


Derickson, A
Doran, E., and J. Robertson
   2009 Australia’s Pharmaceutical Cost Sharing Policy: Reducing Waste or Affordability?
Farley, P.
   1985 Who Are the Underinsured? Millbank Memorial Fund Quarterly—Health and Society
   63:476-503.
Feulner, E.
   2012 President Interfering with GM and Chrysler Saved United Auto Workers. The
   union-bailout/print/ (accessed June 1, 2012).
   2006 Generosity and Adjusted Premiums in Job-based Insurance: Hawaii Is up, Wyoming Is
Gabel, J., R. McDevitt, R. Lore, J. Pickreign, H. Whitmore, and T. Ding
   Health Affairs 28:w595–w606.
Gabel, J., J. Pickering, R. McDevitt, and T. Briggs
Geronimus, A. T.
   2000 To Mitigate, Resist, or Undo: Addressing Structural Influences on the Health of Urban
Gladwell, M.
   2005 The Moral Hazard Myth: The Bad Idea behind Our Failed Health-care System. The
   (accessed November 24, 2012).
Glied, S., and P. Borzi
   2004 The Current State of Employment-based Health Coverage. Journal of Law, Medicine,
   and Ethics 32:404–409.
Gottschalk, M.
Gruber, J.
   362:2050–2051.
Gusmano, M. K.
   2011 Do We Really Want to Control Health Care Spending? Journal of Health Politics,
Gwande, A.
   2009 The Cost Conundrum: What a Texas Town Can Teach Us about Health Care. New
   Yorker, June 1, 36–44.
Healthcare.gov
Heilman, K. M.

Heimer, C. A.

Herbert, B.

Hoffman, B.

Horton, S. J. McCloskey, C. Todd, and M. Henriksen

Hyman, D. A.

Kinney, E. D.

Kuttner, R.

Lambrew, J. M.

Lamphere, L.
2005 Providers and Staff Respond to Medicaid Managed Care: The Unintended Consequences of Reform in New Mexico. Medical Anthropology Quarterly 19:3–25.

Lee, H. J., W.-H. Tian, and A. Tomohara

Lee, M.

Leonhardt, D.

Lopez, L.

Mariner, W. K.

Maskovsky, J.

Merlis, M.

Morgen, S., and J. Maskovsky

Norman, J.

Nyman, J. A.

Oberlander, J.

Pauly, M. V.

Pellathy, T., and S. Singhal

Retail, Wholesale and Department Store Union (RWDSU)

Rodwin, M.

Rowland, D., C. Hoffman, and M. McGinn-Shapiro

Rylko-Bauer, B., and P. Farmer
2005 Insured but Not Protected: How Many Adult Are Underinsured. Health Affairs web 
exclusive (June):w5289–w5302 (accessed June 1, 2012).
Schoen, C., S. R. Collins, J. L. Kriss, and M. M. Doty 
Affairs27:w298–w309.
Shearer, G. 
(accessed July 30, 2012).
Short, P., and J. Banthin 
1995 New Estimates of the Underinsured Younger than 65 Years. The Journal of the 
American Medical Association 274:244–255.
Singer, M., and A. Castro 
xi–xx. Walnut Creek, CA: AltaMira.
Sirovich, B., P. M. Gallagher, D. E. Wennberg, and E. S. Fisher 
2008 Discretionary Decision Making by Primary Care Physicians and the Cost of U.S. Health 
Care. Health Affairs 27:813–823.
Star, P. 
2011 Remedy and Reaction: The Peculiar American Struggle over Health Care Reform. New 
Haven: Yale University Press.
Stone, D. 
896.
Swartz, K. 
2006 Reinsuring Health: Why More Middle-Class People Are Uninsured and What 
Thomasson, M. A. 
United Steelworkers (USW) 
2010 USW Applauds Historic Steps for Health Care Reform. 
n.d.a What Health Care Reform Means to Us. 
n.d.b The Affordable Care Act: Important Information about Health Care Reform and Health 
Van Willigen, J. 
Woolhandler, S., and D. U. Himmelstein 
2007 Consumer Driven Healthcare: Except for the Healthy and Wealthy It’s Unwise. Journal
Zeckhauser, R. J.