

MANDATES AND THE AFFORDABILITY OF HEALTH CARE

Health care reform debates invariably confront the challenge of determining who can afford to buy insurance. Proposals to mandate coverage must determine who will be exempt, and proposals for subsidies must specify who is eligible. In either case, policymakers must make difficult decisions about how to define affordability.

A new essay by economist Sherry Glied of Columbia University discusses the historical and economic context for these decisions. Glied notes that while most people have some working notion of what it means to be able to afford an item, there is no standard economic definition of affordability that can be readily operationalized for policy purposes. She discusses the concept of affordability as it has been used in debates over policy toward publicly supported housing and food, then lays out the ways in which health care is different. Key points of her discussion include:

- Many public and private subsidy programs, including income support and food stamps, rely on the federal poverty threshold as a criterion for eligibility. The federal poverty threshold originated in the 1950s as a food affordability measure, classifying households as living in poverty if the household income was less than three times the cost of purchasing a minimally adequate food bundle. Today's poverty threshold is an inflation-adjusted version of the original measure.
- In the context of housing policy, the U.S. Department of Housing and Urban Development (HUD) considers housing affordable if spending on housing accounts for no more than 30 percent of a household's income, with adjustments for family size and local housing prices.
- Establishing affordability guidelines for health insurance policymaking is different from food or housing. Few people voluntarily forego purchasing food or housing – households that can afford them buy them, at varying quantities and prices. A significant fraction of the uninsured, however, could purchase health insurance based on a number of different definitions of affordability. This lack of purchase may, to some extent, be due to imperfections in the market for health insurance that do not affect markets for food or housing.

Most of the reforms under discussion at the national level include some provision for income-based subsidies to help families pay for insurance (whether or not these subsidies are accompanied by a mandate). As Glied notes, the poverty level is subject to a number of criticisms, including the fact that it has not been updated to reflect the declining share of the average family's budget devoted to food.* Glied discusses ways to improve the affordability standard for health care, suggesting ways to vary the threshold both over time and according to the content of coverage. She concludes with describing the implications of such a standard for proposals to expand coverage through mandates and subsidies.

* In an interview with ERIU, economist Rebecca Blank discusses some of the other critiques of the poverty level (<http://eriu.sph.umich.edu/forthemedia/conversations.html#blank>); in particular, the fact that only some kinds of income are taken into account and some expenses – including medical care – are not considered deductible.

