Editor's Note

Affordable for Whom?

In March 2011 the American public made it through another budget negotiation just in the nick of time without losing the basic function of its federal government. We're safe, but no one feels safe. Entitlements are boldly on the table for scraping and cutting. Given that the political pillars of the American welfare state are these middle-class entitlements (Medicare and, I would argue, Medicaid as well), this does indeed seem like a bold, though perhaps foolhardy, political move. On the other hand, the boldest political move today would be to attack economic inequality — which is at its most extreme level in history, even worse than during the Gilded Age (Krugman, 2007), and still growing — and there doesn't appear to be a soul in Congress willing to put the issue on the table, even for discussion.

It is difficult to confront the issue of affordable health care under the Patient Protection and Affordable Care Act (ACA) without addressing inequality. Yet we focus on the poor and in a microcosm attempt to consider what is fair and affordable. The first article in this issue, by Brendan Saloner and Norman Daniels, points out how the structure of the ACA forces us to consider whether and at what levels health care is affordable for *individuals*. Other countries that do not rely on individual purchasing to achieve universalism ask the question in a dramatically different way — what can we as a society *collectively* afford?

When you ask the latter question, it forces you to think about fairness in contributions across the income distribution. The typical response to this

Journal of Health Politics, Policy and Law, Vol. 36, No. 5, October 2011
DOI 10.1215/03616878-1407622

question is a progressively rated financing structure, where the wealthy will pay a higher proportion of their income than those lower down on the income distribution. We do a version of this under Social Security, where benefits are progressively distributed according to income (although the financing is based on a regressive flat tax). The key point here is that when we structure entitlement programs we naturally and appropriately consider what a fair distribution of burdens and benefits would look like across society.

An age-old conundrum for means-tested, targeted programs is that when we consider what is fair for the target group, there is always concern about those people just above or below the cutoff. For example, under the ACA subsidies for the purchase of health insurance are available to households earning up to 400 percent of the federal poverty level (FPL). Inevitably, we will find some individuals earning 375 percent of the FPL — but who own assets worth much more if they were taken into account — who receive a subsidy while others earning 425 percent of the FPL but have no assets receive no help. Many people comparing the circumstances of these two households may claim that the latter is more deserving than the former and feel disgusted by a perceived unfairness. This is the conundrum as it plays out on the ground. Saloner and Daniels offer ethical principles for how we might develop fair and affordable health insurance when trying to set up the mechanisms for this individual-purchasing playground (i.e., health insurance exchanges). They offer important suggestions not only for thinking about earnings but also for considering out-of-pocket costs in determining adequate subsidies.

The irony of creating universal access to health insurance with a progressive financing structure (see Tom Rice's essay in *JHPPL* 36.3) by relying on an individual mandate is that it raises these age-old, means-testing-like questions about deservedness. When we are forced to think about affordable insurance premiums for low-income individuals, we naturally ask: What percent of income should people devote to health insurance? What level of income warrants a full subsidy? How generous should a partial subsidy be? Should it guarantee that families never pay more than 5 percent of their income on health insurance? Seven percent? Nine percent? Should this percentage increase as income rises? These are exactly the questions that arose when Peter Muennig and his colleagues asked experts to provide a set of standards for affordability. The most important finding to emerge from this study is that, while experts can offer useful data on premium costs and how costs vary by different benefit structures, the basic question about affordability is inherently value laden.

For example, if a family earning 400 percent of the FPL just bought a new house and the mortage is high relative to earnings, which means that when mortgage payments are combined with all other expenses the family has no money left over to pay health insurance premiums, is the mandated premium unaffordable for this family? Should such families receive an exemption from the mandate, or a "mortgage income disregard," because as a society we want to encourage home ownership? Or did they make some bad choices, meaning that they must reprioritize expenses and pay the monthly premium for health insurance? These are the types of discussions that took place among experts asked to determine standards. Following the article by Muennig and colleagues, one of the study's participating experts, Kathy Swartz, provides a perceptive reflection on how difficult this process was.

Given that health policy experts have no special expertise to offer in the domain of value-based judgments, it is natural in a democracy to ask: what do the people think? Fay Lomax Cook asks exactly that question in her essay and offers practical suggestions for developing public deliberative forums to assess how the American people want to approach the pressing question of affordability.

With all these ideas in mind and the permission of the authors, I used an earlier draft of the Muennig et al. article for a very generative discussion in my health policy class. I also based an assignment on the article. Similar to the questions Muennig and his colleagues pose to experts, each student was asked to interview a person he or she believed to be the most appropriate to answer questions about affordable health insurance. The students wrote two-page summary essays based on their interviews. Each essay contained three parts: (1) an argument advocating why the particular person was important to interview; (2) a summary of the interviewee's perspective; and (3) a reflection on affordability. I learned a lot from reading these essays. I did not systematically analyze the interviews for this editorial note, but a few thoughts stuck with me. First, most of my students interviewed either low- to moderate-income people who had purchased health insurance in the private market (i.e., those who did not have access to employer-based health insurance) or professionals who worked extensively with low- to moderate-income families. These students argued that it was helpful to hear directly from people who have made or are currently making these purchasing decisions. Second, almost all the respondents quickly pointed out that the other side of the affordability coin is the high cost of health care. Many had difficulty discussing individual obligations to pay without crying out for something to be done about the

costs. Third, even self-described conservatives saw the need to provide subsidies because, otherwise, "good people" would continue to struggle. I posted the summaries online (see www.ssa.uchicago.edu/faculty/cgrogan.shtml). Read them for yourself. And here's an idea: if you teach a health policy course, include this assignment and post it online to this Web site. We could create a nationwide database on how individuals think about affordable health insurance in the beginning of the twenty-first century. I welcome your thoughts about this.

If the ACA is to achieve one of its primary objectives — providing affordable health insurance to all American citizens — then these questions must be answered with utmost importance and care. Through the process of setting subsidies for purchasing public insurance through Children's Health Insurance Programs (CHIP), many states already have experience answering such questions. The article by Carole Gresenz and colleagues reviews the experiences and process of setting subsidies in three states — Illinois, Pennsylvania, and Washington. They uncover some of the factors states considered in setting subsidies and also show the implications of these policy decisions. In particular, they report for each state the average percent of income families spent on premiums according to different subsidy levels. This is important information because it shows actual affordability levels in the states as well as how these levels compare with expectations under the ACA. There are many important takeaway points, but let me highlight two. First, the data illustrate the conundrum in action. Because Pennsylvania provides a progressively rated subsidy up to 300 percent of the FPL, there is a significant jump in the percent of income devoted to paying for health insurance for the group just above 300 percent of the FPL. Then, because there is no subsidy above 300 percent, the percent of family income devoted to premiums is regressive — it decreases as family income increases (see Gresenz et al. table 5). Second, the data illustrate how comparisons across the income distribution are important even when deciding on the income levels for a low-income target group. It forces us to ask, as Kathy Swartz does in her reflection, is it fair for the ACA to specify that families with incomes at 400 percent of the poverty level pay at least 9.5 percent of their income on premiums, when upper-income Americans devote less than 2 percent of their incomes to coverage?

New Special Section: Behind the Jargon

In this issue, we introduce the first "Behind the Jargon" special section. The idea of this section is to deconstruct a term used in popular discourse, to reveal its political uses. It is especially fitting that Deborah Stone will start us off with the first essay. In discussing this idea with her and seeking her advice (yet again!) it was she who encouraged the idea and—in her characteristically clever way—came up with the title for the section. She writes about the term "moral hazard" and its power over the framing of health policy problems and solutions in the United States. It's a must-read—even if you wholeheartedly believe that moral hazard is a problem!

On Logistics

Some of you might have noticed that this issue is a "themed issue." We are using this term for issues in which we've organized unsolicited peer-reviewed articles around a common theme. We'll thus be using "special issue" to signify a set of mainly solicited (and often peer-reviewed) articles, whereas themed issues will be made up largely of unsolicited articles independently submitted to *JHPPL*. In this issue, the two main research articles by Muennig et al. and by Gresenz et al. were original unsolicited submissions, whereas the essays by Saloner and Daniels, Swartz, and Lomax Cook were solicited to fill out the issue on this theme of affordability.

There are a few points about *JHPPL* I want to drum home (for those reading editorial notes, you will notice this repeated drumming). First, we welcome input and feedback and ideas. If you have questions about or ideas for submissions, please contact me, the associate editors, or the respective special-section editors. Second, it is important to be responsive to authors. We are working hard to keep the editorial turn-around time competitive and efficient. Please let us know how we are doing—good and bad.

Colleen M. Grogan

Reference

Krugman, P. 2007. Gilded Once More. Editorial. *New York Times*, April 27.