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Defining Health Affordability

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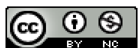
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Defining Health Affordability

Govind Persad[*]

ABSTRACT: Affordable health care, insurance, and prescription drugs are priorities for the public and for policymakers. Yet the lack of a consensus definition of health affordability is increasingly recognized as a roadblock to health reform efforts. This Article explains how and why American health law invokes health affordability and attempts, or fails, to define the concept. It then evaluates potential affordability definitions and proposes strategies for defining affordability more clearly and consistently in health law.

Part I examines the role health affordability plays in American health policy, in part by contrasting the United States's health system with systems elsewhere. Part II then reviews and categorizes approaches to affordability in American health law. It highlights how conceptions of affordability are woven into the Affordable Care Act's premium assistance tax credits for marketplace buyers and how the American Rescue Plan and Inflation Reduction Act have implicitly shifted the definition of affordability. It also discusses how rulemaking around the "affordability guardrail" for state waivers of ACA provisions has prompted contestation between presidential administrations over the place of health equity and racial justice. After discussing these federal provisions, it identifies the role of affordability definitions in recent state-level innovations, such as affordability standards for health insurance and pharmaceutical affordability boards.

The latter two Parts situate these legal enactments within a cohesive framework and make recommendations. Part III categorizes existing or proposed definitions of health affordability according to their normative commitments, drawing on sociological and philosophical scholarship. Part IV then evaluates potential

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approaches to defining affordability. Options include continuing to leave affordability undefined, rejecting affordability as a cornerstone of health law, or replacing affordability with some of its constituent concepts. Rather than these alternatives, I propose a hybrid definition that combines different definitions discussed in Part III. It proposes that health spending is affordable if it delivers value for money without worsening access to basic needs or a reasonable opportunity range.

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INTRODUCTION

On January 2, 1918, George Chandler was bitten by a dog on his way to work. When his doctor recommended antirabies serum, Chandler balked: "[H]e could not afford the expense."[1] He was dead not long afterward.[2]

America's health system has changed enormously since 1918. But the affordability barriers that killed George Chandler persist. Before the Affordable Care Act ("ACA"), experts estimated that health care unaffordability caused forty-five thousand premature deaths yearly.[3] Even after the ACA's passage, Americans continue to see health care as unaffordable. Just under half of respondents to a 2022 survey said health care was "very or somewhat difficult for them to afford."[4] Another survey reported that a quarter of adults who take prescription drugs struggle to afford them.[5] And insurance itself often appears unaffordable. A third of adults purchasing health insurance through the ACA's marketplaces reported difficulty affording insurance premiums, as did over one-sixth with employer-based insurance.[6]

In an effort to address these challenges, federal, state, and local affordability initiatives have continued and even accelerated over the past decade. The Inflation Reduction Act's provisions that lower out-of-pocket pharmaceutical costs for Medicare beneficiaries have been pitched as realizing affordability,[7] as has the American Rescue Plan Act's expansion of health insurance subsidies.[8] Meanwhile, exploiting their ability to move more quickly than a gridlocked Congress, states have also pursued affordability innovation. Prescription drug

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1. Chandler v. Indus. Comm'n of Utah, 208 P. 499, 500 (Utah 1922).

2. *Id.* at 499.

3. Texas v. United States, 945 F.3d 355, 417 (5th Cir. 2019) (King, J., dissenting) ("America's uninsured population could not afford spiraling healthcare costs, thus exacerbating health problems, leading to an estimated 45,000 premature deaths annually . . . ." (citing Andrew P. Wilper et al., *Health Insurance and Mortality in US Adults*, 99 AM. J. PUB. HEALTH 2289, 2292 (2009))), *rev'd on other grounds*, 141 S. Ct. 2104 (2021).

4. Alex Montero, Audrey Kearney, Liz Hamel & Mollyann Brodie, *Americans' Challenges with Health Care Costs*, KFF (July 14, 2022), https://www.kff.org/health-costs/issue-brief/americans-challenges-with-health-care-costs [https://perma.cc/F62N-P886].

5. *Id.*

6. Jennifer Tolbert & Katherine Young, *Paying for Health Coverage: The Challenge of Affording Health Insurance Among Marketplace Enrollees*, KFF (Apr. 7, 2016), https://www.kff.org/health-reform/issue-brief/paying-for-health-coverage-the-challenge-of-affording-health-insurance-among-marketplace-enrollees [https://perma.cc/ZK3S-AYWD].

7. *The Inflation Reduction Act Lowers Health Care Costs for Millions of Americans*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Oct. 5, 2022), https://www.cms.gov/newsroom/fact-sheets/inflation-reduction-act-lowers-health-care-costs-millions-americans [https://perma.cc/B5MB-YDYS] ("[The Inflation Reduction Act] makes health care more accessible, equitable, and affordable by lowering what Medicare spends for prescription drugs and limiting increases in prices.").

8. *American Rescue Plan and the Marketplace*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 12, 2021), https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace [https://perma.cc/QQY9-8Q8L] ("ARP makes major improvements in access to and affordability of health coverage through the Marketplace by increasing eligibility for financial assistance to help pay for Marketplace coverage.").

affordability boards, which identify and implement strategies for stemming drug costs, have been created in seven states and proposed in eleven more.[9] Health insurance affordability standards have been enacted in three states and considered in more.[10] Highlighting the connection between improving affordability and addressing racial health inequities, the National Association for the Advancement of Colored People ("NAACP") has adopted a resolution "support[ing] the creation of a Prescription Drug Affordability Board in each state."[11]

These proposals to improve health affordability all leave something undefined: affordability itself. Although affordability is often invoked, it is seldom defined—and offered definitions are seldom defended.[12] When definitions are adopted, there is little consistency across programs.[13] Surveys reporting health affordability challenges likewise only ask respondents whether affordability—left undefined—presented problems for them.[14] The United Nations's General Comment on the right to health also declines to define affordability,[15] as does much excellent scholarship on health affordability.[16]

9. Bobby Clark & Marlene Sneha Puthiyath, *Can State Prescription Drug Affordability Boards Address High-Cost Drug Prices?*, COMMONWEALTH FUND (Oct. 11, 2022), https://www.commonwealthfund.org/blog/2022/can-state-prescription-drug-affordability-boards-address-high-cost-drug-prices [https://perma.cc/E7SW-QXJC] ("Currently, six states (Colorado, Maine, New Hampshire, Ohio, Oregon, and Washington) have followed Maryland and enacted laws establishing PDABs. According to the National Academy for State Health Policy, a number of other states (Arizona, Connecticut, Illinois, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, Pennsylvania, Rhode Island, and Virginia) have introduced legislation that is currently pending.").

10. *Provider Rate Regulation: Affordability Standards—Implementation Map*, SOURCE ON HEALTHCARE PRICE & COMPETITION, https://sourceonhealthcare.org/provider-rate-regulation/affordability-standards [https://perma.cc/63A8-9VFG].

11. *Resolution: Prescription Drug Affordability*, NAACP (2019), https://naacp.org/resources/prescription-drug-affordability [https://perma.cc/K3ZU-XZ3L].

12. *Cf.* PENN LEONARD DAVIS INST. OF HEALTH ECONS. & U.S. OF CARE, WHAT IS "AFFORDABLE" HEALTH CARE?: A REVIEW OF CONCEPTS TO GUIDE POLICYMAKERS 1 (2018) ("There is near unanimity on the goal of affordable health care, but little agreement on how to define and measure affordability, much less how to operationalize a definition into workable policy.").

13. *See infra* Section II.

14. *See infra* Section III.A.1.

15. U.N., Off. of the High Comm'r for Hum. Rts., Comm. on Econ., Soc. & Cultural Rts., General Comment 14: The Right to the Highest Attainable Standard of Health, ¶ 12, U.N. Doc. E/C.12/2000/4 (Aug. 11, 2000) (asserting that "health facilities, goods and services must be affordable for all," but not defining affordability).

16. *E.g.*, Jaime S. King, Katherine L. Gudiksen & Erin C. Fuse Brown, *Are State Public Option Health Plans Worth It?*, 59 HARV. J. ON LEGIS. 145, 212 (2022) (arguing that "[t]he most common goal of all public option proposals is to improve the affordability of health care coverage for individuals, employers, and the state," but not defining affordability); Michelle M. Mello, Trish Riley & Rachel E. Sachs, *The Role of State Attorneys General in Improving Prescription Drug Affordability*, 95 S. CAL. L. REV. 595, 597 (2022) (explaining that "[p]rescription drug affordability has risen to the very top of the policy agenda for lawmakers and the public," but not defining the concept); Timothy Stoltzfus Jost & Harold A. Pollack, *Making Health Care Truly Affordable After Health Care Reform*, 44 J.L. MED. & ETHICS 546, 546 (2016) (stating that "[t]he most immediate health care problem faced by most Americans is affordability," but not defining affordability).

The lack of a consensus definition of health affordability has hampered health reform. The prominent health economists Kate Bundorf and Mark Pauly argue that "without an acceptable working definition, it is not possible either to assess the extent to which the affordability of health insurance is a barrier to obtaining coverage for the uninsured or to choose among alternatives for dealing with the problem of the uninsured."[17] Advocacy organizations similarly contend that "the absence of an agreed upon and standard definition of affordability . . . makes creating equitable solutions to accessing health care difficult to operationalize,"[18] and that "[c]reating healthcare affordability standards may seem like an inherently subjective exercise—what seems affordable to some may not seem affordable to others of similar means—but evidence and experts suggest that it is both possible and useful to explore this question."[19]

This Article explains how and why American health law invokes health affordability and how it strives, or fails, to define affordability. It then evaluates potential affordability definitions and proposes strategies for defining affordability more clearly and consistently. Taking a cross-disciplinary approach, this Article draws on prior efforts by health economists, lawyers, and policy experts. But while this Article builds on prior research inside and outside of law, it is novel: No work of legal scholarship has yet attempted to define health affordability, nor examined recent affordability efforts—like prescription drug affordability boards or affordability standards—in depth.

Part I examines affordability's role in American health policy, in part by contrasting the United States's health system with health systems elsewhere. Part II describes current approaches to health affordability by reviewing and categorizing approaches to affordability in American health law. Part III then categorizes existing or proposed definitions of health affordability according to their normative goals. Section III.A examines *descriptive* definitions of affordability, which base affordability on what people say is affordable or what purchasing choices they make. Section III.B turns to *tradeoff* definitions of affordability, under which something is affordable if obtaining it does not involve unacceptable tradeoffs. Unacceptable tradeoffs can be defined, variously, as tradeoffs that jeopardize basic needs; that do not leave open a reasonable range of opportunities; that jeopardize the household's accustomed lifestyle;

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17. M. Kate Bundorf & Mark V. Pauly, *Is Health Insurance Affordable for the Uninsured?*, 25 J. HEALTH ECON. 650, 651 (2006).

18. *Affordability Standards*, U.S. OF CARE, https://unitedstatesofcare.org/affordability-standards [https://perma.cc/M963-XY76].

19. HEALTHCARE VALUE HUB, ALTARUM, RSCH. BRIEF NO. 16, MAKING HEALTHCARE AFFORDABLE: FINDING A COMMON APPROACH TO MEASURE PROGRESS 1 (2017), https://www.healthcarevaluehub.org/application/files/7215/6379/4407/Hub-Altarum_RB_No._16_-_Making_Healthcare_Affordable.pdf [https://perma.cc/S4PG-8XXH]; CHRISTINE BARBER & MICHAEL MILLER, CMTY. CATALYST, AFFORDABLE HEALTH CARE FOR ALL: WHAT DOES *AFFORDABLE* REALLY MEAN? 1 (2007), https://www.legis.iowa.gov/docs/publications/SD/6824.pdf [https://perma.cc/M6RP-M3GE] ("[S]ome effort to define affordability must be made. Without it, state reforms are more likely to fail in their avowed purpose . . . .").

or as any tradeoff at all. Section III.C considers *value-based* definitions of affordability that incorporate the notion of getting good value for money.

Part IV then considers how we can choose among the potential definitions. One approach would continue to leave affordability undefined. Another rejects affordability as a goal for health reform. Yet another discusses approaches that replace affordability with some of its constituent concepts. Part IV closes by discussing and defending hybrid definitions of affordability that combine different definitions discussed in Part III. It proposes that health spending is affordable if it delivers value for money without worsening access to basic needs or a reasonable opportunity range.

I. WHY HEALTH AFFORDABILITY?

Affordability can be applied in myriad ways across health and social policy. This Article uses "health affordability" to encompass the affordability of health insurance and care, where health care includes outpatient and inpatient care as well as drugs and devices. Insurance and care are linked: Insurance with low premiums that leaves patients exposed to high costs for health services may be "affordable" *insurance*, but not promote health affordability. Health affordability also should be understood as distinct from the affordability of social determinants of health, such as housing, education, and clean air and water. While the affordability of rent or a mortgage is probably more important to health than the affordability of most health care services,[20] housing affordability should not be subsumed into health affordability.

Health affordability for individuals and households has been an American preoccupation for decades. As early as 1979, Henry Waxman and Ted Kennedy introduced bills in the House and Senate that would "assure provision of adequate comprehensive health-care services, including protection against catastrophic health-care expenses, to all residents of the United States at affordable prices."[21] In 1983, resolutions were introduced in both chambers "in support of affordable and decent health care for older Americans."[22] During the 1980s, interest became bipartisan, with later Vice President Dan Quayle sponsoring efforts "to study, develop, and market mechanisms . . . that address the problems of providing affordable health insurance to targeted elements of the employed, high risk population."[23] Other Republicans proposed

20. *See, e.g.*, Dayna Bowen Matthew, *Structural Inequality: The Real COVID-19 Threat to America's Health and How Strengthening the Affordable Care Act Can Help*, 108 GEO. L.J. 1679, 1697 (2020) ("It is estimated that only ten to fifteen percent of health outcomes are determined by access to healthcare and genetic make-up of individuals respectively. In contrast, social determinants—the environments in which people live, work, and play—are estimated to represent forty percent of the influences that determine health outcomes." (footnote omitted)).

21. Health Care for All Americans Act, H.R. 5191, 96th Cong. (1979); Health Care for All Americans Act, S. 1720, 96th Cong. (1979).

22. S. Res. 180, 98th Cong. (1983); *see also* H.R. Res. 281, 98th Cong. (1983) (introducing a resolution "in support of affordable health care for the elderly and all Americans").

23. Workers' Health Insurance Demonstration Act of 1988, S. 2027, 100th Cong. § 1506 (1988).

legislation to improve the affordability of private coverage,[24] while Democrats focused on affordability for currently uninsured households.[25] During the 102nd Congress in 1991 to 1992 alone, legislators introduced the Affordable Health Insurance Tax Act,[26] the Affordable Health Insurance Act of 1991,[27] the Better Access to Affordable Health Care Act of 1991,[28] the Improved Access to Affordable Health Care Act of 1992,[29] and HealthAmerica: Affordable Health Care for All Americans Act[30]—as well as numerous other pieces of legislation emphasizing health affordability. This emphasis on affordability continued up to, and following, the passage of the ACA.[31]

Affordability's centrality to American health law and policy reflects the United States's distinctive social and economic arrangements. The myriad goods and services on which Americans rely can be classified, roughly, into three categories. One category is *fully publicly financed*: individuals do not pay out of pocket. Fully publicly financed services include classic economic "public goods" like national defense, clean air, and roads.[32] Goods and services that are regarded as civic entitlements, like primary and secondary education as well as voting,[33] are also fully publicly financed. A second category is *privately purchased*: fully paid for out of pocket. Restaurant meals, entertainment, and vacations are examples. A third, intermediate category—including most health care and insurance—is *publicly subsidized*: costs are split between purchasers and taxpayers. Some publicly subsidized insurance programs define eligibility based on group membership, like Medicare (age) and the Veterans Health Administration (military service).[34] Others, like

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24. Comprehensive and Uniform Remedy for the Health Care System Act of 1989, S. 1274, 101st Cong. tit. II (1989) ("Removing Barriers to Affordable Health Insurance[.]"); Universal Health Benefits Empowerment and Partnership Act of 1990, H.R. 4070, 101st Cong. (1990) (aiming "[t]o provide for universal access to basic group health benefits coverage and to remove barriers and provide incentives in order to make such coverage more affordable").

25. *E.g.*, Managed Health Care Access and Cost Containment Act of 1989, H.R. 2996, 101st Cong. (1989).

26. Affordable Health Insurance Tax Act, S. 2095, 102nd Cong. (1992).

27. Affordable Health Insurance Act of 1991, H.R. 3084, 102nd Cong. (1991).

28. Better Access to Affordable Health Care Act of 1991, S. 1872, 102nd Cong. (1991).

29. Improved Access to Affordable Health Care Act of 1992, H.R. 5049, 102nd Cong. (1992).

30. HealthAmerica: Affordable Health Care for All Americans Act, S. 1227, 102nd Cong. (1992).

31. *See, e.g.*, MAURA CALSYN, HOW STATES CAN BUILD ON THE ACA TO IMPROVE AFFORDABILITY AND LOWER HEALTH CARE COSTS, CTR. FOR AM. PROGRESS (July 15, 2021), https://www.americanprogress.org/article/states-can-build-aca-improve-affordability-lower-health-care-costs [https://perma.cc/663T-RVR3].

32. Daphna Lewinsohn-Zamir, *Consumer Preferences, Citizen Preferences, and the Provision of Public Goods*, 108 YALE L.J. 377, 377 (1998).

33. *Cf.* Ilya Somin, *Political Ignorance and the Countermajoritarian Difficulty: A New Perspective on the Central Obsession of Constitutional Theory*, 89 IOWA L. REV. 1287, 1314–15 (2004) ("[V]oting is a public good in the economic sense of the term.").

34. BERNADETTE FERNANDEZ, CONG. RSCH. SERV., RL32237, HEALTH INSURANCE: A PRIMER 12–13 (2015), https://crsreports.congress.gov/product/pdf/RL/RL32237 [https://perma.cc/JAR9-GLV4].

Medicaid, Children's Health Insurance Program ("CHIP"), and the ACA's marketplace subsidies, use a "means test," where households must show lower income or wealth.[35] Employer-based health insurance is also heavily subsidized through favorable tax treatment.[36] In addition to subsidized insurance, access to some health care interventions is directly subsidized, such as via the insulin subsidies in the Inflation Reduction Act.[37]

Public subsidies are not unique to health insurance. For housing, poorer households can access means-tested housing assistance; military veterans receive subsidized mortgages; and middle-class and wealthy households benefit extensively from the home mortgage interest deduction.[38] For higher education, poorer households are eligible for Pell Grants and other means-tested grant programs.[39] Military veterans receive GI Bill benefits.[40] Middle-class and wealthy households can use tax-advantaged savings arrangements like Section 529 plans to supplement their private earnings.[41]

The boundaries of these categories are concededly porous. Even privately purchased goods and services typically depend on some public spending. For instance, although airline tickets are privately purchased, air passengers benefit from public spending on air traffic control and airport construction.[42] And some private spending is often required in order to benefit from fully publicly financed goods: Although roads are maintained at taxpayer expense, a vehicle is needed to use them. Yet these categories of full public financing, private purchase, and public subsidy are a helpful way of understanding where health insurance and other essentials fit into the "mixed economies" that characterize developed democracies like the United States.[43]

The ubiquity of public subsidies in American public policy places affordability front and center. Provision of public subsidies for a good or service—like health or housing—signals that access is a public priority but nevertheless requires private outlays. In contrast, full public financing eliminates the

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35. *Id.* at 8 n.30 (discussing Medicaid and CHIP); *see also* BERNADETTE FERNANDEZ, CONG. RSCH. SERV., R44425, HEALTH INSURANCE PREMIUM TAX CREDIT AND COST-SHARING REDUCTIONS 4 (2023), https://crsreports.congress.gov/product/pdf/R/R44425 [https://perma.cc/MBR8-LX4E] (discussing ACA premium tax credits).

36. FERNANDEZ, *supra* note 34, at 4–5.

37. 42 U.S.C. § 1395w–102(b)(9) (2018).

38. MAGGIE MCCARTY, LIBBY PERL & KATIE JONES, CONG. RSCH. SERV., RL34591, OVERVIEW OF FEDERAL HOUSING ASSISTANCE PROGRAMS AND POLICY 21–25 (2014), https://crsreports.congress.gov/product/pdf/RL/RL34591 [https://perma.cc/44LB-883Z].

39. ELAINE M. MAAG & KATIE FITZPATRICK, URB. INST., FEDERAL FINANCIAL AID FOR HIGHER EDUCATION: PROGRAMS AND PROSPECTS 4 (2004).

40. *Id.*

41. *Id.*

42. *See* James V. DeLong, *New Wine for a New Bottle: Judicial Review in the Regulatory State*, 72 VA. L. REV. 399, 402 (1986).

43. *See* David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541, 578–79 (2008) (discussing the United States's "'mixed economy' of public- and private-sector involvement").

challenge of individual affordability because individuals face no cost at the point of purchase or receipt. Meanwhile, if goods are purely privately purchased, affordability may be a priority for purchasers, but the general public has no duty to assist in realizing affordability.

Our choice to deliver health care and insurance through public subsidies, rather than full public financing, makes individual affordability distinctively central to American health law and policy.[44] Elsewhere, health care—particularly physician and hospital services—and health insurance come closer to being fully publicly financed.[45] Even when public financing is incomplete, out-of-pocket spending and private insurance premiums are much lower elsewhere.[46] Nearly eighty percent of Americans believe that it is "very important" that "poor American families receiv[e] [the] same quality of health care as rich American families,"[47] and a similar proportion believe that "[a]ll Americans should have a right to health care regardless of their ability to pay."[48] Yet American health policy treats health more like housing: an essential good, but one where substantial variation in quality is tolerated and households must shoulder much of the cost.

Comparing the United States to other developed nations underscores how our unique health system centers individual affordability. In the United Kingdom, individual affordability is largely irrelevant because of the National Health Service, which directly employs physicians and so shifts health affordability from an individual to a public concern. Reflecting this, British discussions of domestic health affordability focus on the affordability of health service delivery to public payers, such as localities.[49] Because public payers are ultimately financed by tax revenues, excessive health costs can present

44. *Cf.* Brendan Saloner & Norman Daniels, *The Ethics of the Affordability of Health Insurance*, 36 J. HEALTH POL., POL'Y & L. 815, 815–16 (2011) (explaining how differences between the American health system and other systems cause "ethical concerns about affordability [to] become focused on households").

45. *See, e.g.*, COMMONWEALTH FUND, INTERNATIONAL PROFILES OF HEALTH CARE SYSTEMS 21 (Elias Mossialos, Ana Djordjevic, Robin Osborn & Dana Sarnak eds., 2017) (discussing the Canadian health care system).

46. Munira Z. Gunja, Evan D. Guman & Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*, COMMONWEALTH FUND (Jan. 31, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 [https://perma.cc/M28K-BADP].

47. COMMONWEALTH FUND, N.Y. TIMES & HARVARD T.H. CHAN SCH. PUB. HEALTH, AMERICANS' VALUES AND BELIEFS ABOUT NATIONAL HEALTH INSURANCE REFORM 10 (2019); *see also* HARRIS INTERACTIVE, FUNDAMENTAL HEALTH CARE VALUES 1 (Humphrey Taylor & Robert Leitman eds., 2003) ("Most Americans believe in equal access to care . . . .").

48. COMMONWEALTH FUND ET AL., *supra* note 47, at 6.

49. *E.g.*, DARLINGTON BOROUGH COUNCIL, INTERMEDIATE CARE PLUS STRATEGY 1 (2011), https://www.darlington.gov.uk/PublicMinutes/Cabinet/September%2013%202011/Item%207a.pdf [https://perma.cc/EDP3-LT3K].

problems of affordability even in a single-payer system.[50] But for households, these costs are not distinctively problems of *health* affordability, but rather of overall tax affordability: The effects of excessive health spending fall on households regardless of their health needs or participation in the health system. In other developed countries such as Australia and Canada, services are provided by privately employed physicians but are fully or almost-fully covered by subsidized insurance.[51] In these countries, health services not covered by insurance, such as pharmaceuticals, can raise individual affordability concerns,[52] but affordability remains less of a systemic concern.

In contrast, in the United States, health services are only fully publicly provided for a few groups, such as military veterans. Medicare and Medicaid recipients receive publicly subsidized health insurance to cover privately provided health services, but Medicare involves much more cost exposure than analogous insurance programs abroad, and Medicaid is much less comprehensively accepted.[53] One source of out-of-pocket exposure is deductibles and copayments, accentuated by the increasing movement toward high-deductible health plans.[54] Another area of exposure involves health services not covered by insurance: Many mental health professionals refuse insurance,[55] and neither private insurance nor Medicare typically cover long-term care services.[56]

Health is not the only sector in which countries make different choices about full public financing versus subsidized private purchase. Some countries, like Germany and Norway, provide zero-cost higher education, while the United States and most Anglophone nations do not.[57] Some countries also

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50. *See* John Appleby & Kamran Abbasi, *The NHS at 70: Loved, Valued, Affordable?*, BMJ, 2018, at 1, 2.

51. *See* COMMONWEALTH FUND, *supra* note 45, at 11–17, 21–26.

52. Justin Trudeau, Canadian Prime Minister, Statement by the Prime Minister on World Health Day (Apr. 7, 2019), https://pm.gc.ca/en/news/statements/2019/04/07/statement-prime-minister-world-health-day [https://perma.cc/X9YX-B77V]; Steven G. Morgan & Jamie R. Daw, *Canadian Pharmacare: Looking Back, Looking Forward*, 8 HEALTHCARE POL'Y, no. 1, 2012, at 14, 16 ("Canada is the only country with a universal health insurance system that excludes coverage of prescription drugs."); Judith Healy, Evelyn Sharman & Buddhima Lokuge, *Australia: Health System Review*, 8 HEALTH SYS. TRANSITION, no. 5, 2006, at i, xvi.

53. Lindsay F. Wiley, *Privatized Public Health Insurance and the Goals of Progressive Health Reform*, 54 U.C. DAVIS L. REV. 2149, 2199 (2021).

54. Stephen Miller, *High-Deductible Plans More Common, but So Are Choices*, SHRM (Feb. 9, 2018), https://www.shrm.org/resourcesandtools/hr-topics/benefits/pages/high-deductible-plans-more-common-but-so-are-choices.aspx [https://perma.cc/QX8V-QA7Q].

55. Nicole M. Benson, Catherine Myong, Joseph P. Newhouse, Vicki Fung & John Hsu, *Psychiatrist Participation in Private Health Insurance Markets: Paucity in the Land of Plenty*, 71 PSYCHIATRIC SERVS. 1232, 1234 (2020).

56. *Who Pays for Long-Term Care?*, ADMIN. FOR CMTY. LIVING (May 10, 2022), https://acl.gov/ltc/costs-and-who-pays/who-pays-long-term-care [https://perma.cc/XE6S-58GB].

57. Emma Melton, *An Analysis of the Right to Education in* Hurley and Moore v. Secretary of State for Business, Innovation & Skills *and Its Application in the United States*, 13 WASH. U. GLOB. STUD. L. REV. 393, 405 n.81 (2014) ("[T]he cheapest educational costs are in those countries

provide infant care and early childhood education at no cost, while the United States does not.[58] But the United States is unique in excluding health care from the set of tax-financed, fully publicly provided goods, while also exposing households to high costs when they attempt to obtain private health insurance or health care. These phenomena—the United States's fragmented health system and its skepticism of fully funding most health care services through government provision—drive the preoccupation with individual health care and insurance affordability in the United States.

II. HEALTH AFFORDABILITY IN AMERICAN LAW

Part I has explained why individual health affordability is so central to the American health system. This Part examines how individual affordability suffuses health law, beginning with federal law in Section II.A, and then turning to states in Section II.B.

A. *HEALTH AFFORDABILITY IN FEDERAL LAW*

Most references to health affordability in federal law invoke the concept without defining it.[59] However, a few quantitative metrics for health affordability are included in federal law. Additionally, a qualitative description of affordability has been included in administrative guidance and rulemaking around the "affordability guardrail" states must satisfy in order to obtain an Affordable Care Act innovation waiver. The history of this guidance reveals how federal policy around affordability shifted from the Obama to Trump to Biden administrations.

1. Quantitative Thresholds

Although disclaiming any single federal definition of health affordability, the Center on Medicare and Medicaid Services ("CMS") identifies two affordability metrics in federal law.[60] CMS suggests that these quantitative metrics proxy for the qualitative goal of ensuring that "a household is able to cover their health care costs and also pay for necessities such as housing, transportation, and food."[61]

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where tuition fees do not exist or exist only in patches: Sweden, Norway, Germany, and Denmark." (quoting ALEX USHER & JON MEDOW, GLOBAL HIGHER EDUCATION RANKINGS 2010: AFFORDABILITY AND ACCESSIBILITY IN COMPARATIVE PERSPECTIVE 12 (2010))).

58. Claire Cain Miller, *How Other Nations Pay for Child Care. The U.S. Is an Outlier*, N.Y. TIMES (Oct. 7, 2021), https://www.nytimes.com/2021/10/06/upshot/child-care-biden.html# (on file with the *Iowa Law Review*).

59. *E.g.*, Exec. Order No. 14,009, 86 Fed. Reg. 7793, 7793–04 (Jan. 28, 2021) (directing "the heads of . . . executive departments and agencies with authorities and responsibilities related to Medicaid and the ACA" to consider revising "policies or practices that may reduce the affordability of coverage"); 42 U.S.C. § 18003; 42 U.S.C. § 1397hh; 34 U.S.C § 11245; 42 U.S.C. § 1803.

60. U.S. CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP'T OF HEALTH & HUM. SERVS. AFFORDABILITY IN THE MARKETPLACES REMAINS AN ISSUE FOR MODERATE INCOME AMERICANS 2 (2021).

61. *Id.*

The threshold at which medical expenses become tax deductible is the first affordability metric CMS identifies.[62] This threshold has changed over time. Initially, all unreimbursed medical expenses exceeding five percent of net income were deductible.[63] The threshold was increased to 7.5 percent of adjusted gross income,[64] and later to ten percent of adjusted gross income for taxpayers under sixty-five.[65] It has since reverted to 7.5 percent.[66] This metric can be seen as a threshold establishing when overall health expenditure, including both spending on health care and on insurance premiums, becomes unaffordable.

The ACA's affordability threshold for employer-provided health insurance is the second metric. Such insurance is explicitly described in federal law as affordable if the cost falls below a defined threshold.[67] Prior to 2014, the threshold was "9.5 percent of the applicable taxpayer's household income."[68] Since 2014, the threshold has been indexed to the amount that health insurance premium growth outpaces income growth,[69] and is currently 9.12 percent of income.[70]

In addition to the two thresholds CMS identifies, the ACA also includes a similar threshold for health insurance plans sold through the individual marketplace. Households receive subsidies, in the form of tax credits, that absorb the cost of health insurance premiums that exceed a defined percentage of income. Although these subsidies are not explicitly named as ensuring affordability, agencies and courts have recognized them as such.[71] Prior to

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. *Id.*

67. 26 U.S.C. § 36B(c)(2)(C)(i) ("Coverage must be affordable[.]").

68. *Id.* § 36B(c)(2)(C)(i)(II); *see also* 26 C.F.R. § 1.36B–2(c)(3)(iii)(C)(v)(A)(1)(2016) ("[A]n eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay . . . for self-only coverage does not exceed the required contribution percentage . . . of the applicable taxpayer's household income for the taxable year.").

69. 26 U.S.C. § 36B(c)(2)(C)(iv) ("In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii)."); *id.* § 36B(b)(3)(A)(ii)(I) ("[T]he initial and final applicable percentages under clause (i) . . . shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year."). For 2022, the percentage is 9.61 percent. Rev. Proc. 2021-36, 2021-35 I.R.B. 357.

70. *Affordable Coverage*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS.: HEALTHCARE.GOV, https://www.healthcare.gov/glossary/affordable-coverage [https://perma.cc/Z237-MCWQ] (data assessed in 2023).

71. *E.g.*, 42 C.F.R. § 435.4 (2015) (defining "Insurance affordability program" to include "[a] program that makes coverage in a qualified health plan through the Exchange with advance payments of the premium tax credit established under section 36B of the Internal Revenue Code available to qualified individuals"); Ass'n for Cmty. Affiliated Plans v. U.S. Dep't of the Treasury, 966 F.3d 782, 795 (D.C. Cir. 2020) (Rogers, J., dissenting) ("As to affordability, Congress offered

2021, the maximum percentage of income a household would need to pay for health insurance was 9.5 percent for households up to four hundred percent of the federal poverty line; households above that threshold were ineligible for subsidies.[72] From 2021 to 2025, the maximum percentage of income a household is asked to pay toward insurance premiums before tax credits kick in begins at two percent (for households up to 133 percent of the federal poverty line) and ends at 8.5 percent regardless of income.[73] This more generous affordability threshold for households above three hundred percent of the federal poverty line was adopted as part of the American Rescue Plan, extended by the Inflation Reduction Act, and legislation has been introduced to make it permanent[74]—all suggesting a shift in the definition of affordability.

The ACA also includes another affordability threshold. "Individuals who cannot afford coverage," defined as those for whom insurance would "exceed[] 8 percent of such individual's household income,"[75] are not required to make the shared responsibility payment otherwise required of individuals who do not have minimum essential coverage. However, the shared responsibility payment (often dubbed the "individual mandate") was set to zero dollars as part of 2017 tax legislation, reducing the relevance of the affordability exemption.[76] The affordability exemption, however, remains one of the pathways for people over thirty to enroll in a catastrophic health plan, which "offers lower-priced coverage that mainly protects you from high medical costs if you get seriously hurt or injured."[77]

Reviewing these federal enactments reveals three important things about American health law's approach to affordability definitions. First, efforts to quantitatively operationalize affordability often float free of a qualitative definition that explains the operationalization. Second, to the extent operationalizations of affordability are tied to a qualitative definition, affordability is often defined as households' access to necessities not being jeopardized by

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tax credits to qualifying individuals."); Chinn v. Becerra, No. 20-2662, 2022 WL 4235073, at *1 (D. Kan. Sept. 14, 2022) (explaining that "[t]hrough the FFE [Federally-Facilitated Exchange]" created by the ACA, "eligible individuals may apply for Insurance Affordability Programs," such as "advance payments of premium tax credits").

72. 26 U.S.C. § 36B(b)(3)(A)(i).

73. *Id.* § 36B(b)(3)(A)(iii)(II).

74. *Senator Baldwin Reintroduces Legislation to Lower Health Care Costs & Expand Access to Insurance for Millions More Americans*, TAMMY BALDWIN U.S. SENATOR FOR WIS. (Jan. 24, 2023), https://www.baldwin.senate.gov/news/press-releases/senator-baldwin-reintroduces-legislation-to-lower-health-care-costs-and-expand-access-to-insurance-for-millions-more-americans [https://perma.cc/3DNG-4QST].

75. 26 U.S.C. § 5000A(e)(1) (2010).

76. *Health Coverage Exemptions: Forms & How to Apply*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS.: HEALTHCARE.GOV, https://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply [https://perma.cc/SGU3-Q28X].

77. *Id.*

health spending. Part III will categorize this approach as a *basic needs* definition of affordability. Third, there is no firm consensus either on which operationalization of affordability is most appropriate or on what qualitative outcome these operationalizations are meant to serve.

These enactments also suggest a fairly limited subset of federal options are being used to prevent unaffordability. If affordability is understood—following federal guidance—as ensuring that health spending comprises an appropriate share of household budgets,[78] there are four levers policymakers can pull in order to promote affordability. They can subsidize health care and insurance, as in the above-referenced sections of the ACA (transfer payments) and tax code (tax expenditures). But they can also promote affordability by taking steps to increase households' overall financial resources, through economic policy or all-purpose cash transfer programs. They can also adopt policies that aim to lower the market price of health care and insurance, such as increased competition, negotiation, and price regulations. Last, they can exclude certain costly products from the market entirely, via either disincentives or prohibitions. Yet the provisions above focus entirely on subsidies, largely ignoring other pathways to affordability. As Section II.B will describe, states—which lack the federal government's spending flexibility—are increasingly using other levers to pursue affordability, such as price regulation and policies that may drive costly products from the market.

2. Qualitative Definitions: The "Affordability Guardrail"

Rather than quantitative thresholds, the ACA's provisions for state innovation waivers involve a more holistic and qualitative affordability determination,[79] often termed the "affordability guardrail." State innovation waivers are permitted only if "the State plan . . . will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as" the ACA would itself provide.[80] Although the ACA's implementing regulations require that, "[t]o satisfy the affordability requirement, the Secretary [of the Treasury] and the Secretary of Health and Human Services, as applicable, must determine that the coverage under the State plan is forecasted to be as affordable overall for State residents as coverage absent the waiver,"[81] they do not explain how the Secretaries should make such a determination.[82]

78. *Cf. id.* (stating that affordability may generally be measured by comparing residents' net out-of-pocket spending for health coverage and services to their incomes).

79. *E.g.*, Matthew B. Lawrence, *Fiscal Waivers and State "Innovation" in Health Care*, 62 WM. & MARY L. REV. 1477, 1556 (2021).

80. 42 U.S.C. § 18052 (2018).

81. 31 C.F.R. § 33.108(f)(3)(iv)(B) (2022).

82. The broad discretion provided to agencies has led the provision to be termed "a *big* delegation of waiver authority." Elizabeth Y. McCuskey, *Agency Imprimatur & Health Reform Preemption*, 78 OHIO ST. L.J. 1099, 1137 (2017).

Administrations implementing the affordability guardrail have defined affordability in importantly different ways. In 2015, guidance from the Obama Administration stated that "[a]ffordability refers to state residents' ability to pay for health care and may generally be measured by comparing residents' net out-of-pocket spending for health coverage and services to their incomes."[83] The guidance set no specific proportion of income devoted to health spending as an affordability threshold. It did, however, identify two other dimensions of affordability. First, defining affordability requires more than assessing average spending: "Increasing the number of state residents with large health care spending burdens would cause a waiver to fail the affordability requirement, even if the waiver would increase affordability for many other state residents."[84] Likewise, waivers that worsen affordability for "vulnerable individuals," including those who are low-income, elderly, or in poor health, fail the affordability requirement irrespective of their effect on aggregate affordability. Second, the guidance associated affordability "with coverage that provides a minimal level of protection against excessive cost sharing," where excessive cost-sharing is understood as cost-sharing that would make a plan noncompliant with the ACA's marketplace rules.[85]

In 2018, the Trump Administration replaced the 2015 Guidance. The 2018 Guidance paralleled the 2015 Guidance in seeing affordability as a relationship between health spending and available resources.[86] Under the 2018 Guidance, however, assessments of "affordability of coverage under a waiver should focus on the nature of coverage that is made available to state residents (access to coverage), rather than on the coverage that residents actually purchase."[87] Affordability under the 2018 Guidance was a matter of opportunities, not outcomes. The 2018 Guidance also removed the list of vulnerable groups, stating only that "those with high expected health care costs and those with low incomes" were a coverage priority.[88] These changes prompted litigation that was ultimately dismissed.[89]

In 2021, the Biden Administration adopted an approach echoing the 2015 Guidance. The 2021 approach to affordability—which was formalized through rulemaking rather than being issued as informal guidance—returns to the 2015 approach of considering what coverage is expected to actually be purchased. The list of vulnerable groups was not only restored, but expanded,

83. Waivers for State Innovation, 80 Fed. Reg. 78131, 78131–35 (Dec. 16, 2015).

84. *Id.*

85. *Id.*

86. State Relief and Empowerment Waivers, 83 Fed. Reg. 53575, 53579 (Oct. 24, 2018) ("Affordability refers to state residents' ability to pay for health care expenses relative to their incomes and may generally be measured by comparing each individual's expected out-of-pocket spending for health coverage and services to their income.").

87. *Id.* at 53577.

88. *Id.* at 53579.

89. *See* City of Columbus v. Trump, 453 F. Supp. 3d 770, 804 (D. Md. 2020).

to comprise "low-income individuals, older adults, those with serious health issues or who have a greater risk of developing serious health issues, and people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality."[90] The explicit inclusion of people of color and marginalized groups reflects Executive Order 13,985, which directs all agencies to identify and remedy equity barriers.[91] Although the revised affordability guidance has not prompted waiver denials, agency officials have asked states to document their health equity efforts as part of waiver renewal.[92]

B. *Health Affordability in State Law*

Validating their status as "laboratories of democracy,"[93] states' definitions of health insurance affordability laid the foundation for the ACA's affordability definitions. More recently, states have developed innovative metrics for health care and prescription drug affordability that may influence future federal legislation.[94]

1. Health Insurance

The ACA's premium tax credits that subsidize health insurance for individual purchasers built on Massachusetts's pathbreaking 2006 health care reform. The Massachusetts reform subsidized health coverage for people below three hundred percent of the federal poverty level ("FPL").[95] Premiums were fully subsidized for those below 150 percent of FPL, while those between 150 percent and three hundred percent of FPL were partially subsidized, with subsidies decreasing according to an "affordability schedule" as income

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90. Patient Protection and Affordable Care Act; Updating Payment Parameters, Section 1332 Waiver Implementing Regulations, and Improving Health Insurance Markets for 2022 and Beyond, 86 Fed. Reg. 53412, 53465 (Sept. 27, 2021).

91. Exec. Order No. 13,985, 86 Fed. Reg. 7009, 7009 (Jan. 25, 2021) ("[E]ach agency must assess whether, and to what extent, its programs and policies perpetuate systemic barriers to opportunities and benefits for people of color and other underserved groups.").

92. *E.g.*, MINN. DEP'T OF COM., MINNESOTA 1332 WAIVER APPLICATION EXTENSION 77 (2022), https://www.cms.gov/files/document/1332-mn-extension-application-narrative-july-update.pdf [https://perma.cc/UJ4K-86WT] (asking "states to include in their analysis whether the proposed section 1332 waiver would increase health equity in line with E.O. 13985" (quoting MINN. DEP'T OF COM., MINNESOTA 1332 WAIVER APPLICATION EXTENSION (2021))).

93. *See* New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) ("It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory.").

94. *See, e.g.*, Rebecca E. Wolitz, *States, Preemption, and Patented Drug Prices*, 52 SETON HALL L. REV. 385, 389 (2021) ("[T]he possibility of state-level intervention offers a promising alternative in light of politically stalled and limited federal reform. States, in fact, have been experimenting with various tools to address the problem of excessively priced medications.").

95. Michael T. Doonan & Katharine R. Tull, *Health Care Reform in Massachusetts: Implementation of Coverage Expansions and a Health Insurance Mandate*, 88 MILBANK Q. 54, 56 (2010).

increases.[96] California narrowly rejected a similar reform in 2007, which would have used tax credits to cover all premium costs over 5.5 percent of income for households between 250 percent and three hundred percent of FPL, with credits then decreasing on a sliding scale up to four hundred percent of FPL.[97]

The ACA's enactment led many states to mirror the ACA's affordability definitions in their own laws. For instance, many states that offer catastrophic health insurance plans,[98] or offer state-funded health care plans to children, indigent residents, or others,[99] require enrollees to show that they lack access to a health insurance plan that is affordable under the ACA's definition. Additionally, to fill the gap after the ACA's shared responsibility payment was set to zero dollars in 2017, some states enacted individual mandates with exemptions for households lacking access to affordable insurance. These affordability exemptions often mirrored the ACA's.[100]

Some states, however, have continued to define affordability differently from the ACA, perhaps reflecting differences in local values. Massachusetts still uses its own affordability standard for its individual mandate, which some have praised as "a more progressive approach [than] the ACA."[101] Missouri and South Dakota have developed their own standards to exclude applicants who have access to affordable private coverage from assistance programs.[102]

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96. *Id.* at 56, 58. The Massachusetts reform immediately prompted legal academic interest. *See generally* Symposium, *The Massachusetts Plan and the Future of Universal Coverage—Perspectives on Health Reform*, 55 U. KAN. L. REV. 1091 (2007).

97. KATHERINE HOWITT & MICHAEL MILLER, CMTY. CATALYST, CALIFORNIA'S NEAR MISS: UNDERSTANDING THE POLICIES AND POLITICS OF THE PROPOSED ABX1-1 LEGISLATION 3 (2008).

98. ILL. ADMIN. CODE tit. 50, § 2001.12 (2023); MD. CODE REGS. 14.35.07.10 (2023); OR. ADMIN. R. 945-040-0020 (2021); S.D. ADMIN. R. 20:06:56:19 (2013); CAL. HEALTH & SAFETY CODE § 1367.008 (West 2014).

99. IOWA CODE § 249N.4(2) (2023) ("An individual who has access to affordable employer-sponsored health care coverage, as defined . . . to align with regulations adopted by the federal internal revenue service under the Affordable Care Act, shall not be eligible for participation in the Iowa health and wellness plan."); MINN. STAT. § 256L.07 (2022) (similar, for eligibility for MinnesotaCare); 16 DEL. ADMIN. CODE § 4203-4.1.5.1 (2023) (similar, for eligibility for Delaware cancer treatment assistance program).

100. *E.g.*, CAL. CODE REGS. tit. 18, § 26000.61020 (2023) (explaining that "[a] penalty will not be imposed on an applicable individual who lacks affordable coverage" and that "[a]n applicable individual lacks affordable coverage . . . if the applicable individual's required contribution . . . exceeds the required contribution percentage," where the required contribution percentage reflects the formula set out in the Affordable Care Act for exemptions from the shared responsibility payment); D.C. Mun. Regs. tit. 26, § D201 (2020) (similar).

101. CAL. HEALTH POL'Y STRATEGIES, LLC, TOWARD UNIVERSAL COVERAGE: STATE ALTERNATIVES TO THE FEDERAL INDIVIDUAL MANDATE 9 (2018); *see also* JASON A. LEVITIS, STATE INDIVIDUAL MANDATES 19 (2018) (noting that "some features of Massachusetts' [sic] policy have important advantages" over the federal approach).

102. *E.g.*, MO. CODE REGS. ANN. tit. 13, § 70-4.080 (2023) (specifying that parents and guardians applying for state-funded child health insurance "must certify, as a part of the application process, that the child does not have access to affordable employer-sponsored health care insurance or other affordable health care coverage" and defining affordability as a

Adjudicating family dissolution and child support cases and the ensuing disagreements over who should cover children's health insurance costs has also required states to make *de facto* affordability determinations.[103] Most states use a rebuttable presumption that insurance is a "reasonable cost" if it does not exceed five percent of income.[104] Some, however, use other standards such as ten percent of income or a standard that shifts according to income such that lower-income households are expected to pay less.[105]

Recently, some states have gone beyond the ACA's regime of premium assistance tax credits to define affordability more generously or in greater detail. Prior to the American Rescue Plan's expansion of subsidies to households above four hundred percent of poverty, California expanded subsidies to households up to six hundred percent of poverty,[106] and Washington did the same for households up to five hundred percent,[107] implicitly setting a different affordability standard. Massachusetts, Vermont, and California, meanwhile, provide more generous subsidies to households below four hundred percent of poverty,[108] and New Mexico's Health Care Affordability Fund proposes to do so as well.[109]

Other states have begun to develop more detailed health insurance affordability criteria that go beyond the ACA's percentage-of-income metrics, recalling the discussion around qualitative affordability criteria at the inception of Massachusetts's 2006 reforms.[110] These criteria are often described as

percentage of income ranging from three percent to five percent depending on household income); MO. REV. STAT. § 208.930 (2019).

103. Jane C. Venohr & Robert G. Williams, *The Implementation and Periodic Review of State Child Support Guidelines*, 33 FAM. L.Q. 7, 20 (1999).

104. *See generally* OFF. OF CHILD SUPPORT ENF'T, U.S. DEP'T OF HEALTH & HUM. SERVS., STATE/EMPLOYER CONTACT AND PROGRAM INFORMATION (2023), https://ocsp.acf.hhs.gov/irg/irgpdf.pdf?geoType=OGP&groupCode=EMP&addrType=NMS&addrClassType=EMP [https://perma.cc/26JX-JJYG] (providing a definition of "reasonable cost" by state).

105. *Id.* at 25 (explaining that, in Maine, "[r]easonable cost is defined as 6 [percent] of gross income or, if gross income does not exceed 150 [percent] of the federal poverty level for one person, 0 [percent] of gross income").

106. CAL. GOV'T CODE § 100800 (2021) (repealed 2023); *see also* Sarah Lueck, *Adopting a State-Based Health Insurance Marketplace Poses Risks and Challenges*, CTR. ON BUDGET & POL'Y PRIORITIES (Feb. 6, 2020), https://www.cbpp.org/research/health/adopting-a-state-based-health-insurance-marketplace-poses-risks-and-challenges [https://perma.cc/XB6N-75BH] (describing changes to state marketplaces in states including California).

107. Mark A. Zezza & David Sandman, *Single Payer or Not: Matching Problems with Solutions*, HEALTH AFFS. FOREFRONT (May 19, 2020), https://www.healthaffairs.org/do/10.1377/forefront.20200512.121763/full [https://perma.cc/JZ3P-8QSU].

108. Lueck, *supra* note 106.

109. N.M. CODE R. § 13.10.36.9 (LexisNexis 2023).

110. *E.g.*, Sidney D. Watson, Timothy McBride, Heather Bednarek & Muhammad Islam, *The Road from Massachusetts to Missouri: What Will It Take for Other States to Replicate Massachusetts Health Reform?*, 55 U. KAN. L. REV. 1331, 1353 n.93 (2007) ("Regulators are debating a variety of approaches to defining affordability including using Medicaid and SCHIP standards, average household budgets (as a means to determine the income available to pay for health insurance), and current spending on private health insurance coverage . . . .").

"affordability standards." Although they concern individual affordability, they are typically implemented via processes like rate setting, rather than being used to set subsidies. Rhode Island, for instance, allows its Health Insurance Commissioner to "consider whether the health insurer's products are affordable, and whether the carrier has implemented effective strategies to enhance the affordability of its products."[111] In making affordability determinations, the Commissioner is directed to consider trends in national and regional health insurance, inflation indices, market rates for similar insurance products, "[t]he ability of lower-income individuals to pay for health insurance," administrative cost controls, efforts by the insurer to improve affordability, and "[a]ny other relevant affordability factor, measurement or analysis determined by the Commissioner to be necessary or desirable."[112] Health insurers in Rhode Island are required to follow these affordability standards.[113] Delaware, New Jersey, and Colorado have begun the process of developing similar standards,[114] and other states such as Vermont have also shown interest.[115]

Last, although interest in defining health insurance affordability at the state level appears to be growing, clear definitions remain the exception rather than the rule, just as with federal law. States have invoked affordability, *sans* definition, to support a capacious and conflicting set of policies: single-payer insurance,[116] a public option,[117] deregulation of private insurance,[118] individual mandates,[119] and individual mandate repeal.[120] The most common way states have invoked affordability, however, is to call for further studies of affordability problems[121]—studies that could potentially ripen into efforts to define affordability.

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111. 230-20 R.I. CODE R. § 20-30-4.9(B) (LexisNexis 2022). *See generally* Johanna Butler, *Insurance Rate Review as a Hospital Cost Containment Tool: Rhode Island's Experience*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Feb. 1, 2021), https://www.nashp.org/insurance-rate-review-as-a-hospital-cost-containment-tool-rhode-islands-experience [https://perma.cc/L9RB-P9SF] (describing Rhode Island's affordability standards).

112. 230-20 R.I. CODE R. § 20-30-4.9(C) (LexisNexis 2022).

113. *See* John Aloysius Cogan, Jr., *Health Insurance Rate Review*, 88 TEMP. L. REV. 411, 463 n.297 (2016).

114. COLO. REV. STAT. § 10-16-107 (2021); DEL. CODE ANN. tit. 18, § 334 (2023); Exec. Order No. 217, 53 N.J. Reg. 286(a) (Mar. 1, 2021).

115. *See* JOSHUA SLEN, JULIE TROTTIER, BETH WALDMAN & TIM HILL, REPORT TO THE VERMONT LEGISLATURE 16 (2022).

116. VT. STAT. ANN. tit. 33, § 1821 (2023).

117. COLO. REV. STAT. § 25.5-1-129 (2023).

118. ARK. CODE ANN. § 23-98-101 (2023); FLA. STAT. § 408.910 (2018); OKLA. STAT. tit. 36, § 4415 (2023); TENN. CODE ANN. § 56-7-127 (2023); W. VA. CODE § 33-16F-1 (2023).

119. CAL. HEALTH & SAFETY CODE § 131540 (West 2009); D.C. CODE § 47-5107 (2023).

120. OHIO REV. CODE ANN. § 3901.052 (West 2023).

121. *E.g.*, 20 ILL. COMP. STAT. 2230/5-10 (2023); MINN. STAT. ANN. § 62J.04 (West 2011); CONN. GEN. STAT. § 19a-725 (2023); ME. STAT. tit. 22, § 5411 (2019); OR. REV. STAT. ANN. § 413.011 (West 2022).

2. Prescription Drugs

The public regards prescription drugs as increasingly unaffordable, and the United States spends about twice as much on prescription drugs per capita than comparable countries.[122] Six states (Colorado, Maine, Maryland, New Hampshire, Ohio, and Oregon) have responded by creating prescription drug affordability boards, adding to similar boards already existing in Massachusetts and New York.[123] These boards have also been proposed in other states,[124] some of which are already reviewing the affordability of specific drugs.[125] States not currently contemplating creating boards also recognize prescription drug affordability as an important problem.[126]

Maryland's affordability board represents a useful model to analyze: It defines affordability as primarily a problem of high prices. The board is to identify drugs posing "affordability challenges for the State health care system and patients."[127] Drugs are selected for review due to their absolute cost or due to increases in cost, but the board may also review other drugs at its discretion.[128] Affordability challenges are evaluated using eleven factors, most of which pertain to the drug's net price after discounts but which also include "[t]he impact on patient access resulting from the cost of the prescription drug product relative to insurance benefit design" and other factors that the board may adopt in its regulations.[129] Importantly, the board may "set[] upper payment limits" (reimbursement caps) "for prescription drug products that it determines have led or will lead to an affordability challenge."[130] In addition,

122. Nisha Kurani, Dustin Cotliar & Cynthia Cox, *How Do Prescription Drug Costs in the United States Compare to Other Countries?*, PETERSON-KFF HEALTH SYS. TRACKER (Feb. 8, 2022), https://www.healthsystemtracker.org/chart-collection/how-do-prescription-drug-costs-in-the-united-states-compare-to-other-countries [https://perma.cc/HP45-JPBV].

123. Colleen Becker, *Prescription Drug Trends: Pharmacy Benefit Manager Reform, Affordability Boards and More*, NAT'L CONF. OF STATE LEGISLATURES (Jan. 28, 2022), https://www.ncsl.org/state-legislatures-news/details/prescription-drug-trends-pharmacy-benefit-manager-reform-affordability-boards-and-more [https://perma.cc/TH8T-CRGL]; *see also* Clark & Sneha Puthiyath, *supra* note 9 (discussing prescription drug affordability boards further).

124. Clark & Sneha Puthiyath, *supra* note 9 (explaining that such boards are under discussion in Arizona, Connecticut, Illinois, Massachusetts, Michigan, Minnesota, New Jersey, New Mexico, Pennsylvania, Rhode Island, and Virginia, and that legislation to establish a drug affordability board failed in Wisconsin); *see also* Michelle M. Mello & Rebecca E. Wolitz, *Legal Strategies for Reining in "Unconscionable" Prices for Prescription Drugs*, 114 NW. U. L. REV. 859, 883 (2020) ("There is growing interest among states in using rate setting by 'drug affordability boards' . . . .").

125. N.M. STAT. ANN. § 26-2C-4 (2021) (directing the department of health to study "the affordability and accessibility of medical cannabis").

126. *E.g.*, CAL. HEALTH & SAFETY CODE § 1342.71 (West 2019) ("The Legislature intends to build on existing state and federal law to ensure . . . affordability of outpatient prescription drugs.").

127. MD. CODE ANN., HEALTH–GEN. § 21-2C-08 (West 2023).

128. *Id.*

129. *Id.* § 21-2C-09.

130. *Id.* § 21-2C-13.

the board is directed to study "[p]olicy options being used in other states and countries to lower the list price of pharmaceuticals."[131]

Most state affordability boards resemble Maryland's, though they differ in their enforcement power and in other particulars.[132] For instance, Maine's board aims "to make prescription drugs more affordable for qualified Maine residents, thereby increasing the overall health of Maine residents."[133] This language interestingly suggests that affordability is desirable in view of its contribution to drug access and in turn to health, rather than being affordable because it promotes financial security or other nonhealth goals.

Maryland's focus on price is the inverse of the insurance affordability definitions discussed in Section II.A, which focused only on subsidies rather than prices.[134] Other prescription drug affordability boards have likewise not defined affordability using a percentage-of-income threshold—rather, most boards follow Maryland in using an absolute cost threshold where drugs that cost more than a given amount per year are subject to review.[135]

Affordability boards' price-centric approach to affordability may reflect the myriad groups they aim to protect against affordability challenges: "State residents, State and local governments, commercial health plans, health care providers, pharmacies licensed in the State, and other stakeholders within the health care system."[136] Other boards have adopted a similarly wide scope.[137]

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131. *Id.* § 21-2C-07.

132. *Cf.* Mello & Wolitz, *supra* note 124, at 884–85 (discussing creating boards). Mello and Wolitz explained:

> The general mechanism in rate-setting proposals is the creation of a board that is empowered to review drug prices and set upper payment limits. . . .
>
> . . . . Provisions commonly include setting out criteria for a board or commission's makeup, identifying triggering requirements for which drugs will be subject to potential cost review, identifying information required from manufacturers, establishing policies for public disclosure, determining which drugs based on submitted information will be subject to a maximum payment allowance, establishing criteria for setting payments, and specifying enforcement provisions.

Id. (footnotes omitted).

133. ME. STAT. tit. 22, § 2691 (2023).

134. *See supra* Section II.A.

135. Clark & Sneha Puthiyath, *supra* note 9 ("[T]he boards generally focus on high-priced drugs, which may be defined by a specific threshold—for example, brand-name drugs and biologics with a launch price of $30,000 or more per year."); *see also* Mello & Wolitz, *supra* note 124, at 886–87 ("The primary criterion in determining whether a drug imposes excess costs or an affordability challenge . . . pertains to 'commercial payor, provider, and consumer costs.'" (quoting NAT'L ACAD. FOR STATE HEALTH POL'Y, DRUG RATE SETTING MODEL ACT OVERVIEW, https://nashp.org/wp-content/uploads/2018/08/Rate-Setting-Model-Act-Explanation-final.pdf [https://perma.cc/XV6M-THZD])).

136. MD. CODE ANN., HEALTH–GEN. § 21-2C-02 (West 2023).

137. *E.g.*, OR. REV. STAT. § 646A.693 (2023) (aiming "to protect residents of this state, state and local governments, commercial health plans, health care providers, pharmacies licensed in this state and other stakeholders within the health care system in this state from the high costs of prescription drugs"); N.H. REV. STAT. ANN. § 126-BB:5 (2020) (directing the board to identify

Although the board aims to ensure individual affordability of prescription drugs, it also attempts to ensure affordability to providers, insurers, and state governments. Lower drug prices serve both individual and societal affordability, whereas the use of subsidies to achieve insurance affordability presents tensions between household and societal affordability.[138]

3. Health Services

Although not prompting a movement analogous to prescription drug affordability boards, physician and hospital services have also prompted state-level affordability efforts. These efforts, which aim to constrain "the price or quantity of health care services provided,"[139] complement the ACA's emphasis on achieving affordability via insurance subsidies.[140]

Efforts to realize health service affordability have taken two forms. Direct rate regulation sets maximum prices for specific health care services, guaranteeing that households—whether insured or not—face a predictable menu of prices.[141] In contrast, indirect rate regulation sets a statewide budget for overall health care or hospital services, allowing individual service prices to vary but ensuring that the overall set of services provided does not cost more than a benchmark.[142]

Rate regulation has typically not been based on household affordability. However, recent state-level innovation may change this. Connecticut is piloting "[t]he Connecticut Healthcare Affordability Index (CHAI) [,] [which] measures the impact of healthcare costs, including premiums and out-of-pocket expenses, on a household's ability to afford all basic needs."[143] Rather than focusing on

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"strategies for optimization of affordability of prescription drugs for the state and all of its residents"). This broad language comes from model legislation drafted by the National Academy for State Health Policy. *See* Mello & Wolitz, *supra* note 124, at 885 ("The model legislation seeks to 'protect State residents, state and local governments (including their contractors and vendors), commercial health plans, providers, state-licensed pharmacies, and other health care system stakeholders from excessive costs of certain prescription drugs.'" (quoting NAT'L ACAD. FOR STATE HEALTH POL'Y, AN ACT TO ESTABLISH RATE SETTING OF PRESCRIPTION DRUGS IN [STATE], https://nashp.org/wp-content/uploads/2018/08/NASHP-RX-Rate-Setting-Model-Act.pdf [https://perma.cc/ZLC5-Z6TV])).

138. *See, e.g.*, Sonia Jaffe & Mark Shepard, *Price-Linked Subsidies and Imperfect Competition in Health Insurance*, 12 AM. ECON. J. 279, 284 (2020).

139. Erin C. Fuse Brown, *Health Reform and Theories of Cost Control*, 46 J.L., MED. & ETHICS 846, 851 (2018) (using this language when describing the ACA's shortcomings); Erin C. Fuse Brown & Jaime S. King, *The Double-Edged Sword of Health Care Integration: Consolidation and Cost Control*, 92 IND. L.J. 55, 76–107 (2016).

140. *See* Brown, *supra* note 139 ("[The] ACA['s] affordability provisions are better characterized as policies to promote health care access than to control health care costs.").

141. Brown & King, *supra* note 139, at 104.

142. *Id.* at 107–08.

143. *Affordability Index*, HEALTHSCORECT (2023), https://portal.ct.gov/healthscorect/affordability-index?language=en_US [https://perma.cc/M9RD-W8FT].

specific services, the CHAI attempts to predict overall health care costs for a household based on age and health status.[144]

III. EVALUATING AFFORDABILITY DEFINITIONS

Part II has explained how American health law invokes and defines health affordability and has revealed the lack of a single consensus definition.[145] This Part takes on the task of categorizing and critically evaluating offered definitions.

Defining health affordability is acknowledged to be hard. One senior Clinton and Obama policy staffer described it as "vexing," asking whether "affordability mean[s] insurance premiums should not be greater than a percentage of income, or does it mean an explicit dollar amount?"[146] MIT economist Jonathan Gruber, an architect of both Massachusetts's pre-ACA health reform and the ACA, had an even more adverse reaction: "[T]he law itself simply said that health insurance had to be 'affordable,' but it didn't define what that meant. . . . My first reaction was to simply avoid the conversation; after all, 'affordability' isn't even a real economic concept!"[147] Echoing Gruber's complaint, a recent brief from the University of Pennsylvania's Leonard Davis Institute similarly asserts that "[u]nlike most economic measures, affordability is essentially a sentiment."[148]

Despite grousing about the ambiguity of health affordability and its dissimilarity to other economic metrics, many experts have ultimately recognized the need for definition. The Leonard Davis Institute's brief, for instance, ultimately concludes that health affordability "must be understood as a function of opportunity costs—the value of alternative uses for spending on health care (for example, on other necessities)."[149]

Existing definitions of affordability fall into three groups. *Descriptive* definitions, discussed in Section III.A, regard health spending as affordable

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144. *Id.*

145. *Cf.* Wolitz, *supra* note 94, at 394 n.32 ("Currently, no consensus view—either normative or empirical—exists as to what it means to be an affordable medication. . . . Different conceptions of 'affordable' have been offered in the adjacent literature on affordable health insurance, but again there is no consensus view.").

146. Christopher C. Jennings, *A Conversation with Christopher C. Jennings*, 26 NOVA L. REV. 403, 406 (2002).

147. Jonathan Gruber, *Health Economists in the Real World*, 5 AM. J. HEALTH ECON. 1, 3 (2019); *see also* Steven Russell, *Ability to Pay for Health Care: Concepts and Evidence*, 11 HEALTH POL'Y & PLAN. 219, 220 (1996) ("In conventional economics there is no accepted definition of an affordable price . . . ."); Bundorf & Pauly, *supra* note 17, at 652 ("[W]hile the term 'affordability' is in common use in policy discussions, it unfortunately does not have a precise definition, either in those discussions or in more rigorous economic analysis."). This uneasiness is not confined to health affordability. *See* John M. Quigley & Steven Raphael, *Is Housing Unaffordable? Why Isn't It More Affordable?*, J. ECON. PERSPS., Winter 2004, at 191, 191 ("[E]conomists are wary, even uncomfortable, with the rhetoric of 'affordability,' which jumbles together in a single term a number of disparate issues . . . .").

148. PENN LEONARD DAVIS INST. OF HEALTH ECONS. & U.S. OF CARE, *supra* note 12, at 1.

149. *Id.* at 6.

based on public perceptions or behavior. *Tradeoff* approaches, discussed in Section III.B, regard health spending as affordable if they do not impose unacceptable tradeoffs on households. Last, *value-based* approaches, discussed in Section III.C, regard health spending as affordable if it provides good value for money.

Health affordability definitions serve at least two purposes. First, they can help delimit different health system participants' rights and duties. In this role, affordability establishes that households cannot be asked to contribute more than the affordability threshold toward their health insurance and care, even if they would be able or willing to do so. Second, affordability definitions can help decision-makers price health insurance and services attractively enough that purchasers prefer to buy insurance rather than remain uninsured or receive health care rather than decline it as George Chandler did. This second role is less relevant for services that are provided before payment, such as emergency care and many hospital services. Attractive pricing is important because the American health system currently relies on drawing healthy individuals into insurance risk pools without the use of mandates or automatic coverage.[150] Selecting a definition of health affordability may depend on whether the goal is to define obligations or attract customers.

Like other health law concepts, such as loss of function or patient complexity, affordability definitions have both qualitative and quantitative dimensions.[151] The qualitative definition identifies the outcome we fundamentally care about—households' ability to obtain basic necessities, pursue a reasonable range of opportunities, or avoid disruption of economic status. The quantitative definition, meanwhile, identifies measurable proxies for what we care about. The two most common ways of operationalizing health affordability involve examining either (a) what quantity of financial resources the spender retains after health spending or (b) what proportion of the spender's financial resources health spending consumes. The proportion-of-income approach tends to be attractive to policymakers because it is easy to calculate. However, its fit with the qualitative definitions of affordability, as Section III.B will discuss, is inexact. That health spending consumes a specified quantity of a household's income reveals little about whether the household's access to basic needs is in jeopardy, whether it is able to access a reasonable range of opportunities, or whether its accustomed lifestyle has been disrupted.

150. *See* Wendy Netter Epstein, *Private Law Alternatives to the Individual Mandate*, 104 MINN. L. REV. 1429, 1450 (2020).

151. *See* Timber Town Living, Inc. v. Dep't of Hum. Servs., 513 P.3d 28, 39 (Or. Ct. App. 2022) (Tookey, J., dissenting) (contrasting a "quantitative (*e.g.*, 'more than 7 days')" with a "qualitative (*e.g.*, 'long term') definition" of loss of physical function); *see also* Richard W. Grant et al., *Defining Patient Complexity from the Primary Care Physician's Perspective: A Cohort Study*, 155 ANNALS INTERNAL MED. 797, 802 (2011) (contrasting a qualitative definition of patient complexity with a quantitative one).

Ultimately, although much debate centers on the choice of proxy, it is crucial to remember that what ultimately matters is the qualitative rather than the quantitative outcome. For instance, while the percentage-of-income measures discussed below may *predict* or *correlate with* affordability, it is doubtful that they *constitute* affordability.

A. Descriptive Definitions

Descriptive definitions of affordability use individual statements and choices to define affordability. Survey and deliberative approaches derive definitions from what the public says about affordability, whereas inference approaches use purchasing decisions or prevailing prices as the basis for affordability determinations.

1. Survey Approaches

Open-ended surveys (like those reported in the Introduction) simply ask respondents whether a health spending amount or vignette satisfies affordability.[152] Surveys are straightforward to administer. They also promise to uncover the public's beliefs rather than making prescriptions that may not be supported by democratic consensus.

Survey approaches have three major limitations. First, although they report how individual respondents use terms like "affordability" or "affordable," they don't provide a linguistic *definition* of affordability. Analogously, knowing that survey respondents agree that a given criminal sentence or civil award is excessive doesn't provide a definition of excessiveness. This first problem is connected to a second: When respondents classify health spending as affordable, they must be relying on some idea of affordability other than whether individuals would perceive it as affordable. Respondents' conception of affordability may be inexpressible or ineffable, like Potter Stewart's famous aphorism.[153] But even an ineffable idea of affordability is still distinct from the survey results, which only report how often certain scenarios satisfy people's independently developed conception of affordability.

Third, researchers' framing of affordability questions reflects their own conceptual commitments. If researchers ask respondents a question framed in percentage terms—like "what percentage of household income devoted to health spending is affordable?"—they will get a percentage definition back. A

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152. Peter Muennig, Bhaven Sampat, Nicholas Tilipman, Lawrence D. Brown & Sherry A. Glied, *We All Want It, but We Don't Know What It Is: Toward a Standard of Affordability for Health Insurance Premiums*, 36 J. HEALTH POL., POL'Y & L. 829, 831 (2011); *see also* Leah Zallman, Rachel Nardin, Assaad Sayah & Danny McCormick, *Perceived Affordability of Health Insurance and Medical Financial Burdens Five Years in to Massachusetts Health Reform*, 14 INT'L J. EQUITY IN HEALTH, 2015, at 1, 3 ("We assessed perceived affordability of insurance by asking about agreement with the statement 'your insurance plan is affordable to you' . . . .").

153. Jacobellis v. Ohio, 378 U.S. 184, 197 (1964) (Stewart, J., concurring) ("I know it when I see it . . . .").

conclusion "that, on average, a health insurance policy should be about 4.9 [percent] of household income to be affordable,"[154] should accordingly be interpreted modestly. Respondents are not saying that 4.9 percent or less of income constitutes affordability, but rather only that, *if* a percentage definition of affordability is used, 4.9 percent is the proper cutoff. Ultimately, although survey approaches can be a good way of assessing the public acceptability of a definition of affordability, they struggle to provide the content of the definition itself.

2. Deliberative Approaches

A more promising route to extracting a meaningful definition from public perspectives involves public deliberation, akin to the approaches that scholars such as Susan Goold and Marion Danis have used for designing proposed health insurance plans.[155] Deliberative approaches do not merely poll the public on what they think is affordable, but ask the public what they think affordability encompasses and why, and then have them deliberate together to resolve disagreements. Similar to Goold and Danis's work on health insurance plans, the public could be asked to evaluate established definitions of affordability, similar to what qualitative researchers call an approach based on "preexisting theory."[156] These definitions could be taken from statutes, regulations, scholarly work, or other attempts to define affordability. Alternatively, the public could deliberate together about how they would define affordability and then the definition of affordability could grow out of their discussions, similar to how qualitative researchers describe "grounded theory."[157]

Although public deliberation may be more promising than surveys, it is likely to be insufficient alone. Unless grounded theory is used, potential definitions of affordability—such as those canvassed later in this Part—must be provided in advance to guide the public's deliberation. Additionally, public deliberation often favors the views of interest groups that are well organized

154. Sherry Glied & Peter Muennig, Reforming Reform: Public Assessments of the Affordability of Health Insurance Policies 8 (Mar. 16, 2017) (unpublished manuscript), https://osf.io/preprints/socarxiv/8g4n6 [https://perma.cc/YMX2-WDHP].

155. Marion Danis, Susan D. Goold, Melinee Schindler & Samia A. Hurst, *The Value of Engaging the Public in CHATing About Healthcare Priorities: A Response to Recent Commentaries*, 8 INT'L J. HEALTH POL'Y & MGMT. 250, 250–51 (2019).

156. *See* Lizardo Vargas-Bianchi, Qualitative Theory Testing by Deductive Design and Pattern Matching Analysis 2 (July 30, 2020) (unpublished manuscript), https://www.researchgate.net/publication/343318941 [https://perma.cc/97TM-3YUW] ("Th[e] [qualitative deductive] method requires the researcher to work on an existing theory, collect empirical data to prove it, and reflect on its confirmation (or rejection) grounded by the findings." (citation omitted)).

157. *See* Elisa W. v. City of New York, No. 15-cv-5273, 2021 WL 4027013, at *6 (S.D.N.Y. Sept. 3, 2021) (describing grounded theory as "a well-accepted . . . research method that entails comparing large volumes of data and developing conclusions that are 'grounded in data' as opposed to being driven by a predetermined hypothesis").

and may not capture the overall beliefs of the general public.[158] Last, deliberators could end up selecting a definition inconsistent with other values they hold, but about which they might not be asked.

3. Inference Approaches

Inference approaches base affordability determinations not on what people say, but on what they (individually or collectively) do. The economists Mark Pauly and M. Kate Bundorf have suggested a "behavioral" definition of affordability, on which insurance is "affordable if the majority of people in similar circumstance[s] purchase coverage."[159] This definition is appealing for policymakers designing subsidies to draw uninsured individuals into a health insurance market, but has limited applicability to health *care* affordability since many health care interventions are either delivered before payment or face inelastic demand, where patients will pay "whatever it takes."[160] Although the behavioral approach is interesting, it appears less a definition of afford*ability*—individuals' capacity to afford a good—and more a definition of popularity, measured by individuals' actual uptake of that good.

A similar approach to affordability was taken in research that undergirded Massachusetts's 2006 reforms, which defined affordability as a function of "people's actual spending on health care (health insurance premiums and out-of-pocket expenses), at various income levels."[161] The researchers defend this approach by asserting "that basing the benchmark standard for affordability on the share of income now devoted to health spending by privately insured people is a sound approach because it reflects actual experience."[162] Based on detailed analysis, they propose amounts ranging from two percent to thirteen percent of income as potential affordability standards mirroring status quo spending levels, with eight percent and ten percent the most common suggestions.[163] They also propose that "[e]quity considerations suggest that affordability standards should be lower for people below 300 percent, since spending for other necessities will constitute a bigger share of their spending than it does for a higher-income family,"

158. *Cf.* Ganesh Sitaraman, *The Puzzling Absence of Economic Power in Constitutional Theory*, 101 CORNELL L. REV. 1445, 1500 (2016) ("[T]hose designing institutions might adopt rules and regulations to increase public participation . . . , but the well-to-do and their associated interest groups will in practice be better suited to navigate those rules and regulations.").

159. Bundorf & Pauly, *supra* note 17, at 667.

160. *See, e.g.*, Kelly v. St. Vincent Hosp., 692 P.2d 1350, 1353 (N.M. Ct. App. 1984) ("Most services associated with medical care . . . are characterized by inelastic demand relationships. Inelastic demand means, because the services are necessary, consumers will continue to purchase them no matter how highly priced the services are."); Robert H. Blank, *Regulatory Rationing: A Solution to Health Care Resource Allocation*, 140 U. PA. L. REV. 1573, 1587 n.37 (1992).

161. Linda J. Blumberg, John Holahan, Jack Hadley & Katharine Nordahl, *Setting a Standard of Affordability for Health Insurance Coverage*, 26 HEALTH AFFS. w463, w465 (2007).

162. *Id.* at w471.

163. *Id.* at w472.

though they are uncomfortable admitting this normative commitment into their otherwise descriptive account, ultimately stating that "the precise shape of the affordability-income tradeoff has an inherently arbitrary component" and that "[p]olitical and social values will clearly play a major role in determining the particular design chosen."[164]

The assumption that "people can afford to spend what they are in fact spending"[165] on health care or insurance has been echoed in more recent proposals that anchor affordability definitions in the status quo.[166] Proposals for "an upper limit on family health care spending that includes premiums and out-of-pocket costs," for instance, suggest that "[t]he upper limit should reflect what middle-income families typically pay for health care."[167] Another research team similarly asserted that "[o]ne way of benchmarking affordability is to look at current healthcare spending, which provides an accurate picture of what consumers are willing and able to pay."[168]

Most recently, multiple state insurance affordability standards have equated affordability with cost increases no higher than a selected multiple (e.g., 101 percent) of status quo spending.[169] The benchmark is sometimes indexed to economy-wide wage or economic growth.[170] Many of the prescription drug affordability boards discussed in Part II have likewise focused on price increases.[171] Although these approaches use a multiplier of aggregate spending

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164. *Id.* at w467–68.

165. Carla Saenz, *What Is Affordable Health Insurance? The Reasonable Tradeoff Account of Affordability*, 19 KENNEDY INST. ETHICS J. 401, 403 (2010).

166. *Cf.* David B. Spence, *The Political Economy of Local Vetoes*, 93 TEX. L. REV. 351, 396 (2014) ("Decision makers tend to frame choices with respect to the status quo—that is, to 'anchor' on the status quo. In so doing we tend to treat the status quo . . . as a legitimate distribution of net benefits." (footnote omitted)).

167. CMTY. CATALYST & PICO NAT'L NETWORK, VOICES FROM THE FIELD: THE CASE FOR A COMMONSENSE AFFORDABILITY STANDARD 2 (2009), https://www.communitycatalyst.org/wp-content/uploads/2022/11/affordability_brief_cc_pico.pdf [https://perma.cc/35CN-RXLG].

168. KEN JACOBS, KOREY CAPOZZA, DYLAN H. ROBY, GERALD F. KOMINSKI & E. RICHARD BROWN, U.C. BERKELEY LAB. CTR., HEALTH COVERAGE EXPANSION IN CALIFORNIA: WHAT CAN CONSUMERS AFFORD TO SPEND? 2 (2007), https://laborcenter.berkeley.edu/pdf/2007/health_expansion07.pdf [https://perma.cc/T3V7-CBCD].

169. GLENN MELNICK, CAL. HEALTH CARE FOUND., HEALTH CARE COST COMMISSIONS: HOW EIGHT STATES ADDRESS COST GROWTH 2–7 (2022).

170. *Id.* at 5.

171. Tara Sklar & Christopher Robertson, *Affordability Boards—The States' New Fix for Drug Pricing*, 381 NEW ENG. J. MED. 1301, 1302 (2019) ("Most state bills trigger board review for patented drugs when drugs enter the market with a wholesale acquisition cost of at least $30,000 per year or treatment course or undergo a price hike of at least 10 [percent], $10,000, or $3,000 within 1 year . . . ."); Michelle Mello & Stacie Dusetzina, *NASHP's Proposal for Imposing Penalties on Excessive Price Increases for Prescription Drugs*, NAT'L ACAD. FOR STATE HEALTH POL'Y (Aug. 14, 2020), https://nashp.org/nashps-proposal-for-imposing-penalties-on-excessive-price-increases-for-prescription-drugs [https://perma.cc/L6HV-HDEW] ("[A]lthough defining what constitutes an excessive or unfair *launch* price for a drug is highly controversial, defining an unjustified price *increase* is more tractable because there is a clear basis for comparison: the rate of general or medical inflation.").

rather than an average of individual spending, they also define affordability as a multiple of the status quo.

Lawmakers' attraction to inference approaches is understandable. Basing affordability on the status quo buttresses the politically attractive case that policymakers are improving affordability without entangling them in challenging normative questions like what "constitutes an excessive or unfair launch price for a drug"[172] or the "highly prescriptive" task of "categorizing spending as 'essential'"[173] that alternative approaches might require. Politically active middle-class voters may not fear that health costs will deprive them of basic needs. Rather, they seek stability and are distinctively upset by increases in health costs compared to their accustomed baseline.[174] Inference definitions of affordability promise to save them money.

Despite its political attractiveness, defining affordability via actual spending has two problems. First, people sometimes elect to spend less than they could: Even assuming that "people can afford to spend what they are in fact spending,"[175] we can't conclude that they can *only* afford to spend what they are in fact spending. Actual spending therefore does not provide a complete definition of affordability. Second, people can, and often do, purchase necessary goods and services even though they, or others, would describe these purchases as unaffordable. The concept of affordability extends beyond, rather than being coextensive with, the concept of formal ability to pay.[176] Defining affordability in terms of the status quo may shield middle-class households from cost increases, but it leaves poor households struggling to meet health care needs in the same poor situation.[177]

As with surveys and deliberation, these problems need not mean that approaches based on actual spending have no place in policy or law. Knowing what people spend or what plans they are willing to purchase could be part of a hybrid account of affordability, along the lines Part IV will discuss.

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172. Mello & Dusetzina, *supra* note 171.

173. Blumberg et al., *supra* note 161, at w465.

174. *Cf.* Ariel Jurow Kleiman, *Tax Limits and the Future of Local Democracy*, 133 HARV. L. REV. 1884, 1933 (2020) (explaining how loss aversion may lead voters to reject property tax increases); Aaron Tang, *The Radical-Incremental Change Debate, Racial Justice, and the Political Economy of Teachers' Choice*, 169 U. PA. L. REV. ONLINE 2015, 2029 (2021) (explaining that "loss aversion" is one of the "psychological biases that generate intense suburban opposition to integration and genuine public school choice").

175. Saenz, *supra* note 165, at 403.

176. *Id.* ("If what people should do is determined by what they actually do, one simply legitimizes the *status quo*. For example, there is empirical evidence that people lie. Yet from that evidence one does not conclude that people should lie, or that they are morally justified in doing so. By the same token, there needs to be a normative account of how much people should be required to pay for health coverage that is not just a function of what people happen to pay for it.").

177. *Cf.* JOHN MYLES, OLD AGE IN THE WELFARE STATE 55 (Univ. Press of Kan. 1989) ("To provide income security to the poor is only to secure them in their poverty.").

B. Tradeoff Definitions

The opportunity costs, or tradeoffs, associated with health spending are also used to define affordability.[178] Tradeoff views of health affordability often reason as follows: "No one should have to choose between health care/insurance and . . . ."[179] This Part examines four potential endings for this sentence: (1) basic needs; (2) a reasonable range of opportunities; (3) a household's accustomed lifestyle; or (4) anything else.

The sociologist Gøsta Esping-Andersen's taxonomy of social insurance programs provides a useful framework for analyzing tradeoff definitions.[180] Esping-Andersen identifies three categories of social insurance programs. "Liberal" programs comprise means-tested assistance and modest benefits in the form of a guaranteed minimum.[181] "Conservative-corporatist" programs provide social insurance that aims to preserve and replicate status differentials among citizens.[182] Last, "social democratic" programs provide universal assistance not just to the poor but to the better-off, aiming to realize "an equality of the highest standards" rather than merely meeting "minimal needs."[183] Basic needs definitions parallel Esping-Andersen's "liberal" programs. Those organized around preserving an accustomed lifestyle parallel conservative-corporatist

178. *E.g.*, Penn Leonard Davis Inst. of Health Econs. & U.S. of Care, *supra* note 12, at 2 ("Any statement about affordability is essentially a statement about opportunity costs, about the value placed on other important goods foregone."); *see also* Wolitz, *supra* note 94, at 394–95 ("In the case of prescription medications, unaffordability suggests that a patient must give up her medication itself or a necessity of another kind. For instance, a patient may be compelled by the high price of a prescription drug to choose between her medication and rent when it is not possible to pay for both. In such a case, the patient faces a tradeoff she ought not have to make." (footnote omitted)); Sherry Glied, *Mandates and the Affordability of Health Care*, 46 Inquiry 203, 204 (2009) ("A household is said to 'afford' such a purchase if it would be left with enough income to meet its other socially defined minimum needs.").

179. Prominent politicians from both major parties have endorsed this framing. *E.g.*, Joe Biden, President of the United States, Statement Marking the 57th Anniversary of Medicare and Medicaid (July 30, 2022) ("Congressional Democrats and I are fighting to strengthen these programs, so no American has to face a choice between health care and putting food on the table."); Bill Clinton, President of the United States, Remarks to the 21st Constitutional Convention of the National Council of Senior Citizens (July 2, 1996) ("If there's a problem with Medicare, solve the problem, but don't solve it by asking families to go back to the days when they had to choose between health care for the parents or college educations for the kids."); *Health Care*, Congressman Robert B. Aderholt, https://aderholt.house.gov/issues/health-care [https://perma.cc/9JF8-EDSE] ("[T]he Administration needs to . . . ensure our senior citizens and future generations do not have to choose between buying groceries and prescription drugs.").

180. Gøsta Esping-Andersen, The Three Worlds of Welfare Capitalism 26–27 (1990). Esping-Andersen's framework has recently influenced legal scholarship beyond health law. *See, e.g.*, Abbye Atkinson, *Rethinking Credit as Social Provision*, 71 Stan. L. Rev. 1093, 1121 n.153 (2019); Aditi Bagchi, *Lowering the Stakes of the Employment Contract*, 102 B.U. L. Rev. 1185, 1189 n.9 (2022); Maxine Eichner, The Free-Market Family: How the Market Crushed the American Dream (and How It Can Be Restored) 233 n.101 (2020).

181. Esping-Andersen, *supra* note 180, at 26.

182. *Id.* at 27 (describing "welfare-state regimes" as "conservative and strongly 'corporatist'").

183. *Id.*

programs. Those that reject tradeoffs between health spending and anything else parallel social-democratic programs. Last, reasonable opportunity definitions sit somewhere between liberal and social-democratic programs, guaranteeing something more that minimal needs but less than the full "de-commodification"—independence from market provision—that characterizes ideal social-democratic programs.[184]

1. Basic Needs

Basic needs definitions classify health spending as affordable when it does not worsen individuals' ability to meet basic needs.[185] These definitions have been highly influential in public policy. In Jonathan Gruber's pathbreaking work on Massachusetts's health reform plan that presaged the ACA, he "simply defined 'affordable' as 'can pay for it without reducing spending on necessities,' and [he] defined necessities as shelter, utilities, food, and clothing."[186] According to Gruber, this definition shaped "how we set up the subsidies in Massachusetts" and "was used during debates over how to set subsidies under the ACA."[187]

Connecticut's definition of affordable health care discussed in Section II.C is also a basic needs definition: "Health care is affordable if a family can reliably secure it to maintain good health and treat illnesses and injuries when they occur, without sacrificing the ability to meet all other basic needs including housing, food, transportation, childcare, taxes, and personal expenses or without sinking into debilitating debt."[188]

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184. *Id.* at 48–49; *see also id.* at 46 (describing the evolution of social-democratic regimes from programs providing a basic minimum to providing more generous benefits).

185. PENN LEONARD DAVIS INST. OF HEALTH ECONS. & U.S. OF CARE, *supra* note 12, at 7 (2018) (explaining that "[i]n terms of opportunity costs, most notions of affordability imply that families should not have to forego basic necessities to pay for health care"); *see also* Russell, *supra* note 147, at 223 (illustrating graphs for ability to pay for health care in terms of affordability in conjunction with nonhealth expenditures/consumption).

186. Gruber, *supra* note 147, at 3.

187. *Id.* at 4.

188. Victoria Veltri & Kevin Lembo, *A Tool to Improve Policymaking in Health Care Affordability*, MILBANK MEM'L FUND: SUSTAINABLE HEALTH CARE COSTS (Sept. 14, 2021), https://www.milbank.org/2021/09/a-tool-to-improve-policymaking-in-health-care-affordability [https://perma.cc/2SKE-P5GS].

Similar basic needs definitions have been used or proposed in Missouri, California, Colorado, and elsewhere,[189] and employed in academic analyses.[190] Basic needs definitions are often described as "residual" because they consider whether there is sufficient residual income for all other basic needs after meeting the need in question. Basic needs definitions are also used for essentials other than health and insurance—housing, in particular.[191]

Basic needs definitions' greatest strength is their ethically compelling foundation.[192] The importance of basic needs is common ground among a wide range of normative perspectives. Support in meeting basic needs is recognized as a human right.[193]

Basic needs definitions, however, face three challenges. First, the heterogeneity of household incomes and needs can make operationalizing basic needs definitions challenging. Second, selecting which needs count as basic involves challenging normative judgments. Last, basic needs definitions approach the risk of turning affordability into an interest only of poor and working-class households.

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189. COVER MO., DEFINING AFFORDABLE HEALTH CARE FOR MISSOURI 5 (2008), https://www.communitycatalyst.org/doc-store/publications/cover_missouri.pdf [https://perma.cc/GMR6-3MBL] (defining affordability "as the percentage of annual household income that can be devoted to health care while maintaining sufficient resources to pay for other necessities"); LAUREL LUCIA & KEN JACOBS, U.C. BERKELEY LAB. CTR., TOWARDS UNIVERSAL HEALTH COVERAGE: CALIFORNIA POLICY OPTIONS FOR IMPROVING INDIVIDUAL MARKET AFFORDABILITY AND ENROLLMENT 8 (2018), https://laborcenter.berkeley.edu/pdf/2018/CA-policy-options-individual-market-affordability.pdf [https://perma.cc/3W56-4NM2] ("Affordability can be evaluated using a household budget approach—at each level of income, are sufficient funds available to pay for healthcare after accounting for spending on other essentials like housing, food, transportation, and childcare?"); COLO. DEP'T OF REGUL. AGENCIES: DIV. OF INS. & COLO. DEP'T OF HEALTH CARE POL'Y & FIN., DRAFT REPORT FOR COLORADO'S STATE COVERAGE OPTION 15 (2019), https://drive.google.com/file/d/1GrwnJ_IWpXHE2M-5LvAFeRAljVcwptYc/view [https://perma.cc/PDW2-ZW2F] ("[A]ffordability for the State Option will include the following considerations: . . . . Ability to be purchased without sacrificing other budgetary priorities required for basic self-sufficiency . . . .").

190. Obiajulu Nnamuchi, Jirinwayo Jude Odinkonigbo, Uju Beatrice Obuka & Helen Agu, *Successes and Failures of Social Health Insurance Schemes in Africa—Nigeria Versus Ghana and Rwanda: A Comparative Analysis*, ANNALS HEALTH L. & LIFE SCIS., Winter 2019, at 127, 142 (2019); HELEN LEVY & THOMAS DELEIRE, WHAT DO PEOPLE BUY WHEN THEY DON'T BUY HEALTH INSURANCE? 3 (2002).

191. *E.g.*, DANILO PELLETIERE, NAT'L LOW INCOME HOUS. COAL., GETTING TO THE HEART OF HOUSING'S FUNDAMENTAL QUESTION: HOW MUCH CAN A FAMILY AFFORD? A PRIMER ON HOUSING AFFORDABILITY STANDARDS IN U.S. HOUSING POLICY 12 (2008), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=1132551 [https://perma.cc/PBJ9-J2LA] ("In the first approach, necessary non-shelter expenses, determined as part of a quantity based budget, are met first. The income remaining after paying for the non-housing items is considered the amount of money that a household has available for housing. Comparing this 'residual' to the household's gross income reveals the [housing cost] that is affordable.").

192. NAT'L RSCH. COUNCIL & INST. OF MED. OF THE NAT'L ACADEMIES, MEDICAL CARE ECONOMIC RISK: MEASURING FINANCIAL VULNERABILITY FROM SPENDING ON MEDICAL CARE 40 (Michael J. O'Grady & Gooloo S. Wunderlich eds., 2012).

193. G.A. Res. 217 (III) A, Universal Declaration of Human Rights, art. 25 (Dec. 10, 1948).

Commentators who ultimately reject or modify basic needs definitions sometimes do so for logistical reasons. Sherry Glied, for instance, questions the practicability of basic needs definition because they necessitate:

> defining, for each household, the minimum socially desirable level of consumption of the index merit good (i.e., health care) and of other merit goods; assessing the prices faced for each good or service; and measuring income. This exercise is likely to be computationally daunting as a research project and intractable as a policy standard. . . . Instead, analysts and policymakers have adopted a variety of more limited, short-hand rules for affordability.[194]

Shorthand rules based on percentages of income, Glied claims, are more workable than actually assessing whether health spending is competing with basic needs.[195] Connecticut, however, has proposed using the very approach Glied believed was too complicated.[196]

Many other critiques of basic needs definitions are less persuasive. Some charge that basic needs definitions do "not treat health care as an essential good, but rather as a luxury item" because they "consider[] any remaining money after the purchase of necessities in the household budget to be available for the purchase of health care."[197] This is unconvincing. Basic needs definitions simply add health spending to a list of essential goods or necessities. If the household budget—supplemented by available subsidies—exceeds the cost of necessities, then health care is affordable for that household; if not, health care is unaffordable. Others complain that basic needs definitions provide "no guidance about how much of any residual income should be spent on health."[198] But the point of a basic needs definition is that health is just one among many basic needs: As long as spending on health plus other basic needs does not exceed household income, affordability has been achieved.

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194. Glied, *supra* note 178, at 205.

195. *Id.*; *see also* Katherine Swartz, *Expert Reflection: Easier Said than Done*, 36 J. HEALTH POL., POL'Y & L. 855, 855, 857 (2011) (explaining that "it is difficult to judge people's ability to afford a necessity like health insurance on the basis of simple factors such as income, age, number and age of family members, and their health status" along with "'deserving' exceptions" and sharing that "[she] grudgingly began to realize that a simple percent-of-income rule was more practical and avoided moral debates that were sure to arise").

196. *See supra* note 143 and accompanying text.

197. Karen Davenport, Garrett Groves & Avinash Kinra, *The Price Isn't Right: The Facts on Affordable Health Care*, CTR. FOR AM. PROGRESS (Aug. 19, 2008), https://www.americanprogress.org/article/the-price-isnt-right-the-facts-on-affordable-health-care [https://perma.cc/8WNK-XYQ3].

198. Blumberg et al., *supra* note 161, at w465; *see also* Saenz, *supra* note 165, at 404 (critiquing needs-based accounts of affordability, on which "insurance payments would only be considered affordable if they do not prohibit families from purchasing the other necessities that are required for living" (quoting Jonathan Gruber, Evidence on Affordability from Consumer Expenditures and Employee Enrollment in Employer-Sponsored Health Insurance 4 (Mar. 2007) (unpublished manuscript) (on file with the *Iowa Law Review*))).

Others complain that a basic needs definition of affordability "is highly prescriptive, particularly in categorizing spending as 'essential.'"[199] The concern about prescription is hardly fatal: It is an inevitable consequence of taking a normative rather than descriptive approach and is encountered elsewhere.

Definitions of basic needs remain important and contested.[200] Carla Saenz has challenged Gruber's definition of basic needs, which influenced the Massachusetts plan, as overly narrow.[201] Instead, Saenz argues for defining basic needs "to include goods and benefits that are necessary for a moderately fulfilling life and not just for survival."[202] But while Saenz's critique of Gruber's approach is compelling, her attempt to define basic needs in terms of a moderately fulfilling life is flawed. Many people far below the U.S. poverty line lead fulfilling lives. And many goods and services subsidized as necessities are not necessary for a moderately fulfilling life. Most American adults do not have a college degree, and nearly ten percent have not completed high school.[203] One-third do not own homes.[204] Many medicines we regard today as essentials were unavailable ten or twenty years ago—yet people could still lead fulfilling lives. The lesson is that policymakers can plausibly see homes, medicines, and advanced education as basic needs or essentials even though they are not necessary for a moderately fulfilling life. Instead of trying to define basic needs in terms of fulfillment—a task known to be treacherous—

199. Blumberg et al., *supra* note 161, at w465; *see also* Russell, *supra* note 147, at 224–25 (outlining a scenario where a household may choose to spend resources on "nonessentials" to the detriment of its health care spending).

200. *E.g.*, State *ex rel.* Dep't of Hum. Servs. v. Shugars, 121 P.3d 702, 713 (Or. Ct. App. 2005) (canvassing potential definitions of "basic needs," in the absence of a statutory definition); Koehler v. Colo. Dep't of Health Care Pol'y & Fin., 252 P.3d 1174, 1180 (Colo. App. 2010) (concluding that "[a]lthough the statute and case law do not define . . . basic needs, it is [implied] that they include subsistence necessities such as housing, food, and medical costs"); *see also* Carlos A. Ball, *Autonomy, Justice, and Disability*, 47 UCLA L. REV. 599, 626 (2000) ("The starting point for a theory of justice that prioritizes the meeting of needs entails the formulation of a list of basic needs that society is morally obligated to provide. In many ways, the development of such a list is the most challenging part of constructing a theory of justice based on needs because the list is likely to be considered incomplete by some and arbitrary by others.").

201. Saenz, *supra* note 165, at 405 (criticizing Gruber for excluding from the definition of basic needs "entertainment, carry out or fast food . . . , savings, credit card debt or emergency expenses such as car repairs," as well as "longer-term needs (such as retirement savings or college tuition), purchases of major items (such as a car), emergency expenses, or even items such as school supplies or birthday gifts" (quoting *Self-Sufficiency Standard FAQs; How the Standard Differs*, WIDER OPPORTUNITIES FOR WOMEN (2009), http://www.wowonline.org/pdf/SSS-FAQ [https://perma.cc/9S23-T9PV])).

202. *Id.* at 406.

203. *Census Bureau Releases New Educational Attainment Data*, U.S. CENSUS BUREAU (Feb. 24, 2022), https://www.census.gov/newsroom/press-releases/2022/educational-attainment.html [https://perma.cc/P67W-3X3M].

204. *Census Bureau Releases New 2020 Census Data on Age, Sex, Race, Hispanic Origin, Households and Housing*, U.S. CENSUS BUREAU (May 25, 2023), https://www.census.gov/newsroom/press-releases/2023/2020-census-demographic-profile-and-dhc.html [https://perma.cc/P5UK-XMHA].

it would be preferable to rely on consensus definitions of basic needs. This is the approach Connecticut has taken in constructing its affordability index.[205]

Last, basic needs conceptions of health affordability face political disadvantages because they fail to promise benefits to middle-class and wealthier households, who may feel secure in their access to basic needs but nevertheless squeezed by health costs. Esping-Andersen's framework forecasts this, noting that liberal social insurance programs offering modest benefits tend to suffer an "erosion of middle-class support," and come to "depend on the loyalties of a numerically weak, and often politically residual, social stratum."[206] His conclusion is that "enthusiasm for the needs-tested approach . . . is inherently logical but creates the unanticipated result of social stigma and dualism."[207] Bearing out Esping-Andersen's prediction, this lack of middle-class buy-in was a major early challenge for the ACA's affordability programs.[208]

The history of affordability initiatives in the ACA's individual marketplace also fits with Esping-Andersen's framework, which predicts that greater spending on the middle class can garner more buy-in and shore up a program's political fortunes. The ACA's marketplace subsidies can be understood as having moved steadily over time from a liberal structure toward an increasingly social-democratic one that offers more generous benefits to middle-class households. The Massachusetts health reform and congressional draft legislation leading up to the ACA was less generous to the middle class than the ultimately passed legislation. Massachusetts's reform ended subsidies at three hundred percent of FPL,[209] while the draft legislation that ultimately became the ACA allowed subsidies up to four hundred percent of FPL but asked households at the top end of the subsidy range to pay up to twelve percent of income toward health insurance.[210] In contrast, the ACA as enacted allowed subsidies up to four hundred percent and did not ask subsidized households to pay more than ten percent of their income toward health

205. *See Affordability Index*, *supra* note 143.

206. ESPING-ANDERSEN, *supra* note 180, at 26, 33.

207. *Id.* at 64.

208. *See* Jacqueline Chattopadhyay, *Is the Affordable Care Act Cultivating a Cross-Class Constituency? Income, Partisanship, and a Proposal for Tracing the Contingent Nature of Positive Policy Feedback Effects*, 43 J. HEALTH POL., POL'Y & L. 19, 28 (2018) (explaining that one "factor that may hinder a cross-class constituency is that ACA subsidy administration brightens income differences within America's economically diverse middle class, particularly the line between middle and upper middle incomes").

209. *See supra* note 95 and accompanying text.

210. Sara R. Collins, Karen Davis, Jennifer L. Kriss, Sheila Rustgi & Rachel Nuzum, *The Health Insurance Provisions of the 2009 Congressional Health Reform Bills: Implications for Coverage, Affordability, and Costs*, COMMONWEALTH FUND (Jan. 7, 2010), https://www.commonwealthfund.org/publications/fund-reports/2010/jan/health-insurance-provisions-2009-congressional-health-reform [https://perma.cc/DB5K-QD6U] (explaining that the Senate bill asked households at four hundred percent of poverty to pay up to twelve percent of income toward health insurance, while the house bill asked households between three hundred percent and four hundred percent of poverty to pay up to 9.8 percent).

insurance.[211] But the absence of subsidies for households above four hundred percent of FPL prompted substantial resentment from the middle-class households on the other side of the "subsidy cliff," which presented a persistent political problem for the ACA.[212] Various fixes, such as reinsurance, have been proposed to address these issues. They were finally and comprehensively tackled by the American Rescue Plan's ("ARP") subsidy reforms, which guaranteed that no household—irrespective of income—would have to pay more than 8.5 percent of income for individual marketplace insurance.[213] In Esping-Andersen's terms, this approach was a major shift toward universal benefits that included more of the middle class.[214] In 2022, four hundred percent of FPL was around $111,000 for a four-person household—above the median income in states like Florida, Texas, Michigan, and Wisconsin—so the ARP's extension of benefits above that mark reached well into the middle, if not upper-middle, class.[215]

Despite its political attractiveness, extending subsidies to upper-middle-class households fits uneasily with the idea of protecting basic needs, leaving it unclear what conception of affordability the post-ARP benefits serve. The next two Subsections will discuss two distinct alternatives: extending the definition of affordability to guarantee a reasonable opportunity range and altering the definition of affordability to focus on the protection of accustomed economic status.

2. Reasonable Opportunity Range

One approach to affordability that goes beyond basic needs defines affordability as achieved when health spending does not unreasonably shrink a household's range of opportunities. Something akin to the reasonable-opportunity view is defended by Brendan Saloner and Norman Daniels, who

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211. 26 U.S.C. § 36B(b)(3)(A).

212. *See* Manoj Viswanathan, *The Hidden Costs of Cliff Effects in the Internal Revenue Code*, 164 U. PA. L. REV. 931, 981 (2016); *see also* Chattopadhyay, *supra* note 208, at 28 ("The ACA leaves many people whose incomes exceed 400 percent FPL 'in the uncomfortable middle: not poor enough for help, but not rich enough to be indifferent to cost.' The subsidy cutoff at 400 percent FPL may feel 'especially arbitrary to people whose incomes vary from year to year' and to people who are 'just right over that line.'" (citation omitted) (quoting Katie Thomas, Reed Abelson & Jo Craven McGinty, *New Health Law Frustrates Many in Middle Class*, N.Y. TIMES (Dec. 20, 2013), https://www.nytimes.com/2013/12/21/business/new-health-law-frustrates-many-in-middle-class.html (on file with the *Iowa Law Review*))).

213. *American Rescue Plan and the Marketplace*, U.S. CTRS. FOR MEDICARE & MEDICAID SERVS. (Mar. 12, 2021), https://www.cms.gov/newsroom/fact-sheets/american-rescue-plan-and-marketplace [https://perma.cc/ZS4V-HWKW].

214. Jon Walker, *The Almost Big F*cking Deal in the COVID Relief Bill*, AM. PROSPECT (Mar. 9, 2021), https://prospect.org/health/covid-relief-bill-health-insurance-subsidy-cliff [https://perma.cc/AH8Q-STUU] ("The ACA provided subsidies only to individuals making less than $51,000 a year; middle-class people were still left vulnerable to the whims of the market.").

215. *Median Family Income by Family Size*, U.S. DEP'T OF JUST., https://www.justice.gov/ust/eo/bapcpa/20220401/bci_data/median_income_table.htm [https://perma.cc/SQ4D-XGFA].

suggest that "health insurance is only affordable where spending on health care leaves households with enough financial resources to realize their fair share of the normal opportunity range."[216] It is not clear, however, what Saloner and Daniels mean by a "fair share" of the opportunity range—language that frames opportunity as a limited, divisible good. Nor, particularly in light of compelling critiques of normality, is it clear why a normal as opposed to reasonable opportunity range is the proper benchmark.[217]

Instead of Saloner and Daniels's "fair share of the normal opportunity range,"[218] it would be more compelling to define affordability in terms of reasonableness: Health spending is affordable when it does not worsen households' access to a reasonable opportunity range. I use the language of worsening intentionally: Assisting households who would lack access to a reasonable opportunity range regardless of health spending is an important social priority, but not a task the health system is specially equipped to handle.

Defining affordability in terms of reasonableness naturally poses the question: What is a reasonable opportunity range? Although the answer will vary by social circumstances and context, a reasonable opportunity range is something less than a maximal set of opportunities, but more than merely being able to meet basic needs.[219] Analogously, reasonable accommodation requirements aim not to ensure that one's religious beliefs or health conditions do not narrow one's opportunities, but rather that opportunities are not narrowed excessively.[220] Health spending might be understood similarly: A household may acceptably lose out on some opportunities due to health spending, but not others.

To identify which opportunities are core to a reasonable opportunity range, two conceptual frameworks can provide a helpful guide. One is the idea of "fertile functionings" and "corrosive disadvantages": capabilities that are particularly valuable in opening opportunities or whose lack closes off many opportunities.[221] Among the capabilities that have been so identified are education and affiliation.[222] Another is the concept of a "bottleneck"—a

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216. Saloner & Daniels, *supra* note 44, at 823.

217. *Cf.* Mayo Moran, *The Reasonable Person: A Conceptual Biography in Comparative Perspective*, 14 LEWIS & CLARK L. REV. 1233, 1248 (2010) ("[S]o long as reasonableness is understood in terms of normality, it will almost inevitably draw on age- *and* gender-specific conceptions of what degree of care or prudence the law will demand.").

218. Saloner & Daniels, *supra* note 44, at 823.

219. Elias Feldman, *Vaccination and the Child's Right to an Open Future*, 25 LEWIS & CLARK L. REV. 209, 229 (2021) (contrasting "a maximally open future" with "a future sufficiently open to allow for a reasonable range of opportunities").

220. *Cf.* Samuel R. Bagenstos, *Bottlenecks and Antidiscrimination Theory*, 93 TEX. L. REV. 415, 427–28 (2014) ("[O]pportunity pluralism is satisfied if every individual has a sufficiently large range of opportunities from which to choose.").

221. JONATHAN WOLFF & AVNER DE-SHALIT, DISADVANTAGE 138 (2007).

222. *See, e.g.*, Martha C. Nussbaum, *Climate Change: Why Theories of Justice Matter*, 13 CHI. J. INT'L L. 469, 483 (2013).

qualification, aspect of development, or instrumental good without which individuals are unable to access a substantial subset of opportunities.[223] In circumstances where bottlenecks cannot or should not be removed, individuals have a special claim to be helped to pass through them.[224] The list of bottlenecks, such as literacy and college credentials,[225] closely resembles the list of fertile functionings.

Both the fertile-functioning/corrosive-disadvantage and bottleneck frameworks tend to center civic and economic opportunities. But opportunities in private life can also be protected by a reasonable-opportunity-range approach. Saenz provides the example of someone who is unable to marry their partner due to health insurance costs or who selects a partner to marry due to health insurance considerations.[226] This sort of limitation on life plans may be inconsistent with a reasonable opportunity range. Expression of one's identity can also be regarded as a fertile functioning.[227]

The flexibility of reasonable opportunity definitions leaves open the question of which real-world policies protect households against deprivation of a reasonable opportunity range. Saloner and Daniels suggest policies that aim to protect funds needed for education and entrepreneurship.[228] The rejection of asset tests in affordability programs could also be seen as aligning with an opportunity definition.[229]

A further question is whether asking households to smooth the cost of "big-ticket" health expenses over multiple years is consistent with preserving a reasonable opportunity range. To obtain housing and higher education, households are often asked to incur debt such as mortgages or student loans. In contrast, many policymakers and advocates perceive medical debt as fundamentally objectionable.[230] Health economists and others, however, have long suggested that "health care loans" or "medical loans" could allow households to finance high-cost treatments over time.[231] On this approach, loans can

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223. JOSEPH FISHKIN, BOTTLENECKS: A NEW THEORY OF EQUAL OPPORTUNITY 20–21 (2014).

224. *Id.* at 208–09.

225. *Id.* at 148–50.

226. Saenz, *supra* note 165, at 415.

227. Andrew S. Park, *Respecting LGBTQ Dignity Through Vital Capabilities*, 24 J. GENDER, RACE & JUST. 271, 336 (2021).

228. Saloner & Daniels, *supra* note 44, at 825 (suggesting that the ACA's "exchanges could be redesigned to protect specific types of investments by providing income disregards for money that low-income families set aside for paying children's college tuition, opening a small business, or saving for retirement").

229. *E.g.*, CMTY. CATALYST & PICO NAT'L NETWORK, *supra* note 167, at 3 ("The Affordability Standard should not include an asset test.").

230. CHI CHI WU, JENIFER BOSCO & APRIL KUEHNHOFF, NAT'L CONSUMER L. CTR., MODEL MEDICAL DEBT PROTECTION ACT 7 (2019).

231. Laurence S. Seidman, *Medical Loans and Major-Risk National Health Insurance*, 12 HEALTH SERVS. RSCH. 123, 123 (1977) (discussing "[t]he availability of medical loans for households unable to afford immediate payment of medical bills"); *see also* Martin S. Feldstein, *A New Approach to National Health Insurance*, PUB. INT., Spring 1971, at 93, 99 (proposing the use of "major risk

sometimes represent an alternative or adjunct to insurance.[232] More recently, debt financing has been proposed for treatments, such as new hepatitis C antivirals and novel gene therapies, that have a high, concentrated cost but postpone or eliminate the risk of treating a long-term illness.[233] Rather than focusing on the yearly cost of these therapies, an alternative approach would consider whether their cost is affordable when compared to lifetime income.[234] Limits on acceptable health spending, such as the yearly out-of-pocket maximum defined in ACA-compliant insurance plans, are often defined by comparing health spending to a household's yearly income.[235] Medical loans complicate these limits by allowing health spending to be spread out over time.

3. Accustomed Economic Status

A different way of building on basic needs regards a household's economic status quo as a normative entitlement, rather than merely a convenient metric. Some descriptive approaches implicitly adopt this view by regarding any reduced spending within a basic needs category, such as food, as a threat to basic needs.[236] Gruber's influential approach likewise regards all expenses in a category that includes essentials, such as food or clothing, as *ipso facto* essential. But households who reduce clothing spending due to health care needs may nonetheless remain able to meet basic needs. That some spending on clothing is essential does not entail that all of a household's clothing spending is essential.[237]

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insurance . . . and government guaranteed postpayment loans" as a way for households to spread out health-related expenditures).

232. *See* Anup Malani & Sonia P. Jaffe, *The Welfare Implications of Health Insurance* 18 (Nat'l Bureau of Econ. Rsch., Working Paper No. 24851, 2018) (examining whether certain "gains of health insurance may be obtainable by improving access to credit").

233. Vahid Montazerhodjat, David M. Weinstock & Andrew W. Lo, *Buying Cures Versus Renting Health: Financing Health Care with Consumer Loans*, SCI. TRANSLATIONAL MED., Feb. 2016, at 1, 3.

234. *Cf.* Ezekiel J. Emanuel, *When Is the Price of a Drug Unjust? The Average Lifetime Earnings Standard*, 38 HEALTH AFFS. 604, 610 (2019) ("[A]fter paying for a lifetime's use of a drug, there must be enough resources left over from an average person's lifetime earnings for other medical services and to permit the pursuit of meaningful life activities.").

235. *See, e.g.*, 42 U.S.C. § 18001(c)(2)(B)(ii) (defining an out-of-pocket limit for a qualified high-risk pool by reference to computation of annual taxable income).

236. *E.g.*, Nicole Willcoxon, *Older Adults Sacrificing Basic Needs Due to Healthcare Costs*, GALLUP (June 15, 2022), https://news.gallup.com/poll/393494/older-adults-sacrificing-basic-needs-due-healthcare-costs.aspx [https://perma.cc/HHC2-FYNV] ("When it comes to covering basic needs to pay for healthcare, more Americans aged 50[to] 64 face hardship. Three in 10 in this age group forgo at least one basic need to cover the costs of care. Specifically, 14 [percent] reduce spending on food, 15 [percent] cut back on over-the-counter drugs, and 26 [percent] buy less clothing.").

237. Gruber himself concedes this point. *See* JONATHAN GRUBER & IAN PERRY, THE COMMONWEALTH FUND, REALIZING HEALTH REFORM'S POTENTIAL: WILL THE AFFORDABLE CARE ACT MAKE HEALTH INSURANCE AFFORDABLE? 13 (2011) ("Our approach . . . does not differentiate 'necessary' from 'unnecessary' expenditures within these categories. For example, it considers total food spending as a necessity, regardless of whether the consumption was done at home or

If households cutting back on food or clothing expenses to obtain health care still seems objectionable even when it does not jeopardize basic needs or a reasonable opportunity range, this suggests defining affordability in a way that provides protection to households based on their prior economic status. This approach can be summarized as "no one should have to choose between health care and *their* home, or job, or lifestyle."

Defining health affordability as the ability to spend on health without threat to one's accustomed lifestyle has political advantages. For many middle- and upper-income households, spending on health care or health insurance does not threaten basic needs, and may not impede access to a reasonable opportunity range. But middle- and upper-income households still may experience subjective burdens due to health spending. Defining and operationalizing affordability policies to materially benefit middle- and upper-income households might better secure their investment in those policies. As Esping-Andersen observes, conservative-corporatist insurance models that aim to preserve accustomed economic status against shocks can be successful in securing middle-class political allegiances.[238]

Some policies that secure accustomed economic status for better-off households also protect lower-income households by ensuring that health spending does not jeopardize basic needs or a reasonable opportunity range: The expanded tax credits in the American Rescue Plan, for instance, can be understood this way. In contrast, other policies shield middle- and upper-income households from economic disruption due to health spending with little benefit to lower-income households. For instance, the tax deductibility of health care expenses only protects households who are wealthy enough to benefit from itemized deductions,[239] while offering no protection at all to poorer households. Reinsurance programs similarly targeted their benefits to households who were too well-off to qualify for ACA subsidies.[240]

Although promising to prevent health spending that disrupts economic status can be politically attractive, it is less clear why avoiding status disruption should be a normative priority. A status-disruption definition of affordability makes it acceptable to ask a household at five hundred percent of the poverty line to spend eight percent of their income on health insurance, but not acceptable for a household that is ten times wealthier to spend ten percent, even though the wealthier household is left with far more absolute income

a nice restaurant; if budgets were pressured by health insurance, individuals might be able to spend less on food without sacrificing nutrition.").

238. ESPING-ANDERSEN, *supra* note 180, at 32 ("In . . . corporatist regimes, hierarchical status-distinctive social insurance cemented middle-class loyalty to a peculiar type of welfare state.").

239. Emily Cauble, Essay, *Itemized Deductions in a High Standard Deduction World*, 70 STAN. L. REV. ONLINE 146, 152 (2018).

240. Govind Persad, *Expensive Patients, Reinsurance, and the Future of Health Care Reform*, 69 EMORY L.J. 1153, 1187 (2020) (explaining "[t]hat the benefits of reinsurance flow primarily to better-off households under the ACA's current subsidy structure").

and wealth afterward. Carla Saenz critiques definitions of affordability that focus on "impeding one's ability to pursue one's chosen plan of life."[241] I agree with Saenz that recognizing a right to pursue one's chosen plan of life wrongly elevates personal tastes to the level of civic entitlements.[242]

Beyond Saenz's critique, status-disruption definitions of affordability can also be criticized for entrenching income, racial, and gender disparities and confusing wants with needs. Protecting households from health spending that might disrupt what they are accustomed to enjoying is different from ensuring that households can meet their basic needs or enjoy a reasonable range of opportunities. Some scholars suggest "that people are . . . concerned about the reranking effects or permutations in social status resulting from healthcare payments," and that in view of this concern "fair health financing is inconsistent with income or utility rank reversals of households."[243] This approach draws on earlier work by tax theorists who argued that taxes should preserve the status-quo pretax distribution.[244] It is questionable that society should be concerned about households merely being "reranked" in a relative distribution, rather than impoverished or deprived of reasonable opportunity, by health spending. Reranking is only fundamentally unfair if we assume that the status quo constitutes a fair distribution.[245] But there are many reasons to believe that the economic status quo is inequitable, and indeed that it involves entrenched inequities including along lines of race, sex, and other forms of identity-based marginalization.[246]

Additionally, status-disruption definitions imply that if a household is accustomed to lacking basic needs or opportunities, health spending that perpetuates that lack does not disrupt the status quo and therefore does not

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241. Saenz, *supra* note 165, at 407.

242. *Id.* at 413 ("Society should not be expected to subsidize plans of life that include music lessons or high fashion even if they are very important to the individual. People with extravagant plans of life thus can be extremely wealthy and still claim that they cannot afford health insurance.").

243. Hyacinth Ementa Ichoku, Fonta M. William & M. Leibbrandt, *Can Out-of-Pocket Health Financing Be Fair: Empirical Evidence from Nigeria*, 10 ASIAN-AFRICAN J. ECON. & ECONOMETRICS 371, 382 (2010); *see also* Adam Wagstaff & Eddy van Doorslaer, *Progressivity, Horizontal Equity and Reranking in Health Care Finance: A Decomposition Analysis for the Netherlands*, 16 J. HEALTH ECON. 499, 502–04 (1997) (explaining the connection between horizontal inequities and reranking).

244. *See* Ichoku et al., *supra* note 243, at 383; *cf.* David Elkins, *Horizontal Equity as a Principle of Tax Theory*, 24 YALE L. & POL'Y REV. 43, 45 n.8 (2006) ("Some commentators argue that horizontal equity requires respect for the ranking of taxpayers: one who is better off in the market distribution should remain better off after paying taxes.").

245. *See* Wagstaff & van Doorslaer, *supra* note 243, at 504 n.7 ("It may, of course, be the case, that some rerankings are considered . . . equitable. To assume that any reranking must be inequitable is to accept that the initial ranking is fair[,] . . . [which] may not be the case."); *cf.* Barbara H. Fried, *Fairness and the Consumption Tax*, 44 STAN. L. REV. 961, 1009 (1992) ("[I]t is hard to see the normative appeal of maintaining the relative rank ordering of taxpayer wealth . . . absent some belief that the initial rank ordering was itself just.").

246. *See generally* DOROTHY A. BROWN, THE WHITENESS OF WEALTH (2021) (discussing racial inequities in America).

present an affordability concern. This implication will also serve to entrench inequities. Others have documented that approaches that define entitlements via prevailing or settled expectations will tend to have this result.[247] This inequitable result may be especially likely if the expectations are understood subjectively or psychologically.[248]

4. The No-Tradeoff View

The view that health spending should be insulated from all tradeoffs can be summed up as "no one should have to choose between health and something else they value." During debates over the ACA, Timothy Jost argued that "most of us would rather not be forced to make tradeoffs between health care that might save our lives and that new car we have been dreaming about."[249] Jost's example helpfully differentiates an approach to affordability that rejects tradeoffs altogether from the basic needs, reasonable opportunity, and economic disruption approaches. A new car is not a basic need and its absence is not a deprivation of a reasonable opportunity range. Nor is an inability to buy a new car a type of economic disruption: It is the denial of a gain, not the loss of a status quo entitlement. Yet the tradeoff Jost describes may nevertheless be burdensome.

Christopher Robertson and David Yokum have recently analyzed the psychological burdens presented by health spending tradeoffs in more depth. Robertson and Yokum identify "a subjective disutility experienced by patients when navigating a difficult, and potentially unwanted, choice amongst a complex set of options, requiring tradeoffs between health and wealth."[250] They note that introducing financial dimensions into health care decisions "may make healthcare decisions more difficult, in part because it adds a criterion that is possibly incommensurate with the others being considered."[251] Although Robertson and Yokum do not discuss it, health/wealth tradeoffs exist both under traditional cost sharing—which asks patients to pay part of their health care costs "out of pocket" at the point of care—and within the "into-pocket" subsidy programs Robertson and others have advocated for—which financially

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247. *See, e.g.*, Cheryl I. Harris, *Reflections on Whiteness as Property*, 134 HARV. L. REV. F. 1, 8 (2020) ("Expectations and, specifically, settled expectations are inscribed and reinscribed through racial hierarchy and are recognized in law as property.").

248. *Cf.* Molly S. McUsic, *The Future of* Brown v. Board of Education*: Economic Integration of the Public Schools*, 117 HARV. L. REV. 1334, 1355–57 (2004) (describing how expectations may depend on prior advantage); Cass R. Sunstein, *Legal Interference with Private Preferences*, 53 U. CHI. L. REV. 1129, 1146–50 (1986) (describing the effects of preferences on opportunity).

249. Timothy Stoltzfust Jost, *Our Broken Health Care System and How to Fix It: An Essay on Health Law and Policy*, 41 WAKE FOREST L. REV. 537, 589 (2006).

250. Christopher T. Robertson & David V. Yokum, *The Burden of Deciding for Yourself: The Disutility Caused by Out-of-Pocket Healthcare Spending*, 11 IND. HEALTH L. REV. 609, 610 (2014).

251. *Id.* at 617; *see also id.* ("Consumers . . . don't wish to be forced to make rational trade-offs when they are confronted with medical care consumption decisions." (quoting Bruce C. Vladeck, *The Market v. Regulation: The Case for Regulation*, 59 MILBANK Q. 209, 211 (1981))).

reward patients by paying them a share of the savings that insurers or society realize when patients decline high-cost health care.[252] Psychological burdens may arise both from increasing the sheer number of choices that patients face and from introducing an additional dimension, financial cost and benefit, into these decisions.[253] They may also come from creating the possibility of regret.[254]

Robertson and Yokum explain that psychological costs associated with tradeoffs are mostly avoided by outsourcing decisions to third parties, such as proxy decision-makers or government agencies.[255] This does not eliminate the task of navigating tradeoffs, but merely transfers them to another decision-maker. As Robertson and Yokum explain, practical constraints typically mean that outsourced tradeoff decisions are made for the entire community, state, or nation, rather than in light of individual patients' specific values.[256] When decisions are outsourced, households still lose out on things they would have valued highly because of the need to pay for health care and health insurance, but the tradeoffs are concealed by moving health care and insurance out of the budgets that households control. Returning to Jost's example, rather than agonizing over whether to purchase a new car or a costly diagnostic test with their limited funds,[257] households may receive the diagnostic test at no out-of-pocket charge, while the new car will not present itself as a realistic possibility. The choice will be made upstream, rather than at the household level. We may prefer a situation where we are unable to buy the new car we dream of because society-level health care spending has crowded out public investments in automotive innovation or has left us with a high, competing tax bill, rather than a situation where we have enough funds to pay for the new car or the novel procedure, but not both, and so must choose between them.

A further problem that Robertson and Yokum note is that the decision-maker to whom choices are outsourced may simply decide to avoid tradeoffs by spending whatever it takes to meet all health care needs.[258] This option may be attractive because it shields the decision-maker from being blamed for health rationing: The decision-maker is less likely to be blamed for overspending in the context of a large budget that imposes diffuse burdens on many households than to be blamed for denying health care procedures to a defined group of households.

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252. *E.g.*, Christopher Robertson, *The Split Benefit: The Painless Way to Put Skin Back in the Health Care Game*, 98 CORNELL L. REV. 921, 944–45 (2013); Harald Schmidt & Ezekiel J. Emanuel, *Lowering Medical Costs Through the Sharing of Savings by Physicians and Patients: Inclusive Shared Savings*, 174 JAMA INTERNAL MED. 2009, 2012 (2014).

253. Robertson & Yokum, *supra* note 250, at 627–29.

254. *Id.* at 631–33.

255. *Id.* at 633.

256. *See id.* at 620.

257. *See supra* note 249 and accompanying text.

258. *See* Robertson & Yokum, *supra* note 250, at 621, 630.

One important question when evaluating psychological burden is why health care and insurance spending is special. Hard choices are ubiquitous in other domains—choices between housing and education, or between fulfillment at work and retirement savings. Moreover, these other hard choices also affect health outcomes, and indeed may affect them more than health care. Some of the issues here may be empirical: Perhaps households experience tradeoffs between health spending and other spending as more stressful and a less valuable exercise of autonomy than navigating other types of tradeoffs.

A view that aims to avoid psychological burden might, however, still allow tradeoffs between health care (or insurance) and other spending that only imposes de minimis tradeoffs. It would allow, for instance, arrangements where households have to make nominal copayments for health services, pay out of pocket for over-the-counter medications like aspirin, or pay nominal insurance premiums. Such nominal out-of-pocket payments are permitted in some state Medicaid programs that otherwise shield participants from out-of-pocket spending for insured services[259] and are used abroad in health systems that otherwise do not expect households to pay out of pocket for health insurance or services.[260] On this approach, households can be asked to make choices between health and other spending—just not *hard* choices.

A more uncompromising version of a no-tradeoff view is that it is unacceptable for households to face *any* tradeoffs between health and other aims. Health, on this view, should play no role in a household's budgeting or economic decision-making. Einer Elhauge has discussed the pervasiveness of such a rejection of tradeoffs between health care and other goods, albeit at the national rather than individual level.[261] Elhauge observes that "the absolutist position that health care must be provided whenever it has any positive health benefit" is "obviously untenable: at some point tradeoffs must be made between health care and other social goods."[262] Yet Elhauge also recognizes that an absolutist rejection of tradeoffs "is by far the moral norm most pervasive in actual health law policy debate and most commonly invoked in actual allocative decisionmaking,"[263] and also concedes that "[a]ctual human beings, forced to make actual decisions framed as health versus money, find themselves seeming and feeling inhumane," and accordingly

259. Sweeney v. Bane, 996 F.2d 1384, 1385 (2d Cir. 1993) ("The federal Medicaid law permits, but does not require, states to charge certain recipients 'nominal' payments ('co-payments') for specific services.").

260. *See* Victor Laurion & Christopher Robertson, *Ideology Meets Reality: What Works and What Doesn't in Patient Exposure to Health Care Costs*, 15 IND. HEALTH L. REV. 43, 56 (2018) (describing German and French systems).

261. *See generally* Einer Elhauge, *Allocating Health Care Morally*, 82 CALIF. L. REV. 1449 (1994) (advocating for the use of philosophic and moral analysis to structure the allocation of health care decisions).

262. *Id.* at 1454.

263. *Id.* (emphasis omitted).

"resort to just about any mechanism of denial or short-term spending measure to avoid or postpone facing the reality of scarcity."[264]

Despite the seeming extremism of the no-tradeoff view, it has been endorsed at the individual level as well. One reason for endorsing it involves the intimate nature of many health needs, which implicate bodily autonomy. Seana Shiffrin has argued that "decisions [that] are highly personal ones involving the body" and "are ones that are difficult to make and involve hard cases [or] difficult judgments" are strong candidates for public financial support.[265] The goal of such support is to create an insulated decision-making space for individuals that allows them "to focus on some of the distinctive reasons associated with the activity," and shields them "from worrying about certain goods and reasons only contingently or indirectly associated with the activity."[266] The centrality of health to individual identity has also been used to support the view that health decisions should be fully publicly financed.

Another ethical framework that might support the view that individuals should never be asked to choose between health care and anything else emphasizes the unchosen nature of health needs. In antidiscrimination theory and law, unchosen ("immutable") characteristics often form the basis of protected categories on the basis of which individuals may not be disadvantaged and often must be affirmatively accommodated. As Robertson and Yokum note, "[i]f one conceives of sickness as simply an unlucky draw from the genetic lottery, or a broader lottery that includes other disease vectors, then it may seem unfair for sick individuals to bear part of their own healthcare costs, while the luckily healthy bear no such costs."[267] The unchosen nature of medical spending is frequently used to justify treating medical debt differently from debt incurred to obtain other essentials.[268] Scholars discussing "healthism" have similarly argued that treating individuals differently on the basis of health status is often a form of unfair discrimination.[269]

Although these aspects of health needs may support treating them differently from discretionary spending, they likely do not justify proscribing all tradeoffs. First, many needs for specific types of health care—just like needs for specific types of housing and education—reflect an interplay between

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264. *Id.* at 1464.

265. Seana Valentine Shiffrin, *Paternalism, Unconscionability Doctrine, and Accommodation*, 29 PHIL. & PUB. AFFS. 205, 248 (2000).

266. *Id.* at 247.

267. Robertson & Yokum, *supra* note 250, at 615.

268. *E.g.*, WU ET AL., *supra* note 230, at 2 ("Medical debt is different from many other types of consumer debt—people do not plan to get sick or get hurt, and health care services are not only necessary, but can be a matter of life or death.").

269. *See* JESSICA L. ROBERTS & ELIZABETH WEEKS, HEALTHISM: HEALTH-STATUS DISCRIMINATION AND THE LAW 5 (2018).

choices and societal circumstances. Second, as Robertson and Yokum argue, we often ask individuals to bear some of the costs of bad luck.[270]

Because resources are finite, tradeoffs between health and other values are ultimately inescapable. Individual households can be protected against having to choose between health care and other types of spending by removing health care from the set of spending decisions made at a household level. But this merely moves the spending decision upward to the community, state, or national government, who still must decide how to trade off health against other aims. These inescapable national-level tradeoffs inevitably fall on the shoulders of individual households in the forms of taxes and foregone public spending. Analogously, although no *individual* American faces the choice between spending on national defense and buying groceries, Eisenhower's famous point that "every gun that is made, every warship launched, every rocket fired signifies, in the final sense, a theft from those who hunger and are not fed, those who are cold and are not clothed" remains unassailable.[271] The no-tradeoff view simply conceals the tradeoff between health care spending and other spending: It does not eliminate it. This concealment may be desirable for psychological reasons. But concealment is the most we can do. In a world of finite resources, tradeoffs between health and other values cannot be avoided, even though they can be taken from the hands of individual households.

If national-level tradeoffs are also resolved by giving health care and insurance primacy over everything else, counterproductive implications arise for household budgets. Households will have unlimited ability to meet health care needs, but limited ability to meet other needs such as housing and education, creating an incentive to find ways to reclassify other needs as health care needs.[272] And because health care needs are a malleable category, the expansion of health care needs is likely to present problems that access to currently recognized civic entitlements such as voting or clean air do not. It is hard to contend that education or housing are voting or clean air, but many have argued that education and housing are health care.[273]

270. Robertson & Yokum, *supra* note 250, at 616 ("[I]t is hard to motivate a theory of justice that would require redistribution of bearable risks. After all, individuals are exposed to all sorts of bearable risks in the modern society—everything from the mundane risks, such as the need for plumbing repair or roadside assistance for a flat tire, to more substantial risks, such as having the value of one's house decrease. Americans do not typically suppose that justice requires that these risks be redistributed, at least as long as they are small enough to be bearable.").

271. *See* Dwight D. Eisenhower, President of the United States, Address Delivered Before the American Society of Newspaper Editors: The Chance for Peace (Apr. 16, 1953).

272. *Cf.* Zach Weinersmith, SMBC, https://www.smbc-comics.com/index.php?db=comics&id=2045 [https://perma.cc/ST7K-QNY4] (depicting attempts to reclassify needs).

273. Zachary Siegel, *Single-Payer Health Care Is the First Step in the Revolution*, NATION (Sept. 9, 2019), https://www.thenation.com/article/archive/medicare-for-all-timothy-faust-new-book-review [https://perma.cc/4B8R-RWNR] (discussing "[h]ealth justice—an expanded notion of health care that includes housing, food, the environment, and income"); Mindy Thompson

A further consequence of a system that treats medical needs as uniquely eligible for public subsidy is the medicalization of other needs, notwithstanding the fact that the health care system is unlikely to be best equipped to deliver housing, education, and many other forms of social support. Casting housing, education, or civic equality as health care needs is a canny advocacy strategy under social arrangements that nest a boundless, publicly subsidized entitlement to health-related assistance within otherwise market-based or means-tested social arrangements.[274] But it stretches the concept of a health system in ways that lead to misdirected expertise[275] and resource misallocation. It would be more honest and better in the long run to face the inescapability of tradeoffs squarely.[276]

C. *Value for Money*

Acceptable tradeoff definitions make affordability a matter of cost: Health spending is affordable if it can be fit into a household's budget. An alternative approach would instead examine whether health spending brings value for money—whether the cost a household pays is commensurate with the health benefits it receives for its health spending. For other essentials, affordability metrics often vary according to the good at issue.[277] It is acceptable for a household to devote a greater proportion of its financial resources to a house than a car because a house is more essential and less likely to lose value over time.

Analogously, health affordability definitions could consider the benefits realized by the health spending at issue. Some types of health spending, such

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Fullilove, *Housing Is Health Care*, 39 AM. J. PREVENTATIVE MED. 607, 607 (2010). *But see* Richard Asinof, *An Interview with Christopher Koller*, CONVERGENCERI (Nov. 30, 2020), http://convergenceri.com/stories/an-interview-with-christopher-koller,6199 [https://perma.cc/YHW7-2A59] (statement of Christopher Koller, former Rhode Island Health Insurance Commissioner) ("Housing is not health care. It is not reasonable to expect insurance to pay for housing costs.").

274. *See* Craig Konnoth, *Medicalization and the New Civil Rights*, 72 STAN. L. REV. 1165, 1185–94 (2020) (describing advocacy advantages of a medical framing); *see also* Craig Konnoth, *Medical Civil Rights as a Site of Activism: A Reply to Critics*, 73 STAN. L. REV. ONLINE 104, 117 (2020) ("While society has shifted risk for other misfortunes—poverty, unemployment, and the like—back onto individuals, similar attempts in the medical context have failed. . . . [W]hen tasks are framed as medical, assistance is forthcoming." (footnote omitted)).

275. *See, e.g.*, Allison K. Hoffman, *How Medicalization of Civil Rights Could Disappoint*, 72 STAN. L. REV. ONLINE 165, 168 (2020).

276. *Cf.* David A. Hyman, *The Medicalization of Poverty: A Dose of Theory*, 46 J.L., MED. & ETHICS 582, 585 (2018) ("[E]ven if the medicalization strategy works initially, unless we do something about the amount of money that we spend on healthcare, we will eventually run out of (other people's) money."); Adam M. Samaha, *What Good Is the Social Model of Disability?*, 74 U. CHI. L. REV. 1251, 1308 (2007) (observing that "[d]evotion to elevating the status of a single interest group is not conducive to [the] task" of "effectively [addressing] the problems of limited resources and competing claims of justice").

277. K. Sabeel Rahman, *Constructing Citizenship: Exclusion and Inclusion Through the Governance of Basic Necessities*, 118 COLUM. L. REV. 2447, 2471, 2473 (2018) (identifying different percentage thresholds for utility and housing affordability).

as spending on cures, may confer both health and financial benefits over many years. Novel Hepatitis C antivirals, which have been priced very highly but convert a chronic illness to a curable condition, exemplify this type of health spending.[278] Other types of spending, such as the purchase of comprehensive health insurance, may shield households against unpredictable health spending, just as purchasing a well-built home or reliable car may reduce future spending.[279] It would make sense for a metric of health affordability to consider value as well as cost.[280]

In the health care systems that exist in other developed countries, affordability is often conceptualized in terms of value for money.[281] On this metric, a product may be more expensive in absolute terms *and* as a percentage of income, but nevertheless be more affordable in the sense that it is a better deal: It provides better value for money. Some pharmaceutical affordability boards accordingly examine value criteria, such as a drug's benefit or ability to treat conditions for which no treatment exists, when determining whether a drug is affordable.

Although value for money may be a necessary condition for affordability, it seems unlikely that it is enough for affordability on its own. The debate over the best method of financing new hepatitis C antivirals illustrates this: Many hepatitis C antivirals had exceptional value for money, but their absolute cost was far too large for household budgets.[282] This suggests that value for money should comprise part of a hybrid definition of affordability, rather than being used as a standalone definition of affordability.[283]

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278. *See* Atkins v. Parker, 972 F.3d 734, 736 (6th Cir. 2020).

279. *See* CMTY. CATALYST & PICO NAT'L NETWORK, *supra* note 167, at 3 ("Benefit packages that exclude health care services that people need (such as limits on mental health coverage, policies that don't cover prescriptions, or policies with low lifetime benefit limits) have the same result as packages that impose high premiums or other out-of-pocket costs, leaving people at risk financially when they need coverage the most.").

280. *Cf.* Brent T. White, *Underwater and Not Walking Away: Shame, Fear, and the Social Management of the Housing Crisis*, 45 WAKE FOREST L. REV. 971, 1013 (2010) ("[A]s 'economists might argue . . . an unaffordable mortgage is one that is really too expensive, in the sense that the benefits that come with making payments on the mortgage no longer outweigh the opportunity costs of doing so.' To account for this fact, 'affordable' might instead be defined not only according to one's gross income, but also in relation to the fair rental value of one's home." (footnote omitted) (quoting Christopher Foote, Kristopher Gerardi, Lorenz Goette & Paul Willen, *Reducing Foreclosures: No Easy Answers* 4 (Nat'l Bureau of Econ. Rsch., Working Paper No. 15,063, 2009))).

281. Saloner & Daniels, *supra* note 44, at 816 ("Within such a system, especially if it has limited individual co-payments at the point of service, getting value for money—that is, efficiency—is important because it improves the collective affordability of universal coverage.").

282. *See* Patricia J. Zettler & Erin C. Fuse Brown, Commentary, *The Challenge of Paying for Cost-Effective Cures*, 23 AM. J. MANAGED CARE 62, 63 (2017).

283. *Cf.* Emanuel, *supra* note 234, at 606 ("While cost-effectiveness analysis is necessary for determining an excessive drug price, it is not sufficient."); Fernando Antoñanzas, Robert Terkola, Paul M. Overton, Natalie Shalet & Maarten Postma, *Defining and Measuring the Affordability of New Medicines: A Systematic Review*, 35 PHARMACOECONS. 777, 787 (2017) ("[A]ffordability of

IV. AFFORDABILITY'S PLACE IN HEALTH REFORM

The multiple potential definitions of affordability present a multiplicity of policy options, which this Part will examine. One is to exploit affordability's multiple meanings to continue referencing affordability while eschewing a clear definition, in the hope of drawing support from anyone who might endorse one of the definitions. Another would jettison affordability because it ultimately classifies healthcare as a service to be purchased on the market, rather than a fundamental entitlement or an exercise of professional skill to be provided outside of market constraints and incentives. A less precipitous abandonment of affordability might instead replace it with some of the concepts that comprise the definitions reviewed in Part III, such as value for money or access for lower-income households. Last, as this Article has suggested, the task of definition might be embraced. I close this Part with some suggestions as to how that might be accomplished.

A. *ESCHEWING DEFINITION*

In health policy, some have sought to preserve the ambiguity of affordability, arguing that:

> [A]ffordability is a suitable concept for communications in political forums. Its vagueness allows communications to circulate without necessarily reaching final commitments. Precision is dangerous; polarizes discussions. Instead, the affordability flag expresses comfortable "uncommitted commitments." . . . One can easily get away without specifying what is to be affordable and who will pay for what . . . .[284]

Strategically avoiding definition has a long pedigree. Richard McKeon, the Rapporteur for the committee drafting the Universal Declaration of Human Rights, ended his philosophical analysis of human rights with a paean to ambiguity:

> Agreement can doubtless be secured concerning the list of human rights only if ambiguities remain both because of the absence of a uniform manner of administering them and because of the absence of a single basic philosophy; but that ambiguity is the frame within which men may move peacefully to a uniform practice and to a universal understanding of fundamental human rights.[285]

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healthcare products does not depend solely on available [gross domestic product], but is affected by efficiency . . . and price . . . .").

284. Joao Costa, *Affordable Universal Health Coverage—a Conceptual Challenge*, INT'L HEALTH POL'YS NETWORK (Nov. 19, 2019), https://www.internationalhealthpolicies.org/blogs/affordable-universal-health-coverage-a-conceptual-challenge [https://perma.cc/XP5L-F52X].

285. Richard McKeon, *The Philosophic Bases and Material Circumstances of the Rights of Man*, 58 ETHICS 180, 187 (1948); *see also* Paul A. Freund, *Individual and Commonwealth in the Thought of Mr.*

Ambiguity has also been used for political and practical advantage elsewhere in health policy, for instance in defining "public health."[286]

Despite the appeal of ambiguity, there are compelling reasons to seek a definition in at least some contexts. First, definitions further productive discussion and debate.[287] Absent common definitions, interlocutors with different understandings of affordability may talk past one another. Second, refusing to define affordability may foster public cynicism and undermine trust. The public may come to dismiss affordability as a buzzword unrelated to their actual needs, or a subterfuge to advance controversial or divisive political goals. Third, as multiple commentators emphasize, leaving affordability undefined makes it more challenging to effectively evaluate programs that aim to promote affordability.[288] The consensus among diverse interlocutors on the importance of defining affordability is a powerful point in favor of seeking a definition.

B. *Rejecting Affordability*

Despite affordability's centrality to American health policy and its importance to Americans and their political leaders, it has typically received a colder reception from those with firm ideological commitments either for or against markets. Affordability serves as a compromise between seeing health services as market commodities and as civic entitlements: Households can be expected to pay for their health care and insurance, just as they pay for market commodities like iPhones, but society can also be expected to subsidize part of the cost of health care and insurance, just as it (fully) covers the cost of civic entitlements like primary education. Those who want health shifted fully inside, or outside, the realm of market transactions are often uncomfortable with this compromise.

Part III's introduction discussed economists' unease with health affordability. This Section, in contrast, will focus on market skeptics. Advocates who reject markets in general, or health care markets in particular, see policies emphasizing affordability as a betrayal of health care's status as a human right or civic entitlement in favor of market ordering.[289] Other commentators have

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Justice Jackson, 8 STAN. L. REV. 9, 10 (1955) ("Ambiguities become open-ended, or at any rate double-ended; they make possible the creation and functioning of constitutions.").

286. *E.g.*, Micah L. Berman, *Defining the Field of Public Health Law*, 15 DEPAUL J. HEALTH CARE L. 45, 64 (2013) (suggesting that a prominent definition of public health "may have been deliberately ambiguous about the scope of the field for" strategic reasons).

287. *See, e.g.*, HEALTHCARE VALUE HUB, ALTARUM, *supra* note 19.

288. *E.g.*, Bundorf & Pauly, *supra* note 17, at 656.

289. *Cf.* Volker H. Schmidt, *Models of Health Care Rationing*, 52 CURRENT SOCIO. 969, 978 (2004) ("Affordability means that there will be different standards and qualities of treatment for different social groups, depending on their willingness and ability to pay. This has often been criticized as ethically inappropriate because health care is deemed special, a good so important that all should have equal access to it."); Sarah Horton, Cesar Abadía, Jessica Mulligan & Jennifer Jo Thompson, *Critical Anthropology of Global Health "Takes a Stand" Statement: A Critical Medical*

similarly criticized the ACA's emphasis on affordability as inconsistent with the proper status of health care as a civic entitlement.[290]

Rather than seeing affordability as desirable, market-rejecting critics of affordability castigate it as an unacceptable concession to market distribution of essential services:

> Pushes to make vital public goods such as health care or education "affordable"—whether well-intentioned or deliberately misleading—still invariably imply a transaction taking place between a seller and a consumer: the dynamic of the market in its most elemental form. Even if the good in question *does* become cheaper (and therefore easier for more people to access), the basic dynamic is maintained and the good remains a commodity to be bought and sold rather than a universal right to be guaranteed and enjoyed.[291]

Rather than ensuring affordability, these critics believe policymakers should "democratize social goods, removing the market altogether and extinguishing the need for anyone to worry about whether they have the requisite funds to see a doctor, acquire education, put their children in a safe and caring environment during working hours, or sleep with a roof over their heads."[292] These critiques parallel similar rejections of affordability for other essential goods.[293]

As an initial matter, "removing the market altogether" from the health sector is politically unrealistic. Although Americans are friendly to a "public option"—governmental provision of health insurance or services as one option among many—the complete replacement of market-provided health care or insurance with full public financing fails to garner majority support.[294]

Anthropological Approach to the U.S.'s Affordable Care Act, 28 MED. ANTHROPOLOGY Q. 1, 10 (2014) (criticizing Medicaid spending as a "government-run insurance scheme[ ]").

290. Daniel Skinner, *The Politics of Native American Health Care and the Affordable Care Act*, 41 J. HEALTH POL., POL'Y & L. 41, 53 (2016) ("Taking aim at the ACA's focus on affordability, Trahant writes, 'Affordable coverage is not the same as pre-paid, treaty-based health care.'").

291. Luke Savage, *The "Affordability" Hustle*, JACOBIN (Feb. 7, 2019), https://jacobin.com/2019/02/affordability-health-care-booker-harris-democrats [https://perma.cc/HD7X-QTW9].

292. *Id.*; *see also* Matthew Adarichev, *Why the Heck Should Health Care Be Affordable?*, LI HERALD.COM: ELMONT (Sept. 1, 2022), https://www.liherald.com/elmont/stories/why-the-heck-should-health-care-be-affordable,143549 [https://perma.cc/P636-XHG3] ("[H]ealth care *shouldn't* just be affordable. It should be free. . . . When did the idea that we should pay for necessary medical procedures become accepted? It's as barbaric as demanding payment to breathe air.").

293. Linda Annala Tesfaye, Martin Fougère & Yewondwossen Tesfaye, *Humans and Water: The Problem(s) with Affordability*, *in* TRANSFORMATIVE ACTION FOR SUSTAINABLE OUTCOMES: RESPONSIBLE ORGANISING 120, 122 (Maria Sandberg & Janne Tienari eds., 2022) (lamenting that "the emphasis on 'affordability' within the human right to water discourse . . . makes the discourse compatible with private, market-led solutions to accessing water," and derails "a potentially radical argument for making water a fundamental human right" in favor of seeing water access as "a technical issue that can be solved simplistically by rendering it 'affordable enough' for all").

294. Amanda Seitz, *Americans Give Health Care System Failing Mark: AP-NORC Poll*, ASSOCIATED PRESS (Sept. 12, 2022, 7:18 AM), https://apnews.com/article/covid-health-medication-prescript

Likewise, the United Nations concludes that "affordability means making health services financially accessible, not free of charge."[295] This may reflect the fact that health care, unlike clean air, is not a public good: It is both rivalrous (two patients can't take the same pill or see the same doctor at once) and excludable (pills and appointments can be, and are, limited to those who pay for them).[296]

Ultimately, rejecting affordability may seem attractive given the recognized limitations of market approaches in healthcare provision. But as long as markets continue to play a role in distributing essentials, affordability remains important as a fairness constraint on their operation. Furthermore, although removing health care from the market will ensure, at least initially, that no one faces tradeoffs between health spending and other spending, nonmarket systems of distribution appear no less vulnerable to hierarchy and bias.[297] Supposedly universal programs that dispense with the role of choice often take on a majoritarian character that subordinates minority interests or fails to effectively serve diverse communities. Meanwhile, affordability definitions have shown the capacity to evolve to incorporate broadening conceptions of fairness and equity.[298]

C. *Replacing Affordability*

Another possibility would refocus policy on the questions underlying affordability rather than attempting to define the term: Is insurance accessible to the poor? Is it available at prices that do not disrupt middle-class economic status? Does it offer good value for money? Rather than working to define affordability in terms of other concepts, this approach replaces it with the underlying concepts themselves.

Similar replacement of an "umbrella" concept, one that encompasses many underlying concepts,[299] with the underlying concepts themselves has

ion-drug-costs-drugs-63b342945f9b6ab3ce0ed3920deb935a [https://perma.cc/ZTM6-SRDB] ("About 4 in 10 Americans say they support a single-payer health care system that would require Americans to get their health insurance from a government plan. More, 58 [percent], say they favor a government health insurance plan that anyone can purchase.").

295. Antenor Hallo de Wolf & Brigit Toebes, *Assessing Private Sector Involvement in Health Care and Universal Health Coverage in Light of the Right to Health*, HEALTH & HUM. RTS. J., Dec. 2016, at 79, 83 tbl.2.

296. *See* Govind Persad & Ezekiel J. Emanuel, *Can COVID-19 Vaccines Be Global Public Goods?*, BMJ OP. (July 22, 2021), https://blogs.bmj.com/bmj/2021/07/22/can-covid-19-vaccines-be-global-public-goods [https://perma.cc/FD5N-P9US].

297. *See, e.g.*, Dorothy E. Roberts, *Welfare and the Problem of Black Citizenship*, 105 YALE L.J. 1563, 1595 (1996) (describing how market-skeptical reformers failed to achieve racial inclusion and equality); Barbara Havelková, *Resistance to Anti-Discrimination Law in Central and Eastern Europe—a Post-Communist Legacy?*, 17 GERMAN L.J. 627, 648 (2016) (recounting the persistence and centrality of gender-differentiated policies under "state socialism").

298. *See supra* Section II.A.2 (describing reforms to "affordability guardrails").

299. *Cf.* Richard Thompson Ford, *Bias in the Air: Rethinking Employment Discrimination Law*, 66 STAN. L. REV. 1381, 1390 (2014) (describing "an umbrella concept under which we struggle over distinct, and at times conflicting, policy goals").

been advocated in other areas of law. The classic argument for this approach is Thomas Grey's argument for "disintegration" of the concept of property and its replacement with the underlying concepts, often termed the "sticks in the bundle."[300] More recently, Meera Deo has argued that rather than using umbrella concepts such as "BIPOC" or "persons of color," the law would do better to explicitly name the relevant groups falling under the umbrella.[301] These proposals share a common theme: Rather than using a popular umbrella concept, we would do better to use the concepts or categories that underpin that concept.

Should we argue for the disintegration of affordability? Using a common concept has at least three advantages. First, in the case of affordability, the concept is popular: People want health care and insurance to be affordable. Second, using the umbrella concept of affordability enables greater brevity in presentation. By referencing affordability, reform proposals can avoid lengthy explanations of what it means for insurance to be accessible to the poor or to be priced at a level that the middle class can purchase. Third, an affordability-based framing has advantages in coalition-building. Those whose basic needs are securely met regardless of how much health spending they incur have less of a self-interested reason to prevent health spending from jeopardizing basic needs. Individuals who are currently poor may perceive goals that primarily benefit the middle class or even the wealthy as less relevant. In contrast, framing that emphasizes affordability may be able to prompt buy-in from groups up and down the income scale and so create stronger impetus for reform.

Ultimately, the question of replacing affordability versus maintaining and improving the concept should consider both the balance between conceptual precision and superior presentability and the fact of path-dependence. Affordability is now deeply embedded in the American health care system as a goal. Replacing it with other concepts would present many of the same problems as eliminating it altogether. Instead of replacing affordability, the better course would be to retain the concept while clarifying the underlying aim, or aims, that it incorporates.

D. Defining Affordability

Should affordability be defined using only one of the approaches discussed in Part III? Many of the definitions proposed in that part have merit. But their merit does not make any of them sufficient alone. The merit of multiple definitions suggests combining them into a hybrid or pluralistic definition.[302]

300. *See* Thomas C. Grey, *The Disintegration of Property*, 22 NOMOS 69, 77–79 (1980).

301. Meera E. Deo, *Why BIPOC Fails*, 107 VA. L. REV. ONLINE 115, 118 (2021).

302. *Cf.* Govind Persad, Alan Wertheimer & Ezekiel J. Emanuel, *Principles for Allocation of Scarce Medical Interventions*, 373 LANCET 423, 426 (2009) (distinguishing "insufficient" principles, which can be combined into an appropriate policy, from "flawed" principles, which should be excluded from policy).

Normatively, as Part III argued, the most compelling definitions involve basic needs and a reasonable opportunity range. For instance, a health insurance plan might be regarded as affordable if it is both available without jeopardizing basic needs and while preserving a reasonable opportunity range. Affordability could also include some metric of value for money. One way of incorporating value is to think about some basic level of value for money as being a requirement for the spending to serve *health* affordability. Even if spending fits into a household's budget, it does not satisfy health affordability criteria unless it adequately promotes health.

In light of the above, I propose the following qualitative definition: *Health spending is affordable if it meaningfully improves households' health without worsening their access to basic needs or depriving them of a reasonable range of opportunities.*

This definition could be operationalized by considering how health spending fits into household budgets for households at different economic levels. Percentages of income could be used as a proxy, but should not be confused with the fundamental goal of affordability and should be adjusted progressively according to household income. To achieve equity and address narrow racial and other disparities, it would also be desirable to consider economic factors beyond income, in particular household wealth and assets.[303] Although asset tests for eligibility have recognized drawbacks, households with fewer assets have less capacity for health spending outlays. Given the challenges of assessing household assets,[304] implementation may require innovative methods: For instance, households living in geographic areas where asset poverty is prevalent could be provided additional health spending support.[305] Policy could also focus on limiting price increases in these jurisdictions.[306]

Public opinion research could serve to constrain and make more precise the definition of affordability. For instance, the public could be surveyed about what constitutes a basic need and a reasonable opportunity range. The public and experts could also deliberate about operationalizations: For

303. *Cf.* NAACP v. E. Ramapo Cent. Sch. Dist., 462 F. Supp. 3d 368, 407 (S.D.N.Y. 2020) (explaining how focusing only on income rather than wealth underrates the economic advantages white households have enjoyed). *See generally* MELVIN L. OLIVER & THOMAS M. SHAPIRO, BLACK WEALTH/WHITE WEALTH: A NEW PERSPECTIVE ON RACIAL INEQUALITY (2006) (analyzing racial inequality in the United States by examining wealth instead of income alone).

304. *See* Shayak Sarkar, *Need-Based Employment*, 64 B.C. L. REV. 119, 153 (2023) ("Wealth itself is difficult to measure. . . . [W]ealth tests can be difficult to administer and may create complicated incentives.").

305. *Cf.* Misbah Husain & Melissa K. Scanlan, *Disadvantaged Communities, Water Justice & the Promise of the Infrastructure Investment and Jobs Act*, 52 SETON HALL L. REV. 1513, 1518 (2022) (describing prioritization of disadvantaged communities for water assistance).

306. *Cf.* Prince George's Hosp. Ctr. v. Advantage Healthplan Inc., 985 F. Supp. 2d 38, 44 (D.D.C. 2013) (explaining the Public Health Service Act's "340B" program, which "enable[s] healthcare providers that deliver health services to low-income people to obtain important drugs at a controlled cost that is lower than what the drugs would cost on the open market").

instance, what percentage of income it is reasonable to ask a given household to contribute toward health insurance costs. In addition to being asked what percentage is reasonable to have households contribute, the public should be asked about why. Understanding their view of why might help to eventually articulate a normative grounding that could strengthen the case for this hybrid approach.

A major shortfall in current affordability definitions—one that reflects the fragmentation of the American health system—is that few definitions or policies capture the breadth of health spending. The ACA's affordability definitions focus on the cost of health *insurance*, but most marketplace and many employer policies leave buyers exposed to substantial out-of-pocket health *spending*, through deductibles, copayments, and coinsurance, even for services that are covered by insurance.[307] Additionally, many important health services remain largely uncovered by insurance, including long-term care and assisted living and psychological and psychiatric services.[308] Receipt of health services also involves ancillary costs, such as lost income due to time off work, spending on transportation and childcare, and sometimes lodging.[309] Policy implicitly recognizes travel and lodging—though not childcare or lost wages—as health expenses by permitting them to be reimbursed as "qualified medical expenses" from health savings and flexible spending accounts.[310] Health insurance, however, does not cover ancillary expense nor do most affordability definitions include them.

The fragmentation of affordability definitions leaves households exposed to multiple sources of health spending. For instance, even under current proposals, a household with a seriously ill member might end up spending 8.5 percent of income on health insurance, plus another eighteen thousand dollars on unreimbursed health care, plus additional funds on ancillary needs such as transportation, childcare, and time off—all while likely experiencing a simultaneous loss of income. Even proposals to cover long-term care via insurance still contemplate an additional five to ten percent of income being

307. *See* Miller, *supra* note 54; Timothy Stoltzfus Jost, *Access to Health Care: Is Self-Help the Answer?*, 29 J. LEGAL MED. 23, 37 (2008) ("[A]ffordability is defined in terms of premium costs, not in terms of whether the insurance makes health care affordable. Some fear that 'affordable' policies will be high deductible policies that, again, simply postpone the moment at which health care becomes unaffordable." (footnote omitted)).

308. *See* Benson et al., *supra* note 55, at 1234–37; *Who Pays for Long-Term Care?*, *supra* note 56.

309. Susan Gubar, *The Financial Toxicity of Illness*, N.Y. TIMES (Feb. 21, 2019), https://www.nytimes.com/2019/02/21/well/live/the-financial-toxicity-of-illness.html (on file with the *Iowa Law Review*).

310. *See* Jost, *supra* note 249, at 586 (explaining that qualified expenses "include many things not covered by traditional health insurance, such as nonprescription drugs and transportation or lodging while away from home to receive medical care").

devoted to long-term care costs, in addition to often expecting some asset drawdown.[311] These costs quickly overwhelm even stably resourced families.[312]

One attractive way of defragmenting affordability definitions would utilize the tax code. The deduction for unreimbursed medical expenses over 7.5 percent of income—which is currently and inequitably unavailable to most lower- and middle-class taxpayers who do not itemize deductions—could be restructured as an "above the line" deduction from which all taxpayers can benefit.[313] Rather than a flat 7.5 percent threshold, it could incorporate a stepped structure similar to the ACA's tax credits. It could then phase out—similar to other deductions—at income levels that reach the upper class. This crosscutting deduction for health spending could help compensate for the fragmentation of present definitions.

Implementing an affordability definition via the tax code, however, still has limitations. Taxpayers without tax liability will not benefit fully unless the deduction is combined with or replaced by a refundable credit for those payers. More importantly, the tax code is limited to a single strategy for addressing affordability—subsidies via tax expenditures. But an effective strategy should also address household incomes and the price and availability of costly health services.

Last, even a broadened and better-developed definition of affordability should not be treated as a panacea. For instance, further efforts to improve health insurance *affordability* may not succeed in realizing universal health insurance *coverage*. Traditional health insurance analyses have typically assumed that affordability is the main barrier to purchasing insurance—that purchasers are shopping based on price and are interested in saving money. But new research suggests that affordability in health insurance may have limited power to drive enrollment, and even be stigmatized to some extent: Subsidies that decrease the purchaser-paid monthly premium for health insurance below ten dollars per month may not increase health insurance uptake substantially because purchasers may reason that low-cost insurance must be poorer in quality.[314] Although health affordability may be necessary for a better American health system, achieving affordability—however defined—will not be sufficient on its own.

311. *See, e.g.*, Elizabeth Pendo, *Working Sick: Lessons of Chronic Illness for Health Care Reform*, 9 YALE J. HEALTH POL'Y, L. & ETHICS 453, 465–67, 465 n.73 (2009).

312. *Cf.* Gubar, *supra* note 309 ("In other words, cancer treatment escalates the possibility of penury, and treatment-produced fiscal catastrophes are tied to cancer deaths.").

313. *Cf.* M. Todd Henderson & Anup Malani, *Corporate Philanthropy and the Market for Altruism*, 109 COLUM. L. REV. 571, 611 (2009) (proposing shifting charitable deduction to "an above-the-line deduction" available to taxpayers who do not itemize, to improve fairness to lower-income taxpayers).

314. Wendy Netter Epstein et al., *Can Moral Framing Drive Insurance Enrollment in the United States?*, 19 J. EMPIRICAL LEGAL STUD. 804, 815–16 (2022).

CONCLUSION

A better definition of affordability might not have gotten George Chandler the timely care he needed in order to survive. But it almost certainly would have averted some of the thousands of similar deaths that have happened over the last century. We now have the technological tools to cure many illnesses that would have once been fatal, but still struggle with the financial logistics of determining what it would mean to make those tools affordable and carrying through that affordability promise.

This Article has three main takeaways for affordability. Descriptively, affordability has long been distinctively important in American health policy and is taking on increasing importance in many states today, particularly states interested in progressive health reforms and achieving health equity. Yet affordability is often invoked without definition, and even when it is defined, there is a lack of consensus across definitions. Second, choices about how to define affordability implicate important normative questions, in particular questions about what financial tradeoffs are acceptable consequences of health spending. Third, the best definition is a hybrid account, centered on protecting basic needs and access to opportunity, whose specific contours are informed by public surveys and deliberation.

As they go forward with innovative attempts to operationalize affordability, policymakers can learn important lessons from the successes and limits of existing policy. Operationalizing a definition of affordability is important for implementation, but operationalization should not lose sight of the underlying values that affordability aims to serve. Although it is tempting for policymakers with expertise in a particular health sector, such as pharmaceuticals or insurance, to craft a sector-specific affordability definition, households will be best served by laws that achieve *overall* health spending affordability. Last, although subsidies are the most visible and most recently popular strategy for achieving affordability, truly realizing affordability at both the household and societal level will require policies that address other drivers of unaffordability, such as wage stagnation, price increases, and the market availability of excessively priced services and drugs. Only such a cross-cutting approach can establish affordable access to health insurance, health services, and medicines as not just an increasingly vague buzzword, but a recognized and well-defined national commitment.