

## **SESSION I:**

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Good morning. I was pleased to accept the Chuck Nelson and Dan Weinberg's invitation to speak today on the role that health should play in the measurement of poverty, for one very simple reason. It's now been eight years since our panel's report has been published and invitations to speak on the panel's work are fewer and far between.

For those who've read the National Academy of Science panel's report on poverty measurement and the dissent by one of its members, one does get the impression that the role of health in poverty measurement was, and still is a contentious issue. It is, not because any one believes that health is unimportant to the concept of poverty but because there is honest disagreement over the appropriate methods of how to incorporate health into the poverty concept. The goal that I have for my remarks today is to describe the panel's rationale for the recommendations, in the context of two alternatives.

My mother is fond of the saying "when you have your health, you have everything." This adage suggests a lexicographic ordering of human needs where individuals should be willing to sacrifice enormous personal resources to improve or maintain their own health. The implications for poverty measurements should be evident. Regardless of the income they possess, only those in poor health should be considered poor. The point of this observation is not to suggest that my mother's views, by themselves provide a sensible foundation for poverty measurement, but to really raise the question which we've started already: What role does health play in poverty measurement today.

The current official poverty measure in the United States asks whether a family has sufficient cash and hence, extremely fungible resources to meet a specific level of consumption that the government deems necessary for their livelihood. Now, it might surprise an outside observer that the government is unable to definitively detail how the poverty threshold can be allocated to specific categories of needs, such as shelter or transportation, or whether certain goods are even included in the government's definition

of need. For example, do we really know whether or not health care needs are even included in the threshold amounts? One would think so, but based upon personal conversations that Gordon Fisher had with Mollie Orshansky, the creator of our poverty thresholds, she indicated that it wasn't her intention that health care be included in the construction of the poverty threshold, so for the sake of argument, let us assume that the current threshold do not reflect any amount placed upon health care needs.

Does that mean that health care plays no role in determining who is poor in the United States? Of course, the answer is no. Those in poor health are likely to have lower wages and salaries and hence, have a higher chance of being labeled poor. Health status plays a role in the current poverty measurement, although a rather indirect one. The trillions of dollars that the US spends on medical care annually, is testament that individually and collectively the nation believes that health must be an important determinant of well being. To reflect this national priority, one might assume that medical expenditures should be directly recognized and be an important component of a family's need and hence be included in the poverty threshold, just as other necessities are such as food, clothing, and shelter -for those who have read our poverty report, those are three very important factors.

To maintain consistency in the poverty measure, one would want to account for any direct or indirect medical assistance provided by employers or the government. The problems in the disputes arise when one suggests specific way to include medical needs and assistance to meet these needs. The straightforward approach would be to place a dollar value on the medical needs of a family and add that amount to the poverty threshold. A typical suggestion and this is just one of many, is to add the value of health insurance policy that would cover 100% of the minimum, but also socially acceptable set of medical events. In other words what you would wanted to do is to try to say "these are the medical events that we feel is a minimum level of coverage that an insurance policy should cover" and then ask the question of "what would be the cost of providing that coverage". Another variant which has also been mentioned is to include the insurance value or premium of a policy that would cover a selected array, the same medical contingencies but also require some level of co-participation by the family. That level of co-participation is money and would reflect the levels of deductibles and other forms of co-payments that the family would expected to pay. In this case, the premium

for that policy and the expected amount of medical out of pocket expenditures would be used to reflect the medical needs of the family. To identify poor families this revised poverty threshold would then be compared to an expanded measure of the family's available resources that would include the insurance value of either government or employer provider health care insurance. I am going to denote this approach as *the single index insurance value methodology*. It is a long name, but I just want to talk a little bit more about it with this slide.

For those who have read the report, the panel proposed a series of recommendations other than just the treatment of health care. At this point, I just want to briefly mention these recommendations. The poverty threshold that the panel had recommended would reflect the food, clothing, and shelter needs of a family. The level of needs were determined, not on basis of what experts would have determined was needed by the family, but on the actual behavior and the actual consumption patterns of families in the United States. That was an important distinction for the panel. But what we were trying to do was to get at a level of non medical consumption or needs and that was to reflect food, clothing and shelter. Now, what the above proposal would add a premium for an insurance policy that would cover a level of medical contingencies that are deemed necessary and also would add the amount of deductibles and co-payments that are expected to be made by the family. The term PIP is the insurance value of that premium. The next term is the expected medical out-of-pocket. This would reflect the average amount of medical out of pocket expenses for families of a given set of demographic characteristics. I have abbreviated as this concept as EMOOP. And MOOP here is one of the famous acronyms that came out of our panel's report; MOOP is the medical out-of-pocket expenses.

Against this measure of needs we ask, does the family have sufficient resources to meet these needs? The panel recommended in a series of changes to the Census current money income definition (Census money income reflects only the cash income of the family). We will denote this income concept as *adjusted cash*. Now, the *adjusted cash income* for the family reflects all the resources the family has available in a fungible but also not so fungible sources. To accomplish this measurement of this income concept, the panel recommended subtracting from the current definition of cash income, the amount of *taxes* that they would have to pay. Also, the panel recommended

subtracting work related expenses up to an unlimited amount. This not only includes child care, but other work-related expenses. The panel proposed adding the value of all government provided *in-kind transfers* directed towards meeting the family's food, clothing, and shelter needs. While currently the government does not have any programs that provide help directly in-kind with clothing, they do have assistance for other kinds of food and shelter needs. For example, the government provides public housing, as well as section eight subsidies for shelter, as well as direct food assistance through the Food Stamp Program and other food assistance programs. After these modifications to Census money income are made, we have arrived at AC or *Adjusted Cash income*.

To maintain consistency between the needs side of the measure and the resource side, one would have to add to the adjusted cash income of the family any assistance that the family receives in the form of insurance or even direct medical assistance in form of free health care. If you examine the history of the inclusion of health care in poverty measurement, numerous analysts have suggest that the family's medical assistance, especially the provision of Medicaid and Medicare, be added to the resource side but failed to add anything to the needs side of the poverty measure to reflect medical needs. But a consistent and honest approach to this would be to add both of these concepts to both, the resources and the needs side. Hence, a person would be poor or a family would be poor *if their adjusted cash income plus any provided premiums -provided by the employer or government-, were less than what we would think would be their needs in terms of non medical needs plus the cost of this insurance policy, plus any expected out of pocket or conversely -as the other equation states -, the insurance premium that would cover 100% of needed medical contingencies.*

The panel numerous problems with this approach, but probably the one that it first grappled with was the issue of *fungibility*. The problem was, if insurance is provided by the government and the employer, and the employer or the government provides more health insurance than what would have been mandated by this socially minimal social or health care policy, the family's available resources would be overstated because they couldn't take money out of that policy and use that to finance other non-medical needs. While the family would have covered their medical needs -this approach would have said- it would have possibly overstated their ability to meet their non medical

needs. However, the real reason why the panel backed away from this approach was the question of whether or not this could ever be implemented. This approach requires a significant amount of information. On the resource side it requires valuing the employer's contributions or the employer's provision of health care insurance as well as the evaluation of all government provided health care insurance. That in itself is a large data requirement, but the panel questioned whether it was possible to arrive at which set of medical contingencies would be deemed socially acceptable.

One has to remember that the panel's report was written during the period of 1993 to 1995, during the time of the Clinton Health Care Plan. The experience faced by this health policy initiative served as a warning that it would be difficult to get a political, let alone some definition of actually what should be covered by this policy. For that reason, we started looking at some other alternatives and the alternatives that we next looked at were trying, in general to reduce the amount of data and information that we would actually need to implement any poverty measure.

One such alternative was proposed by Henry Aaron, who attributed the idea of this proposal to somebody who will speak a little later today, Gary Burtless. This proposal was a two-step procedure. This two-step procedure asks: Can we identify people who are either *cash poor* or the *medical poor*. The *cash poor* are individuals who have insufficient fungible cash income to meet their non medical needs plus the amount reflecting the medical out of pocket expenses that the family would be expected to cover (EMOOP). If they do not, then they are *cash poor*. The other group is to look at those people who are *medically poor*. Now the *medically poor* are done in a fairly crude way, but it's fairly suggestive. What is being proposed begins by asking whether a family is currently uninsured or do they have policies that then makes them underinsured compared to the socially minimal type of policy that we have in mind? If that is the case and they did not have enough money to purchase of socially acceptable health care policy, then they would be determined to be *medically poor*.

Now, the panel was extremely attracted to this idea of creating separate indexes; one to reflect the family's ability to meet non medical needs plus an expected amount to be paid towards medical expenditures but also through the form of cash. The second one focusing on medical needs alone. However, the panel has still had concerns with

this approach. The source of the panel's concern was whether poverty is an *ex-ante* or an *ex-post* concept. Consider two families; one family whose cash income is \$1,000 less than their non medical needs plus another \$2,000 reflecting their expected amount of medical out-of-pocket expenses. In other words, there is a \$1,000 less than the NNM plus EMOOP, but during the period of time they are healthy, they have no large medical expenditures, maybe only \$500 dollars of medical out of pocket expenses. Consequently, this family is not poor; they can meet their non medical needs because of their good health. Conversely, another family who is \$1,000 dollars over the poverty threshold could be pushed into poverty if they had a medical emergency. Comparisons such as these lead the panel to consider an alternative that it is really a modification to the Burtless approach. This approach was a two-index approach that denoted families *economically poor* if their adjusted cash income minus their actual medical out-of-pocket expenditures was less than their non medical needs. Now you can see that this definition of the poor is mathematically similar to the Burtless approach with the exception that the panel proposed using actual medical out-of-pocket expenses and not expected or average. However, conceptually the two definitions pose different questions. The panel proposed asking the question, after a family has incurred some health cost can they continue meet their non-medical needs? The Burtless proposal asked could the family be expected to meet their non medical needs.

As with in the Burtless approach, the panel proposed to have another index that would measure the ability of the family to meet their medical needs. However, the panel did not propose a specific index but left its construction to good offices of our government agencies. One crude index would be whether or not the family was uninsured which is a fundamental cornerstone of the Burtless approach.

Contrary to Aaron and Burtless, the panel felt that these two indexes should be kept separately. The reason for this recommendation was for purposes of policy analysis. The policies that you would attack *cash non medical needs* may be entirely different than the kinds of policies you would attack *health care needs*. Since I have exceeded my time I will stop here and address other issues during the period for discussion.