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The Growing Financial Burden Of Health Care: National And State Trends, 2001–2006

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ABSTRACT The financial burden of health care—the ratio of total out-of-pocket spending for health care services and premiums to total family income—continues to increase nationally. As a result of this trend, more people have been exposed to high costs and lack essential services. This study examines trends nationally and among selected states between 2001 and 2006. The results show considerable state-to-state variation associated mainly with differences in family income and, to a lesser extent, out-of-pocket spending for insurance premiums. Nationally, middle- and higher-income people with private insurance experienced the largest increases in financial burden. Moreover, almost 30 percent of the U.S. population either had a high financial burden of health costs or were uninsured. These facts underscore that escalating health care costs affect all socioeconomic strata, not just the poor.

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The recent severe recession and ongoing high unemployment rates have raised concerns that the number of uninsured Americans will continue to increase sharply. If so, more people will be exposed to the high costs of health care and may lack needed care. In fact, the so-called financial burden of health care—the ratio of total out-of-pocket spending for health care services and premiums to total family income—was increasing even before the current economic crisis.

An earlier study found that the percentage of people in families that had spent more than 10 percent of their income on health insurance premiums and health care services increased 11 percent between 2001 and 2004.¹ Other recent studies have also reported increases in the percentage of people who were underinsured (that is, experiencing high out-of-pocket costs relative to their income) and had problems paying medical bills between 2003 and 2007.^{2,3}

A key aspect of these earlier trends is that increasing financial burdens were experienced pri-

marily by people with private insurance coverage—including those with employer-sponsored health insurance. The higher burdens were driven by the fact that out-of-pocket spending for premiums and health services rose faster than family incomes, despite modest economic growth between 2001 and 2004. Although the number of uninsured people also increased during this period, this trend had little impact on the overall percentage of people reporting high financial burden.

This paper updates the trends reported in an earlier paper with data from the 2006 Medical Expenditure Panel Survey (MEPS), the largest and most comprehensive source of information on out-of-pocket medical expenditures for both health insurance premiums and health services. Although the results reported in this paper predate the recent recession, between 2004 and 2006 there were increases in the proportion of Americans with high financial burden (families that spend more than 10 percent of their income on health care) at a time when the nation's economy was relatively strong and unemploy-

ment was low. Thus, a return to strong economic growth and low unemployment by itself will not necessarily reduce the financial burden of health care for most Americans.

The paper also expands on the earlier analysis by showing extensive state-to-state variation in the percentage of the population with high financial burdens as well as state-by-state changes in financial burdens between 2001 and 2006. To our knowledge, this is the first analysis to show either. The analysis shows the correlation between state variations in high financial burden and other key characteristics of states, including total family health expenses, income, enrollment in health maintenance organizations (HMOs), and the prevalence of major chronic conditions.

Study Data And Methods

DATA The analysis is based on data from the Medical Expenditure Panel Surveys for 2001–2006. This household survey, sponsored by the Agency for Healthcare Research and Quality (AHRQ), collects detailed information on health care expenditures and use of services, insurance coverage, sources of payment, health status, employment, and other sociodemographic details of individuals and families. The survey supplements household reports on use of services with information on third-party payments as well as billing codes from medical providers' billing records.

Sample sizes for people younger than age sixty-five are about 28,000 people for each of the survey years. National estimates are weighted to be representative of the U.S. civilian, noninstitutionalized population under age sixty-five.

METHODS Although MEPS is designed primarily to produce nationally representative estimates, the survey design and weights also allow estimates for twenty-nine states that have sufficient sample sizes and representation of primary sampling units—geographic areas that include one or more counties.⁴ State-level estimates cannot be produced using the MEPS public-use files because state identifiers are not available on these files. Even so, the AHRQ Data Center provides access to geographic identifiers, which we used to produce state-level estimates for this study. For each of the twenty-nine states, we combined estimates from the 2001–2003 and 2004–2006 surveys to increase sample sizes and statistical precision.⁵

We defined *financial burden* as previous studies have: as the ratio of total out-of-pocket spending for health care services and premiums to total family income.^{1,6} We measured both income and

financial burden for health care at the family level, although we reported population estimates at the person level and assigned each individual the family-level burden measure. Additionally, we defined *high-burden individuals* as those in families that spend more than 10 percent of family income on health care.

In contrast to two earlier studies estimating financial burden, we measured family income using before-tax rather than after-tax, or disposable, income.⁷ After-tax income is not available in the public-use files, and the measure for 2006 was not available from the AHRQ Data Center at the time the analysis was conducted. After-tax income is a technically more accurate measure of financial resources available to a family. However, point estimates of financial burden are only slightly higher using before-tax measures, and the trends over time and variations across income and insurance groups are virtually identical.

We inflated measures of family income and expenditures to 2006 values based on the Consumer Price Index for urban areas. We classified individuals who lacked coverage for an entire year as uninsured, and we assigned the remaining individuals to one of three mutually exclusive insurance categories based on the type of coverage they held for the longest period of time during the year (measured monthly).

Premiums include out-of-pocket payments for private policies reported in MEPS as well as simulated Medicare Part B (physician services) premiums for people who were enrolled in Medicare and were not eligible for Medicaid premium support. We prorated all premiums to account for the duration of coverage during the year.

Study Results

FINANCIAL BURDEN OF HEALTH CARE The percentage of Americans with high financial burden from health care spending continued to increase during the middle part of the decade, from 16.4 percent in 2004 to 19.1 percent in 2006 (Exhibit 1). The increase was about evenly split between 2004–5, and 2005–6. Over the five-year period 2001–6, the percentage of Americans with high financial burden increased, on average, by about one percentage point per year.

The increase in financial burden between 2004 and 2006 occurred at a time when the economy was expanding. Growth in real gross domestic product (GDP) averaged 3 percent annually over the period—slightly higher than the 2.5 percent between 2001 and 2004). Unemployment was low.⁸ After 2003, the increase in health insurance premiums declined sharply, averaging 8.5 percent annually for 2004–6 compared to

EXHIBIT 1
Components Of Family Out-Of-Pocket Burdens, By Insurance Status, Among People Younger Than Age 65, Selected Years 2001–2006

Insurance status ^a	Population (thousands)	Family income (\$) ^b	Out-of-pocket spending on care (\$)	Out-of-pocket spending on premiums (\$) ^c	Total out-of-pocket burden (\$) ^d	Percent in families with high out-of-pocket burden ^e
TOTAL POPULATION						
2001	248,412	61,981	1,154**	1,299**	2,453**	14.4**
2004	256,485	61,393	1,282	1,567**	2,849**	16.4**
2005	258,708	60,631	1,307	1,705	3,012	17.8**
2006	261,287	61,094	1,367	1,724	3,091	19.1
PRIVATE EMPLOYMENT-RELATED						
2001	171,142	75,337	1,259**	1,617**	2,875**	12.3**
2004	168,013	77,049	1,462	2,054**	3,516**	15.1**
2005	167,873	75,686	1,445	2,230	3,675	16.8**
2006	170,113	76,805	1,555	2,287	3,842	18.4
PRIVATE NONGROUP INSURANCE						
2001	8,825	66,514	1,530**	3,449**	4,980**	35.9**
2004	8,987	63,483	1,950	3,922**	5,872**	44.7
2005	9,083	68,762	2,093	4,717	6,809	46.5
2006	8,272	67,812	2,179	4,716	6,895	47.8
PUBLIC INSURANCE						
2001	35,440	23,026**	781	273	1,055	19.3
2004	43,456	23,920	777	309	1,086	17.7
2005	45,306	25,885	826	326	1,152	17.9
2006	45,486	25,150	829	287	1,116	19.6
NO COVERAGE						
2001	33,005	33,341	914	173**	1,087	13.9
2004	36,030	33,062	884	228	1,112	14.0
2005	36,445	32,449	1,076	253	1,328	15.3
2006	37,416	31,873	985	248	1,233	15.3

SOURCE Medical Expenditure Panel Surveys, 2001, 2004, 2005, and 2006. **NOTES** Income and expenditure amounts are in 2006 U.S. dollars. Statistical significance denotes difference from 2006. ^aInsurance status is based on monthly insurance indicators and reflects coverage for the entire year; people with multiple coverage sources are assigned the coverage with the longest duration. ^bFamily income reflects income from all family members, before taxes. ^cPremiums include out-of-pocket premiums for private coverage and Medicare Part B premiums. Premiums for those with public insurance and no coverage reflect private coverage held for part of the year or private coverage for other family members, or both. ^dBurden includes out-of-pocket spending on medical care and on health insurance premiums. ^eHigh burden is defined as spending more than 10 percent of family income out of pocket for services and premiums. ***p* < 0.05

12.7 percent for 2001–4.⁹

Nevertheless, after accounting for general inflation, family incomes remained stagnant between 2004 and 2006, while out-of-pocket spending on premiums and health care services increased 8.5 percent over the two-year period. Overall, total out-of-pocket spending increased, on average, about 5 percent annually between 2001 and 2006, and was similar for the 2001–4 and 2004–6 periods.

HEALTH INSURANCE COVERAGE AND FINANCIAL BURDEN As in the 2001–4 period, the economic realities facing privately insured people drove the overall increases in the percentage of people with high financial burden. Among those with employment-sponsored private insurance, the percentage with high financial burden increased from 15.1 percent in 2004 to 18.4 percent in 2006—an increase that was very similar to that seen in the 2001–4 period. Most of the increase in out-of-pocket spending stemmed from premium in-

creases—from \$2,054 in 2004 to \$2,287 in 2006—while spending on services increased by less than \$100, on average. After accounting for inflation, we found no increase in family income for those with employer-sponsored coverage between 2004 and 2006.

The relatively small increase in spending on services over the 2004–6 period appears inconsistent with employer surveys showing steady increases in deductibles and copayments.¹⁰ Using claims data, Jon Gabel and colleagues projected that the higher cost sharing would lead to a much higher increase in out-of-pocket spending on services between 2004 and 2007 than was observed in the MEPS data.¹¹ The two data sources are not directly comparable; for example, the MEPS estimates in this paper include actual spending for the entire family, not just the employee. Also, it's possible that families may have adjusted their spending in the face of higher cost sharing. They could have done so, for example,

by using more in-network providers, where cost sharing is generally lower than for out-of-network providers, or by changing the mix of services they use, such as substituting lower-cost generic for brand-name prescriptions.

As in the 2001–4 period, spending on premiums and services increased more dramatically among those with private, nongroup insurance. This group saw a 17 percent increase in total out-of-pocket spending during 2004–6, compared to 9 percent for people with employer-sponsored coverage. Some of that increase, however, was offset by increases in family income between 2004 and 2006. By contrast, family income was unchanged for people with employer-sponsored coverage.

As a result, the increase in the percentage with high financial burden among this group was far smaller between 2004 and 2006 than in prior years, and the increase was not statistically significant. Nevertheless, the dramatic increase in burden experienced by people with nongroup coverage between 2001 and 2004 means that close to half experienced high burden by 2006—by far the highest level of burden among all of the insurance groups.

The percentage with high financial burden among both the uninsured and people with pub-

lic coverage did not change significantly between 2001 and 2006. Despite much lower out-of-pocket spending, financial burdens among those with public coverage were higher than among those with employer-sponsored coverage because of their much lower incomes.

The relatively low levels of financial burden among the uninsured may be surprising, given their greater exposure to out-of-pocket expenses. But the uninsured spend less overall because of their reduced access to care and lower use of health services.¹² Therefore, examining out-of-pocket spending greatly understates the level of financial burden among the uninsured, because their greater exposure to health care costs discourages the use of and spending for necessary services.

FINANCIAL BURDEN AND INCOME Financial burden among the privately insured increased among all income groups between 2004 and 2006, except for those between 100 and 200 percent of the federal poverty level (Exhibit 2). It is not surprising that high burdens among people below poverty continued to increase—given that most poor people can no longer afford private insurance—and that two-thirds of the poor with private insurance have high burden, compared to 9.3 percent of high-income privately insured

EXHIBIT 2

Percentage Of Population Younger Than Age 65 In Families With High Out-of-Pocket Burden, By Income And Insurance Status, Selected Years 2001–2006

Income ^a	Population (thousands)	All (%)	Private-group and nongroup insurance (%)	Public insurance (%)	No coverage (%)
POOR					
2001	29,972	33.1	57.4**	24.5	29.7
2004	33,903	32.2**	60.8	24.1**	29.5
2005	33,895	32.0**	60.8	23.9**	29.3
2006	33,499	36.3	67.3	28.6	29.4
LOW INCOME					
2001	42,729	23.1	32.4**	15.9	12.7
2004	44,008	25.8	40.4	14.9	12.2
2005	44,311	23.8	36.3	15.0	13.2
2006	44,476	26.0	40.9	15.4	14.9
MIDDLE INCOME					
2001	77,439	14.6**	15.4**	15.5	8.8
2004	82,019	16.7**	18.8**	11.3	8.9
2005	82,063	20.4	23.1	11.7	11.8
2006	82,452	20.6	24.1	11.8	9.6
HIGH INCOME					
2001	98,273	4.7*	4.7**	7.9	4.2**
2004	96,555	6.4**	6.6**	4.6	4.6**
2005	98,438	8.2	8.2	11.4	6.6
2006	100,860	9.2	9.3	5.5 [^]	9.1

SOURCE Medical Expenditure Panel Surveys, 2001, 2004, 2005, and 2006. **NOTES** High burden is defined as having combined out-of-pocket expenses for services and premiums greater than 10 percent of family income for people in families. Insurance status is based on monthly insurance indicators and reflects coverage for the entire year; people with multiple coverage sources are assigned the coverage with the longest duration. Statistical significance denotes difference from 2006. ^aPoor: family income below 100 percent of the federal poverty level. Low income: 100–199 percent of poverty. Middle income: 200–399 percent of poverty. High income: 400+ percent of poverty. **p < 0.05

people.

However, the relative increase in high burden has been much greater among both middle- and higher-income privately insured people, which reflects in part their much lower burden levels to start with. Between 2001 and 2006, high burdens among the privately insured increased 17 percent for those below poverty, 56 percent among middle-income people, and 98 percent among higher-income people. An additional eleven million people with private insurance

had high burdens in 2006 than in 2001; of these, 39 percent were high-income and 48 percent were middle-income.

STATE VARIATION IN HIGH FINANCIAL BURDEN

There is substantial variation in levels of financial burden across states (Exhibit 3). Because the measure of high financial burden will be understated in states with high uninsurance rates and overstated in states with low uninsurance rates, the analysis of state variation includes separate estimates of high financial burden among the

EXHIBIT 3

State Variation In The Uninsured And High Financial Burden Among The Insured, 2001-3 And 2004-6

State	Sample size	Percent of nonelderly people in state, 2004-6		Change between 2001-03 and 2004-06 (percentage points)	
		Insured with high financial burden	Uninsured	Insured with high financial burden	Uninsured
US	86,300	15.7	14.2	1.9	0.7
AL	1,100	26.4 ^a	14.1	5.6 ^d	3.0 ^c
OK	1,000	24.8 ^a	25.0 ^a	7.7 ^c	0.3
TN	1,500	21.8 ^a	10.2 ^a	3.6	1.8
KY	1,500	21.2 ^a	16.5 ^a	1.6	2.6
SC	1,000	20.0 ^b	13.2	3.3	0.5
LA	1,200	19.3 ^b	19.0 ^a	0.9	0.3
NC	2,700	18.9 ^a	17.1 ^a	3.9 ^c	3.2 ^c
OR	1,400	17.4 ^a	12.5	3.4	-0.2
PA	2,600	17.2 ^a	10.6 ^a	0.3	1.1
CT	1,200	17.2 ^b	9.1 ^a	6.7 ^c	2.4 ^c
WI	1,600	17.0	7.1 ^a	6.6 ^c	0.2
OH	2,600	16.6	11.1 ^a	1.8	0.5
FL	4,300	16.3	19.9 ^a	-0.1 ^c	0.2
MO	1,500	16.0	13.2	5.9 ^c	3.8 ^c
NY	4,900	16.0	11.0 ^a	3.0	-1.6 ^c
MN	1,400	15.7	8.9 ^a	-0.8	0.2
MD	1,700	15.6	10.9 ^a	6.5 ^c	0.5
CO	1,000	15.5	16.7 ^a	0.9	3.0 ^c
VA	1,700	15.0	11.4 ^a	-0.3	3.3 ^c
MA	900	14.9	6.6 ^a	2.2	0.6
TX	10,400	14.6 ^a	23.5 ^a	0.9	0.9
IN	900	14.6	16.5 ^a	0.6	4.1 ^c
MI	2,600	14.5	10.4 ^a	1.8	0.2
NJ	2,100	14.3 ^a	11.3 ^a	3.3	2.2 ^c
WA	2,000	14.3 ^a	11.2 ^a	0.6	0.4
GA	2,600	14.1	16.1 ^a	-0.6	-1.5
IL	3,500	13.8 ^a	13.6	-1.4 ^c	1.1
AZ	2,600	13.2 ^a	16.1 ^a	-0.5 ^c	1.7
CA	13,400	12.4 ^a	18.0 ^a	1.2	1.2

SOURCE Medical Expenditure Panel Surveys, 2001–2006. **NOTES** In order of insured with high financial burden in 2004–6. Estimates reflect state averages for 2001–3 and 2004–6. “Insured with high financial burden” is defined as the percentage of people in the state who are insured and have out-of-pocket spending on premiums and services exceeding 10 percent of family income. “Uninsured” reflects coverage status for the entire year. ^aDifference with U.S. average for 2004–6 is statistically significant at the 0.05 level. ^bDifference with U.S. average for 2004–6 is statistically significant at the 0.10 level. ^cDifference between state change from 2001–3 to 2004–6 and change for the overall U.S. is statistically significant at the 0.05 level. ^dDifference between state change from 2001–3 to 2004–6 and change for the overall U.S. is statistically significant at the 0.10 level.

30%

High burden or uninsured

During 2004–6, nearly 30 percent of the U.S. population either had high financial burden or were uninsured.

insured population and the proportion who are uninsured. Among the total nonelderly U.S. population during 2004–6, 15.7 percent were insured people with high out-of-pocket expenses, and 14.2 percent were uninsured for the entire year. Thus, almost 30 percent of the U.S. population either had high financial burden or were uninsured.

There is substantial variation across states in these measures: the proportion who were insured with high financial burden ranged from a high of one-quarter of the nonelderly population in Alabama and Oklahoma to a low of 12.4 percent in California. Some states tend to have both a high uninsurance rate and a high proportion of their insured population with high financial burden. Half of the nonelderly population in Oklahoma, for instance, is either uninsured or insured with high financial burden. Other states—for example, Massachusetts—tend to have both lower uninsurance rates and fewer insured people with high financial burden.

However, the overall correlation between the state's uninsurance rate and high financial burden among the insured is fairly small ($r = 0.20$). The low correlation is exemplified by states such as Texas that have a high uninsurance rate but average burden levels among their insured population, while states such as Tennessee and Alabama have relatively low or moderate uninsurance rates and high burden levels among the insured.

Similarly, many states experienced increases in the number of people with high burden or the number of uninsured people, or both, between 2001–3 and 2004–6. Seven states experienced significantly larger increases in high financial burden among their insured population than the national trend, and four of those states—Alabama, North Carolina, Connecticut, and Missouri—also had a higher-than-average increases in their uninsured populations.¹³ States that experienced the largest increases in high financial burden include some with the highest levels of financial burden overall—Oklahoma, Alabama, and North Carolina—as well as those with average levels of financial burden—Missouri, Maryland, and Wisconsin.

STATE VARIATION IN HIGH FINANCIAL BURDEN AMONG THE PRIVATELY INSURED Most of the state-to-state variation in high financial burden among the insured was attributable to variation among the privately insured. This variation may be associated with a number of factors related to socioeconomic characteristics of the population, the cost of private health insurance coverage, and the overall demand for care.

In fact, much of the state variation in high financial burden among the privately insured

is associated with differences in family income (Appendix Table 1).¹⁴ In general, high burden levels among the privately insured are associated with lower income levels ($r = -0.71$). For example, the eight states—Oklahoma, Alabama, Louisiana, South Carolina, North Carolina, Kentucky, Tennessee, and Florida—with more than 20 percent of privately insured people experiencing high burden have a combined average income of about \$64,000. That compared to about \$81,000 among the ten states—Georgia, Arizona, Massachusetts, New Jersey, Virginia, California, Michigan, Washington, Missouri, and Illinois—where less than 17 percent of the population has high burden levels.

Variation in burden levels across states is also associated with differences in average out-of-pocket premium spending ($r = 0.46$). In general, average premiums are somewhat higher in states that have the highest burden levels—about \$2,600—compared to about \$2,200 in low-burden states. Higher premiums may reflect in part differences in the prevalence of certain types of health plans.

For example, privately insured people in high-burden states tend to have lower enrollment in HMOs, which generally charge lower premiums in exchange for greater restrictions on care (see Appendix Table 1).¹⁴ The proportion of privately insured people enrolled in HMOs is about 32 percent in states with the highest burden levels (greater than 20 percent) compared to 46 percent in states with the lowest burden levels (less than 17 percent).¹⁵

High financial burden levels in some states are not associated with greater total family spending on health care ($r = -0.14$; see Appendix Table 1).¹⁴ This suggests that high burden levels in some states are not the result of either higher demand or higher prices for care, which is consistent with other research that shows that demand and price explain only a small amount of variation in total Medicare spending.¹⁶

Average total family expenditures are about \$7,000 annually for states with burden levels higher than 20 percent, and slightly higher—about \$7,500—for states with burden levels less than 17 percent. New Jersey has the highest total family spending on health services—\$9,746—but has relatively low burden levels. In contrast, Florida, Louisiana, and North Carolina have the lowest total family spending—all less than \$6,000—but are among the states with the highest financial burden levels among the privately insured.

There is also little correlation between burden levels and the percentage of the privately insured population with selected health conditions ($r = 0.10$).¹⁷ This suggests that higher premiums

in high-burden states do not reflect higher health risk or greater demand for medical care.¹⁸

Discussion

The recent recession and increase in unemployment rates since the period of study probably increased the number of people exposed to the high financial costs of health care. These factors both increased the number of people who were uninsured, and decreased access to and affordability of private insurance coverage.

However, a return to robust economic growth and declining unemployment alone will not reduce the financial stress on Americans resulting from high health expenditures. Although attention has been focused on rising health care costs, the fact that real median household income remained largely unchanged between 2000 and 2007—hovering at about \$50,000—was an equally important contributor to increasing financial burden.¹⁹ To stop and reverse the ongoing increase in the number of families with high health care cost burden, strong economic growth must be accompanied by both increases in family incomes—which have been rare during this decade—and more moderate increases in health care costs.

POLICY IMPLICATIONS Regardless of national trends, state variation in high financial burden levels will probably persist without national health care reform. The variation will perhaps grow even larger if wealthier states with already low uninsurance rates implement state reforms that increase the affordability of health insurance coverage, as Massachusetts has done. States with both high uninsurance rates and high financial burdens among the insured should be a concern for both state and national policy makers, as prior research has shown that high uninsurance rates in an area can have detrimental spillover effects.

Because one result of high uninsurance rates is lower aggregate demand for health care, there is less revenue available for capacity and quality improvements—which affects not only the uninsured but also insured people in those areas.²⁰ Such spillover effects may be similar, or compounded, when there are also large numbers of underinsured people or people with high financial burden.

POTENTIAL EFFECTS OF REFORM National reform legislation, if enacted, has the potential to reduce the state variation in high financial bur-

den among the insured population. Low-income states with high financial burden levels are likely to benefit most from the Medicaid expansions and subsidies available for low- and moderate-income families to purchase private insurance coverage through an exchange. Both of these provisions are included in the House and Senate versions of reform legislation.

Also, to the extent that a state or national insurance exchange increases competition among health plans, the overall costs of private insurance could be lowered in some states with high financial burden. There is currently less competition among health plans in states with high financial burden. The combined market share of the top two private insurers is 76 percent, on average, in the five states with the highest financial burden among privately insured people: Oklahoma, Alabama, Louisiana, North Carolina, and South Carolina. This compares to a 65 percent market share of the top two private insurers in the six states with the lowest burden—Illinois, Missouri, Washington, Michigan, California, and Virginia (data not shown).²¹

However, some state variation in high financial burden is likely to remain even if national reform is implemented, especially if *high burden* is defined as expenses exceeding 10 percent of family income. For example, based on the health reform bill passed by the House in November 2009—the Affordable Health Care for America Act, which is more generous than the bill passed later by the Senate—a family of three whose income is 300–400 percent of poverty will still be required to pay up to 10–12 percent of their family income on health insurance premiums alone. In addition, the family would have out-of-pocket spending for services, although there are subsidies to offset some of the latter. But there are no subsidies for families with incomes greater than 400 percent of poverty, a group that has been experiencing the greatest percentage increase in high financial burden in recent years.

Thus, subsidizing private coverage and expanding public coverage for lower- and moderate-income families alone is not sufficient to stem the increase in high financial burden or to reduce the variation in financial burden across states. To stem the increase in financial burden among families at higher income levels—and to sustain proposed subsidies to lower-income people—it will be essential to combine cost containment efforts in health care along with achieving real gains in family income. ■

76%

Market share

The combined market share of the top two private insurers is 76 percent, on average, in the five states with the highest financial burden among the privately insured, but only 65 percent in the six states with the lowest burden.

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NOTES

- 1 Banthin JS, Cunningham P, Bernard D. Financial burden of health care, 2001–2004. *Health Aff (Millwood)*. 2008;27(1):188–95.
- 2 Schoen C, Collins SR, Kriss JL, Doty MM. How many are underinsured? Trends among U.S. adults, 2003 and 2007. *Health Aff (Millwood)*. 2008;27(4):w298–309.
- 3 Cunningham P. Trade-offs getting tougher: problems paying medical bills increase for U.S. families, 2003–2007. Washington (DC): Center for Studying Health System Change; 2008 Sep. Tracking Report no. 21.
- 4 The MEPS sample design and estimation procedures include a number of features to enhance the capability for state estimates. The National Health Interview Survey—which is the sampling frame for MEPS—includes state as a stratification variable for first-stage sampling (that is, the selection of primary sampling units, or PSUs). All of the twenty-nine states used for state-level estimates have multiple PSUs. Almost all have a minimum of four PSUs, including “certainty” PSUs (large urban areas) that together cover about 60 percent of the state population. In addition, weights used to produce state-level estimates were poststratified to state population totals as reported in the Current Population Survey.
- 5 All statistical tests and standard errors used in the analysis reflect the complex survey design of MEPS, including the pooling of multiple years of data for the state estimates.
- 6 Banthin JS, Bernard DM. Changes in financial burdens for health care: national estimates for the population younger than 65 years, 1996 to 2003. *JAMA*. 2006;296(22):2712–9.
- 7 Comparisons with the earlier study by Banthin and colleagues (Note 1) show that differences in burden estimates based on before-tax or after-tax income are two percentage points or less. The differences were somewhat greater for higher-income people (3–4 percentage points). However, these small differences do not affect the trends and conclusions reported in this study.
- 8 U.S. Census Bureau. Table 646: GDP components in real (2000) dollars—annual percent change, 1990–2007. In: *The 2009 statistical abstract*. Washington (DC): Census Bureau; 2009.
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- 15 Estimates of the percentage of privately insured people in HMOs from MEPS are considerably higher than that reported in the KFF/HRET employer survey (about 38 percent in MEPS for 2004–6 versus 20 percent in the KFF/HRET survey in 2006; see Notes 9 and 10). This probably reflects differences in survey respondents’ recall as well as in how respondents define HMO (for example, 13 percent of respondents to the KFF/HRET survey reported being in point-of-service plans; some MEPS respondents may have defined these as HMOs). These differences in point estimates are less consequential for this analysis, because the main focus is variation across states.
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