RISING OUT-OF-POCKET SPENDING FOR MEDICAL CARE: A GROWING STRAIN ON FAMILY BUDGETS

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ABSTRACT: Since the late 1990s, accelerated growth in health care spending has translated into increased burdens on family budgets. In 2001–02, an average of 13 million families per year had direct out-of-pocket (OOP) costs equal to or exceeding 10 percent of family income. When premium costs are added into the equation, even more families are devoting a substantial share of resources to health care expenses. Using data from the Medical Expenditure Panel Survey to examine trends in family OOP spending between 1996–97 and 2001–02, this report examines the components of OOP spending and characteristics of families with high OOP costs, including income level and insurance coverage. Families struggling with high OOP expenses are more likely than other families to report difficulties in obtaining needed care, and often have trouble paying their bills—increasing the possibility that they may face debt or bankruptcy or drop coverage altogether.

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EXECUTIVE SUMMARY

Since the late 1990s, accelerated growth in health care spending has translated directly into increased burdens on family budgets. Between 1996–97 and 2001–02, the average family's out-of-pocket (OOP) spending rose in direct proportion to total medical spending and nearly twice as fast as did family income. As a result, many more families now face high costs relative to income. When rising premium costs associated with employer-based coverage or nongroup insurance are added into the equation, even more families are devoting a substantial share of their resources to health care expenses.

By 2002, nearly one-quarter of all families and one of six nonelderly families devoted high levels of their total income on OOP plus premium costs. The rates were notably high among low- and modest-income working families. Having insurance reduced the likelihood of high OOP costs. But, here too, low- and modest-income families remained at risk for costs that were high relative to their incomes.

This report uses data from the Medical Expenditure Panel Survey (MEPS)—as did an earlier Commonwealth Fund report on this subject, *Family Out-Of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity* (Merlis 2002). MEPS is a household survey continuously conducted by the Agency for Healthcare Research and Quality, providing nationally representative data on health care utilization and spending, insurance coverage, and other characteristics of the civilian noninstitutionalized population.

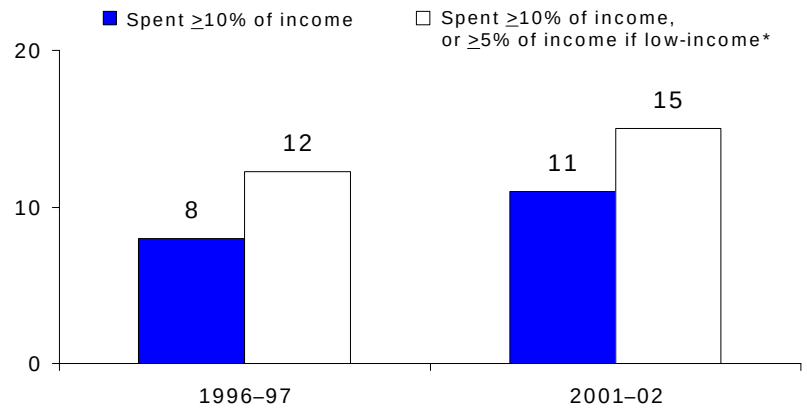
Throughout the report, OOP costs include deductibles, coinsurance or copayments, and payments for services not covered by insurance. Health care costs including premium payments are featured in the final section.

Key Findings

- In 2001–02, an average of 13 million families per year—11 percent of all families—had direct OOP costs equal to or exceeding 10 percent of family income, compared with 8 percent in 1996–97.
- Another 5 million families per year, with incomes below 200 percent of the federal poverty level, had direct costs equal to 5 percent to 10 percent of their income.

- Altogether, an average of 18 million families per year—made up of 35 million individuals—faced OOP medical care costs that were high relative to their incomes.
- The share of families with high OOP costs is up sharply since 1996–97, increasing from 12 percent with spending above the combined income thresholds to 15 percent in 2001–02.

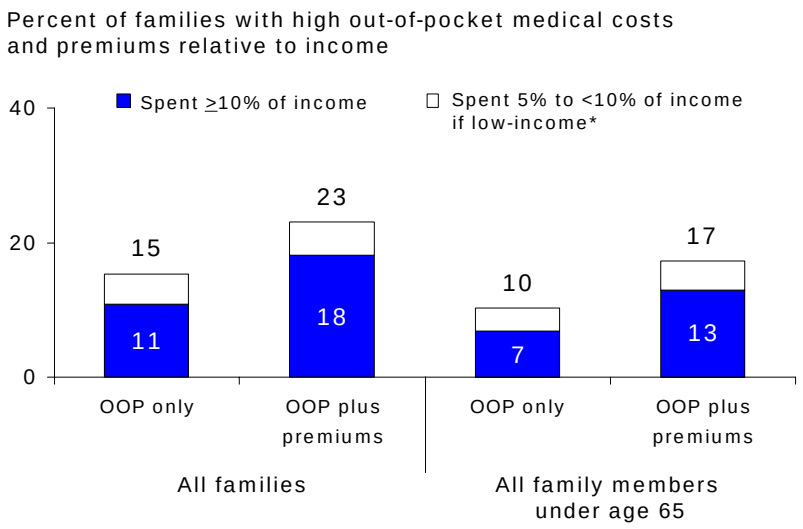
Figure ES-1. Nearly One of Six Families Spent 10% or More of Income (or 5% or More if Low-Income) on Out-of-Pocket Medical Costs, 2001–02



* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 1996–97 and 2001–02.

When the family's share of private health insurance premiums is added to OOP spending for medical care, 18 percent of families had costs greater than 10 percent of income, and nearly one-fourth had costs above the combined threshold (i.e., OOP costs equal to or exceeding 10 percent of family income or, for families with income below 200 percent of the federal poverty level, costs equal to 5 percent to 10 percent of income) in 2001–02. This amounts to 27 million families.

Figure ES-2. Including Premiums, One of Four Families Had High Costs Relative to Income, 2001–02



OOP = out-of-pocket.
* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 2001–02.

Families with any member age 65 or older were much more likely than other families to have high medical care and premium costs relative to income. This is partly due to gaps in Medicare benefits, such as the lack of catastrophic coverage and—in the period covered by this study—almost no coverage of outpatient prescription drugs. It is also due to the fact that beneficiaries pay part or all of the premiums associated with employer-provided or nongroup Medicare supplemental coverage. Still, 10 percent of families without elderly members—close to 10 million families—had high OOP medical care cost relative to their incomes. When premium costs are included, 17 percent had high costs relative to income. Because the gaps in health coverage for the elderly have been extensively documented, the remainder of this report focuses on nonelderly families—those without members age 65 or older.

Nonelderly Families: Poor Health and Low Income Place Families at Risk

As of 2001–02, an average of 9.5 million nonelderly families per year, consisting of 21 million people, had OOP expenses that were high relative to their family income, using the combined threshold.

Health status. When any member of a nonelderly family has a health or functional problem, the family is much more likely to have high OOP costs. Families of people whose self-reported health or mental health is fair or poor are much more likely to have

high costs than families with no problems. The same is true of families with a member who requires assistance with activities of daily living (ADLs), such as bathing or dressing, or instrumental activities of daily living (IADLs), such as cooking or paying bills.

Income. Nonelderly families with low incomes are much more likely to pay a high share of income for direct OOP costs. The disparity is especially large for low-income families reporting any health or disability problems. However, even low-income families with no such problems are paying high OOP costs relative to income.

Insurance coverage and coverage source. The prevalence of high OOP costs is growing most rapidly among fully insured nonelderly families—those in which all members have coverage throughout the year. As of 2001–02, nearly 10 million people in such families had expenses that were high relative to income. Prevalence of high costs is still higher when any or all family members go without coverage for all or part of the year. But fully insured families have seen a larger proportional increase, because their uncovered costs are rising faster than income.

Insurance and health status combined. Regardless of insurance coverage, having a family member with a health problem or ADL/IADL limitation significantly increases the likelihood that a family will have high OOP costs relative to income. Among nonelderly families with fully insured members, the incidence of high costs for families with health problems was close to four times as large as for families reporting no problems.

Persistence of high costs. Overall, 32 million people were in families with high OOP costs in 2001, 2002, or in both years. Of these, over 8 million people were in families with high costs in both years. Families with high direct OOP costs are much more likely than other nonelderly families to report that they went without needed services because they needed the money to pay for other necessities. They are also more likely to report that they postponed obtaining care or had other difficulties.

Adding in premiums. When family contributions to premiums for employer-based plans or other private coverage are added, the proportion of families with high costs relative to income rises markedly. The effect is especially notable for families with nonemployer coverage: two of five (40%) have high costs relative to income when both premiums and direct OOP spending are included. Even among families with employer coverage, an average of one of eight experienced high costs in 2001–02.

Conclusion

This report uses MEPS cost data through 2002. It is likely that spending on OOP and premium costs has been growing even more rapidly since then. Employee contributions toward family premiums increased by 27 percent between 2002 and 2005, and many employers have imposed similar increases in coinsurance and copayment levels. Medicaid beneficiaries have generally been protected against high costs, but the budget reconciliation bill that is scheduled for consideration by Congress in February 2006 will allow states to require more cost-sharing by many participants.

Given these trends, it can be expected that many more families—especially low-income families—will need to devote a steadily larger share of their budgets to health care. Some may choose to drop their health insurance, while others will face increased debt and the threat of bankruptcy. Some analysts contend that requiring consumers to pay more of their own costs will encourage them to become more prudent or savvy users of medical services. Creating financial incentives for consumers may play some part in the solving the problem of growing health care costs, but it is also vital to ensure that the most vulnerable families are adequately protected against the risk of unsustainable medical bills.

RISING OUT-OF-POCKET SPENDING FOR MEDICAL CARE: A GROWING STRAIN ON FAMILY BUDGETS

INTRODUCTION

Since the late 1990s, accelerated growth in health care spending has translated directly into increased burdens on family budgets. The average family's out-of-pocket (OOP) expenses rose from $922 per year in 1996–97 to $1,245 in 2001–02, an increase of almost 35 percent. As a result of this increase, in 2001–02, an average of 13 million families per year had direct OOP costs exceeding 10 percent of family income. When rising premium costs associated with employer-based coverage or nongroup insurance are added into the equation, even more families are devoting a substantial share of their resources to health care expenses.

This report uses data from the Medical Expenditure Panel Survey (MEPS) to examine trends in family OOP spending between 1996–97 and 2001–02, the components of that spending, and the characteristics of families with high OOP costs. Two-year periods are used to increase sample size and improve the reliability of estimates. A "family" includes single individuals as well as families of two or more persons.

Throughout the report, OOP costs include deductibles, coinsurance or copayments, and payments for services not covered by insurance. Health care costs including premium payments are featured in the final section.

Two different thresholds are used to define the sets of families with high OOP costs:

- The family's OOP expenses for medical care during a year equaled 10 percent or more of family income.

- The family's OOP expenses during a year equaled 10 percent or more of family income *or* the family had income below 200 percent of the federal poverty level and OOP expenses equaled 5 percent or more of family income. (In 2002, 200 percent of poverty was $17,720 for a single person or $36,200 for a family of four.)

The second definition reflects the likelihood that lower-income families may have a smaller proportion of income available for health care after meeting basic expenses such

as housing, food, and utilities. The 5 percent-of-income benchmark is used by the State Children's Health Insurance Program (SCHIP) in defining maximum OOP liability for low-income covered families with incomes above 150 percent of poverty.

It should be noted that MEPS does not interview people who are in nursing homes or other long-term care facilities, although people who are institutionalized for only part of a two-year period may be interviewed before or after their stay. This means that spending estimates in this report omit not only the considerable OOP contributions toward nursing home bills, but also any spending for other health services during the period the participant is excluded from the sample.

TRENDS IN OUT-OF-POCKET SPENDING BY ALL FAMILIES

The proportion of families with OOP costs exceeding 10 percent of income dropped between 1987 and 1996–97, but has since returned to the 1987 level (Table 1).

Table 1. Percent of Families with High Out-of-Pocket Costs Relative to Income During a Year

	Average number of families (millions)	OOP ≥10% of income	OOP ≥10% of income, ≥5% if low-income
1977	78.2	9.7%	n/a
1987	97.1	10.0%	n/a
1996–97	109.2	8.1%	12.3%
2001–02	118.3	10.8%	15.3%

Note: Excludes families with zero or negative reported income.

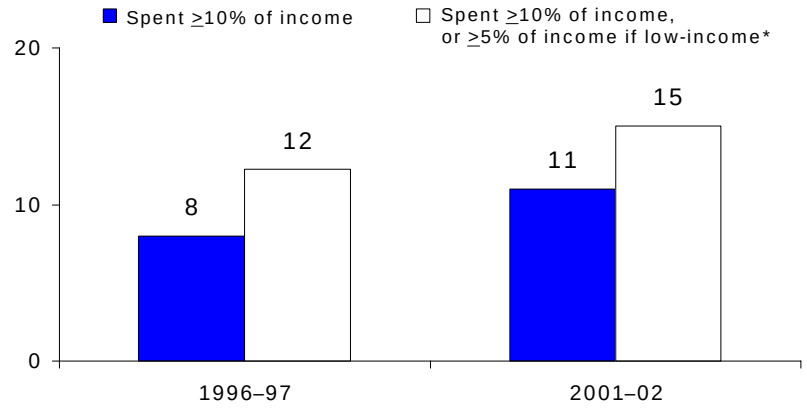
Source: Medical Expenditure Panel Survey. 1977 and 1987 data from Taylor and Banthin (Taylor and Banthin 1994), based on National Medical Care Expenditure Survey and National Medical Expenditure Survey. (The poverty-related spending measure cannot be calculated for 1977 and 1987 from the published data.)

The drop between 1987 and 1996–97 was largely due to the fact that family incomes were rising while OOP payments remained almost constant. In this period, OOP payments grew more slowly than total medical spending, in part because people with employer-based coverage were shifting from conventional indemnity plans, which often imposed deductibles and substantial coinsurance payments, to managed care plans, which tended to require less cost-sharing.

However, between 1996–97 and 2001–02, OOP spending per family grew slightly faster than overall medical spending per family, by about 35 percent as compared to 29 percent. Meanwhile, family income was rising more slowly, by an average of 19.5 percent between 1996–97 and 2001–02. As a result, the share of families with costs greater than

10 percent of income grew by one-third, while the share meeting the broader measure of high OOP cost grew by one-quarter (Table 1 and Figure 1).

Figure 1. Nearly One of Six Families Spent 10% or More of Income (or 5% or More if Low-Income) on Out-of-Pocket Medical Costs, 2001–02



* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 1996–97 and 2001–02.

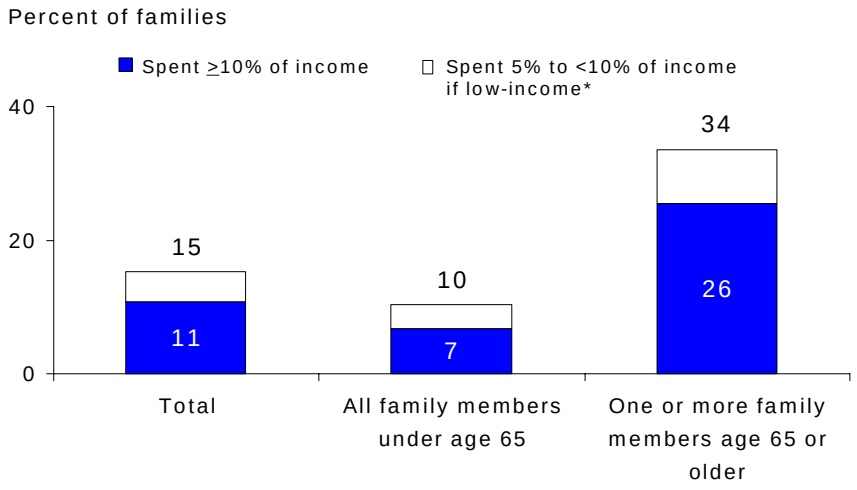
Families with any member age 65 or older are much more likely than younger families to have high costs relative to income, for several reasons. Elderly people are more likely to have costly health problems and tend to have lower family incomes. In addition, nearly all elderly people rely on Medicare, which has substantial coverage gaps—particularly, in the period covered here, almost no coverage of outpatient prescription drugs (Table 2 and Figure 2).

Table 2. Percent of Families with High Out-of-Pocket Costs Relative to Income During a Year, by Presence of Member(s) Age 65 or Older, 2001–02

	OOP ≥10% of income		OOP ≥10% of income, ≥5% if low-income	
	1996–97	**2001–02**	**1996–97**	**2001–02**
All families	8.1%	10.8%	12.3%	15.3%
One or more family members 65+	18.6%	25.5%	26.7%	33.5%
All family members under 65	5.2%	6.8%	8.3%	10.3%

Note: Excludes families with zero or negative reported income.
Source: Medical Expenditure Panel Survey.

Figure 2. One of Ten Nonelderly Families and One-Third of Elderly Families Had High Out-of-Pocket Health Care Costs Relative to Income, 2001–02



* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 2001–02.

While younger families have better protection against prescription drug costs, growth in OOP spending for prescription drugs accounts for most of total OOP spending growth for families of all ages. (See Appendix Table A-1 for a summary of OOP as a share of income and Table A-2 for details on family OOP spending by type of service.) Families typically pay a high share of drug costs—more than for any other major service except dental care. Growth in drug payments accounted for over two-thirds of the total growth in OOP spending during this period.

The new Medicare prescription drug benefit beginning in 2006 will reduce the proportion of beneficiaries with high OOP costs. However, this benefit is limited, and many beneficiaries will still face high costs for Medicare deductibles, coinsurance, and noncovered services. Even after eliminating drug expenses, 7 percent of families with any elderly member would still have had direct OOP costs equal to 10 percent of income or more in 2001–02.

The gaps in health coverage for the elderly have been extensively documented (Moon and Storeygard 2001; Stuart, Shea, Briesacher 2001; Safran, Neuman, Schoen et al. 2005). In addition, other surveys such as the Medicare Current Beneficiary Survey include a much larger sample of beneficiaries and allow for a more detailed analysis than the MEPS. For these reasons, the remainder of this paper focuses on nonelderly families—those with no member age 65 or older.

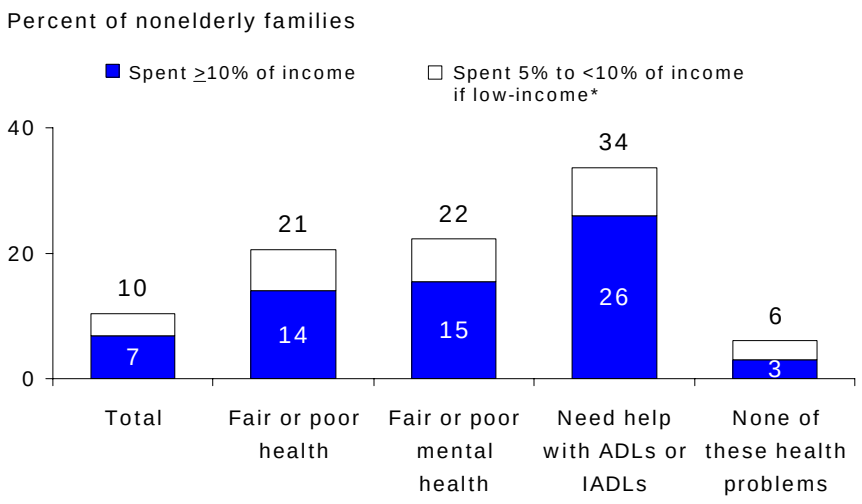
OUT-OF-POCKET SPENDING BY NONELDERLY FAMILIES

In 2001–02, an average of more than 6 million nonelderly families per year had OOP costs equal to 10 percent or more of income; another 3.2 million families had annual incomes below 200 percent of poverty and costs between 5 percent and 10 percent of income. Using the combined threshold, 9.5 million nonelderly families, constituting 21 million people, had expenses that were high relative to their incomes. This section reviews how health status, income, and insurance coverage affect the likelihood of having high OOP costs. It then examines the extent to which high OOP costs persist over time.

Health Status

Families of people whose self-reported health or mental health is fair or poor are much more likely to have high costs than families with no problems, using either measure of high costs. The same is true of families with a member who requires assistance with activities of daily living (ADLs), such as bathing or dressing, or instrumental activities of daily living (IADLs), such as cooking or paying bills (Figure 3 and Appendix Table A-1).

Figure 3. One-Fifth or More Nonelderly Families with Health Problems Spent a High Portion of Income on Health Care

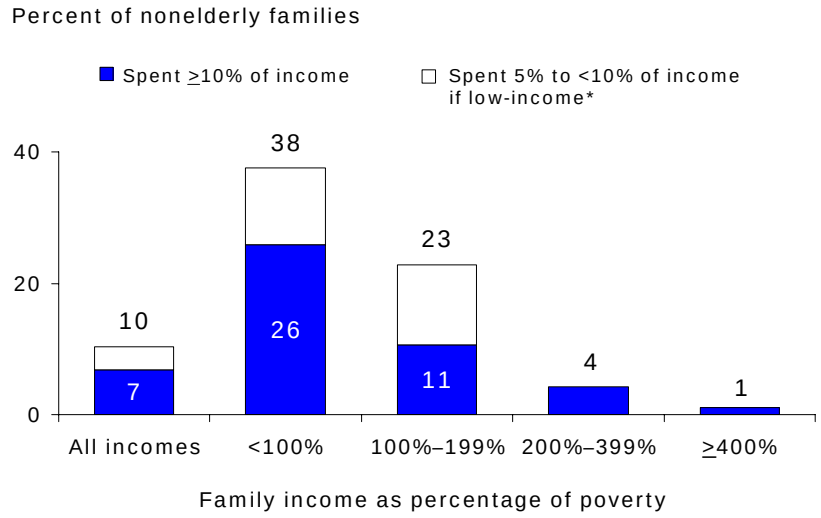


ADLs = activities of daily living; IADLs = instrumental activities of daily living.
* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 2001–02.

Income

The likelihood of spending a high share of income on OOP costs drops as income rises (Figure 4). This is not surprising: if two families with different incomes spend the same amount for medical care, the family with the lower income will have spent a higher share of income. However, it is also the case that low-income families are more likely to have health problems—either because poverty contributes to poor health or because poor health reduces income.

Figure 4. Low-Income Families at High Risk for Burdensome Out-of-Pocket Costs



* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 2001–02.

In Table 3, families are classified as having a health problem if any family member reported any of the following conditions: fair or poor health, fair or poor mental health, or need for help with ADLs/IADLs. Half of all nonelderly families with incomes below 200 percent of poverty reported health problems, compared with 28 percent of higher-income families. Still, even lower-income families with no reported health problem were much more likely than higher-income families to report high costs.

Table 3. Percent of Nonelderly Families with High Out-of-Pocket Costs Relative to Income, by Family Income and Presence of Health Problem, 2001–02

	Number of families (millions)	OOP ≥10% of income	OOP ≥10% of income, ≥5% if low-income
Family income <200% of poverty	27.2	17.3%	29.2%
Any health problem	13.6	24.0%	32.5%
No health problem	13.7	10.7%	20.2%
Family income 200%+ of poverty	65.7	4.2%	4.2%
Any health problem	18.4	5.1%	5.1%
No health problem	47.3	1.3%	1.3%

Note: Excludes families with zero or negative reported income.
Source: Medical Expenditure Panel Survey.

Insurance Coverage

While having health insurance reduces the likelihood that a family will have high OOP costs, the type of insurance a family has may be at least as important as having insurance in determining the level of OOP expenditures.

In Table 4, nonelderly families are grouped into three categories: those in which all family members had some form of insurance throughout the year; those in which no family member had insurance at any time during the year; and a middle group of families that had some uninsured and some insured members or members who had insurance for only part of the year.[1]

Although families with insurance were better protected than partially insured or uninsured families, an average of 4.5 million families per year with no gaps in insurance (i.e., all members insured all year) had high OOP expenses relative to their incomes. Of the nearly 10 million nonelderly families per year with high expenses, nearly half (47%) were in families with insurance all year.

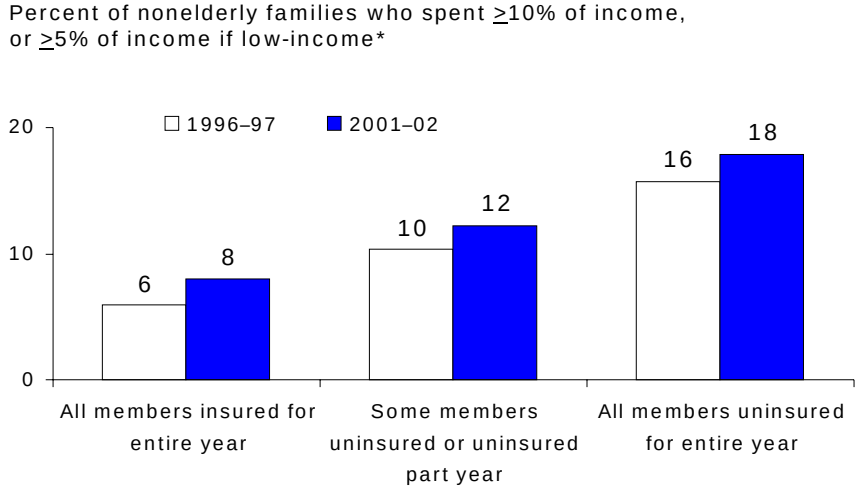
Table 4. Percent of Nonelderly Families with High Out-of-Pocket Costs Relative to Income, by Insurance Status of Family Members, 2001–02

	OOP ≥10% of income		OOP ≥10% of income, ≥5% if low-income	
	1996–97	2001–02	1996–97	2001–02
All nonelderly families	5.2%	6.8%	8.3%	10.3%
All members insured all year	4.0%	5.5%	6.0%	8.0%
Some members uninsured all or part of year	5.8%	7.5%	10.3%	12.2%
All members uninsured all year	10.7%	12.4%	15.7%	17.9%

Note: Excludes families with zero or negative reported income.
Source: Medical Expenditure Panel Survey.

Nonelderly families without insurance throughout the year are much more likely to have high OOP costs than families fully insured throughout the year. However, the proportion of fully insured families with high OOP costs grew by one-third between 1996–97 and 2001–02. Families with some members uninsured or those that have a spell of uninsurance fall midway between the two other groups. The difference between these families and fully insured families has been narrowing, in proportional terms, since 1996–97 (Figure 5).

Figure 5. Out-of-Pocket Exposure Increased over Past Five Years for Insured and Uninsured Families, 1996–97 vs. 2001–02



* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 1996–97 and 2001–02.

Regardless of insurance coverage, having a family member with a health problem or ADL/IADL limitation significantly increases the likelihood that a family will have high OOP costs relative to income. Even among nonelderly families with all members insured throughout the year, the incidence of high costs for those with health problems was close to four times as great as for families reporting no problems (Table 5).

Table 5. Percent of Nonelderly Families with High Out-of-Pocket Costs Relative to Income, During a Year, by Insurance Status of Family Members and Presence of a Health Problem, 2001–02

	Number of families (millions)	OOP ≥10% of income	OOP ≥10% of income, ≥5% if low-income
All members insured all year			
Any health problem	16.5	11.9%	16.8%
No health problem	37.7	2.7%	4.2%
Some members uninsured all or part of year			
Any health problem	12.5	13.2%	20.4%
No health problem	17.9	3.5%	6.5%
All members uninsured all year			
Any health problem	2.8	20.4%	28.9%
No health problem	5.3	8.2%	11.8%

Note: Excludes families with zero or negative reported income.
Source: Medical Expenditure Panel Survey.

Among fully insured nonelderly families, the source of coverage has a significant effect on the likelihood of high OOP costs. Different members of a family may have different sources of coverage, or family members may change coverage over the course of a year. In order to isolate the effects of specific coverage sources, Table 6 is limited to families all of whose members had either employer coverage or other private insurance throughout the year.[2]

Table 6. Percent of Nonelderly Families with High Out-of-Pocket Costs Relative to Income, During a Year, Families with Private Health Insurance and Only One Source of Coverage Throughout a Year, 2001–02

	Number of families (millions)	OOP ≥10% of income	OOP ≥10% of income, ≥5% if low-income
All members had employer coverage all year	41.8	2.9%	4.3%
All members had other private coverage all year	2.9	12.2%	18.7%

Note: Excludes families with zero or negative reported income.
Source: Medical Expenditure Panel Survey.

Families with employer coverage are much less likely to have high costs than families with other private insurance—chiefly nongroup coverage, including coverage of the self-employed.[3] One reason may be that nongroup policies often require higher cost-sharing and have less extensive benefits than employer plans. A recent study found that the average nongroup plan pays 63 percent of a family's medical bills, while an average group plan pays 75 percent (Gabel, Dhont, Whitmore et al. 2002).

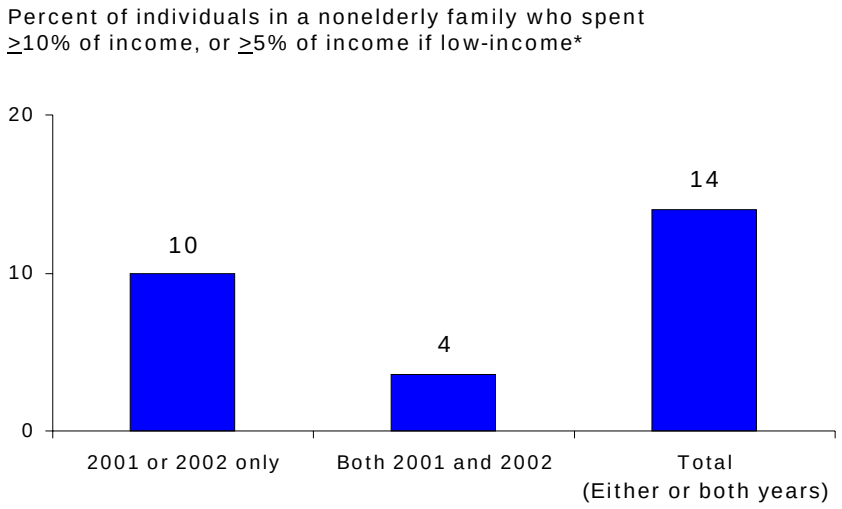
Persistence of High Out-of-Pocket Costs

Some families may experience high OOP costs in a single year because of a costly but nonrecurring health problem, while others may have members with chronic illnesses and experience high costs year after year.

While most people who participated in the MEPS during 2001 continued to participate in 2002, people can enter or leave MEPS-defined family units over time (for example, through marriage or divorce). The MEPS weighting system does not allow tracking of the experience of entire families over the two years. However, the design does allow for following individuals over time. Thus, it is possible to determine the number of individuals in nonelderly families with high OOP costs in 2001 who were also in families that incurred high costs in 2002.

Overall, 32 million people were in families with high OOP costs in at least one of the two years. Of these, over 8 million people—or one of four—were in families with high costs in both years. For these people, high medical costs are not a one-time event but an ongoing financial burden. Among people in all nonelderly families, one of seven faced high spending relative to income over the course of two years (Figure 6 and Appendix Table A-3).

Figure 6. Over the Course of Two Years, One of Seven Individuals in Nonelderly Families Faced High Spending



* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 2001–02.

Effects of High Costs on Access to Care

The MEPS survey includes a number of questions about access to care. Families with high direct OOP costs are much more likely than other nonelderly families to report that they went without needed services because they needed to pay for other necessities. They are also more likely to report postponing care or having other difficulties (Table 7).

Table 7. Reported Access Problems, Nonelderly Families with High Out-of-Pocket Costs Relative to Income During a Year, 2001–02

	Did not obtain needed care	Difficulty or delay obtaining needed care
All families reporting on access measures	7.0%	13.5%
Family with OOP ≥10% of income	15.9%	20.6%
Family with OOP ≥10% of income, ≥5% if low-income	16.3%	21.8%

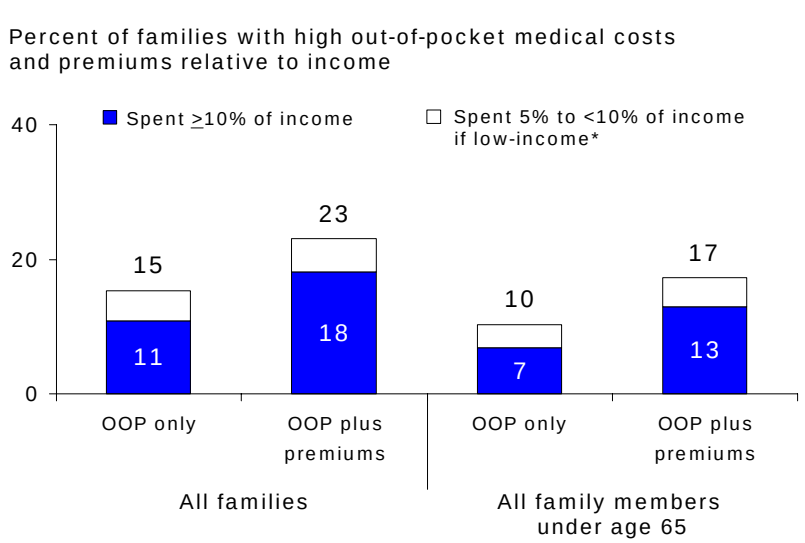
Note: Percentages based on access problems reported in either 2001 or 2002 by families that had high OOP costs in either year. Excludes families with zero or negative reported income and families for which responses to access questions were not available.

Source: Medical Expenditure Panel Survey.

FACTORING IN PREMIUMS FOR PRIVATE INSURANCE

Families with private insurance must pay, in addition to direct OOP costs for services, premiums for nongroup coverage or any required employee contribution for group coverage. Figure 7 and Table 8 show the share of families with high costs relative to income, counting OOP costs only and then adding premiums.[4] With premiums added, nearly one-fourth of families—27 million families—have high costs. As when only direct OOP costs are considered, families with any elderly member are much more likely to have high costs. Note that the estimates for these families include premiums for Medigap, retiree benefits, or other supplemental coverage, but do not include the Medicare Part B premium paid by all but the lowest-income beneficiaries. MEPS does not capture these payments or premium payments required by some states for certain groups of Medicaid and/or SCHIP enrollees.

Figure 7. Including Premiums, One of Four Families Had High Costs Relative to Income, 2001–02



OOP = out-of-pocket.
* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 2001–02.

Table 8. Percent of Families with High Costs Relative to Income, Counting Out-of-Pocket Costs Only and Out-of-Pocket Costs Plus Premiums, 2001–02

	OOP costs only		OOP costs plus premiums	
	≥10% of income	≥10% of income, ≥5% if low-income	≥10% of income	≥10% of income, ≥5% if low-income
All families	10.8%	15.3%	18.2%	23.0%
One or more family members 65+	25.5%	33.5%	37.6%	43.8%
All family members under 65	6.8%	10.3%	12.9%	17.2%
Family insurance coverage, nonelderly families				
All family members insured all year	5.5%	8.0%	13.4%	16.5%
Some members uninsured all or part of year	7.5%	12.2%	11.8%	18.6%
All members uninsured all year	12.4%	17.9%	12.8%	18.1%
Nonelderly families, by family income as a percent of poverty				
Under 100%	25.9%	37.5%	33.5%	45.8%
100%–199%	10.6%	22.8%	20.2%	38.1%
200%–399%	4.2%	4.2%	12.9%	12.9%
400% and higher	1.0%	1.0%	3.8%	3.8%
Nonelderly families with full-year private insurance, by family income as percent of poverty				
Under 200%	18.7%	35.5%	41.6%	64.9%
200%–399%	3.8%	3.8%	16.2%	16.2%
400% and higher	0.7%	0.7%	3.7%	3.7%
Total	3.5%	5.2%	11.5%	13.8%

Note: Excludes families with zero or negative reported income.

Source: Authors' analysis of Medical Expenditure Panel Survey, 2001–02.

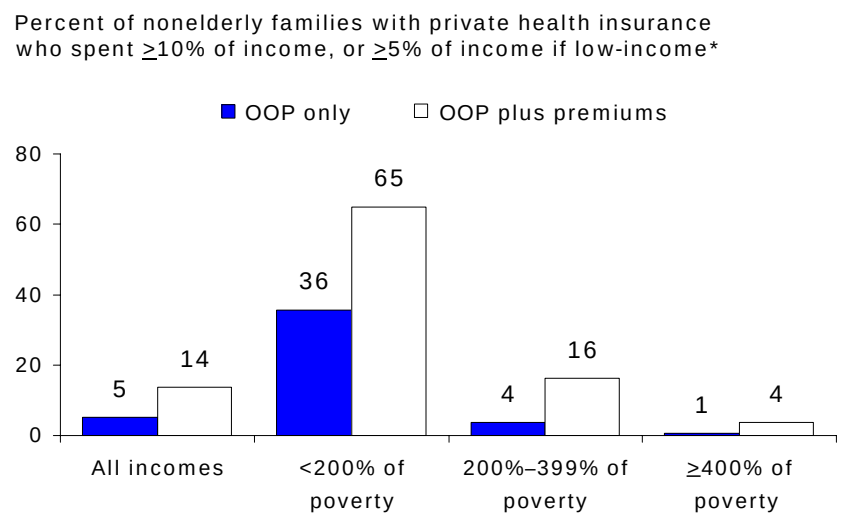
Once premiums are added, nonelderly families with insurance throughout the year are about as likely to have high costs as families with some period of uninsurance or with no insurance at all. (Families are counted as uninsured if they do not have general

hospital/medical coverage. They may report premium payments for limited policies, such as dental or prescription drug plans or "dread-disease" policies.)

When insurance premiums are included in costs, two of five (41%) low-income (below 200% of the poverty level) nonelderly families had expenses amounting to 5 percent or more of income (data not shown). Families with incomes below the poverty level or between 100 percent and 199 percent of the poverty level were at risk of exceeding the high-cost thresholds (Table 8).

Low-income families with private coverage are especially vulnerable. Close to two-thirds have high costs when both direct OOP and premiums are considered (Figure 8).

Figure 8. Total Out-of-Pocket Costs and Premium Costs for Nonelderly Families with Private Health Insurance, 2001–02



OOP = out-of-pocket.
* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 2001–02.

Even families with full-year employer coverage may be at risk (Table 9). For many families, the required employee contribution for premiums alone can represent a high share of income. One of five low-income families with employer coverage spent 10 percent or more of their income on premiums alone. Even more families have high costs relative to income when both premiums and direct OOP costs are considered.

Table 9. Percent of Employer-Covered Families with High Out-of-Pocket Costs Relative to Income During a Year, Counting Out-of-Pocket Costs Only, Premium Costs Only, and Both, 2001–02

	≥10% of income	≥10% of income, ≥5% if low-income
All families (41.8 million)		
OOP costs only	2.9%	4.3%
Premiums only	4.1%	5.9%
OOP plus premiums	9.7%	11.8%
Family income under 200% of FPL (average of 3.4 million families)		
OOP costs only	16.9%	33.4%
Premiums only	20.2%	42.6%
OOP plus premiums	40.0%	66.7%
Family income between 200% and 399% of FPL (average of 13.8 million families)		
OOP costs only	3.4%	3.4%★
Premiums only	5.4%	5.4%★
OOP plus premiums	14.2%	14.2%★
Family income 400% of FPL and higher (average of 24.6 million families)		
OOP costs only	0.7%	0.7%★
Premiums only	1.1%	1.1%★
OOP plus premiums	3.1%	3.1%★

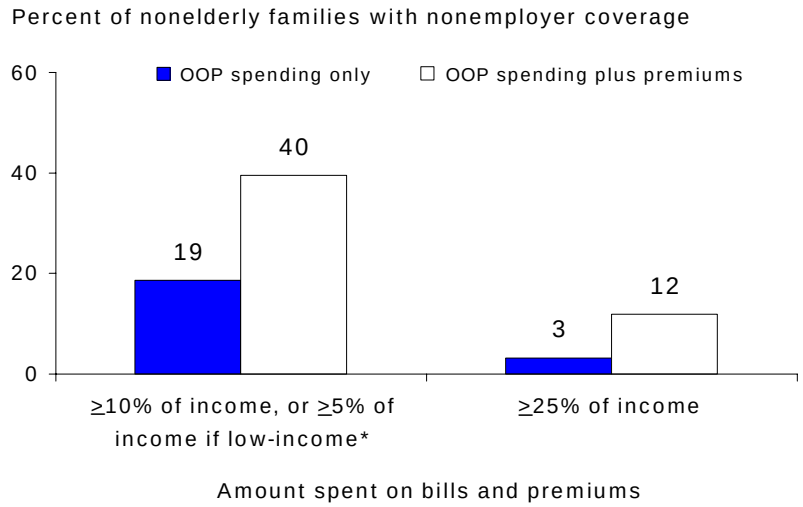
Note: Excludes families with zero or negative reported income.

★ These percentages remain the same because the ≥5% threshold applies to low-income families only.

Source: Medical Expenditure Panel Survey.

Families that rely on nonemployer private insurance are subject to high costs. This group consists chiefly of families buying coverage in the nongroup market. Premiums for nongroup coverage can be high, sometimes very high. Forty percent of nonelderly families in this market spent 10 percent or more of their income on OOP costs and premiums, or, for low-income families, 5 percent or more of income (Figure 9). One of eight nonelderly families with this coverage spent 25 percent or more of their income on health care when premiums were included (Appendix Table A-4).

Figure 9. Two of Five Families with Private Nonemployer Coverage Face High Costs When Premiums Are Included



OOP = out-of-pocket.
* Low-income includes families with incomes <200% of the federal poverty level.
Source: Authors' analysis of data from the Medical Expenditure Panel Survey 2001–02.

DISCUSSION

Out-of-pocket costs for medical care have been increasing faster than income for many different types of families: those with insurance, those without insurance, those with private health insurance, and those in public programs. Although MEPS data used for this report were available only through 2002, it is likely that families' spending has been growing even more rapidly since 2002, given recent trends in premiums and cost-sharing.

Annual increases in employee premium contributions after 2002 were much higher than those of the period covered by this study (Table 10). Many employers have imposed similar increases in coinsurance and copayment levels. At least one observer contends that there has been a fundamental shift in strategy among insurers and employers (Robinson 2004). Given the backlash against managed care, which sought to influence the behavior of providers, insurers now seek to influence patient behavior by providing financial incentives to limit or target use of services. Employers, especially in the smallest firms, may also increase cost-sharing in order to hold down premium increases (Gabel and Pickreign 2004).

Table 10. Changes in Employee-Paid Premiums and Deductibles Under Employer Plans, 1996–2002 and 2002–2005

	1996	2002	Annual % change, 1996–2002	2005	Annual % change, 2002–2005
Employee premium contribution					
Single	$444	$468	0.9%	$612	9.4%
Family	$1,464	$2,136	6.5%	$2,712	8.3%
Individual deductible, in-network					
Conventional plan	$264	$295	1.9%	$602	26.8%
PPO	$180	$251	5.7%	$323	8.7%

Source: Kaiser/HRET Employer Benefits Annual Survey (Gabel, Claxton, Gil et al. 2005).

Cost-sharing amounts paid by Medicaid and SCHIP participants are currently subject to statutory limits, although a number of states have recently increased premiums and copayments within these limits.[5] The budget reconciliation legislation that is scheduled for consideration by Congress in February 2006 will give states greater flexibility to increase cost-sharing and to reduce the scope of covered services for some classes of beneficiaries.

Given these trends, it can be expected that many more families—especially low-income families—will need to devote a steadily larger share of their budgets to health care. This may have several consequences, as follows:

- *Access barriers.* As noted earlier, families struggling with high OOP expenses are much more likely than other families to report difficulties in obtaining needed care. Other studies have found that "underinsured" families—those with coverage that leaves them exposed to high costs—face access barriers similar to those experienced by families without insurance (Schoen, Doty, Collins et al. 2005).

- *Declining coverage.* Families with public or private insurance that requires premium payments may drop coverage if the premiums increase. For example, in 2003, Oregon's Medicaid waiver program, the Oregon Health Plan, raised premiums and copayments, tightened penalties for nonpayment, and reduced benefits. Within 18 months, two-thirds of its existing low-income enrollees had left the plan temporarily or permanently; half did so because of the premium increases or other changes (Wright, Carlson, Smith et al. 2005).

- *Increased debt or bankruptcy.* Families facing high OOP costs often cannot pay their bills or go into debt to do so. A 2003 survey found that 41 percent of nonelderly adults had medical payment or debt problems; over half reported that they were insured at the time the problems began (Doty, Edwards, Holmgren 2005). Medical debt is also a major contributor to bankruptcy. In a survey of people who filed for bankruptcy in 2001, 27 percent reported unpaid medical bills of $1,000 or more in the two years before filing (Himmelstein, Warren, Thorne et al. 2005).

Even Americans with health insurance are finding that rising health care premiums and cost-sharing are putting an increasing strain on family budgets. Some analysts contend that requiring consumers to pay more of their own costs will encourage them to become more prudent or savvy users of medical services. For those with low incomes or health problems, however, the consequences can be reduced access to care, indebtedness, possible loss of insurance, or insolvency. While changing incentives for consumers may play some part in the solution to growing health care costs, it is also vital to assure that the most vulnerable families are adequately protected against the risk of unsustainable medical bills.

NOTES

[1] For part-year survey participants, the "year" is the portion of the year for which data are available. Thus someone who participated for nine months was fully insured if he or she had coverage for all nine months, or partially insured if he or she had coverage during only some of those months.

[2] Relatively few families have public coverage throughout a year. Many families relying on public coverage have fluctuating eligibility, or some family members have coverage while others are uninsured. The sample of families with only Medicare or only Medicaid throughout the year is too small for reliable estimates.

[3] The "other" category also includes coverage from someone outside the household and coverage from an unknown source.

[4] Reliable premium data are available through the MEPS beginning in 2000, so a comparison of premium costs in 1996–97 and 2001–02 is not possible.

[5] States cannot usually charge premiums for Medicaid enrollment, but may do so under waiver programs that extend eligibility to broader populations.

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APPENDIX. TABLES

Table A-1. Percent of Families with High Out-of-Pocket Costs Relative to Income During a Year, by Family Characteristics, 2001–02

	Average number of families (millions)	OOP ≥10% of income	OOP ≥10% of income, ≥5% for low-income family
All families	118.3	10.8%	15.3%
One or more family members 65+	25.6	25.5%	33.5%
All family members under 65	92.7	6.8%	10.3%
Any individual in nonelderly family reports:			
Fair or poor health	23.3	14.1%	20.5%
Fair or poor mental health	14.5	15.4%	22.3%
Need for ADL/IADL help	6.1	26.0%	33.6%
Family income as percent of federal poverty level, nonelderly families			
Under 100%	11.9	25.9%	37.5%
100%–199%	15.2	10.6%	22.8%
200%–399%	28.8	4.2%	4.2%
400% and higher	36.7	1.0%	1.0%
Family insurance coverage, nonelderly families			
All family members insured all year	55.5	5.5%	8.0%
Some members uninsured all or part of year	29.7	7.5%	12.2%
All members uninsured all year	7.4	12.4%	17.9%

Note: Excludes families with zero or negative reported income.

Source: Medical Expenditure Panel Survey.

Table A-2. Average Annual Family Out-of-Pocket Spending by Type of Service, 1996–97 and 2001–02

	All families		One or more family members 65+		All family members under 65	
	1996–97	2001–02	1996–97	2001–02	1996–97	2001–02
Ambulatory	$273	$312	$233	$264	$283	$325
Inpatient	$44	$50	$59	$55	$40	$48
Dental	$203	$256	$220	$287	$198	$248
Prescription	$284	$512	$612	$1,081	$195	$356
Other	$118	$115	$274	$262	$76	$75
Total	$922	$1,245	$1,398	$1,949	$793	$1,052

Percent of total OOP spending

	All families		One or more family members 65+		All family members under 65	
	1996–97	2001–02	1996–97	2001–02	1996–97	2001–02
Ambulatory	29.5%	25.1%	16.7%	13.5%	35.7%	30.9%
Inpatient	4.8%	4.0%	4.2%	2.8%	5.1%	4.6%
Dental	22.0%	20.6%	15.7%	14.7%	25.0%	23.5%
Prescription	30.8%	41.1%	43.8%	55.5%	24.6%	33.8%
Other	12.8%	9.3%	19.6%	13.4%	9.6%	7.1%
Total	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

Percent change in OOP spending, 1996–97 to 2001–02

	All families	One or more family members 65+	All family members under 65
Ambulatory	14.5%	13.2%	14.8%
Inpatient	12.4%	–5.2%	19.2%
Dental	26.4%	30.7%	25.0%
Prescription	80.1%	76.5%	82.4%
Other	–2.7%	–4.6%	–1.3%
Total	35.0%	39.4%	32.7%

OOP spending as percent of total spending, 2001–02

	All families	One or more family members 65+	All family members under 65
Ambulatory	13.9%	8.8%	16.0%
Inpatient	2.4%	1.4%	3.1%
Dental	49.7%	70.9%	45.3%
Prescription	43.1%	52.9%	37.4%
Other	27.4%	25.7%	29.2%
Total	19.4%	18.8%	19.8%

Note: "Other" includes home health care, vision services, and medical supplies.

Source: Medical Expenditure Panel Survey.

Table A-3. Individuals in Nonelderly Families with High Out-of-Pocket Costs, 2001, 2002, or Both Years

	OOP ≥10% of income		OOP ≥10% of income, ≥5% if low-income	
	Individuals (millions)	**Percent of all individuals in nonelderly families**	**Individuals (millions)**	**Percent of all individuals in nonelderly families**
Either 2001 or 2002 only	17.9	7.7%	24.1	10.3%
Both 2001 and 2002	3.7	1.6%	8.3	3.6%
Total	21.6	9.3%	32.4	13.9%

Note: Excludes families with zero or negative reported income.

Source: Medical Expenditure Panel Survey.

Table A-4. Nonemployer Private Insurance: Percent of Nonelderly Families with High Costs Relative to Income During a Year, with and Without Premium Payments, 2001–02

				All 3 groups:
	Under 200% poverty, 5%–9.9% of income	**10%–24.9% of income**	**25% or more of income**	**≥10% income; ≥5% if low-income**
OOP only	6.5%	9.1%	3.1%	18.7%
OOP plus premiums	5.5%	22.1%	12.0%	39.6%

Note: Excludes families with zero or negative reported income.

Source: Medical Expenditure Panel Survey.

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Impact of Changes to Premiums, Cost-Sharing, and Benefits on Adult Medicaid Beneficiaries: Results from an Ongoing Study of the Oregon Health Plan (July 2005). Bill J. Wright, Matthew J. Carlson, Jeanene Smith, and Tina Edlund. In 2003, Oregon raised premiums, required copays for the first time, and imposed a six-month lockout for individuals missing premium payments. This study reports that nearly two-thirds of surveyed individuals lost their coverage after the initial premium and cost-sharing increases, many directly resulting from increased costs.

Insured But Not Protected: How Many Adults Are Underinsured? (June 14, 2005). Cathy Schoen, Michelle. M. Doty, Sara R. Collins, and Alyssa. L. Holmgren. *Health Affairs* Web Exclusive (*In the Literature* summary). While some states could reduce their uninsured rate by as much as 20 percent under federal proposals such as tax credits or public program expansions, other states might not see much change at all.

Prescription Drug Coverage and Seniors: Findings from a 2003 National Survey (April 19, 2005). Dana Gelb Safran, Patricia Neuman, Cathy Schoen et al. *Health Affairs* Web Exclusive (*In the Literature* summary). According to a national survey, four of 10 seniors did not take all the drugs prescribed to them by doctors in the past year, due to cost, side effects, perceived lack of effectiveness, or the belief that they did not need the medication.

Risky Business: When Mom and Pop Buy Health Insurance for Their Employees (April 2004). Jon R. Gabel and Jeremy D. Pickreign. The authors of this issue brief find that small businesses that provide health insurance for their employees experience more frequent premium increases and steeper jumps in deductibles over time than large firms.

Family Out-of-Pocket Spending for Health Services: A Continuing Source of Financial Insecurity (June 2002). Mark Merlis. This report examines trends in out-of-pocket spending, the components of that spending, and the characteristics of families with high out-of-pocket costs.