



Issue Brief

Overburdened and Overwhelmed: The Struggles of Communities with High Medical Cost Burdens

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ABSTRACT: The number of people with potentially high medical cost burdens varies widely across the nation, reflecting differences in the number of people who lack health insurance coverage and people who have coverage but nevertheless have high costs relative to their income. To address this problem, many states are undertaking expansions of insurance coverage, but federal support will be critical, particularly in states with large numbers of low-income residents.

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Background

The nationwide financial burden of medical care expenses for U.S. families is increasing because of growth in the number of uninsured people and greater out-of-pocket costs for health insurance, as well as sluggish income gains.¹ This burden varies considerably across the country because of differences in rates of health insurance coverage, family incomes, and the generosity of public and private health insurance benefits.² Thus, some communities are more likely than others to experience extremely high levels of medical cost burdens.

These high costs threaten the financial well-being of U.S. families and can lead to delays in receiving health care. Using data from the 2003 Community Tracking Study (CTS) Household Survey, which includes a representative sample of 60 communities across the country, this issue brief shows the extent of variation in cost burdens across U.S. communities and examines underlying causes of extremely high costs in some communities.³

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Large Geographic Variation in Medical Cost Burdens

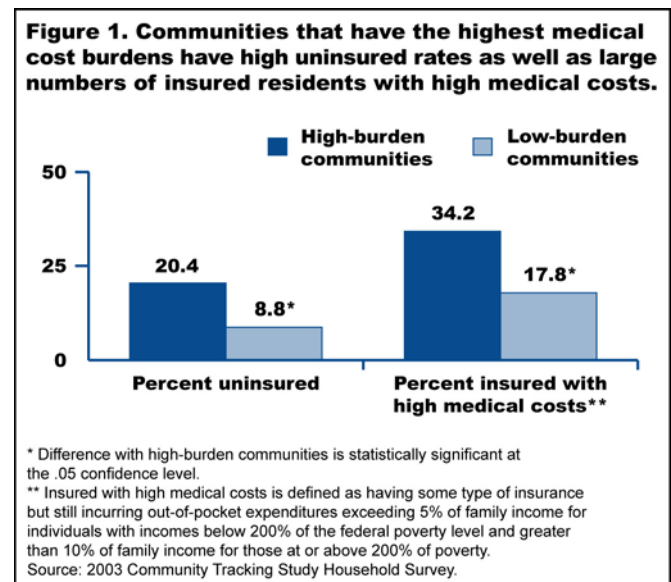
The pervasiveness of high medical cost burdens within a community is driven by the number of people who lack health insurance as well as the number who have coverage but whose premiums and out-of-pocket expenses are high relative to their income. In this analysis, people with insurance were considered to have high cost burdens if their expenses for medical care and insurance premiums exceeded 5 percent of family income if their income was below 200 percent of the federal poverty level, or 10 percent of family income if their income was equal to or above 200 percent of poverty. Also included in the measure were insured people who reported in the CTS survey that they had experienced problems paying medical bills in the previous year.⁴

The CTS data showed that 16.7 percent of all people in the U.S. were uninsured at some point during the previous year (Table 1). More than one-fifth of people surveyed were insured but had high cost burdens, including 15.3 percent with high out-of-pocket burdens and an additional 6.2 percent who reported problems paying medical bills. Combining these estimates, 38.2 percent of people in the United States had potentially high medical cost burdens in 2003.

The prevalence of people with potentially high medical costs varied substantially across U.S. communities, from a high of about 55 percent in West Palm Beach, Fla., to a low of about 16 percent in Bridgeport, Conn. (Table 2).⁵ Communities with high cost burdens were more likely to be in rural areas and the South. Among people living in the 15 communities with the highest medical cost burdens (the upper quartile of communities), 31.5 percent were in nonmetropolitan areas (compared with 19.5 percent of the total U.S. population), and almost 80 percent were in the South (compared with 34.1 percent for the general population) (findings not shown). For people living in the 15 communities with the lowest medical cost burdens,

all were in metropolitan areas with a population of at least 200,000, none were in rural areas, and more than 85 percent were either in the Northeast or Midwest (compared with 40 percent for the general population) (findings not shown).

Among the 15 communities that had the highest medical cost burdens, an average of about 20 percent of people were uninsured during all or part of 2003, compared with 8.8 percent of people in the 15 communities with the lowest medical cost burdens (Figure 1). Among insured (public and private combined) people, about twice as many had high cost burdens in high-burden communities (34.2%) compared with low-burden communities (17.8%).

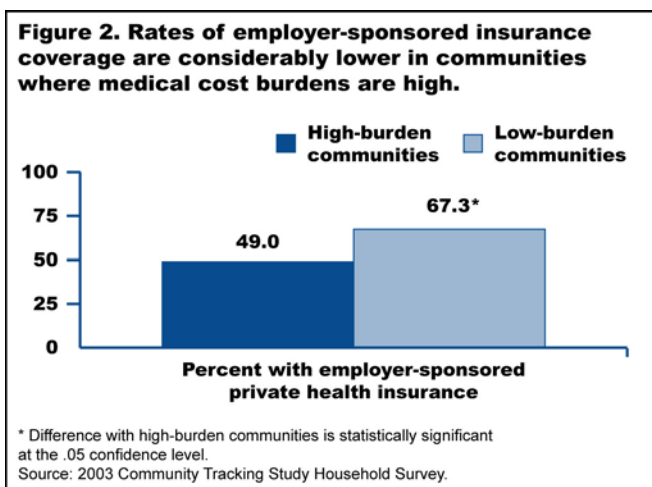


Explaining Differences in Uninsured Rates

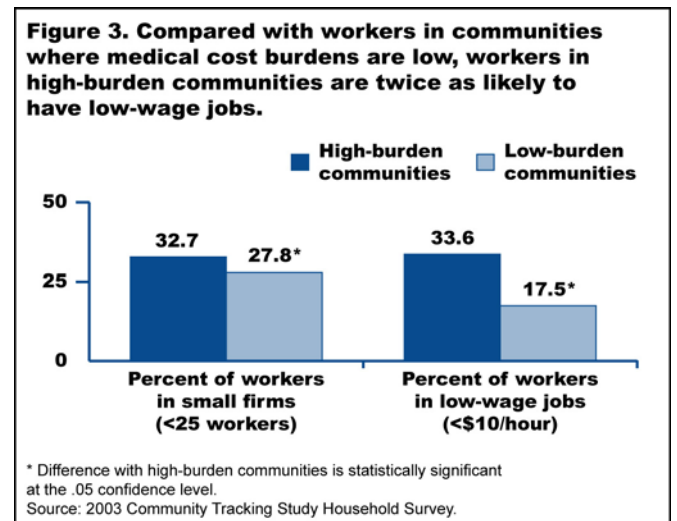
High uninsured rates within communities primarily reflect labor market characteristics that result in lower availability of employer-sponsored coverage. Lower public program eligibility and enrollment are also reflected in these high rates.⁶

Most people obtain insurance coverage for themselves and family members through employer health benefits. Rates of employer-sponsored private health insurance coverage were considerably lower in high-burden communities compared with

low-burden communities (49% in high-burden communities vs. 67% in low-burden communities) (Figure 2 and Table 3). Lower levels of employer-sponsored coverage in high-burden communities reflect both lower employment rates among the working-age population, as well as fewer workers being offered health benefits at their place of employment. About two-thirds of working-age adults were employed in high-burden communities, compared with about 71 percent in low-burden communities. Among those who were employed, 66.1 percent were offered and eligible for health benefits by their employer in high-burden communities, compared with 72.6 percent in low-burden communities.



Variation in employer-offered rates across communities reflects differences in key labor market characteristics. Nationally, employer-offered rates were lowest among small firms (fewer than 25 workers), firms that had a high proportion of low-wage jobs, and among nonunionized workers.⁷ These patterns were consistent when looking at differences between high- and low-burden communities. Compared with low-burden communities, workers in high-burden communities were more likely to be employed in small firms, twice as likely to have low-wage jobs, and only half as likely to be members of labor unions (Figure 3 and Table 3).

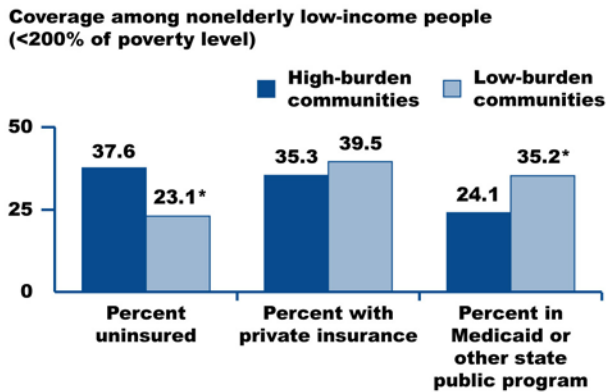


When the employer offered coverage, about 80 percent of workers across all three community groups (high-, moderate-, and low-burden communities) enrolled in the plan. This is notable, since high-burden communities have a much higher proportion of low-wage workers (and low-income people generally)—who are usually less likely to “take up,” or enroll in, coverage, because they are less able to afford to do so.⁸ In sum, lower rates of employer-sponsored coverage in high-burden communities reflect lower availability of employer health benefits, not less willingness among workers to take up coverage when available.

High uninsured rates also reflect lower levels of public coverage among the low-income population. Among nonelderly low-income people (incomes under 200% of poverty), about 24 percent were enrolled in Medicaid or other state coverage in high-burden communities, compared with 35 percent in low-burden communities (Figure 4 and Table 4); most of this difference reflects variations among adults rather than children. For low-income children, Medicaid/state coverage rates were similar—about 50 percent—across all three community groups.

Lower public coverage rates for adults in high-burden communities most likely reflect lower program eligibility levels for adults. Whereas most states have expanded children’s eligibility for public

Figure 4. High uninsured rates in communities with high medical cost burdens often reflect lower levels of public coverage for low-income people.



* Difference with high-burden communities is statistically significant at the .05 confidence level.
Source: 2003 Community Tracking Study Household Survey.

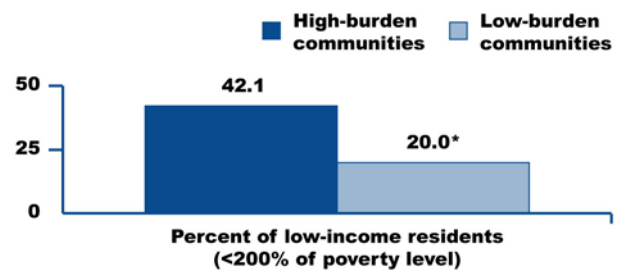
coverage to 200 percent of poverty or higher, pregnant women are the only adults for which Medicaid eligibility levels exceeded 100 percent of poverty throughout the country. Some states, however, have used Medicaid waivers and state-funded programs to expand public coverage for other adults, including those with and without children. Among the 15 communities with the highest cost burden levels at the time of the survey, only three were in states (Arkansas and Alabama) that had expanded Medicaid eligibility for some adults (other than for pregnant women) to 100 percent of poverty or above, and these expansions were limited to women.⁹ By contrast, 11 of the 15 low-burden communities were in states that had expanded public coverage to 100 percent or above for both adults with and without children, including California, Massachusetts, New York, Ohio, and Pennsylvania.

Explaining Differences in the Numbers of Insured People with High Cost Burdens

Differences in the proportion of people who have high costs relative to income across the communities surveyed reflect a variety of factors. The most important are differences in income levels among the population and differences in the structure and generosity of health insurance benefits, particularly for the privately insured.

Differences in income. Since high cost burdens were defined relative to family income, it is not surprising that high-burden communities tend to have a much higher proportion of low-income people. On average, 42 percent of people in high-burden communities had family incomes below 200 percent of the federal poverty level, more than twice as high as low-burden communities (Figure 5). Both uninsured and insured people were more likely to have low incomes in high-burden communities compared with those in low-burden communities.

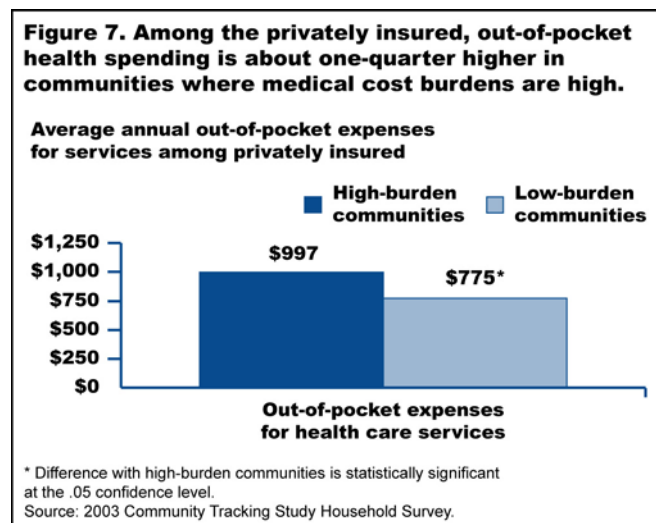
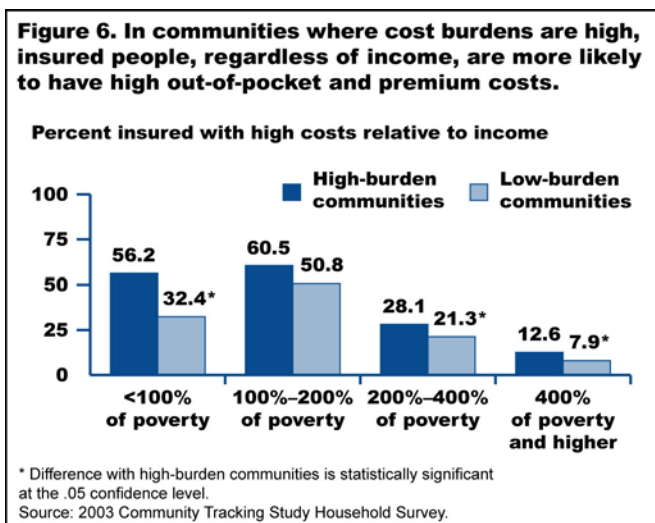
Figure 5. In communities where medical cost burdens are high, the proportion of residents who are low-income is more than twice that of low-burden communities.



* Difference with high-burden communities is statistically significant at the .05 confidence level.
Source: 2003 Community Tracking Study Household Survey.

Insured people in high-burden communities, however, also are more likely to have high out-of-pocket costs regardless of their income. Among insured people with family incomes below the poverty level, more than half had high costs relative to their income in high-burden communities, compared with about one-third in low-burden communities (Figure 6). Cost burdens were consistently greater in high-burden communities across all income levels—including high-income people—although the difference for near-poor (100%–200% of poverty) was not statistically significant. These results suggest that lower overall income levels in high-burden communities do not fully account for the higher rates of those with high cost burdens.

Differences in health insurance benefits among the privately insured. Large numbers of insured people with high costs in some communities may also



reflect less generous health insurance plans, or plans that are structured to require greater cost-sharing in exchange for fewer limits on services. In particular, direct purchase—or nongroup policies—typically involve much larger deductibles and higher copayments than employer-sponsored plans.¹⁰ Among people with private insurance coverage, high-burden communities had a higher percentage enrolled in nongroup coverage compared with low-burden communities (7.8 percent vs. 4.5 percent, findings not shown).

In addition, health maintenance organizations (HMOs) generally offer lower deductibles and copayments for services in exchange for greater restrictions on use of specialists and other high-cost services. Indeed, HMO enrollment among privately insured people is considerably lower in high-burden communities versus low-burden communities (39.8% vs. 54.4%, findings not shown).

More detailed information on private insurance plan benefits is not available in the CTS database. However, higher overall out-of-pocket spending for health services in high-burden communities is suggestive of less-generous health insurance benefits in those areas. Average annual out-of-pocket spending for services among the privately insured was about \$1,000 in high-burden communities, about 25 percent higher than in low-burden communities (Figure 7).

Moreover, even this difference may understate the actual differences in private plan benefits between high- and low-burden communities. Out-of-pocket spending in high-burden communities may be partly constrained by the higher proportion of low-income people, as well as higher percentages of racial/ethnic minorities which are associated with lower access to care and lower levels of health care use. When differences in out-of-pocket expenditures are adjusted to account for these and other factors, such as health status and chronic conditions, the difference in average out-of-pocket spending between high- and low-burden communities increases, from about \$222 (unadjusted) to \$286 (adjusted).¹¹ Accounting for the higher levels of nongroup coverage and lower HMO enrollment in high-burden communities narrows the gap somewhat, although out-of-pocket spending in these communities is still more than \$200 greater on average than in low-burden communities.

The findings on labor market characteristics shown above are also consistent with the conclusion that private insurance policies tend to be less generous in high-burden areas. Small firms and those that employ primarily low-wage workers are not only less likely to offer health benefits, but prior research has shown that even when these jobs do come with health benefits, they tend to be less generous in terms of copayments, deductibles, and covered services.¹²

Differences in health status. This study also examined the effect of health status on the burden of health care costs. A high proportion of people with high cost burdens in some communities may in part reflect greater need for care because of either a larger number of elderly people and/or greater morbidity in the population. Higher need for care would increase demand for and use of health care services, which would likely increase out-of-pocket expenses for those services. In addition, significantly higher demand for care in some communities could lead to overall higher health costs, making insurance premiums less affordable and increasing the number of uninsured.

Some evidence shows that the need for care is higher in high-cost communities, although much of this need appears to reflect a somewhat higher percentage of elderly people in high-burden communities compared with low-medical-cost communities. Among the insured population, people in high-burden communities had a higher prevalence of selected chronic conditions compared with low-burden communities (Table 5). In addition, insured people in high-burden communities were more likely to report their health as fair or poor. Virtually all of these differences, however, reflect the higher proportion of elderly in high-burden communities (who have poorer relative health overall than the nonelderly), and the much poorer health of elderly people in these areas. Among the nonelderly insured population, those in high-burden communities were only slightly more likely to report their health as fair or poor, and no statistically significant differences were found in chronic disease prevalence. In sum, with the exception of elderly Medicare beneficiaries, higher numbers of insured people with high costs in high-burden communities do not reflect substantially greater need or demand for medical care.

As confirmation of this finding, there were few differences found between high- and low-burden communities on general measures of health care utilization, such as the number of physician

visits, hospital inpatient nights, and emergency department (ED) visits in the previous year (data not shown). While ED visits were somewhat higher in high-burden communities (48 visits per 100 people in high burden areas compared with 40 visits in low burden areas), no statistically significant differences were found between high and low areas in average number of physician visits and nights in the hospital (findings not shown). The lack of meaningful differences in utilization between high- and low-burden communities is consistent across different insurance coverage types.

Conclusion

Medical cost burdens are highly concentrated in some areas of the country, and some states and communities have considerably higher uninsured rates than others.¹³ The results of this analysis indicate that the number of insured people with high cost burdens also varies across communities, and those communities with high uninsured rates also tend to have a large number of insured residents with high costs. High medical cost burdens are clearly endemic to some communities—particularly in the South and some rural areas—partly because of the local economies, which tend to produce a higher number of low-wage jobs with less generous health benefits. These disparities are made worse by less expansive public program eligibility standards, especially for adults, which may be constrained by a lower revenue base from which to fund public programs.

Prior research has shown that people without health coverage and those with coverage but high out-of-pocket costs are much more likely to experience problems getting needed medical care, primarily because of the fear of incurring additional health care expenditures.¹⁴ A high uninsured rate combined with a high prevalence of medical cost burdens can pose a threat to the health of an entire community. Since the data used in this report are from a single time period, researchers cannot assess the effects of high medical costs on

the health of the population. The nonelderly population in high-burden communities was somewhat more likely to report fair or poor health compared with low-burden communities, although no differences in chronic disease prevalence were found. On the other hand, the health of elderly people in high-burden communities was considerably worse than the elderly in low-burden communities, both in terms of self-reported health and chronic disease prevalence. Although virtually all elderly people in the study were enrolled in Medicare, a sizeable number of elderly Medicare beneficiaries in high-burden communities had likely spent a good part of their lives either uninsured or “underinsured.” Consequently, some health problems may have gone undetected or untreated, leading to significantly worse health in older age groups.¹⁵

Policy Implications

Lack of action at the federal level has driven many states to undertake their own health care reform efforts. Massachusetts has the most far-reaching and widely discussed of these state reforms. Using a combination of Medicaid expansions, state subsidies for the purchase of private group coverage, and an individual mandate to have health coverage, the state is considered to be a leader in health reform in which other states will follow.

Massachusetts, however, has several advantages that other states may not have, making it difficult to emulate. Along with some other states in the Northeast and upper Midwest, Massachusetts already has a relatively small number of uninsured and underinsured residents. This status comes from an economic mix that produces higher paying jobs and/or a more unionized workforce, more generous health benefits, and generous state coverage programs. While expansive public programs in these states may reflect a strong ethic of government support for the medically underserved, higher incomes in these states also mean that a larger tax base is supporting expansions of public programs.

Moreover, a key aspect of the Massachusetts reform is defining what constitutes “affordable” health insurance coverage to determine the amount the state can subsidize individuals to purchase coverage. To meet the same affordability standards as the well-insured states, other states and communities with a higher number of insured residents with high cost burdens will either have to subsidize coverage at a much higher level (which will be difficult to do given the lower tax base in these areas), or accept higher affordability standards (i.e., greater cost-sharing) for their low-income populations.

In sum, states and communities are far from having equal starting points in terms of implementing affordable health reforms. States that have the largest numbers of uninsured and underinsured residents will face difficulties in achieving universal and affordable coverage for their citizens. Therefore, reliance on state efforts alone is unlikely to lead to major national expansions in coverage—let alone universal coverage—and will likely lead to a persistently high degree of variation across the country in the number of uninsured and underinsured people.

NOTES

¹ J. S. Banthin, P. J. Cunningham, and D. M. Bernard, “Trends in the Financial Burden of Health Care Expenditures, 2001–2004,” *Health Affairs* (forthcoming); and J. S. Banthin and D. M. Bernard, “Changes in Financial Burdens for Health Care: National Estimates for the Population Younger Than 65 Years, 1996 to 2003,” *Journal of the American Medical Association*, Dec. 13, 2006 296(22):2712–19.

- ² P. J. Cunningham and P. B. Ginsburg, “What Accounts for Differences in Uninsurance Rates Across Communities?” *Inquiry*, Spring 2001 38(1):6–21.
- ³ A description of the survey is included in the [Methodology](#). For a more detailed discussion of the CTS Household Survey, see R. Strouse, B. L. Carlson, and J. Hall, *Community Tracking Study: Household Survey Methodology Report 2003 (Round 4)*, Technical Publication No. 62 (Washington, D.C.: Center for Studying Health System Change, 2003).
- ⁴ Part of the rationale for including medical bill problems in the measure is to compensate for some underreporting of out-of-pocket expenses in the CTS Household Survey compared with the Medical Expenditure Panel Survey.
- ⁵ Sample sizes for the 60 communities range from about 500 to 1,800 people. While all estimates in [Table 2](#) meet standards for statistical reliability (i.e., standard errors are less than 30% of the estimate), the exact ordering of the communities from “highest burden” to “lowest burden” is subject to error due to large confidence intervals around the estimates for some communities.
- ⁶ Cunningham and Ginsburg, “What Accounts for Differences,” 2001.
- ⁷ Henry J. Kaiser Family Foundation/Health Research and Educational Trust, *Employer Health Benefits: 2006 Employer Health Benefits Annual Survey* (Washington, D.C.: KFF/HRET, 2006); J. Gabel, K. Hurst, H. Whitmore et al., “Class and Benefits at the Workplace,” *Health Affairs*, May/June 1999 18(3):144–50; and P. Fronstin, *Employment-Based Health Benefits: Access and Coverage, 1988–2005*, EBRI Issue Brief No. 303 (Washington, D.C.: Employee Benefit Research Institute, Mar. 2007).
- ⁸ *Ibid.*
- ⁹ National Governors Association, *MCH Update: States Protect Health Care Coverage During Recent Fiscal Downturn* (Washington, D.C.: NGA Center for Best Practices, Aug. 2005).
- ¹⁰ D. M. Bernard, *Premiums in the Individual Health Insurance Market for Policyholders Under Age 65, 1996 and 2002*, Statistical Brief No. 72 (Rockville, Md.: Agency for Healthcare Research and Quality, Mar. 2005).
- ¹¹ Adjusted differences in out-of-pocket spending between high- and low-burden communities were computed based on an OLS (ordinary least squares) regression for privately insured people. The dependent variable in these regressions was out-of-pocket spending for health services, and the independent variables included binary variables for low- and moderate-burden sites (high-burden sites were the excluded category), as well as income, age, gender, race/ethnicity, perceived health status, and chronic condition prevalence. In the second adjustment, enrollment in nongroup and HMO plans was included as independent variables. The coefficient for the “low-burden sites” reflects the adjusted difference in out-of-pocket expenditures compared with high-burden sites (the omitted group).
- ¹² KFF/HRET, *Employer Health Benefits*, 2006; and Gabel, Hurst, Whitmore et al., “Class and Benefits,” 1999.
- ¹³ Cunningham and Ginsburg, “What Accounts for Differences,” 2001; and P. Fronstin, *Sources of Health Insurance and Characteristics of the Uninsured: Updated Analysis of the March 2006 Current Population Survey*, EBRI Issue Brief No. 305 (Washington, D.C.: Employee Benefit Research Institute, May 2007).
- ¹⁴ C. Schoen, M. M. Doty, S. R. Collins, and A. L. Holmgren, “[Insured But Not Protected: How Many Adults Are Underinsured?](#)” *Health Affairs* Web Exclusive (June 14, 2005):w5-289–w5-302; S. R. Collins, J. L. Kriss, K. Davis, M. M. Doty, and A. L. Holmgren, [Squeezed: Why Rising Exposure to Health Care Costs Threatens the Health and Financial Well-Being of American Families](#) (New York: The Commonwealth Fund, Sept. 2006), and J. H. May and P. J. Cunningham, *Tough Trade-offs: Medical Bills, Family Finances, and Access to Care*, Issue Brief No. 85 (Washington, D.C.: Center for Studying Health System Change, 2004).
- ¹⁵ J. M. McWilliams, E. Meara, A. M. Zaslavsky, and J. Z. Ayanian, “[Use of Health Services by Previously Uninsured Medicare Beneficiaries](#),” *New England Journal of Medicine*, July 12, 2007 357(2):143–53.

Table 1. Percentage with High Medical Cost Burdens, Total U.S., 2003

Percent with high medical cost burdens	38.2
Uninsured all or part year	16.7
Insured with high cost burden	21.5
Insured all year, percent with high out-of-pocket costs* relative to income	15.3
For all others, percent reporting problems paying medical bills	6.2

* Out-of-pocket costs for health services and premiums (privately insured) are 5% or higher for people with incomes < 200% of poverty, and 10% or higher for people with incomes \geq 200% of poverty.

Source: 2003 Community Tracking Study Household Survey.

Table 2. Variation in High Medical Cost Burdens Across the 60 CTS Communities

Community*	Percent with High Medical Cost Burden	Percent Uninsured	Percent Insured with High Medical Cost Burden
West Palm Beach, FL	54.6	26.1	28.6
Eastern North Carolina (nonmetro)	51.8	12.4	39.4
Northern Georgia (nonmetro)	50.1	15.4	34.6
Houston, TX	47.2	23.8	23.4
Central Arkansas (nonmetro)	45.7	19.4	26.3
Miami, FL	45.5	26.7	18.9
West Central Alabama (nonmetro)	45.0	17.1	27.9
Greenville, SC	45.0	17.6	27.4
Dothan, AL	44.3	13.6	30.7
Shreveport, LA	44.2	23.4	20.8
Terre Haute, IN	44.0	14.9	29.1
Greensboro, NC	43.4	14.8	28.6
Huntington, KY/WV/OH	43.3	17.6	25.7
Wilmington, NC	43.2	17.9	25.3
Tulsa, OK	40.7	14.5	26.3
Cleveland, OH	40.4	11.0	29.4
Santa Rosa, CA	40.3	13.9	26.4
Little Rock, AR	40.2	18.1	22.1
Augusta, GA	39.7	12.5	27.2
Riverside, CA	39.4	20.1	19.4
Chicago, IL	39.1	13.3	25.9
Knoxville, TN	38.9	19.6	19.3
Northeast Indiana (nonmetro)	38.4	11.2	27.3
Los Angeles, CA	39.4	30.2	8.2
Orange County, CA	37.7	24.9	12.8

* All communities are based on Primary Metropolitan Statistical Areas except for five communities indicated as nonmetro.

Source: 2003 Community Tracking Study Household Survey.

continued on next page

**Table 2. Variation in High Medical Cost Burdens
Across the 60 CTS Communities (continued)**

Community*	Percent with High Medical Cost Burden	Percent Uninsured	Percent Insured with High Medical Cost Burden
Denver, CO	36.5	15.1	21.3
Northern Utah (nonmetro)	36.4	10.9	25.5
Phoenix, AZ	36.0	15.6	20.4
Killeen, TX	36.0	18.6	17.4
Indianapolis, IN	35.9	13.1	22.8
Eastern Maine (nonmetro)	35.5	10.9	24.6
New York City	34.8	17.8	17.0
Portland, OR	34.6	16.9	17.8
San Antonio, TX	34.0	16.3	17.7
Northwest Washington (nonmetro)	33.6	15.0	18.6
Modesto, CA	33.3	18.1	15.2
Atlanta, GA	33.3	15.8	17.5
Seattle, WA	33.1	11.1	22.1
Northern N.J.	32.9	14.8	18.1
Northeast Illinois (nonmetro)	32.9	8.2	24.7
Milwaukee, WI	31.2	9.7	21.5
Las Vegas, NV	31.2	17.3	13.8
Syracuse, NY	31.0	11.9	19.1
Pittsburgh, PA	30.8	11.3	19.6
Baltimore, MD	30.5	11.1	19.4
Tampa, FL	30.0	11.2	18.9
Boston, MA	27.6	7.7	19.9
Detroit, MI	26.9	7.1	19.9
Rochester, NY	26.0	7.1	18.9
Philadelphia, PA	25.8	9.7	16.1
Middlesex, PA	25.8	9.6	16.2
Lansing, MI	25.2	9.1	16.1
Columbus, OH	25.0	9.4	15.7
St. Louis, MO	23.7	5.1	18.6
San Francisco, CA	22.1	9.1	13.0
Minneapolis, MN	21.2	4.0	17.2
Worcester, MA	20.3	4.2	16.1
Washington DC (VA/MD)	19.5	9.0	10.5
Nassau, NY	18.9	8.1	10.8
Bridgeport, CT	15.6	5.0	10.6

* All communities are based on Primary Metropolitan Statistical Areas except for four communities indicated as nonmetro.

Source: 2003 Community Tracking Study Household Survey.

Table 3. Employer Coverage and Job Characteristics

	Level of Medical Cost Burden in the Community*		
	High	Moderate	Low
Employer coverage			
Percent with employer-sponsored private insurance	49.0	54.9†	67.3†
Employment rates for adults (ages 18–64)	65.5	66.0	70.7†
Percent of workers offered and eligible for health benefits by their employer	66.1	66.9	72.6†
Take-up among workers offered coverage	78.8	78.8	78.9
Job characteristics of workers			
Percent in small firm (< 25 workers)	32.7	29.4	27.8†
Percent in low wage job (< \$10 per hour)	33.6	28.7†	17.5†
Percent member of labor union	8.8	16.1†	16.7†

* Communities with high medical cost burdens are based on the upper 25th percentile of communities (15 communities). Communities with low medical cost burdens are based on the lower 25th percentile of communities.

† Difference with high-burden communities is statistically significant at .05 level.

Source: 2003 Community Tracking Study Household Survey.

Table 4. Coverage Among Nonelderly Low-Income People (less than 200% of poverty)

	Level of Medical Cost Burden in the Community*		
	High	Moderate	Low
All nonelderly low-income people			
Percent uninsured during the year	37.6	33.5	23.1†
Percent private insurance	35.3	35.6	39.5
Percent Medicaid/other state	24.1	29.0	35.2†
Adults ages 18–64			
Percent uninsured during the year	47.9	43.4	29.7†
Percent private insurance	36.1	36.5	38.3
Percent Medicaid/other state	11.2	16.1	25.8†
Children ages 0–17			
Percent uninsured during the year	18.6	17.6	12.1
Percent private insurance	33.7	34.0	41.4
Percent Medicaid/other state	48.2	49.7	51.1

* Communities with high medical cost burdens are based on the upper 25th percentile of communities (15 communities). Communities with low medical cost burdens are based on the lower 25th percentile of communities.

† Difference with high-burden communities is statistically significant at .05 level.

Source: 2003 Community Tracking Study Household Survey.

**Table 5. Health Status and Chronic Disease Prevalence
Among People Insured All Year**

	Level of Medical Cost Burden in the Community*		
	High	Moderate	Low
Percent age 65 and older	14.4	11.2†	11.0†
All people			
Percent in fair or poor health	16.9	13.3†	10.3†
Percent with 1 or more chronic conditions	30.4	26.5†	27.8
Percent with 2 or more chronic conditions	14.0	11.4†	11.2†
People age 65 and older			
Percent in fair or poor health	35.8	25.2†	21.9†
Percent with 1 or more chronic conditions	75.3	72.1	71.5
Percent with 2 or more chronic conditions	48.8	42.5†	39.9†
People less than age 65			
Percent in fair or poor health	11.8	10.1	8.1†
Percent with 1 or more chronic conditions	24.3	22.1	23.2
Percent with 2 or more chronic	9.0	8.2	8.0

* Communities with high medical cost burdens are based on the upper 25th percentile of communities (15 communities). Communities with low medical cost burdens are based on the lower 25th percentile of communities.

† Difference with high-burden communities is statistically significant at .05 level.

Source: 2003 Community Tracking Study Household Survey.

METHODOLOGY

The primary data source for this study is the 2003 Community Tracking Study (CTS) Household Survey (Strouse et al., 2006), which was funded by the Robert Wood Johnson Foundation. The survey was designed to produce representative estimates of health insurance coverage, access to care, use of services, and other experiences with health care, as well as out-of-pocket expenditures for health services for the U.S. population and 60 randomly selected communities. The 60 communities were defined as counties or groups of counties using conventionally accepted definitions of statistical and economic areas, including Metropolitan Statistical Areas and Bureau of Economic Analysis economic areas for nine nonmetropolitan sites. The 60 sites were randomly selected with probability in proportion to population to ensure representation of the U.S. population. Because of the random selection of communities, the 15 communities identified as “high medical cost burden” communities (those in the upper 25th percentile in the percent uninsured and underinsured) are representative of communities in the United States with that level of uninsured and underinsured. The 15 “low-burden” communities are similarly representative.

Within each of the 60 sites, the primary sample selection method was random digit dialing. In addition, a small field sample was included to provide coverage of families and people who did not have telephones or who had substantial interruptions in telephone service during the survey year. Interviews were conducted in Spanish for respondents who were not fluent in English or who preferred to conduct the interview in Spanish. Information was obtained on all adults in the family as well as one randomly selected child. The final sample consisted of about 25,400 families and 46,600 individuals. The overall response rate for the survey was 56 percent (including both refusals and households for whom no contact was made). Person-level weights used for making population estimates were post stratified to correct any differences in nonresponse based on age, sex, race, ethnicity, and education (based on the Current Population Survey conducted by the U.S. Census).

The definition of uninsured in this report includes people who were uninsured on the day of the interview as well as people who were uninsured at any time in the preceding 12 months prior to the interview. This was ascertained by asking people who were insured on the day of the interview whether their health insurance coverage changed at any point in the previous 12 months and if so, what type of coverage they had (including no coverage) during the year. People classified as insured include those with coverage the entire 12 months prior to the interview.

All estimates presented in this issue brief were weighted to be representative of the civilian noninstitutionalized population of the continental United States, the 60 communities, as well as groups of communities. Standard errors used in tests of statistical significance were computed using SUDAAN computer software, and take into account the complex survey design, including the clustering of the 60 site sample (Shah et al., 1996).

ABOUT THE AUTHOR

[Peter J. Cunningham, Ph.D.](#), is a senior fellow at the Center for Studying Health System Change (HSC) in Washington, D.C. He has been extensively involved in the design, planning, management, and analysis of the Community Tracking Study (CTS), a large nationally representative and longitudinal study of the U.S. health care system funded by the Robert Wood Johnson Foundation. His main areas of interest include trends in public and private health care coverage, access to medical care for the uninsured, the effects of high medical bills and costs on access, physician charity care, and the viability of the health care safety net. He has published extensively in medical and health services research journals, including *JAMA*, *Health Affairs*, *Health Services Research*, *Inquiry*, *Medical Care*, and *Medical Care Research and Review*. Prior to joining HSC in 1995, Dr. Cunningham was a researcher at the Agency for Health Care Policy and Research (now the Agency for Healthcare Research and Quality). While there, he was extensively involved in the design and analysis of the National Medical Expenditure Survey (NMES). Dr. Cunningham received his Ph.D. in medical sociology and health services research from Purdue University in 1988.

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