



Changes in Health Care Financing & Organization (HCFO)

findings brief

key findings

- Health care spending, both public and private, accounted for more than 20 percent of family income for families in the lowest-income quintile, but no more than 16 percent for families in any other income quintile.
- The Affordable Care Act should reduce, but is unlikely to completely eliminate, some of this inequity through its heavy reliance on federal funding for the Medicaid expansion and income-related subsidies for private insurance.

In Health Care Spending, Americans Who Make the Least Contribute the Greatest Share of Income

Overview

Health care spending accounted for 17.6 percent of the gross domestic product in 2010, or \$2.6 trillion, and this growing expenditure is made up of a combination of public and private funding. Public funding for health care comes from federal, state, and local sources and at all levels is supported by tax revenues paid by families. Private spending incorporates both insurance payments and direct consumer spending. Regardless of whether insurance is purchased privately or through an employer, economic research has demonstrated that individuals ultimately pay for all health care spending.

In a HCFO-funded study¹, Patricia Ketsche, Ph.D., associate professor at the Institute of Health Administration at Georgia State University, E. Kathleen Adams, Ph.D., professor at Emory University's Rollins School of Public Health, and colleagues explored whether the individual burden of health care spending was equally distributed to families across income groups. Within the tax lit-

erature, equity studies measure the burden of payment relative to ability to pay. A vertically equitable tax system requires that low-income families pay a smaller share of their incomes in taxes than do higher-income families. Taxes that impose a heavier burden on low income families are considered "regressive," – that is, the share of income paid in taxes decreases as income increases. Taxes that are "progressive" require a greater share of income paid as income increases. In their study, Ketsche and colleagues sought to evaluate the health care financing system in total to determine who truly pays for health care across the public and private funding streams and whether this financing system is equitable.

Methods

The researchers evaluated a family's financial burden based on their total contribution to health care spending. This contribution was calculated as a percentage of total family income. Health care expenditures included: out-of-pocket payments, net premiums



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paid for public and private insurance, federal, state, and local taxes paid, as well as taxes earmarked for health care. Their primary data source was the Annual Social Economic Supplement to the Current Population Survey (CPS) for 2004. Ketsche and colleagues analyzed public and private spending, determined families' unique contributions through both public and private funding streams, and ultimately calculated a family's contribution as a percentage of their total income. The results were stratified by income quintiles to compare families' financial burden from health care spending across income groups.

Results

The researchers' model was comprehensive, accounting for 94 percent of the National Health Expenditure. Their analysis demonstrated that, after accounting for the tax treatment of employer sponsored health insurance, 58 percent of all spending was publicly financed, and 42 percent was privately financed. Families in the highest income quintile earned half of all family income, while those in the lowest income quintile earned only 3 percent of total family income. Average family income in the lowest quintile was \$14,000. In the highest quintile it was just under \$200,000. The researchers included cash, noncash and in-kind income, and therefore found slightly higher total income values than those typically reported by the Census Bureau. Families in the highest income quintile paid nearly 10 times the total dollar amount that families in the lowest income quintile paid; yet, as a proportion of their income, families in the lowest income quintile contributed more than 20 percent of their income to health care expenditures. All other families, regardless of their income group, contributed only 15-16 percent of their family income to health care spending.

Public Spending

The researchers found that public spending consumed 9 percent of families' income in total but that individual family burdens from publicly financed health care spending vary based on the particular tax used. Health care spending by the federal government is generally progressively financed

because of the heavy reliance on federal income taxes that require higher income families to pay at a higher rate. Yet, in general, state spending imposed a greater burden on low-income families, because states often rely on sales taxes which are regressive. Hence, lower-income families contributed a greater portion of their total income (3 percent) to state-funded health care compared to all other families (less than 2 percent).

When analyzed by major program, Medicare is found to be progressively financed, since tax contributions increase with income. Conversely, Medicaid, with its reliance on state funding, imposes a greater financial burden on lower-income individuals than on all middle income groups. The federal matching of state spending for Medicaid does offset some of the regressive burden on low-income families, but not entirely. The overall burden will vary by state, as each state has a different tax structure and Medicaid program.

Private Spending

On average, low-income families contributed the greatest share of their income to private spending, with more than 10 percent going toward out-of-pocket payments and an additional 6 percent going toward insurance premiums. As a point of comparison, out-of-pocket payments for families in the highest income quintile were less than 1 percent of their total income, and premiums before taxes were less than 5 percent of total income. Out-of-pocket spending for long-term care represents a particularly high burden for low-income families.

Discussion and Policy Implications

The researchers found that low-income families face a greater burden than any other group in terms of their contributions to health care spending. Though higher-income families contribute more dollars in total, health care spending consumes a greater proportion of lower-income families' total income. For lower-income families, much of this spending goes toward private health expenses and state and local taxes. Only federal taxes distribute the burden based on ability to pay. This under-

scores the importance of federal matching funds for Medicaid to offset some of the financial burden on lower-income families from the state financing of this program.

An important and negative consequence of the financial strain on lower-income families associated with high private costs is that they may discourage individuals from seeking needed care or from purchasing health insurance. Forgoing needed care can lead to conditions requiring more costly care at a later date, and lack of insurance further exacerbates the problem of uncompensated care. At the other end of this spectrum, families in the highest-income quintile faced far lower out-of-pocket health care expenditures. As such, higher-income families may not feel the same level of health care cost burden, and thus may overuse services. This cycle of overuse can lead to escalating prices, waste, and cost inflation.

The Patient Protection and Affordable Care Act of 2010 (ACA) may alleviate some of the financial strain placed on lower-income families. Eligibility for Medicaid will reduce out-of-pocket burdens for very low income families, and significant subsidies for insurance and out-of-pocket spending will reduce the share of income spent in the private sector among the near poor and moderate income groups.

The expansion of Medicaid, intended to increase access to coverage among low-income populations, may also increase slightly the public financial burden that lower-income families face. As more individuals become eligible and more of those currently eligible enroll in Medicaid, state spending and taxes will increase which could further burden lower-income families. High levels of federal funding for the expansion of Medicaid included in the ACA should offer some relief for low-income families. The ACA also introduces new taxes to support health reform efforts, some of which are targeted at high income families. However, the final incidence of all new fees and taxes on medical device manufacturers, pharmaceutical companies, and insurers will require additional analysis.

Conclusion

The public and private financing of the U.S. health care system inequitably burdens lower-income families who contribute a greater proportion of their total income to health care spending than do families in any other income group. Although the ACA introduces certain measures to reduce this disparity, states' financing structures as well as the need for private health care spending continue to disproportionately affect this vulnerable population. The research suggests that more work will be

needed to understand how the choices lower income families make after the ACA is fully implemented, the tax burdens inherent in the individual and employer mandates, and all other new fees and taxes alter the overall incidence and equity of financing health care in the United States.

For More Information

For more information, contact Patricia Ketsche, Ph.D., at 404.413.7635 or at pketsche@gsu.edu

About the Author

Megan Collado, M.P.H., is an associate at AcademyHealth with the Changes in Health Care Financing and Organization (HCFO) Initiative. She can be reached at 202.292.6746 or megan.collado@academyhealth.org

Endnotes

1 Ketsche, P., Adams, E.K., Wallace, S., Kannan, V.D., and Kannan, H. "Lower-Income Families Pay a Higher Share of Income Toward National Health Care Spending than Higher-Income Families Do," *Health Affairs*, Vol. 30, No. 9, September 2011, pp. 1637-1646.