

---

# National Health Statistics Reports

---

Number 182 ■ March 22, 2023

## Financial Burden of Medical Care Among Veterans Aged 25–64, by Health Insurance Coverage: United States, 2019–2021

by Robin A. Cohen, Ph.D., and Peter Boersma, M.P.H.

### Abstract

**Objectives**—In addition to health insurance coverage options available to the general population, veterans may have access to Tricare, a healthcare program for uniformed services members and retirees, and U.S. Department of Veterans Affairs (VA) health care. This report measures the financial burden of medical care among veterans aged 25–64 and examines how that burden may vary by health insurance coverage.

**Methods**—Data from the 2019–2021 National Health Interview Survey were combined to examine three measures of financial burden for medical care among veterans aged 25–64: a) living in a family having problems paying medical bills in the past 12 months, b) having forgone medical care due to cost in the past 12 months, and c) being worried about the cost of unforeseen medical care. Estimates of these three measures were presented by four selected mutually exclusive categories of veterans' health insurance coverage. Model-based estimates were generated for each outcome to account for differences in selected sociodemographic, socioeconomic, and health-related characteristics among insurance types that may put veterans at financial risk.

**Results**—Overall, 12.8% of veterans aged 25–64 had problems paying medical bills, 8.4% had forgone medical care, and 38.4% were somewhat or very worried about being able to pay their medical bills if they got sick or had an accident. After adjustment, veterans with VA health care only or Tricare were less likely than veterans with private insurance with or without VA health care to live in a family having problems paying medical bills. In addition, veterans with only VA health care or Tricare were less likely than veterans with private insurance without VA health care to have forgone medical care or worry about being able to pay their medical bills.

**Keywords:** Veterans Affairs (VA) • Tricare • medical bills • cost • National Health Interview Survey (NHIS)

### Introduction

In 2021, an estimated 11.3% of adults aged 18–64 lived in a family that had problems paying medical bills in

the past 12 months (1). Among those aged 18–64, adults with private health insurance coverage were less likely to be in families that had problems paying medical bills than adults with

Medicaid or other state-sponsored health plans (1). The relationship between health insurance coverage type and financial burden of medical care is complex, influenced by such factors as deductibles, copayments, and out-of-pocket maximums, and possibly confounded by various sociodemographic and socioeconomic factors. Wray et al. (2) found that compared with adults with Medicaid, adults with employer-sponsored insurance were more likely to report having medical debt but less likely to report difficulty seeing a physician or not taking medications because of cost. Financial burden of medical care impacts more than the insured person alone because significant medical expenses for one family member may adversely affect the whole family (3–10).

Veterans can access health insurance options available to the general population but also may be eligible for additional options, including coverage through the Department of Veterans Affairs (VA) and the Department of Defense (DOD) (11,12). In 2021, about 19.0 million people in the United States were veterans, of whom more than 9.0 million were enrolled in the Veterans Health Administration healthcare program, called VA health care (13). The VA healthcare program is an integrated



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES  
Centers for Disease Control and Prevention  
National Center for Health Statistics



healthcare network comprising nearly 1,300 healthcare facilities. On separating or retiring from service, veterans can apply for VA health care and are assigned to one of eight priority groups based on military service history, income, and disability rating, with recent expansion to include veterans suffering from more than 20 toxic exposure-related conditions (14,15). Veterans do not pay premiums or deductibles for VA care but may be responsible for copays for care received through VA and for costs of care provided outside of VA, with amounts of each depending on priority group (16,17). Care for an illness or injury related to a veteran's military service is provided for free. For veterans eligible for VA health care, coverage provides preventive, inpatient, emergency, mental health, and other services (16). VA-eligible veterans may choose to enroll in VA health care, either as their only source of healthcare coverage or in combination with non-VA healthcare coverage (18). VA health care for the noninstitutionalized population is generally received through VA medical centers and VA community-based outpatient clinics (19). However, some veterans may be eligible to receive care from community providers through the VA Choice program (19).

In addition to VA health care, veterans may also be eligible for Tricare, a healthcare program for uniformed service members, retirees, and their families provided through DOD (20). On retiring from active duty, eligible former active-duty service members may choose among multiple Tricare health plans for themselves and their family (21). Tricare health plans meet minimum essential coverage under the Affordable Care Act (22,23), with available plans functioning as either a health maintenance organization or a preferred payer organization. Tricare plans generally have deductibles and copayments and may require referrals to see specialists, depending on the selected plan (24). Care is provided through a network of military and civilian providers as well as Tricare-authorized non-network providers (25). Retirees eligible for both Tricare and VA healthcare benefits can use both systems for different healthcare needs.

From 2000 to 2016, the percentage of veterans aged 18–64 with Tricare

increased from 5.9% to 13.8%, while those with only VA health care increased from 3.7% to 10.1%. At the same time, the percentage with Medicaid increased from 2.6% to 6.4%, and the percentage with private insurance decreased from 74.7% to 58.7% (26).

Despite the increasing reliance on Tricare and VA health care among veterans, little data exists on the financial burden of medical care among veterans with VA health care or Tricare relative to veterans with either private insurance or other public coverage. Data from the 2016–2018 Behavioral Risk Factor Surveillance System found that people with military healthcare coverage were less likely to have difficulty seeing a physician because of cost or difficulty taking medications because of cost, and were less likely to have medical debt when compared with those with employer-sponsored private insurance (2). However, this study did not distinguish between VA health care and Tricare. Other in-depth studies have been hindered by a lack of a single data source to simultaneously evaluate care received across all health insurance and provider types, an inability to limit the comparison group to veterans only, or a lack of sociodemographic information on all study participants (27). Differences in sociodemographic characteristics can pose a problem when comparing veterans by insurance type, because it has been shown that veterans who use VA health care are more likely than veterans who do not use VA health care to be non-Hispanic Black, have lower incomes, have a chronic condition, be in fair or poor health, and have a disability (28–30)—all characteristics that have been associated with increased financial burden of medical care in the general population (1,31). Many of these differences in population may stem from how the VA healthcare program prioritizes the delivery of health care based on service-connected disability and income, among other factors (14).

This report first measures the financial burden for medical care among insured veterans aged 25–64 to provide nationally representative estimates overall and by health insurance coverage type. In particular, this report provides estimates of the prevalence of being in a family

having problems paying medical bills, having forgone medical care (delaying or not getting needed medical care due to cost), and being worried about paying medical bills (unforeseeable medical costs). Subsequent multivariate analyses test for differences in the prevalence of these outcomes by health insurance coverage type, accounting for group differences in health, sociodemographic, and socioeconomic characteristics.

## Methods

### Data source

Data from the 2019–2021 National Health Interview Survey (NHIS) were pooled for this analysis. NHIS is a multipurpose health survey of the U.S. civilian noninstitutionalized population conducted continuously throughout the year by the National Center for Health Statistics (NCHS). The NHIS interview begins by identifying everyone who usually lives in the household. One sample adult, aged 18 or over, and one sample child, aged 17 or under (if any children live in the household), are randomly selected to be part of the NHIS sample. The selected sample adult then answers detailed questions about their health insurance, health status, health-related behaviors, and healthcare access and use. Information about the sample adult is collected from the sample adults themselves unless they are physically or mentally unable to report, in which case a knowledgeable proxy can answer for them. The response rate for the Sample Adult component was 59.1% in 2019, 48.9% in 2020, and 50.9% in 2021. Detailed information regarding the design, content, use of NHIS, and annual sample sizes and response rates of NHIS, are available in the annual NHIS Survey Description document (32–34).

### Data collection during COVID-19 pandemic

Interviews are typically conducted in respondents' homes, but follow-up interviews to complete the survey may be done over the telephone. Because of the COVID-19 pandemic, NHIS data collection switched to a telephone-only

mode beginning on March 19, 2020 (33). Personal visits to households resumed in selected areas in July 2020 and in all areas of the country in September 2020. However, cases were still attempted by telephone first, and a majority were completed by telephone. In 2021, interviews were first attempted by telephone from January to April, with personal visits only to follow up on nonresponse, deliver recruitment materials, and conduct interviews when telephone numbers were unknown. In May 2021, interviewers returned to prepandemic procedures, with first contact attempts made in person and follow-up allowed by telephone, although interviewers could use the telephone first for contact attempts based on local COVID-19 conditions (34). In 2020, the Sample Adult file comprised respondents sampled in 2020 only as well as a followback component that included respondents who had completed the 2019 interview (33). Estimates in this report exclude the 2020 NHIS followback respondents who had completed the 2019 NHIS interview to avoid double counting the same participants in the analysis (33).

## Veteran status

All sample adults were asked, “Did you ever serve on active duty in the U.S. Armed Forces, military Reserves, or National Guard?” Veterans were defined as adults who answered yes to this question. NHIS does not sample people experiencing homelessness or those in institutional settings, such as nursing homes and prisons, so veterans in these living situations were not included in the analysis. In addition, NHIS does not include adults who are active-duty military. All analyses in this report were limited to adults aged 25–64. Veterans under the age of 25 were excluded because few veterans are under age 25 in the general population (13) and among NHIS respondents ( $n = 78$ ). Veterans aged 65 and over also were excluded because most have either Medicare or private insurance and rely less on VA health care and Tricare than younger veterans (26). In 2019–2021, 3,211 NHIS respondents aged 25–64 reported that they were veterans (6.1% of respondents aged 25–64).

## Insurance coverage

Veterans were initially classified according to insurance type in the following order: private insurance, Tricare, public coverage (excluding Tricare and VA health care), VA health care, or no insurance. Veterans with multiple types of coverage were classified in the first appropriate category in the ordered list. For instance, veterans who had both private and Tricare coverage were included in the private insurance category rather than the Tricare category. Similarly, veterans who had both Tricare and public coverage were included in the Tricare category rather than the public coverage category.

Private insurance and public coverage categories were subsequently subdivided by whether the adult also had VA health care. This led to seven mutually exclusive categories of insurance coverage:

- Private insurance with VA health care
- Private insurance without VA health care
- Any Tricare (with or without VA health care or public coverage)
- Public coverage with VA health care
- Public coverage without VA health care
- VA health care only
- Uninsured

*Private health insurance coverage*—Includes any comprehensive private insurance plan (including health maintenance and preferred provider organizations). These plans include those obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drug plans.

*Public health plan coverage*—Includes Medicaid, Children’s Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans and Medicare, and military plans not including VA health care or Tricare.

*VA health care only*—Includes adults who reported VA health care and no other coverage type.

*Uninsured*—Veterans were considered uninsured if, at the time of the interview, they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (Tricare, VA health care, or CHAMP–VA), other state-sponsored health plans, or other government programs. Veterans were also defined as uninsured if they had only Indian Health Service coverage or only a private plan that paid for one type of service, such as a dental, vision, or prescription drug plan.

## Measurements of financial burden of medical care

*Forgone care*—Defined as a yes response to either of the following questions: “During the past 12 months, was there any time when you needed medical care, but did not get it because of the cost?” or “During the past 12 months, have you delayed getting medical care because of the cost?”

*Problems paying medical bills*—Based on the family-level question, “In the past 12 months, did (you/anyone in the family) have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care.” This measure may be collected as part of the Sample Adult interview, Sample Child interview, or both depending upon the circumstance (34).

*Worry about paying medical bills*—Based on the question, “If you get sick or have an accident, how worried are you that you will be able to pay your medical bills? Are you very worried, somewhat worried, or not at all worried?” Three outcomes of “any worry,” “very worried,” or “somewhat worried” were included in this report.

## Selected sociodemographic characteristics

*Employment*—Veterans were classified as being in the workforce if they reported that they worked or had a job or business at any time during the 1-week period preceding the interview, were unemployed and looking for work,

were seasonal contract workers, or worked at a job or business but not for pay. Veterans who were retired, unable to work for health reasons, taking care of house or family, going to school, or had any other reason for not working were classified as not in the workforce. Because of the small sample size of veterans who were unemployed and looking for work ( $n = 61$ ), unemployment is not presented separately.

**Family income**—Based on the ratio of the family’s income in the previous calendar year to the appropriate federal poverty level (FPL) threshold (given the family’s size and number of children) defined by the U.S. Census Bureau (35). Missing family income was imputed using multiple imputation methods (36–38).

**Marital status**—Adults who were widowed, divorced, separated, never married, or living with a partner were classified as not married. Adults may identify themselves as married regardless of the legal status of the marriage or sex of the spouse.

**Race and Hispanic origin**—Adults were classified into four race and Hispanic-origin groups: Hispanic, non-Hispanic White, non-Hispanic Black, and non-Hispanic other and multiple races. Adults categorized as Hispanic may be of any race or combination of races. Non-Hispanic adults of multiple or other races are combined in a single category because estimates from remaining individual groups were not sufficiently powered to make group comparisons.

**Urbanization level**—Determined using the county of household residence and the 2013 NCHS urban–rural classification scheme for counties (39,40). This six-category classification measure was consolidated into four categories: large central (inner cities), large fringe (suburbs), medium and small metropolitan, and nonmetropolitan, which includes micropolitan and noncore counties (41).

## Health and disability status

**Disability status**—Defined by the reported level of difficulty (no difficulty, some difficulty, a lot of difficulty, or cannot do at all) in six functioning

domains: seeing (even if wearing glasses), hearing (even if wearing hearing aids), mobility (walking or climbing stairs), communication (understanding or being understood by others), cognition (remembering or concentrating), and self-care (such as washing all over or dressing). Sample adults who responded “a lot of difficulty” or “cannot do at all” to at least one question were considered to have a disability.

**Health status**—Based on the survey question, “Would you say your health in general is excellent, very good, good, fair, or poor?” Adults who answered excellent, very good, or good were categorized into one group, and adults who answered fair or poor were categorized into a second group.

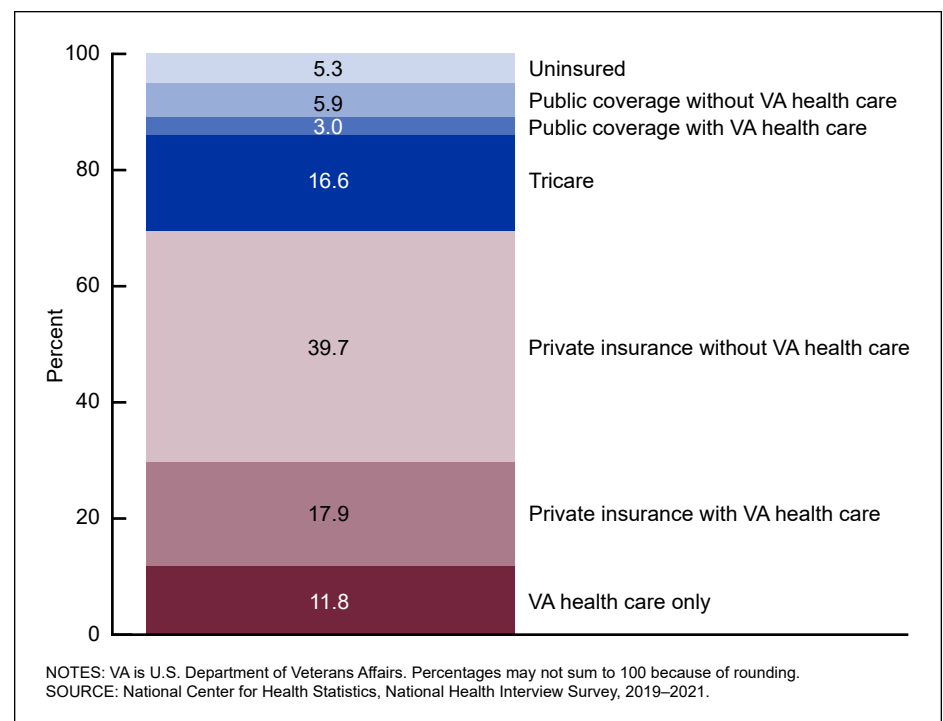
## Statistical analysis

The percent distribution of health insurance coverage among veterans aged 25–64 is shown in the [Figure](#), and the percent distribution of selected sociodemographic characteristics by insurance status is presented in [Table 1](#). Because of small sample sizes for veterans with public coverage with VA health care, public coverage without VA health care, and uninsured ( $n = 116, 178,$

and 148, respectively), these three subgroups were not compared with the other groups as part of the main analysis. However, the distribution of sociodemographic characteristics for these three insurance groups is included in [Table 1](#), and these veterans are included in the overall estimate in [Table 1](#) to provide a more complete description of the sociodemographic composition of veterans aged 25–64. Among remaining insurance subgroups, chi-square tests were used to evaluate the statistical significance of differences in sociodemographic characteristics by health insurance group among veterans with VA health care only, private insurance with VA health care, private insurance without VA health care, and Tricare.

Unadjusted estimates of financial burdens of care are presented by insurance status in [Table 2](#). Veterans with public coverage with VA health care, public coverage without VA health care, and uninsured are included in the overall estimate but are not shown separately due to small sample sizes. Two-tailed significance tests were used to identify significant differences by insurance status among presented groups. Multivariate regression models were used to generate

**Figure. Percent distribution of health insurance coverage among veterans aged 25–64: United States, 2019–2021**



adjusted estimates of all financial burden outcomes to account for known differences in sociodemographic characteristics, health status, and disability status. All sociodemographic characteristics that varied significantly by insurance status were initially included in the multivariate models. Sociodemographic characteristics that were not significant in any multivariate models were excluded from final multivariate models. Final models were adjusted for race and Hispanic origin, family income as a percentage of FPL, employment status, health status, and disability status. Model-adjusted estimates of the percentage of veterans living in families with problems paying medical bills, having forgone medical care, and worried about paying medical bills are presented in [Table 3](#).

Estimates that did not meet NCHS presentation standards were suppressed (42). The 95% confidence intervals were generated using the Korn–Graubard method for complex surveys (43). Statistical significance was set at  $p < 0.05$  for all tests. No adjustments were made for multiple comparisons. To account for the sampling design of NHIS, all estimates and standard errors used sample adult weights and were analyzed using SAS-callable SUDAAN version 11.0.01 (RTI International, Research Triangle Park, N.C.).

## Results

### Insurance coverage

In 2019–2021, 44.6% of civilian noninstitutionalized veterans aged 25–64 had VA health care either alone or in combination with private insurance, public coverage, or Tricare (data not shown). Among veterans aged 25–64, 11.8% had VA health care only, 17.9% had private insurance with VA health care, 39.7% had private insurance without VA health care, 16.6% had Tricare, 8.9% had public coverage with or without VA health care, and 5.3% were uninsured at the time of interview ([Figure](#)).

### Sociodemographic and health characteristics

Overall, veterans aged 25–64 were predominately men (83.5%); in the workforce (77.4%); in good, very good, or excellent health (85.5%); and without disability (91.8%). About one-half of veterans in this population were aged 50–64 (49.5%) and had incomes greater than 400% of FPL (51.1%). Seven out of 10 veterans were non-Hispanic White (68.7%) and 6 out of 10 veterans were married (61.6%) ([Table 1](#)).

Differences in sociodemographic composition were tested for statistical significance among veterans with VA health care only, private insurance with VA health care, private insurance without VA health care, or Tricare. Among these four groups, differences by insurance group were observed for age, family income, race and Hispanic origin, marital status, employment, urbanization level, health status, and disability status. Significant differences were not observed for sex. Veterans with VA health care only had generally greater prevalence of family income less than 200% of FPL, not being married, being in fair or poor health, and having disability compared with veterans with either private insurance (with or without VA health care) or Tricare. Veterans with private insurance (with or without VA health care) were more likely to be in the workforce than veterans with VA health care only or Tricare. Veterans with Tricare were more similar to those with VA health care only for some characteristics, such as race and Hispanic origin and workforce status, but were either more similar to those with private insurance for other sociodemographic factors (marital status) or tended to fall between VA health care and private insurance types on other factors (health status, family income, and disability). Generally, veterans with private insurance without VA health care were similar to veterans with private health insurance with VA health care.

### Financial burden of medical care

#### Unadjusted results

Among all veterans aged 25–64 (including those with public coverage and those who were uninsured), 12.8% were in families having problems paying medical bills in the past 12 months, 8.4% had forgone medical care due to cost in the past 12 months, 11.4% were very worried about paying medical bills, and 26.9% were somewhat worried about paying medical bills ([Table 2](#)).

The percentage of veterans who were in families having problems paying medical bills ranged from 8.9% of veterans with Tricare to 13.4% of veterans with VA health care only, but no significant differences were found by insurance type. The percentage of veterans who reported having forgone care in the past 12 months ranged from 5.2% among veterans with Tricare to 7.8% among veterans with private insurance without VA health care, but again no significant differences were seen by insurance type.

Lastly, the percentage of veterans who were very worried about paying medical bills was significantly higher among veterans with VA health care only (12.9%) compared with veterans who had private insurance with VA health care (6.2%) or Tricare (6.6%). The percentage of veterans who were somewhat worried about paying medical bills was significantly lower among both veterans with VA health care only (22.8%) and those with Tricare (16.3%) compared with both veterans who had private insurance with VA health care (33.0%) and veterans with private insurance without VA health care (30.2%).

#### Model-adjusted results

To account for known differences in sociodemographic characteristics, health status, and disability status among insurance coverage types, estimates of financial burden were adjusted for characteristics that both differed by insurance category and were significantly associated with at least one outcome. [Table 3](#) presents estimates by insurance group for problems paying medical bills,

forgone care, and worry about paying medical bills after adjustment for race and Hispanic origin, family income as a percentage of FPL, employment status, health status, and disability status.

Before adjustment, no differences by insurance coverage type were observed for problems paying medical bills or forgone care. After adjustment, veterans with VA health care only as well as veterans with Tricare were significantly less likely to have problems paying medical bills in the past 12 months than veterans having private insurance with or without VA health care (Table 3). As for forgone medical care, veterans who had private insurance without VA health care were more likely to have forgone medical care in the past 12 months than veterans with VA health care only, private insurance with VA health care, or Tricare.

After adjustment, the percentage of veterans with any worry about paying medical bills was significantly lower among both veterans with Tricare and veterans with VA health care only than among veterans who had private insurance with or without VA health care. By comparison, before adjustment, the percentage of veterans with any worry about paying medical bills was similar among veterans with VA health care only and those with private insurance (with or without VA health care). For veterans who were somewhat worried, differences by insurance coverage types were similar for both adjusted and unadjusted results.

Lastly, in both adjusted and unadjusted analyses, the percentage of veterans who were very worried about paying their medical bills was significantly higher among veterans who had private insurance without VA health care than veterans with either private insurance with VA health care or Tricare coverage. By comparison, the percentage of veterans with VA health care only who were very worried about paying their medical bills was not significantly higher or lower than the other coverage types examined after adjustment. Before adjustment, the percentage who were very worried from this same group was higher than veterans having either private insurance with VA coverage or Tricare.

## Discussion

A wide array of options for health insurance coverage is available to veterans in the United States. About 45% of civilian noninstitutionalized veterans aged 25–64 had VA health care either alone or in combination with private insurance, public coverage, or Tricare. Overall, the most common type of coverage for veterans aged 25–64 was private insurance without VA health care, followed by private insurance with VA health care, Tricare, and VA health care only. Less than 10% of veterans aged 25–64 had public coverage with or without VA health care, and 5.3% were uninsured. This analysis shows that the distributions of race and Hispanic origin, family income, employment status, health status, and disability status varied across veterans for the four most common health care coverage categories examined: VA health care only, private insurance with or without VA health care, and Tricare.

After adjustment for race and Hispanic origin, family income, employment status, health status, and disability status, most measures of financial burden improved for veterans who relied only on VA for their health care. Veterans covered by VA health care only were less likely than those with private insurance either with or without VA health care to have problems paying medical bills or any worry about paying medical bills. In addition, veterans covered by VA health care only were less likely than veterans with private insurance without VA health care to forgo needed medical care. These results were similar to those found in previous analyses by Wu et al. (44) and Wray et al. (2). Those studies found that among insured veterans, those with military coverage were less likely to have problems paying medical bills (44), incur medical debt, or forgo medical care (2) than those with private insurance. However, both studies grouped VA health care and Tricare together in their analyses, so they were not able to differentiate between those who had VA health care only compared with those having Tricare.

Tricare provides a unique health coverage opportunity for veterans who are retired from the military (45). After

adjustment, veterans with Tricare were less likely than their privately insured counterparts (with or without VA health care) to live in families who had problems paying medical bills or worry about paying their medical bills for unforeseen medical expenses. In addition, they were less likely to forgo medical care than those with private insurance without VA health care. While less has been published on health care use among veterans with Tricare, one study found high satisfaction with enrollment in military health care, including either VA health care or Tricare (46).

Previous studies have shown that people with lower or moderate incomes, poorer health status, or disability are more likely to face problems paying medical bills (47,48). Veterans with only VA health care were more likely than their privately insured counterparts to have a lower family income, have fair or poor health, not be in the workforce, and have disability. These differences in socioeconomic, health, and disability status echo those found from an earlier study of veterans based on the 2015 Medical Expenditure Panel Survey (29). After accounting for these differences, this report finds that veterans with only VA health care and veterans with Tricare had similar or lower levels of financial burden compared with veterans with private insurance. The reasons for this difference are likely complex, vary between VA health care and Tricare, and cannot be ascertained from this study. Within the VA health care system, health care for an illness or injury related to the veteran's military service is provided for free, and veterans do not pay premiums or deductibles for care but may be responsible for copays. Previous studies have found that the proportion of health care expenditures paid out of pocket was twice as large among veterans who did not use VA health care (14.6%) than among veterans who did use VA care (7.3%) (29). In addition, the VA healthcare system may also have an additional benefit for veterans in that it works to address health-related social needs specific to veterans (49) which may lessen some of the effects of financial burden of medical care.

## Strengths and limitations

The primary strength of this report is the use of nationally representative, cross-sectional data that is collected consistently across all health insurance groups, allowing comparison among veterans and including rich sociodemographic information. Most other studies comparing care provided within the VA system with care provided outside of VA must often use different data sources to evaluate VA and non-VA care, do not limit the comparison group to only veterans, or lack sociodemographic information on all study participants (27). Furthermore, adding a probe question for VA health care in 2018 brought NHIS estimates of VA health care into alignment with VA estimates (50).

However, findings in this report are subject to at least four limitations. First, NHIS annually collects information from about 2,300 veterans. As a result, even when combining multiple years of NHIS data, reliable estimates were not possible for small veteran subgroups, such as veterans who are uninsured, have public coverage without VA health care, have different levels of a service-connected coverage benefit, or have public coverage with VA health care. Second, for the category on paying medical bills, adults are asked if they or anyone in their family had problems paying medical bills. Consequently, whether the problems paying medical bills referred to a respondent veteran's bill or the bill of a family member who may have different insurance remains unknown. Third, while NHIS data are nationally representative of the civilian noninstitutionalized population, institutionalized people and those experiencing homelessness are excluded from sampling. This may lead to underreporting of the prevalence of financial burden of medical care, particularly given evidence that adults who are homeless, including veterans, have substantial unmet health care needs (51,52), and veterans are overrepresented in the homeless adult population compared with the overall U.S. adult population (53,54). In 2019–2021, more than 8% (37,300) of homeless adults (460,600) were veterans (53,54), while only 6.4% of the overall adult population were veterans (54). Fourth, NHIS does not have questions concerning military

service-connected disability ratings, which may be important for determining the level of health coverage that the VA system will provide and the amount a veteran may need to pay for VA-provided services.

In conclusion, after adjusting for various sociodemographic, socioeconomic, and health variables, veterans with VA health care only and veterans with Tricare reported similar or decreased financial burden of care compared with veterans having private insurance with or without VA health care. Further studies may use NHIS survey data linked to VA administrative records, available through the NCHS Data Linkage Program, to explore access, use, and other health issues among U.S. veterans (55).

## References

- Cohen RA, Cha AE. Problems paying medical bills: United States, 2021. National Health Statistics Reports; no 180. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: <https://dx.doi.org/10.15620/cdc.122191>.
- Wray CM, Khare M, Keyhani S. Access to care, cost of care, and satisfaction with care among adults with private and public health insurance in the US. *JAMA Netw Open* 4(6):e2110275. 2021. DOI: <https://dx.doi.org/10.1001/jamanetworkopen.2021.10275>.
- Cohen RA, Kirzinger WK. Financial burden of medical care: A family perspective. NCHS Data Brief, no 142. Hyattsville, MD: National Center for Health Statistics. 2014.
- Bielenberg JE, Futrell M, Stover B, Hagopian A. Presence of any medical debt associated with two additional years of homelessness in a Seattle sample. *Inquiry* 57:46958020923535. 2020.
- Collins SR, Abouafia GN, Gunja MZ. As the pandemic eases, what is the state of health care coverage and affordability in the U.S.? Findings from the Commonwealth Fund Health Care Coverage and COVID-19 Survey, March–June 2021. Commonwealth Fund. 2021.
- Himmelstein DU, Dickman SL, McCormick D, Bor DH, Gaffney A, Woolhandler S. Prevalence and risk factors for medical debt and subsequent changes in social determinants of health in the US. *JAMA Netw Open* 5(9):e2231898. 2022. DOI: <https://dx.doi.org/10.1001/jamanetworkopen.2022.31898>.
- Rustgi S, Doty MM, Collins SR, Kriss JL. Losing ground: How the loss of adequate health insurance is burdening working families—Findings from the Commonwealth Fund Biennial Health Insurance Surveys, 2001–2007. Commonwealth Fund. 2008. Available from: <https://www.commonwealthfund.org/publications/fund-reports/2008/aug/losing-ground-how-loss-adequate-health-insurance-burdening>.
- Sommers A, Cunningham PJ. Medical bill problems steady for U.S. families, 2007–2010. *Track Rep* (28):1–5. 2011.
- Rabin DL, Jetty A, Petterson S, Froehlich A. Under the ACA higher deductibles and medical debt cause those most vulnerable to defer needed care. *J Health Care Poor Underserved* 31(1):424–40. 2020.
- Lopes L, Kearney A, Montero A, Hamel L, Brodie M. Health care debt in the U.S.: The broad consequences of medical and dental bills. Kaiser Family Foundation. 2022.
- Stroupe KT, Martinez R, Hogan TP, Gordon EJ, Gonzalez B, Tarlov E, et al. Health insurance coverage among veterans receiving care from VA health care facilities. *Med Care Res Rev* 79(4):511–24. 2022.
- Centers for Medicare & Medicaid Services. Health care coverage options for military veterans. Available from: <https://www.healthcare.gov/veterans/>.
- U.S. Department of Veterans Affairs. National Center for Veterans Analysis and Statistics. 2022. Available from: [https://www.va.gov/vetdata/veteran\\_population.asp](https://www.va.gov/vetdata/veteran_population.asp).
- U.S. Department of Veterans Affairs. VA priority groups. 2022. Available from: <https://www.va.gov/health-care/eligibility/priority-groups/>.

15. U.S. Department of Veterans Affairs. The PACT Act and your VA benefits. 2022. Available from: <https://www.va.gov/resources/the-pact-act-and-your-va-benefits/#whats-the-pact-act-and-how-wil>.
16. U.S. Department of Veterans Affairs. About VA health benefits. 2022. Available from: <https://www.va.gov/health-care/about-va-health-benefits/>.
17. Gill LL. Veterans saddled with high medical debt. *Consumer Reports*. 2020.
18. U.S. Department of Veterans Affairs. VA health care and other insurance. 2022. Available from: <https://www.va.gov/health-care/about-va-health-benefits/va-health-care-and-other-insurance/>.
19. U.S. Department of Veterans Affairs. Where you'll go for care. 2022. Available from: <https://www.va.gov/health-care/about-va-health-benefits/where-you-go-for-care/>.
20. Defense Health Agency. Tricare. Available from: <https://tricare.mil/>.
21. Defense Health Agency. Tricare: Life events: Retiring. Available from: <https://www.tricare.mil/LifeEvents/Retiring>.
22. Affordable Care Act of 2010. Pub L No 111–148, Pub L No 111–152. 2010.
23. Military Benefit Association. What is Tricare? Available from: <https://www.militarybenefit.org/membership-benefits/get-educated/what-is-tricare/>.
24. Defense Health Agency. Tricare costs and fees sheet. 2022. Available from: [https://tricare.mil/Publications/Costs/costs\\_fees](https://tricare.mil/Publications/Costs/costs_fees).
25. Defense Health Agency. Tricare plans. Tricare 101. Available from: <https://www.tricare.mil/Plans/New>.
26. Zelaya CE, Nugent CN. Trends in health insurance and type among military veterans: United States, 2000–2016. *Am J Public Health* 108(3):361–7. 2018.
27. Trivedi AN, Matula S, Miake-Lye I, Glassman PA, Shekelle P, Asch S. Systematic review: Comparison of the quality of medical care in Veterans Affairs and non-Veterans Affairs settings. *Med care* 49(1):76–88. 2011. Available from: [https://journals.lww.com/lww-medicalcare/Fulltext/2011/01000/Systematic\\_Review\\_\\_Comparison\\_of\\_the\\_Quality\\_of.11.aspx](https://journals.lww.com/lww-medicalcare/Fulltext/2011/01000/Systematic_Review__Comparison_of_the_Quality_of.11.aspx).
28. Fink DS, Stohl M, Mannes ZL, Shmulewitz D, Wall M, Gutkind S, et al. Comparing mental and physical health of U.S. veterans by VA healthcare use: Implications for generalizability of research in the VA electronic health records. *BMC Health Serv Res* 22(1):1500. 2022. Available from: <https://doi.org/10.1186/s12913-022-08899-y>.
29. Machlin SR, Muhuri P. Characteristics and health care expenditures of VA health system users versus other veterans, 2014–2015 (combined). Statistical Brief no 508. Agency for Healthcare Research and Quality. 2018.
30. Meffert BN, Morabito DM, Sawicki DA, Hausman C, Southwick SM, Pietrzak RH, Heinz AJ. US veterans who do and do not utilize Veterans Affairs health care services: Demographic, military, medical, and psychosocial characteristics. *Prim Care Companion CNS Disord* 21(1). 2019. DOI: <https://dx.doi.org/10.4088/PCC.18m02350>.
31. Hamel L, Horton M, Pollitz K, Levitt L, Claxton G, Brodie M. The burden of medical debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey. Kaiser Family Foundation. 2016.
32. National Center for Health Statistics. National Health Interview Survey 2019 survey description. 2020.
33. National Center for Health Statistics. National Health Interview Survey 2020 survey description. 2021.
34. National Center for Health Statistics. National Health Interview Survey 2021 survey description. 2022.
35. U.S. Census Bureau. Poverty thresholds. 2020. Available from: <https://www.census.gov/data/tables/time-series/demo/income-poverty/historical-poverty-thresholds.html>.
36. National Center for Health Statistics. Multiple imputation of family income in 2019 National Health Interview Survey: Methods. 2020. Available from: [https://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Dataset\\_Documentation/NHIS/2019/NHIS2019-imputation-techdoc-508.pdf](https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2019/NHIS2019-imputation-techdoc-508.pdf).
37. National Center for Health Statistics. Multiple imputation of family income in 2020 National Health Interview Survey: Methods. 2021. Available from: [https://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Dataset\\_Documentation/NHIS/2020/NHIS2020-imputation-techdoc-508.pdf](https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2020/NHIS2020-imputation-techdoc-508.pdf).
38. National Center for Health Statistics. Multiple imputation of family income in 2021 National Health Interview Survey: Methods. 2022. Available from [https://ftp.cdc.gov/pub/Health\\_Statistics/NCHS/Dataset\\_Documentation/NHIS/2021/NHIS2021-imputation-techdoc-508.pdf](https://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHIS/2021/NHIS2021-imputation-techdoc-508.pdf).
39. Office of Management and Budget. Revised delineations of metropolitan statistical areas, micropolitan statistical areas, and combined statistical areas, and guidance on uses of the delineations of these areas. OMB Bulletin No. 13–01. 2013.
40. National Center for Health Statistics. NCHS urban–rural classification scheme for counties: Data files and documentation. Available from: [https://www.cdc.gov/nchs/data\\_access/urban\\_rural.htm#2013\\_Urban-Rural\\_Classification\\_Scheme\\_for\\_Counties](https://www.cdc.gov/nchs/data_access/urban_rural.htm#2013_Urban-Rural_Classification_Scheme_for_Counties).
41. Ingram DD, Franco SJ. 2013 NCHS urban–rural classification scheme for counties. National Center for Health Statistics. *Vital Health Stat* 2(166). 2014.
42. Parker JD, Talih M, Malec DJ, Beresovsky V, Carroll M, Gonzalez JF Jr, et al. National Center for Health Statistics data presentation standards for proportions. National Center for Health Statistics. *Vital Health Stat* 2(175). 2017.
43. Korn EL, Graubard BI. Confidence intervals for proportions with small expected number of positive counts estimated from survey data. *Surv Methodol* 24(2):193–201. 1998.
44. Wu L, Wang G, Birore CMS. Disabilities status, health insurance, and medical hardship among veterans. *Soc Work Public Health* 33(7–8):497–509. 2018.
45. Defense Health Agency. Tricare plans. Retired service members and



- families. Available from: <https://www.tricare.mil/Plans/Eligibility/RSMandFamilies>.
46. Riffkin R. Americans with government health plans most satisfied. Gallup, Inc. 2015. Available from: <https://news.gallup.com/poll/186527/americans-government-health-plans-satisfied.aspx>.
47. Montero A, Kearney A, Hamel L, Brodie M. Americans' challenges with health care costs. Peterson-KFF Health System Tracker. 2022. Available from: <https://www.kff.org/health-costs/poll-finding/data-note-americans-challenges-with-health-care-costs/>.
48. Rae M, Claxton G, Amin K, Wager E, Ortaliza J, Cox C. The burden of medical debt in the United States. Peterson-KFF Health System Tracker. 2022. Available from: <https://www.healthsystemtracker.org/brief/the-burden-of-medical-debt-in-the-united-states/>.
49. Russell L, Cohen A, Chrzas S, Korshak L, Wong M. Identifying and addressing health-related social needs among veterans fact sheet. 2022. U.S. Department of Veterans Affairs. Available from: [https://www.va.gov/HEALTHQUITY/docs/Social\\_Determinants\\_Fact\\_Sheet\\_V2-0.pdf](https://www.va.gov/HEALTHQUITY/docs/Social_Determinants_Fact_Sheet_V2-0.pdf).
50. Cohen RA, Zelaya C. Improving measurement of VA health coverage among military veterans on the National Health Interview Survey. 2021 Federal Committee on Statistical Methodology Research and Policy Conference, Washington, DC. 2021.
51. Tsai J, Mitchell L, Nakashima J, Blue-Howells J. Unmet needs of homeless U.S. veterans by gender and race/ethnicity: Data from five annual surveys. *Psychol Serv* 20(1):149–56. 2021. Available from: <https://dx.doi.org/10.1037/ser0000557>.
52. Baggett TP, O'Connell JJ, Singer DE, Rigotti NA. The unmet health care needs of homeless adults: A national study. *Am J Public Health* 100(7):1326–33. 2010.
53. Henry M, Watt R, Mahathey A, Ouellette J, Sitler A. 2019 AHAR: Part 1 - PIT estimates of homelessness in the U.S. 2020. U.S. Department of Housing and Urban Development. Available from: <https://www.hudexchange.info/resource/5948/2019-ahar-part-1-pit-estimates-of-homelessness-in-the-us/>.
54. U.S. Census Bureau. American Community Survey 1-year estimates subject tables: Veteran status. 2021. Available from: <https://data.census.gov/table?q=veteran&tid=ACSST1Y2021.S2101>.
55. National Center for Health Statistics. The linkage of the National Center for Health Statistics survey data to United States Department of Veterans Affairs administrative data: Linkage methodology and analytic considerations. 2022. Available from: <https://www.cdc.gov/nchs/data/datalinkage/nchs-va-linked-data-methodology-and-analytic-considerations.pdf>.

**Table 1. Percent distribution of selected demographic characteristics, health status, and disability status among veterans aged 25–64, by health insurance coverage: United States, 2019–2021**

Selected characteristic	All veterans	VA health care only	Private insurance			Public coverage		Uninsured
			With VA health care	Without VA health care	Tricare	With VA health care	Without VA health care	
<b>Sex</b>		Percent (95% confidence interval)						
Men . . . . .	83.5 (82.0–85.0)	83.3 (78.7–87.3)	81.7 (77.8–85.1)	84.9 (82.5–87.2)	79.6 (75.3–83.5)	81.5 (70.4–89.8)	88.2 (82.2–92.7)	88.2 (79.8–94.0)
Women . . . . .	16.5 (15.0–18.0)	16.7 (12.7–21.3)	18.3 (14.9–22.2)	15.1 (12.8–17.5)	20.4 (16.5–24.7)	18.5 (10.2–29.6)	11.8 (7.3–17.8)	11.8 (6.0–20.2)
<b>Age group (years)<sup>1</sup></b>								
25–34 . . . . .	16.9 (15.1–18.7)	22.7 (17.3–28.9)	16.9 (13.3–21.1)	13.5 (11.1–16.2)	18.4 (13.8–23.7)	*	23.8 (14.9–34.7)	18.4 (10.1–29.4)
35–49 . . . . .	33.7 (31.7–35.7)	33.1 (27.2–39.4)	42.6 (37.6–47.7)	33.9 (30.8–37.1)	29.4 (24.6–34.6)	26.4 (14.6–41.2)	22.9 (15.4–31.8)	32.5 (22.5–43.8)
50–64 . . . . .	49.5 (47.2–51.7)	44.2 (38.4–50.1)	40.5 (35.4–45.7)	52.6 (49.2–55.9)	52.2 (46.9–57.4)	59.8 (45.2–73.3)	53.4 (43.2–63.3)	49.1 (39.1–59.3)
<b>Family income as percentage of FPL<sup>1,2</sup></b>								
Less than 200% FPL . . . . .	18.2 (16.6–20.0)	32.6 (27.2–38.4)	9.0 (6.4–12.3)	7.3 (5.7–9.1)	15.9 (12.1–20.3)	68.2 (57.1–78.0)	56.4 (46.2–66.2)	36.3 (26.4–47.0)
200%–400% FPL . . . . .	30.7 (28.7–32.8)	39.1 (32.9–45.5)	32.3 (27.6–37.2)	27.5 (24.5–30.7)	33.2 (28.3–38.4)	22.4 (14.4–32.2)	27.8 (18.7–38.5)	30.8 (21.8–41.1)
More than 400% FPL . . . . .	51.1 (48.9–53.3)	28.3 (23.0–34.1)	58.7 (53.4–63.8)	65.2 (61.9–68.4)	50.9 (45.6–56.2)	*	15.8 (8.8–25.4)	32.9 (22.9–44.2)
<b>Race and Hispanic origin<sup>1,3</sup></b>								
Hispanic . . . . .	8.9 (7.5–10.5)	12.7 (8.7–17.5)	10.8 (8.1–14.1)	6.7 (5.1–8.6)	10.2 (6.4–15.1)	*	11.2 (6.4–17.8)	*
Non-Hispanic White . . . . .	68.7 (66.5–70.9)	60.3 (54.1–66.3)	67.6 (62.6–72.3)	77.1 (74.1–80.0)	59.5 (53.9–64.9)	57.7 (43.2–71.2)	63.8 (54.2–72.6)	69.4 (57.1–80.0)
Non-Hispanic Black . . . . .	16.8 (15.0–18.7)	22.1 (17.5–27.2)	17.4 (13.4–22.0)	11.0 (8.9–13.3)	23.8 (18.9–29.3)	30.2 (17.5–45.7)	18.1 (11.7–26.1)	*
Non-Hispanic other and multiple races . . . . .	5.5 (4.5–6.7)	4.9 (2.9–7.7)	4.2 (2.5–6.7)	5.2 (3.7–7.0)	6.5 (3.8–10.2)	*	*	*
<b>Marital status<sup>1</sup></b>								
Married . . . . .	61.6 (59.6–63.5)	42.2 (36.1–48.6)	68.0 (63.8–72.0)	69.4 (66.2–72.4)	67.6 (62.0–72.9)	37.5 (24.7–51.6)	44.6 (34.9–54.6)	37.3 (26.6–49.0)
Not married . . . . .	38.4 (36.5–40.4)	57.8 (51.4–63.9)	32.0 (28.0–36.2)	30.6 (27.6–33.8)	32.4 (27.1–38.0)	62.5 (48.4–75.3)	55.4 (45.4–65.1)	62.7 (51.0–73.4)
<b>Employment<sup>1</sup></b>								
In workforce . . . . .	77.4 (75.5–79.2)	61.6 (56.0–67.1)	86.9 (83.4–90.0)	90.6 (88.6–92.4)	63.3 (57.6–68.7)	28.0 (15.8–43.2)	43.2 (33.6–53.2)	90.3 (84.3–94.5)
Not in workforce . . . . .	22.6 (20.8–24.5)	38.4 (32.9–44.0)	13.1 (10.0–16.6)	9.4 (7.6–11.4)	36.7 (31.3–42.4)	72.0 (56.8–84.2)	56.8 (46.8–66.4)	9.7 (5.5–15.7)
<b>Urbanization level<sup>1,4</sup></b>								
Large central metropolitan . . . . .	24.8 (22.7–26.9)	30.2 (24.3–36.6)	26.6 (22.4–31.2)	25.0 (22.1–28.2)	18.0 (13.9–22.6)	29.8 (16.9–45.6)	21.3 (13.9–30.4)	27.3 (18.0–38.3)
Large fringe metropolitan . . . . .	23.3 (20.9–25.9)	16.3 (11.7–21.7)	27.4 (22.8–32.3)	26.6 (23.3–30.1)	22.1 (16.9–28.1)	16.0 (8.3–26.7)	20.9 (13.2–30.4)	11.2 (6.4–17.9)
Medium and small metropolitan . . . . .	37.3 (33.2–41.4)	39.2 (32.5–46.2)	33.9 (28.5–39.7)	35.1 (30.8–39.6)	45.9 (38.3–53.8)	33.8 (21.4–48.1)	37.5 (27.9–47.8)	35.5 (24.8–47.4)
Nonmetropolitan . . . . .	14.6 (11.6–18.1)	14.4 (9.8–20.1)	12.1 (8.4–16.5)	13.3 (10.2–17.0)	14.0 (8.4–21.4)	20.4 (11.5–32.0)	20.3 (13.4–28.9)	26.0 (16.3–37.8)
<b>Health status<sup>1</sup></b>								
Good, very good, or excellent . . . . .	85.5 (83.9–86.9)	75.8 (70.3–80.7)	89.0 (86.0–91.5)	92.1 (90.2–93.8)	83.7 (80.0–87.0)	57.8 (44.1–70.7)	68.0 (58.6–76.4)	86.0 (77.0–92.5)
Fair or poor . . . . .	14.5 (13.1–16.1)	24.2 (19.3–29.7)	11.0 (8.5–14.0)	7.9 (6.2–9.8)	16.3 (13.0–20.0)	42.2 (29.3–55.9)	32.0 (23.6–41.4)	14.0 (7.5–23.0)
<b>Disability status<sup>1,5</sup></b>								
With disability . . . . .	8.2 (7.2–9.4)	15.8 (12.0–20.3)	6.5 (4.5–9.1)	4.2 (2.9–5.9)	11.0 (8.0–14.7)	18.8 (11.8–27.6)	16.6 (11.3–23.0)	*
Without disability . . . . .	91.8 (90.6–92.8)	84.2 (79.7–88.0)	93.5 (90.9–95.5)	95.8 (94.1–97.1)	89.0 (85.3–92.0)	81.2 (72.4–88.2)	83.4 (77.0–88.7)	**96.3 (91.8–98.7)

See footnotes at end of table.

**Table 1. Percent distribution of selected demographic characteristics, health status, and disability status among veterans aged 25–64, by health insurance coverage: United States, 2019–2021—Con.**

\* Estimate is not shown because it does not meet National Center for Health Statistics standards of reliability.

\*\* Estimate meets National Center for Health Statistics standards of reliability, but its complement does not.

<sup>1</sup>Chi-square test was significant among adults with only VA health care, private insurance with VA health care, private insurance without VA health care, or Tricare ( $p < 0.05$ ).

<sup>2</sup>Federal poverty level (FPL) was calculated using the U.S. Census Bureau's poverty thresholds for the previous calendar year, which consider family size and age.

<sup>3</sup>Adults classified as Hispanic may be any race or combination of races. Adults categorized as non-Hispanic White or non-Hispanic Black indicated one race only. Non-Hispanic adults of multiple or other races (including those who did not identify as White, Black, or Hispanic) are combined into the non-Hispanic other and multiple races category.

<sup>4</sup>Measured using metropolitan statistical area (MSA) status. The Office of Management and Budget defines MSAs based on published standards applied to U.S. Census Bureau data. Generally, an MSA consists of a county or group of counties containing at least one urbanized area with a population of 50,000 or more; see reference 41 and Methods section in this report for more detail. The large central MSA category has a population of 1 million or more and is similar to an inner city. The large fringe MSA category has a population of 1 million or more and is similar to a suburb. The medium and small MSA category has a population of less than 1 million. Nonmetropolitan includes those not living in an MSA.

<sup>5</sup>Defined by the reported level of difficulty (no difficulty, some difficulty, a lot of difficulty, or cannot do at all) in six functioning domains: seeing (even if wearing glasses), hearing (even if wearing hearing aids), mobility (walking or climbing stairs), communication (understanding or being understood by others), cognition (remembering or concentrating), and self-care (such as washing all over or dressing). Sample adults who responded "a lot of difficulty" or "cannot do at all" to at least one question were considered to have a disability.

NOTES: VA is U.S. Department of Veterans Affairs. Veterans were classified according to health insurance coverage type using the following hierarchy of categories: private insurance with VA health care, private insurance without VA health care, Tricare (with or without VA or public coverage), public coverage with VA health care, public coverage without VA health care, VA health care only, and uninsured. Private health insurance includes insurance obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as a dental, vision, or prescription drug plan. Public coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans and Medicare, and military plans not including VA care or Tricare. Veterans were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (Tricare, VA health care, or CHAMP-VA), other state-sponsored health plans, or other government programs. Veterans were also defined as uninsured if they had only Indian Health Service coverage or only a private plan that paid for one type of service, such as a dental, vision, or prescription drug plan.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019–2021.

**Table 2. Unadjusted percentage of selected measures of financial burden for medical care among veterans aged 25–64, by selected health insurance coverage type: United States, 2019–2021**

Selected measure of financial burden for medical care	All veterans	VA health care only	Private insurance		Tricare
			With VA health care	Without VA health care	
			Percent (95% confidence interval)		
Problems paying medical bills <sup>1</sup>	12.8 (11.5–14.3)	13.4 (9.9–17.6)	11.8 (9.1–15.1)	11.1 (8.9–13.5)	8.9 (6.4–12.0)
Forgone care <sup>2</sup>	8.4 (7.3–9.7)	7.6 (5.1–10.9)	5.6 (3.8–8.0)	7.8 (5.9–9.9)	5.2 (3.1–8.1)
Any worry about paying medical bills <sup>3</sup>	38.4 (36.2–40.6)	†35.7 (30.4–41.3)	†39.2 (34.5–44.1)	†41.0 (37.7–44.4)	22.9 (18.1–28.3)
Very worried	11.4 (10.1–12.9)	††12.9 (9.5–17.1)	§6.2 (4.3–8.6)	†10.8 (8.8–13.1)	6.6 (4.2–9.8)
Somewhat worried	26.9 (25.0–28.9)	†§22.8 (18.1–28.1)	†33.0 (28.4–37.8)	†30.2 (27.2–33.4)	16.3 (12.0–21.4)

† Significantly different from Tricare ( $p < 0.05$ ).

‡ Significantly different from private insurance with VA health care ( $p < 0.05$ ).

§ Significantly different from private insurance without VA health care ( $p < 0.05$ ).

<sup>1</sup>Based on responses to the family-level survey question, "In the past 12 months, did [you/anyone in the family] have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care."

<sup>2</sup>Defined as a "yes" response to either of the survey questions, "During the past 12 months, was there any time when you needed medical care, but did not get it because of the cost?" or "During the past 12 months, have you delayed getting medical care because of the cost?"

<sup>3</sup>Based on responses to the survey questions, "If you get sick or have an accident, how worried are you that you will be able to pay your medical bills? Are you very worried, somewhat worried, or not at all worried?"

NOTES: VA is U.S. Department of Veterans Affairs. Veterans were classified according to health insurance coverage type using the following hierarchy of categories: private insurance with VA health care, private insurance without VA health care, Tricare (with or without VA or public coverage), public coverage with VA health care, public coverage without VA health care, VA health care only, and uninsured. Private health insurance includes insurance obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as dental, vision, or prescription drug plans. Public coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans and Medicare, and military plans not including VA care or Tricare. Veterans were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (Tricare, VA health care, or CHAMP–VA), other state-sponsored health plans, or other government programs. Veterans were also defined as uninsured if they had only Indian Health Service coverage or only a private plan that paid for one type of service, such as a dental, vision, or prescription drug plan. Veterans with public coverage and those who were uninsured are included in the All veterans category but are not shown separately.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019–2021.

**Table 3. Adjusted percentage of selected measures of financial burden for medical care among veterans aged 25–64, by selected health insurance coverage type: United States, 2019–2021**

Selected measure of financial burden for medical care	VA health care only	Private insurance		Tricare
		With VA health care	Without VA health care	
		Percent (95% confidence interval)		
Problems paying medical bills <sup>1</sup>	†‡8.5 (6.2–11.4)	§12.8 (10.1–16.0)	§13.3 (10.9–16.2)	7.7 (5.4–10.7)
Forgone care <sup>2</sup>	‡5.2 (3.4–7.7)	‡6.2 (4.4–8.5)	§9.0 (7.1–11.4)	4.6 (2.8–7.4)
Any worry about paying medical bills <sup>3</sup>	†‡§31.1 (26.2–36.5)	§39.4 (34.9–44.2)	§42.3 (39.1–45.7)	23.1 (18.5–28.5)
Very worried	9.0 (6.5–12.3)	‡6.6 (4.8–9.0)	§12.5 (10.3–15.2)	6.0 (3.9–9.1)
Somewhat worried	†‡22.1 (17.6–27.3)	§32.8 (28.4–37.4)	§30.1 (27.1–33.3)	17.1 (12.9–22.4)

† Significantly different from private insurance with VA health care ( $p < 0.05$ ).

‡ Significantly different from private insurance without VA health care ( $p < 0.05$ ).

§ Significantly different from Tricare ( $p < 0.05$ ).

<sup>1</sup>Based on responses to the family-level survey question, "In the past 12 months, did {you/anyone in the family} have problems paying or were unable to pay any medical bills? Include bills for doctors, dentists, hospitals, therapists, medication, equipment, nursing home, or home care."

<sup>2</sup>Defined as a "yes" response to either of the survey questions, "During the past 12 months, was there any time when you needed medical care, but did not get it because of the cost?" or "During the past 12 months, have you delayed getting medical care because of the cost?"

<sup>3</sup>Based on responses to the survey questions, "If you get sick or have an accident, how worried are you that you will be able to pay your medical bills? Are you very worried, somewhat worried, or not at all worried?"

NOTES: VA is U.S. Department of Veterans Affairs. Veterans were classified according to health insurance coverage type using the following hierarchy of categories: private insurance with VA health care, private insurance without VA health care, Tricare (with or without VA or public coverage), public coverage with VA health care, public coverage without VA health care, VA health care only, and uninsured. Private health insurance includes insurance obtained through an employer, purchased directly, purchased through local or community programs, or purchased through the Health Insurance Marketplace or a state-based exchange. Private coverage excludes plans that pay for only one type of service, such as a dental, vision, or prescription drug plan. Public coverage includes Medicaid, Children's Health Insurance Program (CHIP), state-sponsored or other government-sponsored health plans and Medicare, and military plans not including VA care or Tricare. Veterans were considered uninsured if they did not have coverage through private health insurance, Medicare, Medicaid, CHIP, military (Tricare, VA health care, or CHAMP–VA), other state-sponsored health plans, or other government programs. Veterans were also defined as uninsured if they had only Indian Health Service coverage or only a private plan that paid for one type of service, such as a dental, vision, or prescription drug plan. Estimates are adjusted for race and Hispanic origin, family income as a percentage of federal poverty level, employment status, health status, and disability status.

SOURCE: National Center for Health Statistics, National Health Interview Survey, 2019–2021.

**U.S. DEPARTMENT OF  
HEALTH & HUMAN SERVICES**

Centers for Disease Control and Prevention  
National Center for Health Statistics  
3311 Toledo Road, Room 4551, MS P08  
Hyattsville, MD 20782-2064

FIRST CLASS MAIL  
POSTAGE & FEES PAID  
CDC/NCHS  
PERMIT NO. G-284

OFFICIAL BUSINESS  
PENALTY FOR PRIVATE USE, \$300

For more NCHS NHSRs, visit:  
<https://www.cdc.gov/nchs/products/nhsr.htm>.



---

National Health Statistics Reports ■ Number 182 ■ March 22, 2023

---

---

**Suggested citation**

Cohen RA, Boersma P. Financial burden of medical care among veterans aged 25–64, by health insurance coverage: United States, 2019–2021. National Health Statistics Reports; no 182. Hyattsville, MD: National Center for Health Statistics. 2023. DOI: <https://dx.doi.org/10.15620/cdc:124453>.

---

**Copyright information**

All material appearing in this report is in the public domain and may be reproduced or copied without permission; citation as to source, however, is appreciated.

---

**National Center for Health Statistics**

Brian C. Moyer, Ph.D., *Director*  
Amy M. Branum, Ph.D., *Associate Director for Science*

**Division of Health Interview Statistics**

Stephen J. Blumberg, Ph.D., *Director*  
Anjel Vahratian, Ph.D., M.P.H., *Associate Director for Science*

---

For e-mail updates on NCHS publication releases, subscribe online at: <https://www.cdc.gov/nchs/email-updates.htm>.  
For questions or general information about NCHS: Tel: 1-800-CDC-INFO (1-800-232-4636) • TTY: 1-888-232-6348  
Internet: <https://www.cdc.gov/nchs> • Online request form: <https://www.cdc.gov/info> • CS337566