



Center for Social Development

GEORGE WARREN BROWN SCHOOL OF SOCIAL WORK

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The Role of Health Insurance in the Financial Lives of Low- and Moderate-Income Households

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Medical costs, whether expected or unexpected, can present a substantial threat to a household's financial well-being. Health insurance, which generally allows households to seek medical care without assuming significant financial obligation and risk, is one of the most important tools available for protecting financial well-being. Yet despite recent policy innovations like the Affordable Care Act (ACA) and the associated expansion of Medicaid,¹ 10% of the U.S. population remains uninsured.²

Although the costs of insurance may be too high for some households to manage, or the barriers to receiving insurance too great, the costs of being uninsured are substantial. In 2014, 27% of uninsured households went without needed medical care because of its cost (compared with 5% of those who had private health insurance) while 32% postponed seeking medical care for the same reason (compared with 8% of privately insured households).³ Access to insurance has also been shown to increase the number of routine doctor visits and the number of elective surgeries and to reduce health disparities among racial groups and those with differing levels of education.⁴

Research has convincingly linked insurance-provided health-care access to a wide array of improved health outcomes. For example, in a comparison of states that expanded Medicaid between 2000 and 2005 with states that did not, Medicaid expansion was associated with a 6.1% relative reduction in mortality from any cause, and the reduction was most prevalent among older adult, poor, and minority households.⁵ Medicaid expansion was also associated with an improvement in individuals' subjective measure of their own health. Other work has similarly found that the uninsured receive diagnoses at more advanced stages of a disease while receiving less therapeutic care, and access to insurance would reduce mortality rates by 10% to 15%.⁶

The link between health care access and health outcomes is clear, but a lack of health insurance and poor health

may also have substantial financial consequences for households. At the most basic level, a lack of insurance can cause direct financial hardship: The uninsured are twice as likely as the insured to report problems in paying medical bills; they are over twice as likely to report that medical bills led them to exhaust their savings, to have difficulty paying for basic necessities, to borrow money, and to have bills sent to collections.⁷

Beyond the direct relationship between health costs and financial hardship, poor health in general has been shown to lead to worse financial outcomes. Better health outcomes would lead to an increase in annual earnings of 10% to 30%,⁸ while an analysis controlling for family and neighborhood effects indicated that poor childhood health is associated with 13% less income in adulthood.⁹ There is some concern about the direction of causality in the relationship between health and finances, but the extant research implies that health is a stronger predictor of financial strain than financial strain is of poor health.¹⁰ The research also indicates that this link is persistent over the long term.¹¹

The purpose of this brief is to examine the relationships among health insurance coverage, material hardships, and financial difficulties in data from two samples of low- and moderate-income (LMI) tax filers. Given the links among health insurance, health outcomes, and financial well-being, understanding the financial realities faced by LMI households—particularly their insurance status, their debt and asset profiles, their experience with hardship, and their demographics—can yield insights that are important in developing policies and programs to address the needs of the uninsured within this population.

Background

The Refund to Savings (R2S) Initiative is an ongoing partnership of Washington University in St. Louis, Duke University, and Intuit, Inc. The initiative assesses the outcomes of behavioral economics techniques aimed at

Table 1. Sample Demographic Characteristics

Characteristic	2013	2014
Age (years)	36.32	37.04
Gender (%)		
Female	61	59
Male	39	41
Race/ethnicity (%)		
White	75	78
African American	11	8
Latino	8	7
Asian American	2	2
Other	4	4
Income (\$)	17,049	15,937
Filing status (%)		
Single	63	70
Head of household	21	17
Married, joint/widow	15	13
Married, separate	1	1
Employment status		
Full-time	49	45
Part-time	20	30
Unemployed	31	25
Had health insurance	73	76
Lives in Medicaid expansion state	--	45
<i>N</i>	18,585	9,315

Note. Data are from the baseline of the 2013 and 2014 Household Financial Surveys.

Table 2. Types of Health Insurance Coverage

Coverage Type	R2S 2013	U.S. 2013	R2S 2014	U.S. 2014
% employer-sponsored	42	50	46 ^a	49
% private, nongroup	5	4	7	6
% Medicaid	8	18	9	19
% Medicare	5	13	5	13
% other ^b	13	2	11	2
% no insurance	27	13	24	10
<i>N</i>	7,501	313m	7,051	316m

Note. R2S = Refund to Savings Initiative. Data are from the 2013 6-month follow-up and 2014 baseline of the Household Financial Survey (HFS). Column percentage totals may not equal 100% due to rounding.

^aIncludes a response choice added to the 2014 HFS: coverage through a spouse, parent, or other family member. Such coverage was coded as reflecting employer-sponsored dependent coverage.

^bIncludes benefits from U.S. Department of Veterans Affairs and other government plans, and student health-insurance plans.

encouraging LMI tax filers to save all or a part of their expected federal tax refunds. The messages are delivered within TurboTax Freedom Edition online tax-preparation software as individuals prepare their tax returns. In the period covered by this brief, the software was offered for free to tax filers who had adjusted gross income of less than \$31,000, qualified for the Earned Income Tax Credit, and/or were an active-duty member of the military with an adjusted gross income of less than \$57,000.

Data for this brief come from Intuit's TurboTax Freedom Edition administrative tax records for the 2013 and 2014 tax seasons and from the Household Financial Survey for those years. Participants in R2S were invited to complete the baseline of the survey after filing their taxes and to complete the follow-up 6 months later. The analytic

samples included 18,585 R2S participants in the 2013 tax season and 9,315 R2S participants in the 2014 tax season. These samples consisted of participants who were at least 18 years of age and for whom both administrative and survey data were available.

Sample Characteristics

Demographic characteristics of the 2013 and 2014 samples are displayed in Table 1. The two samples were very similar, except that 2014 participants had less income and were more likely to list their tax-filing status as single. Participants in 2014 were also more likely to have health insurance.

Types of Health Insurance Coverage

The sampled R2S participants reported several types of health insurance coverage, and employer-sponsored coverage was the most commonly reported type (see Table 2). Both the 2013 and 2014 R2S samples had rates of employer and private, nongroup coverage that were similar to the rates in national estimates,¹² but participants in the R2S samples were less likely to report a form of public insurance and more likely to report being uninsured. About a quarter of R2S participants lacked health insurance.

The ACA and the 2014 Medicaid Expansion

Participants in the 2014 sample were surveyed soon after the January 2014 Medicaid expansion in 25 states yet before the November 2014 opening of state and federal health-insurance exchanges authorized under the ACA. Among 2014 sample members who lived in a Medicaid expansion state, 13% reported receiving Medicaid. Among members who lived in a state that declined or delayed the expansion, only 5% reported receiving Medicaid. The proportion of participants who reported lacking health insurance coverage was lower in Medicaid expansion states than in nonexpansion states (see Figure 1).¹³

Rates of Uninsurance by Group

Across both of the samples, 25% of participants reported lacking health insurance coverage. The average age (36 years) of participants who reported having health insurance was similar to that of participants who reported lacking it (37 years). However, the proportion of those without health insurance varied by other demographic characteristics. For example, rates of uninsurance were higher among African American and Latino participants than among counterparts in other groups (see Table 3), reflecting broader health disparities in the United States.

Access to employer-sponsored health insurance is generally higher among full-time workers in the United States than among part-time ones.¹⁴ Similarly, R2S participants working full time were much less likely to lack health insurance than were part-time, self-employed, and

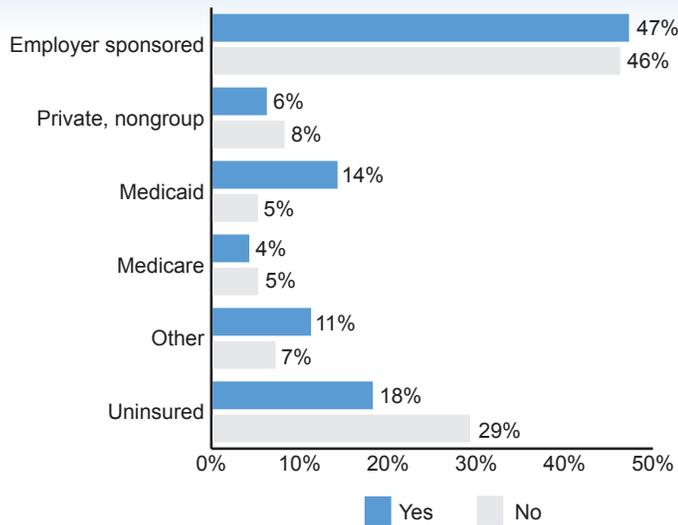


Figure 1. Types of health insurance coverage by state Medicaid expansion status. “Yes” represents participants living in Medicaid expansion states. “No” represents participants living in a state that declined or delayed Medicaid expansion. Employer-sponsored category includes coverage through a spouse, parent, or other family member. Such coverage was coded as reflecting employer-sponsored dependent coverage. Other category includes benefits from U.S. Department of Veterans Affairs and other government plans, and student health-insurance plans. Data are from the 2014 baseline Household Financial Survey ($n = 6,838$).

Table 3. Demographic Characteristics of Uninsured Sample Members

Characteristic	% Uninsured
Gender	
Female	23
Male	27
Race/ethnicity	
White	23
African American	28
Latino	32
Asian American	21
Other	24
Employment status	
Full-time	19
Part-time	34
Self-employed	42
Unemployed ^a	51

Note. Data are pooled from the 2013 and 2014 Household Financial Surveys ($n = 12,575$).

^aUnemployed and looking for work.

unemployed participants. In addition, insured participants (53%) were more likely than uninsured ones (39%) to have a college degree or higher educational attainment.

Financial Characteristics and Circumstances of Insured and Uninsured Participants

Financial Characteristics

Compared with counterparts who lacked health insurance, 2014 R2S participants with health insurance had \$3,119 more in income and \$2,693 more in liquid

assets (see Figure 2). Also, insured participants had \$1,955 less in unsecured debt such as amounts owed on credit card balances.

Medical Debt and Spending

Half (50%) of uninsured participants and 34% of insured ones said that they had outstanding debt from medical care. Medical debt was the major reason for the nearly \$2,000 gap in unsecured debt between insured and uninsured participants. Uninsured participants reported owing \$3,368 in medical debt, and insured participants reported owing \$1,497. Across all other forms of unsecured debt (e.g., credit card balances), the average owed by uninsured participants was only \$134 more than that owed by insured counterparts. To put this differently, medical debt comprised 42% of all unsecured debt owed by uninsured participants but 25% of the unsecured debt owed by insured ones (see Figure 3).

Insured and uninsured participants also differed in their out-of-pocket medical expenses: On average, 2014 participants with insurance spent \$1,786 in 2013 and uninsured ones spent \$1,124 in the same year. The greater spending might have been due to greater medical

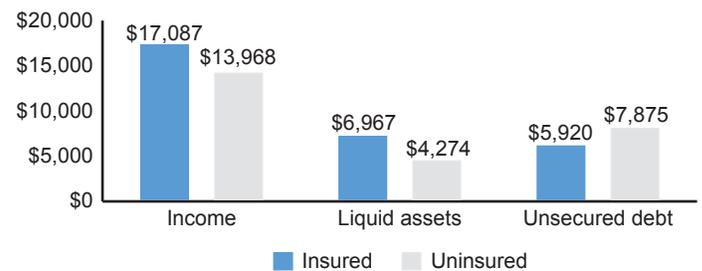


Figure 2. Financial characteristics of insured and uninsured participants. Data are from the 2014 baseline Household Financial Survey ($n = 7,051$).

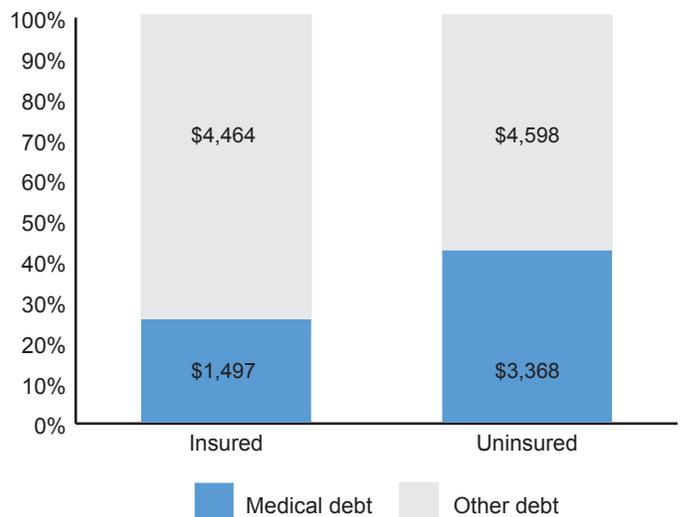


Figure 3. Proportion of medical and other types of unsecured debt by insurance status. Data are from the 2014 baseline Household Financial Survey ($n = 7,051$).

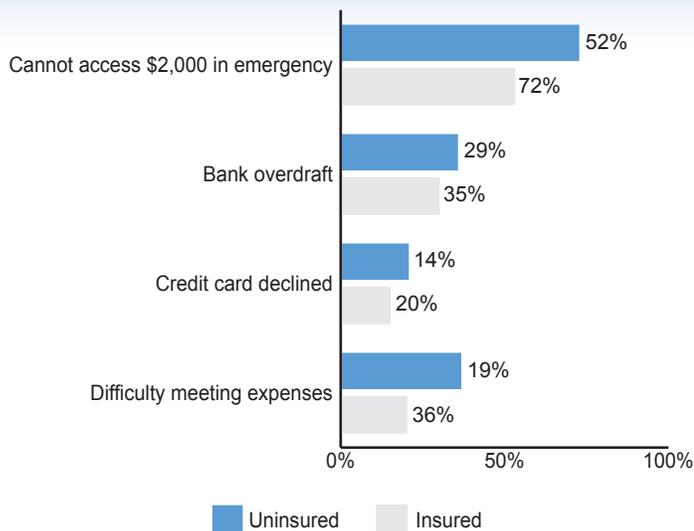


Figure 4. Financial difficulties of participants with and without health insurance (n = 7,050). Data are from the 2014 baseline Household Financial Survey.

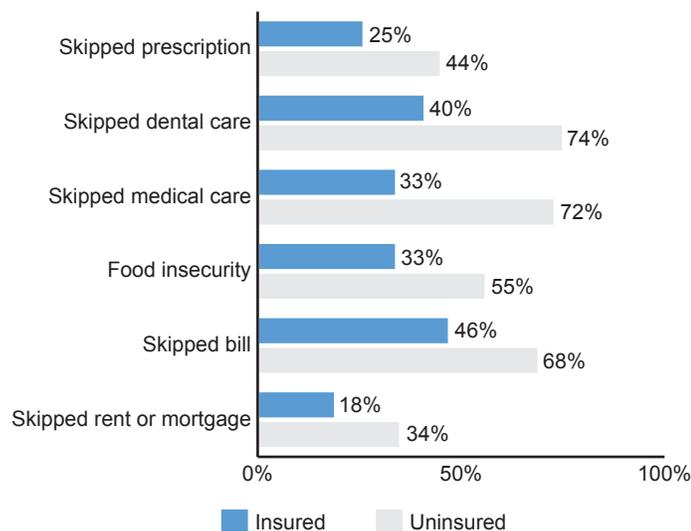


Figure 5. Material hardships of participants with and without health insurance (n = 7,050). Data are from the 2014 baseline Household Financial Survey.

need, yet the two groups were very similar in the rates at which they reported health events requiring a hospital visit in the 6 months after filing their taxes: 22% of insured participants and 21% of uninsured ones reported such an event.

Financial Difficulty

Participants who lacked some form of health insurance were more likely than those with health insurance to report having four financial difficulties: a credit card declined, one or more bank-account overdrafts in the 12 months prior to the survey, difficulty paying for usual expenses, and inability to come up with \$2,000 in an emergency (see Figure 4).

Material Hardship

Participants with and without health insurance differed considerably in the rates at which they reported experiencing material hardships in the 12 months prior to the survey. Uninsured participants were more likely to have experienced all six hardships (see Figure 5).

Reflecting the importance of having health insurance, the largest difference (39 percentage points) between the groups was in the rate at which they reported skipping needed medical care. On average, the likelihood of experiencing any hardship was 25 percentage points higher for uninsured participants.

Conclusion

In this brief, we examine health insurance coverage among two samples of LMI tax filers in the R2S Initiative. We find that R2S participants without health insurance had several disadvantages relative to participants with some form of health coverage. These disadvantages included less income and fewer assets as well as more debt, and greater likelihood of financial difficulty and material hardship.

Our findings concerning unsecured debt and out-of-pocket medical expenses reveal important differences between participants with health insurance and those without it. Medical debt comprised a large proportion of all unsecured debt among uninsured participants. This may impede the ability of participant households to incur other debt, such as credit card debt, in order to meet financial needs when income alone is insufficient. Such a scenario may partially explain why uninsured participants were so much more likely than their insured counterparts to experience material hardships.

Moreover, insured participants spent more out of pocket on medical care and were far less likely to forgo receiving medical care because of its cost. These findings suggest that having health insurance encourages LMI persons to seek care, adding to prior research that identifies a link between coverage and care seeking.¹⁵

One key driver of access to health insurance is employment status. Given the relationship between insurance coverage and use of medical care, employer-sponsored health insurance coverage is an important employee benefit. However, nearly a fifth of R2S participants in the 2013 and 2014 samples worked full time but lacked insurance.

For LMI tax filers who lack employer-sponsored coverage, access to state and federal health insurance exchanges offering subsidized premiums through the ACA is important, especially for individuals living in states like North Carolina, Missouri, and others that have chosen not to expand their Medicaid programs under the act.

The findings in this brief suggest that many LMI households will benefit from expanded health insurance

coverage under the ACA and, despite the expansion, will continue struggling to pay medical bills.¹⁶ Out-of-pocket medical expenses, such as deductibles and coinsurance premiums, may impose particular difficulties. Medical debt continues to pose a risk to LMI households, acting as a drag on the ability of indebted households to save and accumulate assets. If unpaid, such debt will damage credit and can lead to bankruptcy.¹⁷

There are strategies to mitigate the adverse impacts of medical debt on LMI households. First, hospitals and health care systems can make their charity-care policies more accessible to LMI patients who lack insurance or otherwise may have difficulty paying their medical bills. Charity care reduces, but does not eliminate entirely, balances due for services. Thus, it makes eligible recipients less likely to accumulate medical debt. Second, the public-insurance safety net could be strengthened to provide better coverage for catastrophic health events. High-risk insurance pools or expanded Medicaid eligibility could greatly help households whose coverage leaves them responsible for the prohibitively high out-of-pocket costs of very serious illnesses. Third, efforts to purchase and forgive medical debt could go a long way to help LMI households avoid abusive for-profit collections practices. Such an approach has been pioneered by the nonprofit RIP Medical Debt, which pays pennies on the dollar for the debt it acquires.¹⁸

Lack of health insurance is associated with less income and assets, more debt, and greater likelihood of financial difficulty and material hardship. More importantly, being uninsured makes one more likely to skip needed medical care and, thus, may result in poor health outcomes. Universal health coverage is an important policy objective to promote both financial and physical wellness in LMI households.

Acknowledgments

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Disclaimer

Statistical compilations disclosed in this document relate directly to the bona fide research of and public policy

discussions concerning the use of the IRS “split refund” capability and promotion of increased savings in connection with the tax compliance process. All compilations are anonymous and do not disclose cells containing data from fewer than ten tax returns. IRS Reg. 301.7216

End Notes

1. Patient Protection and Affordable Care Act (2010).
2. Kaiser Family Foundation (2016).
3. Kaiser Family Foundation (2015).
4. Card, Dobkin, and Maestas (2008).
5. Sommers, Baicker, and Epstein (2012).
6. Hadley (2003).
7. Kaiser Family Foundation (2015).
8. Hadley (2003).
9. Smith (2009).
10. Lyons and Yilmazer (2005).
11. Smith and Kington (1997).
12. National estimates come from the Kaiser Family Foundation (n.d.) and are based on data from the Census Bureau’s March 2014 and 2015 Current Population Surveys, which asked about health insurance status in 2013 and 2014, respectively.
13. Data were collected in the very early weeks after expansion. Percentages likely differ from what would be observed today as more persons would have the opportunity to apply for Medicaid coverage under expansion plans.
14. Long et al. (2016).
15. Card et al. (2008).
16. Hamel et al. (2016).
17. Jacoby, Sullivan, and Warren (2001); Smith (1999).
18. RIP Medical Debt (2016).

References

- Card, D., Dobkin, C., & Maestas, N. (2008). The impact of nearly universal insurance coverage on health care utilization: Evidence from Medicare. *American Economic Review*, 98(5), 2242-2258. doi:[10.1257/aer.98.5.2242](https://doi.org/10.1257/aer.98.5.2242)
- Hadley, J. (2003). Sicker and poorer—the consequences of being uninsured: A review of the research on the relationship between health insurance, medical care use, health, work, and income. *Medical Care Research and Review*, 60(2, Suppl.), 3S-75S. doi:[10.1177/1077558703254101](https://doi.org/10.1177/1077558703254101)
- Hamel, L., Norton, M., Pollitz, K., Levitt, L., Claxton, G., & Brodie, M. (2016). *The burden of medical debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey* [Report]. Retrieved from Kaiser Family Foundation website: <https://kaiserfamilyfoundation.files.wordpress.com/2016/01/8806-the-burden-of-medical-debt-results-from-the-kaiser-family-foundation-new-york-times-medical-bills-survey.pdf>

Jacoby, M. B., Sullivan, T. A., & Warren, E. (2001). Re-thinking the debates over health care financing: evidence from the bankruptcy courts. *New York University Law Review*, 76(2), 375-418.

Kaiser Family Foundation. (2015). Key facts about the uninsured population. Retrieved from <http://kff.org/uninsured/fact-sheet/key-facts-about-the-uninsured-population/>

Kaiser Family Foundation. (2016). *Health insurance coverage of the total population* (State Health Facts). Retrieved from <http://kff.org/other/state-indicator/total-population/>

Long, M., Rae, M., Claxton, G., & Damico, A. (2016). *Trends in employer-sponsored insurance offer and coverage rates, 1999-2014* (Issue Brief). Retrieved from the Kaiser Family Foundation website <http://files.kff.org/attachment/issue-brief-trends-in-employer-sponsored-insurance-offer-and-coverage-rates-1999-2014-2>

Lyons, A. C., & Yilmazer, T. (2005). Health and financial strain: Evidence from the Survey of Consumer Finances. *Southern Economic Journal*, 71(4), 873-890. doi:[10.2307/20062085](https://doi.org/10.2307/20062085)

Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 (2012).

RIP Medical Debt. (2016). About RIP. Retrieved from <https://www.ripmedicaldebt.org/about-rip/>

Smith, J. P., & Kington, R. (1997). Demographic and economic correlates of health in old age. *Demography*, 34(1), 159-170. doi:[10.2307/2061665](https://doi.org/10.2307/2061665)

Smith, J. P. (1999). Healthy bodies and thick wallets: The dual relation between health and economic status. *Journal of Economic Perspectives*, 13(2), 145-166. doi:[10.1257/jep.13.2.145](https://doi.org/10.1257/jep.13.2.145)

Smith, J. P. (2009). The impact of childhood health on adult labor market outcomes. *Review of Economics and Statistics*, 91(3), 478-489. doi:[10.1162/rest.91.3.478](https://doi.org/10.1162/rest.91.3.478)

Sommers, B. D., Baicker, K., & Epstein, A. M. (2012). Mortality and access to care among adults after state Medicaid expansions. *New England Journal of Medicine*, 367(11), 1025-1034. doi:[10.1056/NEJMs1202099](https://doi.org/10.1056/NEJMs1202099)

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