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 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
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, 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).

**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. Similarly, R2S participants working full time were much less likely to lack health insurance than were part-time, self-employed, and
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
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. 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.

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.

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.

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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).
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.
18. RIP Medical Debt (2016).

References


**Suggested Citation**