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The Role of Health Insurance in the Latinx- White Wealth Gap in the United States

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Abstract

Latinx people have substantially less wealth than non-Latinx, White persons in the United States. One underexplored mechanism behind this wealth gap is healthcare coverage. This study asked: How does healthcare insurance coverage differ between Latinx and White persons, and do such differences help explain the Latinx-White wealth gap? Using the 2014 Survey of Income and Program Participation (SIPP), this study examined how healthcare insurance coverage was associated with net worth and with the probability of having any positive net worth. The analysis had two phases. First, this study conducted a decomposition of wealth differences to assess the extent to which equalizing healthcare insurance coverage would close the Latinx-White wealth gap. Second, given the differential implementation of the Affordable Care Act (ACA) across states, this study leveraged exogenous variation in state adoption to examine the wealth of Latinx and non-Latinx White persons. This study found that 1 in 4 Latinx persons between ages 26 and 62 lacked health insurance. Secondly, this study found that equalizing healthcare insurance coverage would decrease the Latinx- White wealth gap, and that healthcare coverage accounted for more of the wealth gap in the years following the start of the ACA implementation. Specifically, before the ACA's implementation, uninsurance accounted for about 5 percent of the Latinx-white gap in having any positive net worth. This became 8 percent in the waves following the ACA's implementation. Evidence from triple difference-in-difference models shows that the ACA had a higher effect on the continuous wealth of Latinx persons.

Key words: Aging, immigration, public policy, healthcare policy

JEL codes: Z18, J15, I13

1. Introduction

The wealth gap between Latinx individuals and non-Latinx White individuals in the United States is striking. A White household has a median net worth of \$171,000, while the median net worth, usually defined as assets minus liabilities, for Latinx households is about \$20,700 (Bhutta et al. 2020). Racial wealth disparities are due to systemic factors embedded in US society (Oliver & Shapiro 2006, pg. 4). Histories of slavery, disinvestment, redlining, and other forms of disenfranchisement and racism have shaped the wealth gap between Black and White persons in the United States, for instance (Oliver & Shapiro 2006). Related to these inequalities, proximate factors that affect racial and ethnic wealth disparities include educational attainment, occupation, and intergenerational inequality. One underexamined contributor to this wealth gap is healthcare coverage, or the lack thereof. Notable healthcare coverage rate differences exist between non-Latinx White and Latinx persons. Although 7.5 percent of White individuals in the US population lacked health insurance in 2018, 19 percent of Latinx individuals were uninsured (Artiaga et al. 2021).

The racial healthcare coverage gap among Latinxs reflects experiences of racialization, discrimination, and bureaucracy (Vargas 2022). Leading scholars have argued that lack of health insurance is a source of the economic precarity experienced among Latinx in the United States (Vargas 2022). However, less attention has been paid to understanding whether and to what extent differences in healthcare coverage are associated with documented population-level wealth gaps between Latinx and White persons.

Many health-related events influence financial vulnerability. Poor health can be an “asset cost” because it is associated with lower levels of wealth accumulation (Poterba et al. 2011; Richard et al. 2018). Federal health insurance programs such as Medicaid and Medicare mitigate income inequality and leave individuals with more income (Kaestner & Lubotsky 2016). Healthcare-related vulnerabilities are not unlikely to be evenly distributed across racial/ethnic groups. Healthcare costs and expenses are an important force that shapes financial savings behavior (O’Donnell 2019), and health shocks and their associated costs can negatively affect individuals with negative equity, potentially leading to bankruptcy and home foreclosures (Gupta

et al. 2018). As a result, a lack of healthcare coverage or being underinsured can threaten financial security. These costs bear much greater consequence for non-elderly adults, even those who are insured, because of Medicare coverage among older adults (Dobkin et al. 2016). Lower insurance rates and health shocks (e.g., hospitalizations) may be important factors that explain part of the Latinx- White wealth gap.

This study bridged the literature on healthcare coverage inequity with research on wealth inequality by examining the following research questions: 1) To what extent does un-insurance account for the wealth gap between Latinx and non-Latinx, White individuals? 2) How does gaining access to health insurance (via being in an Affordable Care Act expansion state) influence these wealth gaps?

2.Literature Review

Socioeconomic Status, Health, and Healthcare Coverage

The relationship between health and wealth is complex and bidirectional. On the one hand, individuals with poorer health may have fewer opportunities to accumulate wealth compared with healthier persons (for various reasons related to employment, discrimination, etc.). On the other hand, having lower levels of wealth may be a detriment to individuals' health, especially psychological well-being. For instance, previous research has documented that stress caused by lower levels of wealth is associated with psychological distress (Ettman et al. 2020; Yilmazer et al. 2015). This underscores the potential importance of economic precariousness for health status. Yilmazer, Babiarz and Liu (2015) documented that individuals who experienced difficulty paying their mortgage also experienced poorer psychological health. A substantial amount of literature has focused on how socioeconomic resources shape wellbeing, which in turn shape healthcare needs. For instance, wealth has been found to be associated with healthcare-access-related behaviors such as dental visits (Kailembo et al. 2018). Other studies have examined the association between health and wealth, focusing on specific health conditions such as hypertension (López-Cevallos et al. 2018). Some studies have taken racial/ethnic disparities in wealth as the starting point to understanding differences in healthcare access between White and Black persons within the United States (Yearby 2018). Scholarship about the health-wealth link is relevant to research about the associations between healthcare coverage and wealth due to the links between health and healthcare use. People with higher levels of wealth may have had better

health because of their increased access to private and better healthcare coverage (Maskileyson 2014). There is evidence that people who live in areas with lower levels of socioeconomic resources end up having greater hospital utilization and disability rates (Cooper et al. 2012). However, noticeably fewer studies have focused on the relationship between lacking healthcare or being underinsured and how this carries implications for wealth differences between racial/ethnic groups.

Latinxs and Healthcare Coverage Differences

Passed in 2010, the Patient Protection and Affordable Care Act (ACA) substantially reduced income-based gaps in healthcare access in the United States by expanding Medicaid eligibility, increasing consumer protections, and making health insurance a requirement, with some exceptions, among several other changes. However, even after the passage of the ACA, disparities in healthcare coverage among the Latinx population have persisted. Although 7.5 percent of White individuals in the United States were uninsured in 2018, nearly 1 in 5 Latinx individuals were uninsured (Artiaga et al. 2020). Latinx children remain disproportionately under or uninsured even when they are eligible for Medicaid or other health insurance programs (Alvarez Caraveo et al. 2021). Even among adults who are insured, Latinx and Hispanic persons are more likely to experience unstable healthcare insurance than other subgroups, making their experience with the healthcare safety net uniquely volatile (Hernandez-Viver 2020). National-level estimates show that Latinx and Hispanic persons are overrepresented in the populations with unstable healthcare insurance, a.k.a persons who transition in/out of healthcare coverage (Hernandez-Viver 2020).

High un-insurance rates among the Latinx population are concerning for several reasons. First, the Latinx population is a growing and burgeoning population across the United States. It has experienced notable growth in rural America, creating the emergence of new destination areas for immigrants (Lichter 2012). These areas tend to be rural because Latinx immigrants working in agriculture and the meat industries are a growing presence in the Midwest, for example. Although these areas provide employment opportunities, they often have less established community organizations and are more likely to have experienced recent hospital closures compared with urban areas (Kaufman et al. 2016). Accessing healthcare for Latinxs may include a mix of formal and informal care strategies, which may vary depending on geographic context. For example, Raudenbush (2021) found that Latinx immigrants in San

Diego, CA crossed the southern border into Mexico to supplement rather than replace their formal healthcare in the United States. Cervantes, Gomez, and Menjívar (2020) found that Latinx immigrants in Kansas struggled with formal healthcare access if they were undocumented and had language barriers. A commonality across these studies was that Latinx immigrants used remedies outside of the formal healthcare system in the United States, and these alternate remedies often included out-of-pocket costs. Vargas (2022) interviewed Chicagoans after the Affordable Care Act and found that medical debt was a worry, and that lacking health insurance often led Latinx persons to emergency room visits or urgent care center visits that were costly. Lacking health insurance also at times led persons to become burdened with debt. In addition, Latinx immigrants are at greater risk of developing chronic conditions and comorbidities as they stay in the United States for longer periods of time (Engelman & Ye 2019; Flores Morales & Nkimheng 2021).

Latinx Wealth Gaps and Mechanisms Driving Wealth Disparities

Scholars have proposed several explanations for the Latinx- White wealth gap. First, there is variation within Latinx ethnic groups and generational status. For instance, third-generation Mexican Americans still have lower wealth than non-Latinx White persons, but the gap is smaller than the home ownership gap between first- and second-generation Mexican Americans and non-Latinx White persons (Keister et al. 2019). One of the reasons undergirding this trend is lower intergenerational wealth transfers between parents and children of Mexican descent, which means the starting points for wealth accumulation during adulthood differ across racial-ethnic groups (Salgado & Ortiz 2019). Indeed, in the qualitative work on Mexican entrepreneurs and the effects of the Great Recession, entrepreneurs reported starting their businesses with limited or no inherited wealth from parents (Valdez 2019). Another mechanism that may limit wealth is remittance behavior, which is when immigrants send money to social ties in their countries of origin, particularly among first-generation Latinx immigrants (Akresh 2011). Discrimination is one other factor that can explain racial and ethnic differences in wealth building in the US (Akresh 2011). For instance, racial/ethnic minorities' access to safe wealth building mechanisms such as access to credit are not usually available in low-income neighborhoods and ethnic enclaves.

Wealth serves as a private social insurance mechanism for households. For instance, using the SIPP, Rodems and Pfeffer (2021) showed that among households with more wealth,

the association between disruptive events (e.g., job loss) and material hardship was weaker. Thus, examining the association between healthcare access and coverage and wealth among Latinx and non-Latinx White persons helps identify the social factors that influence the levels of wealth that families and households have and are able to maintain.

3. Study Aims and Hypotheses

Aims

This study made several contributions to the study of wealth inequality, healthcare policy, and racialization. First, it contributed to a burgeoning literature about the sources of inequality in economic resources in the United States. Second, it expanded the scholarly understanding regarding the heterogeneous effects of the Affordable Care Act. Systemic barriers to healthcare coverage are important drivers of the persistent wealth gap in the United States. Third, this study provided a broader descriptive portrait of healthcare coverage rates and wealth in states that expanded and did not expand Medicaid following the passage of the Affordable Care Act. The date of implementation varied by state, as did whether a state adopted the ACA. This study leveraged this variation in expansion.

Hypotheses

1. Wealth gaps between Latinx and White persons will be partially explained by healthcare coverage differences.
2. The wealth of White persons in expansion states will be higher than the wealth of Latinx persons in expansion states.
3. Latinx persons in non-expansion states will be most disadvantaged in terms of both healthcare coverage and in wealth levels.

4. Data and Methods

Data

This study used multiple cross sections of data from the Survey of Income and Program Participation (SIPP). The SIPP is a rotating-panel household survey that has been conducted by the U.S. Census Bureau since 1984. This study focused on the 2014 SIPP, which experienced some design changes from previous SIPP panels. The 2014 SIPP was a panel that consisted of about 53,070 living quarters sampled, 29,825 households interviewed, and 67,994 person

interviews. The response rate was over 70 percent. The SIPP's sampling approach was a multistage stratified sample of housing units within the United States. The data used in this study focused on a pool of Wave 1-4 data spanning over 48 consecutive months. Only persons who participated in all waves were included in the analysis.

Dependent Variables

Two variables were used to assess wealth. The first was a measure of continuous net worth, in dollars. This measure described a person's household net wealth (total assets minus total liabilities) using data from respondents' reports about their assets, including having Individual Retirement Accounts (IRAs) and the value of checking accounts, other accounts, bonds, savings bonds, stocks and mutual funds, business equity, other assets, 401k accounts, vehicles, other retirement accounts, primary residence and other properties, and liabilities, including mortgages, rental property debt, credit cards, vehicle debt, and residual debt. The second measure was a dichotomous indicator of whether a person had any positive household net worth.

Independent Variables

The independent variable was a constructed variable in the public-use SIPP files indicating health insurance coverage any time during the reference period. The detailed measures used to inform this measure included a 12-month reference of whether the person had public (Medicare and Medicaid) or other health insurance coverage (military coverage, private insurance, any other coverage). The race/ethnicity variable was based on two survey questions. The first question prompted respondents to indicate: "What race(s) does ... consider herself/himself to be?" Possible answers included: White only, Black only, Asian only, or other. The second variable used was based on this question: "Is ... Spanish, Hispanic, or Latino?" Based on these two survey questions, the race/ethnic category was coded as: non-Latinx white and Latinx.

Covariates

Parsimonious models included basic demographic control variables including age, household size, marital status, and education. Because one of the main purposes of this study was to describe trends, a parsimonious model was preferred. One proxy for socioeconomic status, education, was included in the model. Given that employment status is directly correlated with opportunities to have healthcare, we decided not to include occupation and income in the model.

Analysis

This study answered the above research questions using descriptive statistics, decomposition analyses, and triple differences analysis. An Oaxaca-Blinder decomposition approach was used to assess the contributions of having been uninsured and having had hospitalizations to differentials in wealth between White and Latinx households. This decomposition model yielded the magnitude of mean differences in wealth, which was decomposed into observed and unobserved components. The decomposition provided the amount by which wealth would change if the levels or distributions of the independent variables (un-insurance and hospitalizations) of interest were the same across the two comparison groups. Oaxaca-Blinder decompositions approximate the extent to which the wealth gap would be closed if two racial-ethnic groups had similar distributions of being uninsured. Decomposition has been used previously to analyze racial disparities in wages, wealth, and health. Decompositions were conducted in two periods, reflecting years before and after the ACA (period 1 corresponded with Wave 1; the second period reflected Waves 2-4).

In addition to the period-level decompositions, triple difference models were run to assess the specific effect of the healthcare coverage passage (an exogenous shock) on wealth of Latinxs specifically. The data to construct the policy-level variable used in the triple difference analyses was from the Kaiser Family Foundation.

**Table 1. Unweighted Descriptive Statistics, Survey of Income and Program Participation
2014 Wave 1 Sample of Adults 18 Years Old and Older.**

	Mean or proportion		
	Full sample	White (non- Latinx or Hispanic)	Latinx/Hispanic identifying
Mean	163,998.40	214,103.10	57,017.63
Median	17,540	42,385	1,440
<i>Household Wealth, net worth</i>	338,004.80	426,714.70	155,655.60
	75,980.00	125,095.00	16,380.00
<i>Sociodemographic background characteristics</i>			
Age	47.25 (18.59)	49.44 (18.81)	41.05 (16.54)
<i>Education</i>			
< High school	14.07%	9.44%	32.97%
High school diploma	30.99%	31.03%	30.55%
Some college	21.12%	21.53%	18.34%
College degree or higher	33.81%	38.00%	18.14%
Married	78.51%	77.53%	83.36%
US born	84.78%	95.47%	48.88%
Men	47.39%	48.20%	46.53%

Household size			
N	~60,000	~36,091	~8,058

5. Results

Descriptive Statistics of the Wealth and Un-insurance Trends Among Latins and non-Latinx White Persons

Table 1 shows the summary statistics including average household net worth, health insurance coverage, age, household size, and an indicator of positive net worth among persons in Waves 1-4 of the 2014 SIPP panel. In the entire sample, the average household net worth was 232,970 dollars (s.e.: 14,275). This figure was 285,520 (s.e.: 20,236) among White and 119,041 (s.e.: 31,376) among Latinx persons.

Decomposition of Wealth

Tables 3 and 4 show results from decomposition analyses. Separate decompositions were run for the period before and after ACA implementation. One set of decompositions focused on only Wave 1 data. The second set of decompositions focused on aggregate data from Waves 2-4. These two time periods show before and after the ACA adoption. As shown in Table 3, the difference in wealth (inverse hyperbolic sine transformed wealth) between Latinx and White that was being decomposed was 2.64 (s.e.: 0.27). This model was parsimonious and only included household size, age, marital status, and education as control variables.

Results from the decomposition indicate the amount by which the wealth gap would decrease if the two groups under analysis would have similar levels of any covariate in the model. In this case, if Latinx and White persons had commensurate levels of health un-insurance, the wealth gap among those with positive levels of wealth would decrease by 0.07 or by about 2.74 percent.

Results in Table 4 decomposed a wealth gap of 2.44 (*s.e.*: 0.19). If White and Latinx persons had similar levels of healthcare un-insurance, then the wealth gap would reduce by about 4.8 percent. These results suggest that the levels of being uninsured had a higher level of influence on the wealth gap after the ACA.

Table 5 shows the results from the decomposition of the differences in the proportion of persons with any positive net worth in Wave 1. The specific difference decomposed was a 12 percentage point gap in having any positive net worth in the Wave 1 observations. Although the estimates were small in size, the healthcare insurance variable accounted for 5.04 percent of the difference in having any positive wealth.

Table 6 shows results from the decomposition of the differences in the proportion of persons with any positive net worth in Waves 2-4. The specific difference decomposed was the 0.11 gap (in terms of proportions) in having any positive net worth. The healthcare insurance variable accounted for 8.7 percent of the difference in having any positive wealth.

Triple Differences Results of the Effect of the ACA Passage Across States

Table 2 shows summary statistics in expansion states and non-expansion states. Panel A shows results for all the states across the panel years in the SIPP. Panel B shows descriptive statistics for the expansion state-year observations and Panel C shows non-expansion state-year observations. Overall, the healthcare uninsurance rate across the population was 10.47 percent. Among White persons, the healthcare uninsurance rate was 7.23 percent and among Latinx persons it was 24.53 percent. This means that about 1 in 4 Latinx persons between ages 26 and 62 lacked health insurance. In states that did expand Medicaid, the overall healthcare uninsurance rate was 6.19 percent. It was about 4 percent for White persons and 16 percent among Latinx persons. In states that did not expand, these figures were 12.47 percent, 8.77 percent, and 30 percent, respectively. These results indicate deep disparities in non-expansion states, and they also show that even in expansion states, Latinx persons continued to be underinsured.

Table 2. Descriptive Statistics of Key Variables in SIPP 2014 Panel by Expansion State, Weighted Results.

<i>Panel A</i>	ALL	White	Latinx
No health insurance	10.47%	7.23%	24.53%

Age, mean	44.20	45.08	42.05
Age, standard deviation (SD)	0.03	0.05	0.14
Household size	3.06	2.83	3.88
	0.02	0.02	0.06
Net worth IHS transformed	10.54	11.31	8.75
	0.04	0.04	0.11
Has any wealth +	77.74%	81.79%	71.00%

Panel B

Expansion States

	ALL	White	Latinx
No health insurance	6.19%	4.01%	16.29%
Age, mean	44.20	45.07	42.02
Age, SD	0.08	0.12	0.25
Household size	3.12	2.86	4.01
	0.03	0.03	0.09
Net worth IHS transformed	10.70	11.43	8.72
	0.05	0.04	0.16
Has any wealth +	78.02%	81.93%	70.41%

Non-Expansion States

Panel C

	ALL	White	Latinx
No health insurance	12.47%	8.77%	29.99%
Age, mean	44.30	45.17	42.41
Age, SD	0.12	0.17	0.34
Household size	3.04	2.85	3.78
	0.03	0.03	0.07
Net worth IHS transformed	10.33	11.14	8.95
	0.06	0.07	0.15
Has any wealth +	78.35%	82.47%	73.74%

Table 3. Wave 1 Decomposition of the Inverse Hyperbolic Sine Transformation of Net Worth, SIPP 2014 Panel.

Panel A: Overall	Beta	P-value	95 % Confidence Interval		
White	7.86 0.12	0.00	7.63	8.09	
Latinx	5.21 0.24	0.00	4.74	5.69	
Difference	2.64 0.27	0.00	2.11	3.17	
Endowments	0.76 0.21	0.00	0.35	1.16	
Coefficients	0.57 0.29	0.05	0.01	1.14	
Interaction	1.31 0.22	0.00	0.87	1.75	
Panel B: Endowments	Beta	P-value	95 % Confidence Interval		% of Difference Explained
Age	0.32 0.07	0.00	0.18	0.46	12.18%
No healthcare insurance	0.07 0.09	0.45	-0.11	0.26	2.74%
Household size	0.12 0.16	0.43	-0.18	0.43	4.68%
Marital status	0.09 0.04	0.03	0.01	0.18	3.57%
Education	0.14 0.16	0.35	-0.16	0.45	5.48%
N = 115,868					

Table 4. Waves 2-4, Decomposition of the Inverse Hyperbolic Sine Transformation of Net Worth, SIPP 2014.

Overall	Beta	P-value	95 % Confidence Interval	
White	8.46	0.00	8.27	8.66
<i>standard error</i>	0.10			
Latinx	6.02	0.00	5.68	6.36
	0.17			
Difference	2.44	0.00	2.06	2.83
	0.19			
Endowments	0.65	0.00	0.36	0.94
	0.15			
Coefficients	0.68	0.00	0.24	1.11
	0.22			
Interaction	1.12	0.00	0.76	1.47
	0.18			

Panel B: Endowments	Beta	P-value	95 % Confidence Interval		% of Difference Explained
Age	0.26	0.00	0.15	0.37	10.79%
	0.06				
No healthcare insurance	0.12	0.03	0.02	0.22	4.80%
	0.05				
Household size	0.01	0.92	-0.18	0.19	0.39%
	0.09				
Marital status	0.07	0.02	0.01	0.14	3.03%
	0.03				
Education	0.19	0.12	-0.05	0.42	7.70%
	0.12				

N = 115,868

Table 7 shows results from the triple-difference models. Estimates in this table indicate whether the ACA had a different impact for Latinxs on two measures of wealth, any positive wealth shown in Model 1, and an inverse hyperbolic sine transformation of net worth in Model 2. The full saturated models with all the interaction terms included are in Table 7. The term of interest is the “Post-ACA X Expansion X Latinx” term. The results suggest that the ACA

expansion increased the net worth among Latinx persons in expansion states (Model 2), but the effect did not differ for the probability of having any positive net worth (Model 1). Results from these two models underscore the importance of examining the effects of the ACA on both continuous and binary indicators of wealth, and the importance of examining these impacts across racial/ethnic groups.

Table 5. Wave 1, Decomposition of the Probability of Having any Positive Net Worth, SIPP 2014.

Panel A: Overall	Beta	P- value	95 % Confidence Interval		
White	0.81 0.01	0.00	0.80	0.82	
Latinx	0.69 0.01	0.00	0.66	0.72	
Difference	0.12 0.01	0.00	0.09	0.15	
Endowments	0.05 0.01	0.00	0.03	0.07	
Coefficients	0.03 0.02	0.04	0.00	0.06	
Interaction	0.04 0.01	0.01	0.01	0.06	
Panel B: Endowments	Beta	P- value	95 % Confidence Interval		% of Difference Explained
Age	0.01 0.00	0.00	0.01	0.02	11.09%
No healthcare insurance	0.01 0.01	0.28	0.00	0.02	5.04%
Household size	0.01 0.01	0.25	-0.01	0.03	9.36%
Marital status	0.01 0.00	0.02	0.00	0.01	5.33%
Education	0.01 0.01	0.10	0.00	0.03	11.75%
N = 115,868					

Table 6. Waves 2-4, Decomposition of the Probability of Having any Positive Net Worth, SIPP 2014.

Panel A: Overall	Beta	P- value	95 % Confidence Interval		
White	0.83 0.00	0.00	0.82	0.84	
Latinx	0.73 0.01	0.00	0.71	0.75	
Difference	0.11 0.01	0.00	0.08	0.13	
Endowments	0.04 0.01	0.00	0.03	0.06	
Coefficients	0.04 0.01	0.00	0.01	0.06	
Interaction	0.02 0.01	0.01	0.01	0.04	
Panel B: Endowments	Beta	P- value	95 % Confidence Interval		% of Difference Explained
Age	0.01 0.00	0.00	0.00	0.01	8.20%
No healthcare insurance	0.01 0.00	0.01	0.00	0.02	8.70%
Household size	0.01 0.01	0.26	0.00	0.02	5.87%
Marital status	0.00 0.00	0.02	0.00	0.01	4.45%
Education	0.02 0.01	0.02	0.00	0.03	14.42%
N = 115,868					

Table 7. Triple Diff-in-Diff Model Estimates with any Positive Net Worth and Inverse Hyperbolic Sine Transformed Wealth.

	Model 1 Any positive wealth		Model 2 IHS transformed wealth	
	Coefficient	P-value	Coefficient	P-value
Post-ACA	0.01	0.41	0.13	0.00
	0.01		0.04	
Expansion state	0.00	0.69	0.31	0.00
	0.01		0.06	
Post-ACA X Expansion	0.00	0.64	-0.03	0.47
	0.01		0.05	
Latinx	-0.02	0.30	-0.45	0.00
	0.02		0.11	
Post-ACA X Latinx	-0.02	0.30	-0.13	0.19
	0.02		0.10	
Expansion state X Latinx	-0.05	0.06	-0.58	0.00
	0.03		0.15	
Post-ACA X Expansion X Latinx	0.04	0.14	0.28	0.04
	0.03		0.13	
Marital status				
married, spouse absent	-0.11	0.00	-0.70	0.00
	0.02		0.18	
Widowed	-0.06	0.01	-0.08	0.62
	0.02		0.16	
Divorced	-0.09	0.00	-0.43	0.00
	0.01		0.06	
Separated	-0.21	0.00	-1.07	0.00
	0.02		0.19	
Married	-0.18	0.00	-1.28	0.00
	0.01		0.06	

Education				
High School	0.09	0.00	0.80	0.00
	0.01		0.08	
Some college	0.07	0.00	1.13	0.00
	0.01		0.09	
College degree or higher	0.13	0.00	2.12	0.00
	0.01		0.08	
Constant	0.75	0.00	10.18	0.00
	0.01		0.09	

6. Discussion

Motivated by the striking differences in wealth and in healthcare coverage between Latinx and white non-Latinx persons in the United States, this study filled gaps in knowledge about how healthcare coverage relates to net worth. Using data from the Survey of Income Program and Participation 2014 longitudinal panel, this study presents new findings on the differences in the probability of having positive net worth by Latinx status, and on the effect of the ACA on two measures of wealth.

This study offered three key results. First, this study found that Latinx persons in non-expansion states have high levels of being uninsured. In non-expansion states, the uninsured rate was nearly 30 percent among Latinx persons and about 9 percent among White persons. Second, this study found that in Wave 1, prior to most states' implementation of the Affordable Care Act, healthcare insurance coverage explained less than 3 percent of the gap in net worth. This slightly increased to about 5 percent in the waves following the implementation of the ACA in some states. However, the coefficients were not statistically significant between the two time periods. Third, this study found that the ACA had a particularly notable impact on the net worth of Latinx persons.

This study helps us better understand how health insurance shapes the financial security of households known to be in socially vulnerable positions in US society. It holds implications for the Social Security Administration since lifecycle events such as lapses in health insurance and health shocks drive private savings decisions that then change the experiences and needs of beneficiaries when they reach retirement age. Lack of health insurance can stall retirement

investments and deprive individuals of savings in the future. Health shocks also likely affect employment directly as well as wages.

This study had several limitations. First, testing parallel trends was difficult with the current data set, as there are limited data for the chosen panel in many years before the ACA implementation. Second, it is important to note that wealth accumulates over decades. Thus, there may not always be immediate effects on wealth levels. Future researchers ought to continue to keep an eye on the long-term effects of policies such as the ACA.

Despite its limitations, this study offers several contributions to existing scholarship. The wealth gap between Latinx individuals and non-Latinx White individuals in the United States is striking. Lack of health insurance coverage as well as health emergencies may threaten a person's savings and financial security. Given that the Latinx population has relatively high rates of being uninsured, lower levels of wealth, and a high chronic health burden, this study advances the sociological knowledge related to factors that influence wealth inequality.

7. Conclusions

This study matters for several reasons. First, if the instability of healthcare contributes to individuals' financial security and preparedness for financial retirement resources, then knowing the extent to which unstable healthcare affects individual savings behavior becomes important, as it may be an underlying factor for applying to Supplemental Security Income (SSI) and federal programs. If stable health insurance promotes financial wealth building, then this might be a policy lever that may prevent future need for extra governmental support in older age. Moreover, given research that shows that Latinx immigrants may be more likely to experience unstable healthcare insurance (Reyes & Hardy 2015), this study expands knowledge about which racial/ethnic groups/immigrant groups this effect may be most extreme upon.

Medical expenses due to the lack of health insurance may also threaten intergenerational wealth building among the adult children of older adults. Latinx individuals represent a growing aging population. They are also a population with more unstable health insurance coverage compared with other racial/ethnic groups. Thus, this study offers novel knowledge about one set of health-related factors that may influence the wealth of an emerging aging population. Future studies may wish to examine the specific medical debt of Latinx persons before and after the ACA, and in expansion versus non-expansion states.

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