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P R O C E E D I N G S

MR. KLEIN: Good afternoon. I'm Aaron Klein, a senior fellow in Economic Studies at the Brookings Institution, and I'm very thrilled to welcome everyone here virtually today to discuss an amazingly important topic about how people make health care decisions in the face of income volatility.

We're going to be joined by Dr. Mina Addo and Dr. Lisa Servon, whom I will introduce in a moment. We're going to show some of their groundbreaking new research in terms of talking to individuals during and through the COVID pandemic and experience to see how changes in their income volatility have impacted their health care choices and, importantly, analyzing whether new financial technology, or fintech, has the ability to solve some of these problems.

As we start, I would like to thank and acknowledge the Robert Wood Johnson Foundation as well as the Filene Research Institute, both of whom have helped to make this project and research come together. And I'd like to give a little bit of a peek behind the curtain to the audience that when we started this conversation, none of us, I believe, had heard of SARS-2 or COVID-19 or had thought at all about the upcoming pandemic that would be a defining moment not just for the year, but, frankly, for our generation and for the world's lifetime. We were simply exploring a set of known phenomenon that I don't think people have really connected the dots.

One, income volatility is rising. And this is a function not just for people living paycheck to paycheck, but higher up the income stream. Or put a different way, middle-class people are living paycheck to paycheck. This is not a phenomenon for the lower-income individuals.

Two, most information out there simply assumes people's annual income or monthly income and they smooth it. When in point of fact, everybody who lives in the real world knows income is highly volatile. People are cobbing together multiple income sources and simply looking at average annual earnings tells relatively little in terms of how people are managing their life day to day. People who have very high financial cost to access their funds, the less money you have. Free checking is a phenomenon for the wealthy.

And the final point is health care is expensive and uncertain. And so families are looking at rising income volatility, rising uncertainty about costs, and uncertainty about income. At the same time, there's an ushering wave of new technologies, so much so that the two words of finance and tech have

been sandwiched together into the acronym and hashtag “fintech.” And I would encourage everybody to engage and ask questions on this in the hashtag, #FinHealth. Because we’re trying to turn this conversation and ask the question what of this technology can we have or reasonably expect to allow people to make different health choices? Or, perhaps more concerningly, will some of this technology that’s available and out there for financial technology make people worse off?

Change is inherently neither good nor bad. It just means it’s different. And this research today that we’re going to get is going to show how real people are interacting through the pandemic and before with the options presented to them in the face of these growing uncertainties.

Without any further thought, let me introduce Dr. Mina Addo is a new Ph.D. from the University of Pennsylvania. Dr. Lisa Servon is the former dean of the New School, a professor of design at the University of Pennsylvania. They conducted their research and we’re thrilled at Brookings to welcome both of you here today to talk about your findings. And then we’ll be joined later by others to chime in and respond.

So, with that, Mina, will you take us away?

DR. ADDO: Hi, Aaron. Thank you very much. And Lisa’s going to get us started, but I will put up the slides to kick us off.

DR. SERVON: Thanks, Mina. And thanks, Aaron. Yes, I’m going to take you away. We’re super excited to be here today and grateful to all of you for coming.

We’re going to talk, as Aaron said, about this research that we’ve been engaged in over the past year or so about income volatility and health care decision making. And we’re going to talk for a relatively short amount of time, less than 15 minutes, and then have a robust conversation. And so we’re really looking forward to that and hearing your thoughts, as well.

So, Mina, can you go to the next slide? So, we want to start by thanking the Brookings Institution for engaging us to do this work and the Filene Research Center, which also provided funding and support and also, and really importantly, engaging with us throughout the process of conducting the research and writing up our findings. We had a great authors’ conference earlier, a couple of months ago, where we got terrific feedback.

And we’re also grateful to SaverLife, a nonprofit organization that helps people build

financial security, for collaborating with us. All of the participants in this research are members of SaverLife.

And finally, we are super appreciative of all of the participants in this work, who shared their stories and their struggles with us. Let's go to the next slide.

So, just to give you a little preview about what we'll talk about today, I will start with talking about the background and the research questions. And then I'll hand things over to Mina to tell you about our findings and discuss the implications of the work. Next slide.

So, let me talk a little bit to ground you in the context about what drove us to ask the questions that we asked and to do this work? Mina and I were really curious about how declining economic security was landing on middle-income families and specifically what the impact is on their health care decision making. And in part, our curiosity grew out of earlier research we did on people's use of payday loans.

One of our big takeaways from that work was that a significant number of payday loan users had what we considered to be unexpected profiles. Counter to our expectations, many of these borrowers had graduated from college, owned their homes, and had seemingly solid annual incomes, $50, $60, $70,000. That was not what we thought. That's not what the media portrays as sort of the typical user of alternative financial services. And so our earlier work revealed that many Americans who have the attributes that we associate with being part of the middle class are actually financially precarious.

So, declining economic security arises from several trends that were set in motion in the 1970s and 1980s: stagnant wages, either declining or stagnant; the erosion of benefits from private sector employers, what Jacob Hacker calls "The Great Risk Shift," and rising costs. Housing, child care, health care, and education are all a part of the story. Next slide.

The trend that we were most interested in looking at in the research that we're presenting today and that accompanies the ones that I talked about on the previous slide is rising income volatility. Over the past year, we asked people, in terms of defining income volatility, we asked them over the past year did your income vary often or sometimes? And that's a question that's used by the Federal Reserve's Household Well-Being Survey, so that's how we defined economic income volatility for the

purposes of this research. There's other sources, other studies that looked at whether people's income increased or decreased 25% or more from their monthly average.

But basically, the data on the slide documents how rising income volatility affects families. So, we know that an ability to plan is essential for achieving financial health. Right? We think of it as being able to spend, save, borrow, and plan. It's impossible to plan if you're not sure how much money is coming into your household from month to month and sometimes even from week to week. Financial services jobs often think about budgeting on a monthly level, but we know that income varies even within months. And so the rise in income volatility has really injected unpredictability into people's budgeting struggles. Next slide.

Medical expenses are sometimes hard to predict, too. We know from quantitative research that Americans do not have the support they need to cope with medical expenses. For example, as this slide shows, 60% of all Americans have a chronic illness and more than a third have trouble paying those bills. And the result is that many people are not getting the care they need. They're either delaying or skipping treatment because they simply can't afford it or sometimes because they're not even sure whether their insurance will cover it.

So, we wanted to better understand the interaction between income volatility and people's health care choices. And we wanted to understand it from a more granular perspective than the existing research provides. So, we conducted 33 in-depth interviews with working-age adults in order to have them tell us how they manage the dual challenges of income volatility and health care expenses in their own words and to get those stories that really start to put the flesh on the bones of the data that we already have.

So, let's go to the next slide and I'll introduce the research questions that we set out to examine. We wanted to know, first, what are the characteristics of households experiencing income volatility and recurring medical expenses? We wanted to know how people pay for care. What are their strategies?

We did want to know, also, to what extent do people use technology or, as Aaron said, fintech to meet their needs. And our sort of hidden/not so hidden agenda in that research question was to understand whether there was a larger role that fintech might play that we could start to eliminate.

And finally, we wanted to understand what role income volatility played in the health care decisions of the people that we interviewed.

And so now I'm going to turn it over to Mina, who's going to give you the exciting findings. I'm the set-up person, she is the deliverer.

DR. ADDO: Thank you very much, Lisa. And good afternoon, everybody.

So, as a starting place I'll talk to you about the study population. So, as Lisa mentioned, 33 in-depth interviews. And you can see here that we had a sample that was overwhelmingly female, about 80% female; highly educated, more than half had at least a four-year bachelor's degree as their highest level of education; and it was a racially diverse population, so about 70% of folks were non-white.

In terms of income, median household income was $60,000. And importantly, in terms of health insurance, nearly 90% had health insurance, including almost three-quarters had employer-sponsored plans, which are often considered to be, you know, better quality plans that offer, you know, good coverage.

So, one of the big surprises from this research was understanding the reasons that people's income was changing. And thinking about the idea for the study and where we started, what we thought we might see was that people had a mismatch between when they had some type of medical expense and when they had their income change. But the volatility was more complex than that.

So, first, we saw people having income volatility because they had multiple jobs. They were not able with a primary job to afford their expenses. And this was the case in households with two adults who worked full time. At least one of them would also need a part-time job or they would also be doing some form of gig work in order to afford their expenses. That was the same for people who had hourly jobs, but worked full time in those hourly jobs.

We did also have some people who were independent contractors. And for those folks income was changing either because they had periods where they were not working in between contracts or it could be the case that they had different payment rates on different types of work that they were doing or different projects they were doing.

In terms of hourly work, again folks who worked hourly could have their hours increase or decrease, and that made it difficult to plan.

And then we had some folks who experienced a financial shock, either an illness or a job loss tended to be the type of shocks that came up.

So, as Aaron and Lisa touched on, we wanted to explore the extent to which fintech was a solution for folks. And, you know, this slide sort of outlines the main themes that we heard in terms of how people are using fintech. And overall, people really valued fintech that could simplify their financial transactions, so paying bills, helping them track spending, that type of thing.

People also valued fintech when it could help them sort of see all of their information in one place. So, let's say you have a checking account and you also have a savings account and credit card, having the ability to see all of those in one place was really helpful just so that you could see what position you were in.

And then we had a few people who talked about tracking their credit score, budgeting, those types of things. And perhaps most relevant here, people talked about decision making support. So, there is a fintech app that helps people select a retirement plan. So, you put in information about your demographics and your goals, and it will help you identify a plant that is going to serve you best.

I will say that, you know, people did not see fintech as a direct solution to the challenges they were having. It was more a useful tool. And in the paper we go into more detail about some of the solutions that are out there. But, again, I would say the headline is fintech didn't really seem to be a robust solution for this population.

So, turning to the issue of health care and how people are managing, what we found is that, for the most part, people could manage primary care. So, they were able to afford going to the doctor for routine care, preventive-type visits, using their insurance and affording the co-pays. But when it got into what we've called non-primary care, things were challenging. And on the slide here I've listed the most common health conditions that people raised that were challenging for them to afford.

I won't go through all of them, but just to highlight a few, in terms of dental care, this often was not covered at all as part of people's plans or there was perhaps a limit to the amount of coverage that was available, like an annual dollar limit.

In terms of physical therapy, people talked about the co-pays for physical therapy being more expensive than for primary care. So, just to give a comparison, physical therapy co-pays were

around $50 compared to, say, $20 or $30 for visiting a primary care doctor. And with physical therapy, the other issue is that people require multiple visits. So, if you're having some type of condition, you typically would be seeing your physical therapist, you know, multiple times a week until that condition is managed. And so you can see how that would add up over time.

Another thing that came up was, of course, diagnostic tests. Those can be quite expensive and there's an issue of transparency, as well, with people not being able to anticipate costs.

And then, you know, injury or serious medical incidents. Health care is just expensive and even with the best care you're going to be paying for some portion of that care as the consumer.

So, turning to how people are paying for care, I'll highlight a few of the strategies that came up. So, people talked about using health savings accounts, and these are paired with high-deductible health plans. And high-deductible health plans are attractive because the premiums tend to be lower, but that means that folks are paying for most of their care until they reach that deductible.

Now, this did work well for some people, typically when they could anticipate expenses and when they earned enough so that they were able to actually put some money aside each month. So, I have a quote here from a woman named Elaine and she talked about how she and her husband both knew that they would need some dental care, so they set up an HSA and they saved towards that so that they were able to afford crowns when they needed them.

We had a lot of folks talking about delaying or skipping care. And there were sort of two primary reasons why this happened. So, I touched on this earlier, but an issue of transparency. I have a quote here from a gentleman named Clark, so he's a young man in his 30s, generally pretty healthy. But what he talked about is that, you know, he has at times experienced a health problem, wasn't feeling well, decided, you know, he's not going to go and get that checked out because he couldn't anticipate what it would cost and had concerns about then later facing a costly medical bill.

Another reason why people delayed or skipped care is, again, the cost or just really feeling like it was not accessible based on that cost. So, I have an example here of a young woman named Mercedes, who has diabetes and she goes to see her physician regularly. Every three months she goes in and the doctor checks her blood sugar. But in between those visits Mercedes is not able to check her blood sugar because the test strips and the machine that does the readings, those are

unaffordable. And, you know, people have various severity of illness and such and may need to test different times a day. And so over time, again, the equipment really adds up for people. And in this case, she really deemed it unaffordable even though she had mentioned she would have liked to be able to track her blood sugar herself.

So, what we're really seeing is that health insurance coverage is influencing people's decision making. So, people are prioritizing and getting the treatments that are covered and they're treating as optional things that are not covered or things that they deem are expensive.

I have a quote here from a young woman named Mia, who had taken a health supplement and it caused her to have a skin reaction. And she ended up just saying, you know, I'm just going to stop taking the supplement and not going to go see a dermatologist and kind of hope that it clears up. And, you know, in her words, she sort of said, you know, there are things that are nice to have, and she identified them as nice to have based on the cost, and that was really the decision point for her in terms of why she opted to not seek a dermatologist's care.

And in the paper we have examples of different types of care where people made this same decision. You know, mental health is another one that came up a few times in interviews.

So, thinking about the main themes or sort of takeaways from this research, you know, when people are delaying or skipping care, there implications both for their finances and health. If you are delaying care and your condition worsens, it becomes much more costly to treat later and that can be burdensome financially. And in terms of health, individuals are experiencing poor health and you're thinking about quality of life that comes with not feeling well and feeling like you can't afford to go and seek treatment.

I didn't touch on this much here, but we had people using credit or other forms of borrowing in order to pay for care. Again, that worked well for some people, not as well for others. But as with any type of credit, there are implications for finances if you're not able to pay that balance off quickly and you're incurring a lot of interest.

The high-deductible health plans and HSAs tended to work well for people who could anticipate their health care costs, had the ability to save and really plan. But for those who ended up having a high deductible that they didn't reach, they really just ended up paying for most of their care

throughout the year.

And I will point out one other thing we observed with the high-deductible plans and HSAs. We saw there was a period of learning. So, some people would in one year incur high medical expenses and then sort of adjust. In the next year they would say, okay, well, last year I had these expenses. I'm going to plan this year. I'm going to put some money aside using an HSA so that I can be better prepared in the future.

And then finally, in terms of financial technology, or fintech, there were tools that people used that may mitigate some of what they were experiencing, but not necessarily solve underlying problems. And just one other thing I would touch on with relation to fintech, we see an opportunity in terms of getting at this issue of decision making support and also thinking about transparency. So, there is a new rule that's been issued that deals specifically with hospitals providing more information about crisis. So, having that type of information available and moving it into some type of technology that could make it easier for people to try to identify the plan that's going to work best for them, that could decrease that period of learning that we saw such as with the Health Savings Accounts and, hopefully, help people identify plans that are going to provide better coverage for them.

So, I will stop there and I will turn it back over to Stacey to lead us through the discussion.

And I think, Stacey, you might be muted.

MS. SMITH: Hello. I'm still somehow, a year later, navigating the technology.

Mina and Lisa, I really wanted to congratulate you on this paper. The research is fascinating and it's also quite an extraordinary piece of writing. I feel like all the personal stories, a lot of which you were just touching on, really bring the topic to life in a way that's pretty amazing.

One of the things that struck me when I was first looking at it is I feel like a lot of research often focuses on people who have no health insurance or people who have lost a job. But most of the people that you talked to have a job and often a very solid income and have health insurance, but many of them are still in really dire situations. What is going on there? What does that maybe illustrate for us about what's going on in our country right now?

DR. SERVON: I can start, Mina, and then -- yeah. I think that's an important

observation. And I think that's why we wanted to look at this population of middle-income people because we knew that there was this financial precarity. And, you know, I think it is the result of decades of changes that have left many, many Americans not only -- we think about inequality a lot, but all these Americans in the middle in a financially precarious situation.

And I think one change that I didn't talk about, but I'll throw it over to Mina to talk about, is the change in what we call the standard employment relationship, which is key to this, I think. Do you want to say a word about that, Mina?

DR. ADDO: Sure. So, in the past it used to be the case that people had a long-term I would say relationship with their employer. Jobs generally had opportunities for advancement. There was stability associated with knowing that you had comprehensive benefits that came along with those jobs. And that is true less and less.

And I will say, in terms of this research, one of the things that we expected to see was more people who were engaged in independent contracting. And so that independent contracting is growing. And we thought that would be more of the cause of the income volatility that we were seeing. But as I touched on, it was really the case that people had primary sources of income and they just weren't earning enough money from those primary sources of income. And then they did depend then on these secondary sources. So, I think that is really something that is not as well understood in terms of what is driving income volatility, and I think specifically for a middle-income population.

MS. SMITH: I mean, the numbers that you have on income volatility are really -- I found them very shocking and then the individual stories, like you say, the income volatility seems to come from all kinds of different things: people losing their jobs or their circumstances changing. But as I touched on, Mina, sort of the individual stories seem to be really at the heart of this paper. And I was wondering why you chose that approach as opposed to maybe a more sort of technical approach or something like that. Why are the stories -- I don't know, they seem like the center of this research to me.

DR. ADDO: Sure, absolutely. So, I'll say a couple of things.

So, this is part of a larger project and so -- and the larger project was trying to understand more broadly the financial challenges that middle-class households are facing. And there was, I would say, a small quantitative portion of that. But, you know, based on previous research, one of the things

that we have found is that the quantitative research can tell you what is happening, sort of document it. As you talked or we talked about the income volatility trends, it documents all of that. But without talking to the people who are experiencing it, you really don't know what those dynamics look like and we didn't have a great understanding of the why and I think, again, specifically for this population.

And the last thing I will say is one of the questions that we had included in the questionnaire, taken from a large national survey, we asked people to categorize themselves in terms of their work. So, do you work full time for someone else? Do you work part time for someone else? Are you self-employed? You know, there's five employment categories. People couldn't answer the question.

You know, for many people they were in more than one category. So, if you're a contractor, you do work full time for somebody else, but you're also maybe self-employed or if you have two jobs. If you're working full time and then you have that part-time job on the side, how do you answer that question? And so I think there, again, the qualitative really helped us to tease out a lot of the people's individual experiences and, again, just give us a better understanding.

DR. SERVON: And if I could add to that just a little bit. I think one thing is, you know, we often look at -- we start sometimes with quantitative data or the results of a survey and oftentimes looking at those results you can hypothesize the reasons in multiple ways. You know, like here's this piece of data. It could be because of A, B, or C. And talking to people allows you to use that survey or that quantitative research as the jumping-off point. But then to really understand it a little bit more or a lot more in this case.

And I think another piece is simply strategically, you know, for -- potentially for people who are on this webinar or policymakers, people who are reading. I think stories move people to action and they are much more relatable. People see themselves or they see people that they know. And honestly, I could give you both, but that's another reason.

MS. SMITH: And, Lisa, I'm wondering like what those conversations were like. Was there like a moment that has stuck with you or when you think back on this work that comes to the front of your mind?

DR. SERVON: So, Mina actually did all of the interviews, so I'm going to punt that over

to her. I read and coded all the transcripts, too, but I think it makes a big difference if you're in the conversation.

DR. ADDO: Yeah, thank you for the question. So, I would say the conversations really varied. I would say the tone of the conversations, despite the fact that a number of people were vulnerable in some ways, I would say they were pretty upbeat conversations. And people are pretty resilient and really focused on how can they solve the problems that they're having. And it seemed to me that there was a lot of optimism about being able to get into a better financial position. You know, I can't really make a judgment whether or not that's, you know, real or not real, but that's definitely something that came through, just this idea of feeling a sense of self-efficacy, really like I can work hard and I can improve this and I can get to a better space.

I will say there are a couple of folks who were really in crisis when I talked to them, so we touched on it in the paper, but there was a woman whose husband had been severely injured and was not able to work and they had gone from, you know, two very solid incomes to one. And she talked a lot about, you know, just managing their household expenses and dealing with insurance companies. And they had disability insurance that didn't kick in for months.

And so I think the other thing I would add is that people are experiencing a lot of financial stress. And even though they are sort of making it, that's definitely in the background as well. I would describe it as maybe like a latent stress among a lot of the people I talked to.

MS. SMITH: It's so interesting that --

DR. SERVON: I think like --

MS. SMITH: Oh, please, Lisa, go ahead.

DR. SERVON: Just the other side of the efficacy piece I think is that people often don't realize that there are factors beyond their control that are governing that stress and the problem. You know, in this and other work that Mina and I have done together people tend to blame themselves, I think for not having the financial stability. We are a culture in which there is this sort of bootstrap rhetoric of, you know, you should be able to make it. You want to do all these things and then you'll be stable. And the game has really changed.

So, I think like a lot of people who we -- the kinds of people that we talked to wouldn't

necessarily know about these trends and be able to go like, oh, that's why I'm struggling so much. It's because if I had this job 40 years ago, I would have had better insurance or, you know, that wages have declined.

So, you know, that's part of the trick of this, too, is to how to get the story out more broadly. But I think that's part of it, is that people don't really recognize that it's not their fault that they're in this precarious situation.

MS. SMITH: Yeah. I mean, I think the thing that struck me the most was that people were making very logical decisions in the moment a lot of times. For instance, they don't have extra money, so they're deferring a non-urgent situation. I think there's one woman who has -- she just doesn't get her wisdom pulled because she doesn't have the money in the moment, and it's something that can be put off. But then I think 10 years later she's in terrible pain and she has a cyst that might be a tumor, and an extremely preventable situation has reached a crisis point simply because of her not having the money and also just a lot of the confusion around how much things might cost.

And mental health was another thing people just consistently put off or that seemed like an extra non-crisis expense. And obviously, that has been a huge story this last year.

Mina, I'm wondering, taking that into consideration, like what does that tell you about maybe where we are or the kind of policies we should be looking at?

DR. ADDO: So, I would say a couple of things. I think you're absolutely right in terms of people sort of de-prioritizing mental health treatment. And I think we have made improvements, such as with mental health parity in terms of trying to make mental health treatment more accessible. But I do think there's still a tendency to sort of see the mental health as separate from physical health. And there is a large literature that shows that, you know, having elevated levels of stress for a long time really does have implications for your physical health. And so I think there is more to be done in order to make sure that people are able to actually get the help that they need and not to see it as optional and really prioritize it as much as they're prioritizing if they're having other health conditions.

And then I think a point I maybe made earlier, I just keep coming back to this idea of like a latent stress or latent anxiety. People are working really hard and doing their best to meet all of their needs. And I think about the impact of what's going on when you're at work and you're also worried

about, you know, am I going to be able to pay this bill? You know, I wonder if that affects also other parts of your life in terms of not just your work, but your home and family life, as well.

So, I do see it as quite significant and I do hope that there is more that can be done to make sure that we're not treating mental health as separate from physical health and not de-prioritizing it.

MS. SMITH: Well, with that, I'm going to turn the screen over to Dr. Kavita Patel. She is a physician and nonresident fellow at Brookings, and she is joining us for a response.

DR. PATEL: Great, thank you so much. And I want to just start by -- I was going to start with a couple of statistics based on health research we've done at Brookings and also work that has kind of happened over the years by Kaiser Family Foundation, but I think just listening to Mina, I was struck by I spend most of my time in clinical practice in a federally qualified health center in the D.C. area. Mostly my population is almost exclusively kind of Latina women, Latinx in general.

And interestingly enough, I have a patient yesterday who basically kind of said to me that, you know, she really wanted to make sure, she had had COVID, recovered, but was still having some residual symptoms. And she was on a particular insurance company and had it through her benefits of her work. And she actually said to me, she's like I want to try to get as much as I can in because I'm worried I'm going to lose my job. And I kind of probed and I said what? You know, did something happen? Is there something changing in your workplace? And she just said, she's like, you know, the pandemic has really been hard and people have tried not to let staff go, but it's very clear that we're not going to all be able to keep our jobs.

And she had a decent salary, kind of I'd put her at probably 600% FPL. And it just brought together, I think, Mina, kind of what you discovered in both your qualitative and then what we do know in the quantitative research.

And I have kind of a formal background in policy, so I'm going to try to bring this back to how I would think about this if I were back in government, back in the White House and kind of hearing this information. How do you take these kind of qualitative and quantitative findings and then think about a policy after we've just gone through what I would say hopefully is in our lifetime the worst pandemic? But also close to a depression, close to probably -- and we're still not out of it, so I say this with caution, but close to what I would describe, you know, 40,000 children who lost a parent who was probably the

primary source of income, 6 out of 10 women who were displaced in the workplace or had to make decisions about careers because of needs from school-aged children who were not able to attend school and daycares that were closed.

So, all of these things have an incredible -- it's a reminder of how integrated a lot of our systems are. I spend -- and I want to thank Aaron kind of from Brookings because so much of us even inside think tanks and academic institutions sit in our silos. We're in departments. We focus on our specialty area. And it's only when we have conversations like this do we think about the integration and kind of this that occurs because that's the real world. People don't live their lives in these silos and why should our policies or anything else kind of be different?

So, my thoughts on the research, number one, very unique, very interesting. And then number two, to tie it and wrap kind of my anecdotal story, this research, and the findings together, we really did have through the form of the American Rescue Plan, as well as stimulus packages in the Trump administration, we really did have this push to kind of have I wouldn't call it universal income, but it was a little bit of a peek into could income stability, even in the form of one-time checks, give people confidence? And I think the answer was yes and no with respect to just feeling like you were going to be able to put food on the table, maybe yes. But feeling like, to Mina's point, that you could make decisions about health care or get services that are I would call them essential health services.

I'm a primary care physician, but the number of times I saw people defer not just screening exams, but we're still seeing people defer important cancer, et cetera. But I had a number of diabetics who did not refill medications, blood pressure -- patients with hypertension, all of which I think is kind of in this report. We did not have the kind of stability that allowed for people to feel like their health could be a priority. And if you can't -- you know, to me if that isn't the most important failure to acknowledge across political lines, across sectors, I don't know what else is.

So, if I kind of am sitting here listening and I'm thinking through we're going to have an infrastructure package, some version that gets haggled in Congress, some form of back-and-forth between the private and public sector about tax rates, et cetera, how can I think about some metric for income volatility as one of the income indices that we look for?

And we have a lot of health care indicators. We do a really good job of measuring the

heck out of everything in health care. So, I know lots of information about my population's health outcomes, their quality metrics, accessibility, access in the health care system. But it's a completely reactive health care system. We have yet to think through how can we -- you know, if we understand a little bit more about income volatility and its effect on health care decision making, I could argue that if I were any sort of insurance company, private, public, otherwise, that that would be the group I should target. That is your most vulnerable population. They're the people who are very activated to probably take care of themselves, but because of this volatility they can't do it.

And it reminded me, I have a former life in -- my original career was in health services research. I was at the RAND Corporation. We worked on some of the most kind of cutting-edge surveys on health care quality. And we would also use secondary data analyses from claims data. And it was very clear in health care claims data, health insurance claims data that we had no idea how to estimate kind of the socioeconomic status of that individual for whose claims we saw.

So, we did a lot of like kind of, you know, meshing of databases and I got very good at kind of estimating maybe this population based on their age and somewhat of what we know about their kind of other comorbidities likely made this much money and had this kind of education. But we had no measure of that volatility or what we call in the health care industry the churn. And so I really do think that understanding the role of how this could be an economic indicator along with kind of using this in the health care setting more proactively to reach out and integrate kind of these services would be incredible.

And it reminds me of kind of the second point I wanted to make before I got more really enraptured by Mina, but just your work is fabulous and I hope we can continue to highlight the progress. The second thing that really struck me is that we've had a movement called social determinants of health in health care for a while now. Up to 72% of Medicare seniors have reported some sort of insecurity around food, transportation. I've been part of a movement to incorporate a measure for social isolation or loneliness into some of our basic health screenings. But we really should think about not just social isolation, but how do we think about asking, you know, something around this issue of decision making?

And when I worked mostly with breast cancer patients, the number one question you got after you gave a woman or man a diagnosis of breast cancer and kind of it settled in was how much is this going to cost me? And some of the most important things we could do wasn't finding the

chemotherapy regimen that could probably save someone's life, but it was actually helping them navigate what really has still become catastrophic financial consequences from an illness that sadly now -- one day -- we actually have vaccines for cancer, in cervical cancer and human papilloma virus, but we still have people who don't get those vaccines. And a lot of it is not just access, which, Stacey, you're right, we talk about. But much of this has to do with I think, Mina, what you've highlighted.

So, I'll stop. I clearly could go on and on and hopefully this is, for anybody who's watching, you know, how can we wrestle with this in a place like Washington, D.C., where we talk about billions of dollars, trillions of dollars in infrastructure? How does this become part of what we measure?

So, I'll stop there. Thank you for the chance to be a part of this.

MS. SMITH: I mean, I'm wondering listening to this and, obviously, in the paper you talk about financial technology and that doesn't quite seem to address the problem or even help in a significant way. Also, income volatility, I mean, that's a huge issue. Are there potential solutions? Because it does seem a little overwhelming when you start seeing like how deeply rooted these issues are and how sort of systemic things are, people having a lot of jobs, income volatility. I mean, that predates the pandemic. It's worse now, but I'm wondering if any of you could address like potential solutions or ways to at least start chipping away at this issue?

DR. SERVON: I mean, I think one of the keys, you know, which is not an easy problem to solve, but I think in a lot of our research at the end of the day we kind of say people need more money, like full stop. Right? I mean, when you look at the benefits and the income that's been stripped away and/or, you know, a reinstatement of some of these benefits. And that's a place for policy, especially now that people do not stay at one job for a really long time, portable benefits, you know.

But I think a couple of things I think that were really key in our work was, A, and Mina touched on this, that it's the second job that introduces a lot of the volatility. And so we see people using that second job a lot of the time, sometimes just to make ends meet, but other times going like, okay, I have this extra expense or this special thing which may be a bad thing, like needing to fix my wisdom teeth, or a good thing, like my child is getting married, so I'm going to drive for Uber for a while to get the money that I need. But if you're already working two jobs and you still don't have enough, there's no other -- like working three is not that practical. Right? Like there's -- people are using it kind of like a

buffer, but that has its limitations.

And I think the second thing I would say that's really critical on this point, too, is just on the insurance front. So, transparency and kind of like core benefits that many people got who were insured was critical. So that whereas insurance should be taking the risk and the uncertainty out of people's equations, it actually was adding it in in many cases because they were not sure what would be paid for. Will this test be paid for? Will my medication be paid for? And so that was a deterrent to people getting the care that they needed.

So, I think both on the kind of like the broad policy in terms of reinstating some of these benefits and fighting for better wages and thinking a little bit more about like what could we do on the policy front to make insurance benefits more transparent?

Mina, I'm sure you have other thoughts.

DR. ADDO: I think you covered most of my thoughts pretty well. I will say just building on the health insurance point, so, again, we have really expanded health insurance coverage. Clearly, there's more work to do and, you know, Dr. Patel can certainly speak more to that, but getting beyond the idea of having coverage solves the problem. Because we have seen in this work that that's really not the case. And either parts of care that are not covered, you know, dental care, your mouth is not separate from your body, but that is often separate from health care.

And then also just thinking about the cost piece. So, people are spending a lot of money on premiums and not necessarily getting what they need out of that care. And I know there are some efforts recently, the Recovery Act did include a provision that improves the subsidies for people that are buying care through the health care marketplaces, so that perhaps people will be more able to buy the plans that do cover more and not necessarily relying on the high-deductible plans.

So, I think both of those things go a long way, but I think we also need to get to a place where everybody is covered. Easier said than done, but it's not impossible. Other countries are able to do this.

MS. SMITH: We do have a question from the audience, which is, on price transparency there are mixed findings on folks using health care price information to shop for their health care. Did you get a sense that your participants would engage in price shopping or be less likely to skip or delay care if

the price information was available?

That speaks right to your question of the -- and what you mentioned, Lisa, about the uncertainty being a big issue. I don't know if you could speak to that, Mina or Kavita?

DR. ADDO: Yeah, I'm happy to start and, you know, let others join in, as well. So, I will say offhand, you know, we didn't ask that question directly, so I couldn't necessarily tell you that anybody we spoke to had that experience.

One thing I will say is health care is different than other types of spending in the sense that when you need care, you are very vulnerable. So, when we talked to people who had unexpected costs, it could be I went to the dentist to have a cleaning and they told me I needed a root canal. You didn't plan for that the morning that you went in and you're probably not in a situation where you're going to in the moment comparison shop and try to say, okay, is there another dentist who could do this more inexpensively?

I do think potentially if there is a situation where you can plan for care, you might be in a situation where you could do some of that price comparison in terms of the transparency and having more data available. I guess, you know, to sum up my long rambling, I think there are some cases where that transparency could help, but I do think just acknowledging that vulnerability when something happens, you know, you have to react in the moment and you may not be in a position to do that comparison shopping.

MS. SMITH: Yeah. Kavita, I was so struck by your story of people getting like a really terrible diagnosis and then their first question -- I mean, it's really heartbreaking -- their first question is how much is this going to cost? And the idea that people are picking their care based on cost is difficult.

What is your opinion on this? Do you think price transparency is the key? Do you think lower costs or better insurance is the key? What is -- I don't know, what would be the most helpful, in your opinion?

DR. PATEL: Yeah. So, I mean, I'm a pretty radical supporter of -- when I worked for Ted Kennedy, we introduced a bill that went nowhere every year for adults to be able to buy into the Medicare program. And it's coming back, by the way. It's a trend that's come back. And Senator Stabenow and some others have introduced a bill to lower the Medicare eligibility age.

Why am I talking so much about Medicare? Because I do believe that we need some kind of even playing ground, so price transparency just generally. And just for the people who don't spend time every day on health care policy, there's been a slate of regulations that have gone into the effect from the Trump administration, first, for hospitals to basically have their lists of costs, their charge master lists to be made public, so that anybody can look up, for example, what a C-section should cost at a particular hospital. There's so many caveats you could drive a Mac truck through that if you're in-network, out-of-network, all of that. So, in and of itself that's not helpful.

In 2022, we're going to see a set of requirements in place for insurance companies to be able to be transparent about what they're paying for services. So, the idea is that these thing married together give us more kind of a sense of what the cost to a consumer might be.

I still think that's problematic because, to Mina's point, I haven't met a single patient who has -- and especially those who have income volatility, these are not people who have time to watch webinars about income volatility. They're actually having income volatility.

So, I find it to be then whose responsibility is it? And I come back to the insurer because it ends up being the place, which is why I do think whether it's a public option, Medicare for All, a Medicare buy-in program, Medicare negotiates its provider rates are transparent. They're incredibly -- many hospitals will tell you that you don't make a ton of money on Medicare, but you break even. You lose money on Medicaid. You make a lot more money on commercial insurance. And that's really not what health care should be and I think our country has to wrestle with whether or not we believe that we need to alter the approach.

And then I'll just very quickly our delivery system is broken. It made me feel good as a primary care doctor to hear that primary care is accessible. I don't think I come out of a day in clinic, no matter what the scenario is, no matter what insurance someone has, without feeling like a failure. Because I've got 10 to 15 minutes to handle everything that's happening. And my best ability to be the quarterback that everyone thinks I need to be is to try to micromanage these relationships with specialists. We don't even have a chance to recommend dental and eye care because that's not our, you know, lane even though it's clearly part of health care.

So, there's so much about the system that is set up to not work together. Electronic

health records that don't talk to each other. I think we're the only industry that depends wholly on fax machines. People are always stunned when I tell them I need to get -- I can't tell you how much volume of health care I do on fax. And that should trouble everybody who's watching.

So, I think for those reasons we need a modernization. We need something crazy on the insurance side, Medicare buy-in, Medicare for All, public option, and then we need a delivery system that can kind of match that and be a real provider of health care. I don't think we have a system that provides health or cares a lot of the time.

MS. SMITH: Well, Lisa, I'd like to throw a question to you because so many people in our audience are policymakers or people who are, you know, entrepreneurs, businesspeople. What are you hoping that their takeaway from this research will be, that maybe some action that they may take? What would you like to see in taking steps to solve some of the issues that we're seeing in your research?

DR. SERVON: Yeah, thanks for the question. I think -- I hope that people are watching. And I imagine that they're not just health care folks who are on, but people who are thinking more broadly about income volatility and financial precarity. So, I hope the big takeaway is that this -- you know, we drilled down into a very specific way in which income volatility is affecting people through health care, which is obviously a really important segment. But it's also affecting people in all kinds of other ways, too.

And so I think what I hope that the audience members take away is just how big a problem this is, how widespread financial precarity is throughout the United States, and that it is creating big problems for many, many people. You know, I'm thinking even about this week's Census data coming out and the low birth rate, right, which has a lot of people worried. One theory about what's driving that is that younger people who are of childbearing age are putting it off or deciding not to have children simple because of the expense. Right?

And so, you know, that I think is just an illustration of how all of these trends -- declining wage, the risk shift, the erosion of benefits, and income volatility -- is affecting people on a really large level. So, if you're a policymaker, if you're working on these issues, like what can we do about that?

There are lots of things. There's raising the minimum wage. There is advocating for better benefits for broadly available health care for everyone. And I know these are big things and they're not easy, but I appreciate, Kavita, even your story about working with Senator Kennedy. I think

sometimes they take a really long time, too, and it's easy to kind of like give up the fight. But just, you know, oftentimes an idea, the time of an idea comes and it requires just a lot of slogging through and sticking with it.

MS. SMITH: And, Mina, I would love to hear, too, your thoughts on what you would like the takeaway from your work to be or some actions that maybe industry or policymakers could take.

DR. ADDO: Sure, thank you for the question, as well. So, I think echoing the points that Lisa made, I think the big eye-opener or maybe not totally an eye-opener, but just this is a middle-income, middle-class population. These are a number of people who've done sort of the "right things": pursued education, tried to invest in homes. That pathway that used to be I think we call it the American Dream, I think we should think about that in terms of whether or not that is still possible and think about the policy supports that enabled that pathway to exist before.

So, we have provided incentives for homeownership. You know, there are -- you know, employer-sponsored insurance is also built on federal policy. And so my thinking is the economic context has changed. So, how do we think about what policies are needed to support workers in a place where people are more likely to change jobs within the course of their career or more people are independent contractors, as Lisa touched on. We need to think about portable benefits and other ways to support workers.

And then the last point I would make is, you know, this is a middle-income, middle-class population. They have some advantages, but I would say they're also showing some signs of vulnerability. And for many people, they are that one emergency away from being low-income and not having any resources or, you know, a safety net that's going to be able to support them.

So, I would just say let's not wait until that happens. This should be something that we're thinking about now. And how do we make sure that people do have the protections that they need, you know, in order not just to maintain their lives, but to feel some sense of economic security?

MS. SMITH: It's interesting to me that you talk about this in the context of the American Dream. I feel like that's definitely something that we've all been grappling with and maybe reimagining. How do you see this work as tying into the American Dream?

DR. ADDO: I mean, again, I would speak to the population. I would speak to people who

have, you know, made these investments in and, you know, I would say beyond a college degree. There were people at different ranges of the type of education they had, but a consistent theme was I want to build this skill, I want to advance in my career, I want to save money and buy a home. And as Lisa talked about, not necessarily understanding how the context has changed and how much more difficult it is now than it was perhaps 40 years ago.

So, I don't necessarily think the American Dream is not achievable, but I think it's a very different context and set of challenges that people are facing, and so just thinking about our policies in that way, as well. Assuming we all want people to feel economically secure and be able to live their lives the way that they would choose to, I think we also have to think about how policies are creating or hindering those opportunities.

MS. SMITH: And, Kavita, I'd love to throw that question to you, too. Like having worked with patients and having worked on sort of both sides of the health care system, how do you see it as tying in with the American Dream, with social mobility and the ability to achieve great things?

DR. PATEL: Yeah. Yeah, and I'll be brief. I can't think of anything more important for having hope for the future than trying to really understand the responsibility of -- the generations we leave behind need that hope. To Lisa's point, you know, we're having people who are making choices about not having children because of that fear. I mean, that alone should make everyone kind of pause and say this is not working. This is not working.

So, the only thing we have is kind of generational hope and I see this as intrinsically tied to it. I'm a first generation. It's why my parents immigrated here. Their whole reason for giving up their entire lives in another country and anything they understood was for that hope. And it is because there really was this American Dream.

So, to me it feels like to lose that in a generation feels Earth-shattering to me. And I really do think it should be coming out of this pandemic, I hope some of these things -- so much of us want -- so many of us, including me, want to put things behind us. I hope this is something that kind of haunts us and stays with us, but to find the solutions for it because I think it's there.

MS. SMITH: And, Lisa, finally I'll throw that question to you, too. How do you see this as tying into the American Dream, this work you've done?

DR. SERVON: I think it's completely related and I agree with everything that Mina and Kavita said. I'm thinking about some interviews that Mina and I did years ago with millennials who talked about, you know, I can either have kids or buy a house. I can either pursue the job that I want that will fulfill me or I can, you know, take this job that maybe I don't really want to do and then do these other things that I want.

So, I agree, I think hope is really important and that right now we're in a situation where we're still talking about the American Dream. You see politicians talk about it all the time when they're trying to get elected. But we don't have the policies in place and the practices in place and the cultural push to make that happen.

Now, you know, I do think I'm very encouraged by the policies that are being forwarded right now about helping families. You know, Social Security took older Americans out of poverty. If we can put back some of those things in place I think there is some hope, to use that word. But I do think that this work and other work like it should be just cracking open this myth, that if you do X, Y, and Z, then you'll be stable.

The last thing I'll say on it is just on that note of stability. People have really shifted in their aspirations around finances, from wanting to earn more money and earn more than their parents did to wanting simply financial stability. So, I think, again, that's another sign that things are not right.

MS. SMITH: Well, I would like to thank you, Mina, Kavita, and Lisa, for a really fascinating and very interesting discussion about health care and finances and technology. It's been such a pleasure and an honor to be a part of it.

DR. SERVON: Thank you.

DR. PATEL: Thank you.

DR. ADDO: Thank you very much.

MR. KLEIN: Well, I'd like to thank all of our panelists and Stacey for moderating this fantastic conversation. It's really I think informative, illustrative. A particular thanks to the researchers for this fantastic paper, which hopefully will inform policymakers. As Mina said, your eyes and teeth are still as much a part of your body even if our health care system cuts that aside.

And, you know, the amount of money that's in your wallet today and what you can plan

for tomorrow effects the health care choices we make today. You can't technology or fintech your way out of not having enough money, as Lisa said. On the other hand, we have tremendous advances in technology coming that are going to be transformative for a wide variety of aspects. And it would be my hope at least that this technology can be used in such a way that it makes health care and life more affordable and Americans more healthy rather than simply figuring out ways to provide better and more expensive services to people that can already afford it and generate even more surplus from technology to those who are already fortunate enough.

Time will tell, but it's thanks to research and leadership and the conversations we had here today that give me more hope for the future. I thank everybody and look forward to continuing this conversation virtually and in person for the years to come. Thank you all very much. Have a great afternoon.

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