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Promoting Equity in Retirement, Disability, and Health

SOCIAL SECURITY ADMINISTRATION

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UNIVERSITY OF WISCONSIN-MADISON

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Addressing Barriers to Disability Program and SSI Program Participation for Older Formerly Incarcerated Adults

Ruth K. Finkelstein and christian gonzález-rivera
City University of New York, Hunter College

Prepared for the 26th Annual Meeting of the Retirement and Disability Research Consortium
August 7-9, 2024

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Introduction

Our research project seeks to investigate the challenges faced by older formerly incarcerated individuals in accessing Social Security Administration (SSA) disability benefits (SSDI) and Supplemental Security Income (SSI). These individuals often face compounded disadvantages, including chronic health issues, economic insecurity and limited work histories, and limited access to support services to assist with benefits application. Our goal is to better understand these barriers and inform policies and practices that may improve access to benefits for this population.

Research Question and Context

The primary question we're addressing is: What are the barriers preventing older formerly incarcerated individuals from accessing SSDI and SSI, and how can we mitigate these barriers? It's crucial to understand that disparities in health, wealth, and access to opportunity structures services over a lifetime and are particularly pronounced for formerly incarcerated individuals.

Previous Research

Formerly incarcerated older adults (FIOAs) face numerous barriers upon release. These barriers include significant housing and employment discrimination, leading to difficulties in securing stable living conditions and gainful employment (Bedard, Vaughn, and Murolo 2022 and Pérez, Ro, and Treadwell 2009). Disenfranchisement also limits their ability to participate in civic activities (Bedard, Vaughn, and Murolo, 2022).

Health issues are particularly pronounced among FIOAs. They suffer from chronic impairments, mental health problems, cognitive limitations, and disabilities at higher rates than the general population (Maruschak 2015 and Smoyer, Madera, and Blankenship 2019). The stress and conditions of incarceration contribute to accelerated aging, exacerbating these health problems (Brooke, Diaz-Gil, and Jackson 2020).

Access to federal entitlement programs, such as Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), Medicaid, and Medicare, is crucial for FIOAs who cannot work due to poor health. These benefits can help prevent return to criminal behavior and re-institutionalization (Conly 2005). However, FIOAs face several barriers in accessing these benefits:

1. Suspension or Termination of Benefits: Disability benefits are often suspended or terminated during incarceration, resulting in lengthy delays in reinstatement upon release. Poor discharge and reentry planning exacerbate these delays (Pérez, Ro, and Treadwell 2009).

2. Complicated Application Processes: The application process for new benefits is often complex and difficult to navigate. FIOAs frequently encounter inadequate access to necessary prison health records and long eligibility determination periods (Conly 2005).

3. Employment Barriers: Health limitations, discrimination, and licensure ineligibility further limit employment opportunities upon release, making access to disability benefits essential for economic stability (Bedard, Vaughn, and Murolo 2022 and Pérez, Ro, and Treadwell 2009).

These barriers are part of a broader pattern of cumulative disadvantages that FIOAs face throughout their lives. Social inequalities contribute to their likelihood of being incarcerated and hinder their access to benefits and resources upon release (Maschi et al. 2014). Addressing these barriers requires a comprehensive approach that includes better reentry planning, streamlined benefit application processes, and targeted support programs (Maschi et al. 2014 and McKillop and Boucher 2018).

Project Contribution

Our research entails conducting semi-structured interviews with 30 FIOAs to gather firsthand accounts of their experiences. Additionally, we'll interview key staff from organizations who work with people who have been incarcerated. This qualitative method will provide an understanding of the specific experiences of FIOAs in attempting to access benefits and add valuable insights to the existing body of research. Engaging directly with the community through a Community Advisory Board (CAB) ensures that our research is useful, relevant and respectful.

The gaps in knowledge that our project aims to fill include: the specific challenges faced by older FIOAs in accessing SSDI and SSI benefits, the impact of cumulative disadvantages over the life course on benefit access, and the effectiveness of current reentry programs in facilitating benefit access. By addressing these gaps, our research can inform and potentially improve programmatic support for FIOAs.

Building trust with formerly incarcerated people and the organizations that serve them is crucial for the success of our study. We have established our relationships with our partner organizations over years of engagement with their work, making our collaboration on this project a continuation of that relationship.

Hypothesized Findings and Policy Implications

We hypothesize that our research will reveal several critical barriers to accessing SSDI and SSI benefits, such as bureaucratic complexities, lack of awareness, and systemic biases. Identifying these barriers will allow us to inform and potentially enhance the accessibility of SSI and SSDI benefits for FIOAs. Secondarily, we may identify policy implications for state departments of corrections.

Based on our methodology, which includes in-depth interviews and collaboration with a CAB, we expect to uncover detailed information on the lived experiences of FIOAs. This includes understanding the nature of interactions between SSA offices and FIOAs, the challenges in navigating the benefit application and appeals processes, and the necessity to rely on disability program benefits rather than retirement benefits. Our findings will provide a nuanced understanding of these issues and inform targeted interventions.

One particularly important barrier that we expect to explore in depth is the effect of not qualifying for Social Security benefits due to lack of sufficient work quarters. Many formerly incarcerated older adults are in this position, especially those who have served long sentences. Long prison sentences result in inadequate work histories, as work done in prison doesn't provide eligible quarters for Social Security retirement benefits. This ineligibility limits access to crucial financial support post-release, worsening economic instability and hindering successful reintegration (Whitman, Reznik, and Shoffner 2011).

Through this work, we aim to reduce barriers and increase benefit uptake, ultimately improving the economic security and well-being of older formerly incarcerated individuals.

Conclusion

This research seeks to highlight and address the compounded challenges faced by FIOAs. By understanding and addressing the barriers to benefit access, we aim to empower these individuals and ensure that social insurance programs fulfill their intended purpose. Through our collaborative and community-focused approach, we aspire to inform significant policy changes and improve the support for some of the most vulnerable members of our society.

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Do Older Sexual and Gender Minority Adults Experience Implicit Bias in Interactions with the Social Security Administration?

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Introduction

There are 2.7 million lesbian, gay, bisexual, transgender or gender diverse, queer (LGBTQ+) adults in the U.S. age 50 and older, with 1 million being age 65 or older. These numbers expected to double by 2030 (Fredriksen-Goldsen and Kim 2017). The Social Security Administration (SSA) office is the most frequently reported service used among older LGBTQ+ adults (43%-63%), and help accessing entitlements is a primary reported service need (23%-44%) (Brennan-Ing et al. 2014a; 2014b).

For LGBTQ+ older adults, retirement income reflects the cumulative disadvantages this population has faced in the workplace. Historically, LGBTQ+ older adults faced employment discrimination due to heterosexism and cisgenderism and could be refused employment or fired due to their sexual and gender identities (Cahill and South 2002 and Grant et al. 2011), hindering access to pension benefits and employer-sponsored retirement plans. Even when employed, these older adults are disadvantaged regarding retirement income since SSA and other benefits are tied to wages. Gay and bisexual men in this cohort earned 15% to 25% less than heterosexual peers. Lesbian and bisexual women earn less than men due to the gender pay gap putting them at a disadvantage in retirement (Cahill and South 2002 and Conner and Fiske 2019). Transgender and gender diverse adults experience twice the rate of unemployment compared to the general population (Grant et al. 2011), depriving them of SSA and other retirement benefits. Additionally, federal recognition of same-sex marriage occurred less than a decade ago (Obergefell v. Hodges 576 U.S. 644, 2015), and many widowed LGBTQ+ older adults were never legally married, denying them access to survivor SSA and pension benefits and costing this population approximately $124 million annually (Cahill and South 2002).

Nonetheless, Social Security benefits are a lifeline for these older adults, particularly for those who are low-income or racial/ethnic minorities (Kum 2017). LGBTQ+ older adults face numerous barriers when accessing aging services like the Social Security Administration, including lack of provider competency, fear of LGBTQ+ identity disclosure, structural and social determinants of health barriers, and difficulty accessing services (Brennan-Ing et al. 2014a; Cahill and South 2002; Hughes et al. 2011; Marshall and Cahill 2020; Stinchcombe et al. 2017). This research aims to explore the barriers experienced by LGBTQ+ adults when applying for SSA benefits and interacting with SSA personnel.

Objective

No research could be identified that examined barriers for these older adults in applying for SSA benefits or difficulties interacting with the SSA specifically, or if implicit anti-LGBTQ+ bias contributes to these barriers. Given the importance of SSA benefits for older LGBTQ+ adults, the proposed research explores barriers faced by this population in applying for SSA benefits and difficulties faced while interacting with SSA due to potential implicit bias among staff. The overall goal of our qualitative study is to assess and examine barriers faced by LGBTQ+ retirees and pre-retirees in later life as an initial step in developing a program of research on the economic well-being of these adults in their later years.

Scope

The novelty of this study is significant due to research on the experiences of LGBTQ+ older adults in retirement being largely nonexistent. The aim of this study is to explore barriers experienced by LGBTQ+ older Americans when applying for SSA benefits and interacting with SSA employees. The scope of the study is limited given its utilization of focus groups as it is an exploratory study, examining phenomena that have not yet been explored. However, findings from this study will add to the limited body of scientific literature on this topic.

Methodology

For our community-based participatory research study we have recruited a community advisory board (CAB) of five LGBTQ+ adults who are diverse in terms of race/ethnicity, socioeconomic position, sexual orientation, and gender identity to collaborate with the research team in sharpening our research questions and developing the study protocol (e.g., recruitment, data collection procedures, discussion guides). Research questions for our qualitative study aim to assess the experiences of LGBTQ+ older adults when applying for SSA benefits, barriers or difficulties during the application process related to implicit or explicit bias against sexual or gender minority adults, and interactions between the SSA office and LGBTQ+ older adults and how they differ compared with heterosexual-cisgender adults. We will also explore if there is evidence of implicit or explicit bias towards LGBTQ+ adults due to sexual orientation or gender identity, and if older LGBTQ+ adults have disclosure concerns when interacting with the SSA due to anticipated bias (e.g., identifying same-sex partners, identity document changes needed due to gender transitions). Our goal is to understand what could be done to improve the application process and subsequent interaction with the SSA office for LGBTQ+ older adults. Initial research questions for this qualitative study are:

1. What are the experiences of LGBTQ+ older adults when applying for SSA benefits? Do they differ from heterosexual-cisgender older adults?
2. Are barriers or difficulties during the application process related to implicit or explicit bias against sexual or gender minority adults, or are they similar to what heterosexual and cisgender older adults encounter?
3. Do interactions between the SSA office and LGBTQ+ older adults differ compared with heterosexual-cisgender adults? Is there evidence of implicit or explicit bias towards LGBTQ+ adults due to sexual orientation or gender identity?
4. Do older LGBTQ+ adults have disclosure concerns (e.g., same-sex partners, identity document changes from gender transitions) due to anticipated bias?
5. What could be done to improve the application process and subsequent interaction with the SSA office for LGBTQ+ older adults?

The source of our data will be focus groups and key informant interviews. We will recruit 20 LGBTQ+ adults to participate for two focus groups and 10 heterosexual-cisgender adults for a comparator focus group aged 65 and older from social service and community-based organizations serving these populations using advertising including recruitment flyers at service sites and on-line recruitment materials. Inclusion/exclusion criteria are the ability to speak English and not having any limitations that would preclude participation in a focus group. Focus groups will be convened in a location convenient to public transportation. After obtaining informed consent, the focus group session will be led by a facilitator using a discussion guide developed in collaboration with our CAB. Sessions of 60-90 minutes will be audio recorded. Participants will be thanked, debriefed, and compensated for their time and travel ($50 gift card & round-trip transit card).

In addition, we will recruit five professionals who assist older LGBTQ+ adults in obtaining Social Security and other benefits for key informant interviews from the same organizations used to recruit the older adult focus group participants. Inclusion/exclusion criteria for the key informant interviews are the ability to speak English and not having any limitations that would prevent participating in an interview by telephone or video conference. The semi-structured interview guide for professionals will address parallel topics as well as professional perspectives on challenges facing older LGBTQ+ adults in accessing SSA benefits.

Audio recordings of focus groups and interviews will be transcribed using DESCRIPT software, and any information that could be used to identify participants will be deleted from the transcript prior to analysis. Transcripts will be imported into the Atlas/ti software program for qualitative analysis using an inductive thematic analysis approach. Codes will not be developed a priori but will emerge from qualitative analysis. The project team will meet weekly to discuss the data analysis process. After the initial open-coding phase, a codebook will be developed and used for subsequent data coding. Each transcript will be independently coded by two researchers, and any disagreements will be resolved through discussion. We will use memos throughout the coding process to identify interesting data segments, evaluate the adequacy of the coding scheme, and keep a paper trail of initial impressions and interpretations of the data. Next, we will proceed to axial coding developing broader categories of individual codes. We will then proceed to selective coding using conceptual matrices to compare the data from LGBTQ+ and heterosexual-cisgender older adults for evidence of implicit bias based on sexual orientation and gender identity when applying for SSA benefits and interactions with staff. We will summarize findings to share with our CAB to receive feedback on our work to ensure the validity of our findings. Findings will add to the limited research on the issues concerning LGBTQ+ older adults in their retirement years. Findings will also be used to inform future research (e.g., the impact of rural location on SSA service barriers, retirement resources) as we develop a research program that provides needed data on the retirement experiences and retirement readiness of LGBTQ+ older adults.

Conclusions

As the study is currently underway and in the data collection and analysis phase, we have not yet developed our conclusions. However, we are preparing to discuss initial findings and projected conclusions at the August 2024 conference.

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The Perceived Influence of Race and Gender in Work History and Attitudes, Economic Resources, and Health on Black Women's Retirement

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Abstract

Social Security is essential especially for Black women, as we think about their triple oppression of gendered racism and ageism with the wealth pay gap. Historically in the U.S., retirement favored white people because agricultural and domestic workers were excluded from Social Security old age pensions (Quadagno 1984) and Black families generally did not have the same financial assets of white people (Oliver and Shapiro 2013). Moreover, one study found that Black women are significantly less likely to retire compared to white men (Hogan and Perrucci 2007). Black women are disadvantaged in both employment and retirement income because, like Black men, they lack access to the resources and family wealth, unlike white people (Bielby and Bielby 1992). Additionally, one study found that older Black women in retirement faced problems with housing as they were unable to find suitable and affordable housing (Perkins, 1994). Despite these inequities, Black women can successfully and financially prepare themselves for retirement. Though studies have explored retirement experiences of Black women, few studies have qualitatively explored Black women's experiences with retirement, from a psychosocial perspective. The findings of this research can be used to inform policymakers regarding retirement preparation and planning for Black women.

Introduction

To date, relatively little research has explored the psychosocial outcomes of Black women and retirement (Viceisza 2022). Due to the prevailing myth broadly among women that they will be cared for in old age and/or of the fear of growing old, many women often do not aggressively plan for their retirement. While research has shown that Black women, specifically, are less likely to retire or often delay their retirement relative to their white counterparts, little is known about their perceptions of their retirement experiences. As indicated in SSA Focal Area 1, research on racial, ethnic, and sex equity related to Social Security is essential to understand disparities in retirement security. Consistent with SSA Focal Area 3, it is also critical to explore risks to and sources of economic security, and resource needs to address long-term financial risks. This project in part addresses relevant SSA learning agendas, such as the understanding of structural barriers in the labor market and the impact of COVID-19 on economic security, using intersectionality and qualitative approaches. Thus, this research is important given that Black women are disadvantaged in both employment and retirement income and has implications for the development of retirement educational programs targeted towards Black women. This project will seek to address these limitations by centering Black women to hear first-hand about their retirement experiences and psychological well-being.

Black Women's Retirement and Financial Planning

Black women enter and exit the workforce periodically and for many reasons in their lifetimes. The intentional breaks from full-time, paid work may happen to pursue education goals, parenting needs, or retirement. The unplanned breaks from full-time, paid work may be caused by unemployment, incarceration, or prolonged illness. The motherhood penalty changes an intentional break from work into an unplanned work gap due to negative bias about the job commitment and productivity of working mothers. The consequences of these cycles of employment are linked to opportunities for accumulating savings, acquiring assets, and reducing debts. As such, the numerous job losses caused by the global pandemic highlighted the race and gender retirement gap. For example, in 2020, 54% of Black Americans didn't have enough savings to retire and two thirds of Black singles in retirement didn't have enough income to cover their basic monthly expenses.

Social Security is essential especially for Black women, as we think about their triple oppression of gendered racism and ageism and wealth pay gap. The Social Security retirement benefit replaces part of an individual's income when they reduce hours or retire (SSA 2023). To retire from a job, a career, or permanent employment is an important milestone. However, in one study, more than 75% of the Black women named health and health care as a top stressor for older adults, followed by retirement (Foos, Clark, and Terrell 2006). Black women carry oppression based on race and gender and are underpaid, despite their education and access to jobs (Hogan and Perrucci 2007). Also, one study found that Black and white women are significantly less likely to retire, compared to white men (Hogan and Perrucci 2007). Also, it has been shown that women who do retire, retire prematurely due to health issues. Black women involuntarily retired before the age of 62 because of limitations due to health concerns (Gibson 1993). It is essential for more research to be conducted to understand how the mental health and social factors may influence Black women's decisions with retirement.

To conduct the literature review, we will use existing reports (e.g., Institute for Women's Policy Research), and access current literature from databases (e.g., Psych Info, Google Scholar) on how Black women's work attitudes, resources, and psychological well-being influence their retirement-related decisions and experiences to conduct a brief report. Specifically, we will search for keywords such as Black women, retirement, well-being, and health. Secondly, we will conduct interviews, the data for which will be transcribed and analyzed using thematic coding to determine significant themes that came up across the interviews.

Method

Upon IRB approval, data for the interviews will be collected using a convenience sample of N=30 Black women, recruited through social and professional networks. Inclusion criteria include self-identification as a Black/African American woman, and has retired within the past year or plans to retire within the next three years. The rationale for this sample of 30 is based on the requirement that between 20 and 40 interviews are needed to detect overarching themes in qualitative research (Hagaman and Wutich 2017). Participants will be recruited via emails, text messages, and social media platforms, such as LinkedIn and Facebook. Also, participants will be recruited using the snowball technique, where research participants will assist with identifying other potential subjects.

Participants will review a consent form and be asked to complete a demographic survey to capture information regarding factors such as their age, income level, work history, health, and motherhood status. Next, participants will be asked 10 interview questions. Sample interview questions include: 1. Why are you looking to retirement at this moment in your life, and 2. How has your health impacted your decision to retire? Interviews will be audio recorded, transcribed, and analyzed using phenomenological analysis. Data analysis will be guided by interpretative phenomenological analysis (IPA), an approach to examine personal lived experiences, by constructing emergent themes and searching for connections across the themes related to Black women's retirement and psychological experiences.

Conclusion

Retirement encompasses more than financial issues, it also involves the relationships with family and friends, access to social support, and management of health and wellness. The idea of retirement and being able to take some time for wellness or just to breath as a retiree may not be a reality for many Black women experiencing declining income as they age. Black women are especially vulnerable to these health and wealth issues and are more likely to be alone and isolated due to outliving their partners or their own familial members' inability to provide support. To better understand the retirement experiences of Black women, it is critical to discuss common psychosocial stressors and factors that promote their success with retirement planning.

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Exploring Barriers to the Social Security Disability Insurance and Supplemental Security Income Programs Participation for the Visually Impaired Community

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Abstract/Specific Aims

According to the National Institute of Health-National Eye Institute, there are over 825,000 Black/African American people who have diabetic retinopathy. The number is expected to increase to more than one million by 2030. While this does not include other causes for visual impairment among the Black/African American population, the number is staggering (Ou 2021). Individuals living with a visual impairment encounter challenges navigating daily tasks, even those that may otherwise seem simple. Additionally, remaining employed may not be an option. However, understanding how to apply for monthly compensation can lead to anxiety and depression. Understanding the application process can be daunting and time-consuming. Therefore, applicants seek help from other establishments to support their efforts. Furthermore, the literature describing how to serve visually impaired citizens better remains minimal. This research is exploring the specific case of Prince George's County, Maryland by:

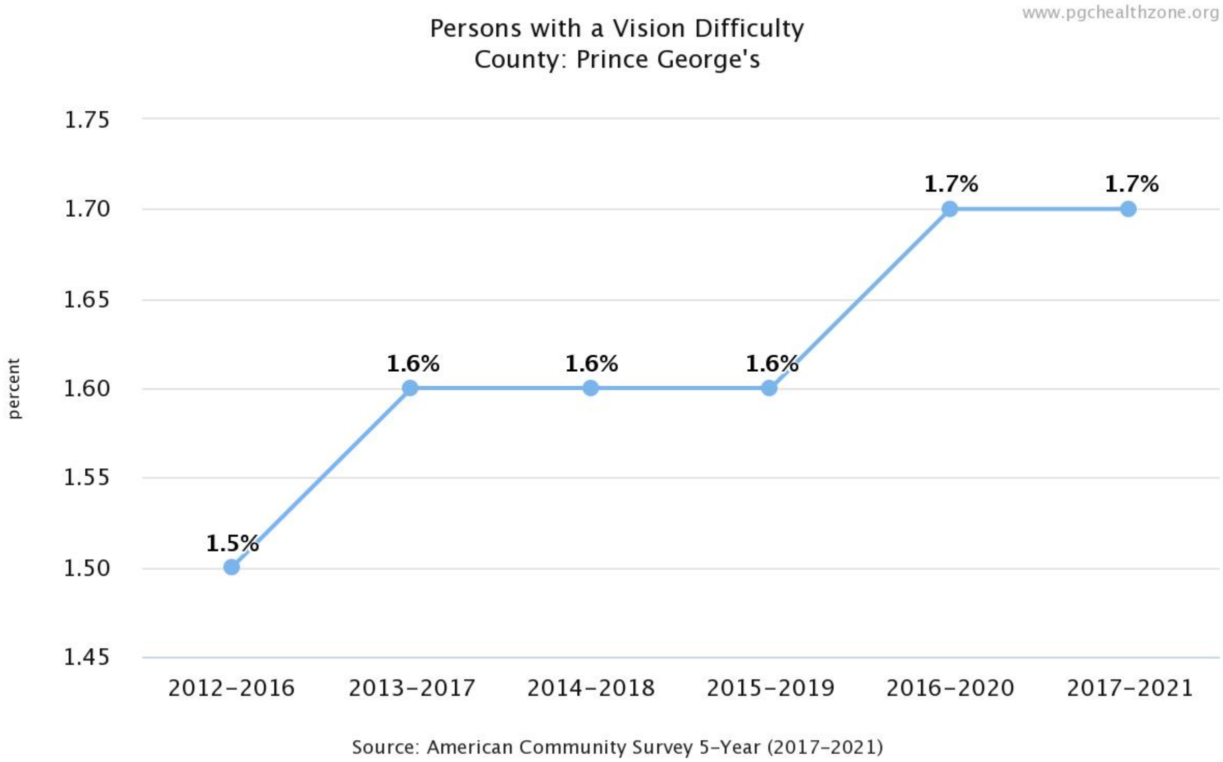
1. Reviewing existing literature on the effects of visually impaired people's access to community resources and services.
2. Conducting focus groups and/or interviews to explore the specific barriers that the visually impaired community contends with in completing the application process for Social Security Disability benefits.
3. Mentoring student research assistants (RAs) from the oldest Historically Black College and University (HBCU) in the state of Maryland, Bowie State University (BSU).

Significance

According to Giesen and Lang (2018), the U.S. Social Security Administration recorded the highest Disability Insurance (DI) benefit payments in 2015 totaling $143.4 billion. Approximately 2 percent of DI beneficiaries are visually impaired (Mann, Mamun, and Hemmeter 2015). Likewise, national statistics also represent the increasing number of persons with vision difficulty in Prince George's County since 2015 (see below).

While resources exist in the County through organizations such as the National Federation of the Blind and the Division of Rehabilitation Services (DORS), access to location and resources prevent these resources from being fully realized (Maryland State Department of Education Division of Rehabilitation Services n.d.).

Figure 1



DORS' 2022 Annual Report states that 38,709 Social Security disability claims were settled. However, the experiences of county residents that impact the need for case adjudication are missing in county public information. Using a qualitative approach to gather participant data includes examining the total experience by exploring barriers involving program awareness, access to support organizations, fees, and time constraints. The findings from this study will contribute to the Social Security Administration's evaluation of how services are provided to the visually impaired community members who apply for Disability Program benefits in Prince George's County.

From a capacity-building standpoint, the study will identify and begin mentoring RAs to improve their future career outcomes, specifically potential enrollment into graduate school.

Data

To explore the barriers to the Disability Program, relationships currently exist with some of the community organizations and resources, including Reid Temple and Back to Basics Church Ministries, whose membership and services specialize in serving people with disabilities and the homeless population, the Ecumenical Health Council, and the former commissioner for Prince George's County Department of Aging – Department of Disabilities. Additionally, we are seeking participants for the study from referrals from County agencies, churches, and other non-profits that serve the visually impaired living in Prince George's County.

Methods

The researchers are using a qualitative method to explore the perceptions and attitudes of N=30 (thirty) visually impaired persons in Prince George's County regarding the application process for the Social Security Disability Benefits Program and Supplemental Security Income. Since receiving IRB approval, participants have been selected using purposeful sampling. This sampling method is used as a recruiting tool targeting participants who will provide insight about a specific experience under investigation. The following questions will guide data collection from the interview protocol: 1) How were you impacted when applying for Social Security Disability Program/Supplemental Security Insurance benefits? 1a) What support did you receive during the application process? 2) What was done well? 3) How can the application process be improved?

The researchers are hosting a series of recorded focus groups and individual interviews. After collecting the data, the transcription process takes place and is verified through member-checking. The data are imported into qualitative analysis software, followed by the coding process. Themes that emerge from this study will be used to emphasize the findings.

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Panel 3: Community-Based Participatory Research

Moderator

Olugbenga Ajilore (U.S. Department of Agriculture)

Panelists

Makini Chisolm-Straker (2022-2023 White House Fellow)
Vernon Grant (Montana State University)
Suhas Kellampalli (Disability Rights and Resources)
Bárbara J. Robles (Federal Reserve Board, Retired)

Panel 4: Disability and Accessibility in Underserved Communities

Moderator

Robert R. Weathers (SSA)

Panelists

Lydia X. Z. Brown (National Disability Institute)
Nanette Goodman (Center for Inclusive Policy)
Susan J. Popkin (Urban Institute)

Panel 5: Let's Ask Them: Examining Barriers to Accessing Support Programs

Moderator

Makini Chisolm-Straker (2022-2023 White House Fellow)

Panelists

"Improving Recipiency in U.S. Social Insurance: A Scoping Examination"
Isaac Marcelin (University of Maryland Eastern Shore) and Wei Sun (Saginaw Valley State)

"What Are the Challenges in Accessing Supplemental Security Income for People with Disabilities?"
Miriam Heyman (Brandeis University)

"Developing a Survey to Understand Barriers to Applying for Disability Insurance"
Lisa Abraham, Jessie Coe, and David Powell (RAND), Derek Ruiz (Southern University and A&M College), and Virginia Zhang (RAND)

"Which LTSS Financial Support Policies Are Preferred among Caregivers and Can They Reduce Racial/Ethnic Disparities in Retirement Security?"
Marc A. Cohen, Claire Wickersham, and Christian E. Weller (University of Massachusetts Boston), Anqi Chen (Boston College), and Brandon G. Wilson (Community Catalyst)

Improving Recipiency in U.S. Social Insurance: A Scoping Examination

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Prepared for the 26th Annual Meeting of the Retirement and Disability Research Consortium
August 7-9, 2024

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Introduction

Poverty among individuals with disabilities continues because of insufficient resources, inadequacies in social protection schemes, low benefit levels, limited enrollment, and implementation barriers (Baptista and Marlier 2022). Social safety net programs offer income to older adults, individuals with disabilities, families, and survivors, but participation depends on eligibility and take-up. Enrollment in Disability Insurance (DI) and Supplemental Security Income (SSI) is lower than projected. This study seeks to identify factors limiting the take-up rates for DI and SSI, comparing recipiency in OECD programs to those in the U.S. to explore potential reforms. It also examines whether race, gender, age, location, and religion influence access to the safety net. The study analyzes how these programs function during economic fluctuations and their financial impacts on eligible individuals. It mainly focuses on the challenges faced by those with long-term disabilities and their efforts to meet basic needs and acquire skills for labor market success, challenges that the COVID-19 pandemic has exacerbated.

Inhibitors to Recipiency

Potential factors that thwart efforts to improve social insurance recipiency include geography, heterogeneous state law, complexity and variability across jurisdictions, stigma and culture, intersectionality, etc. Social insurance programs in the U.S. are highly complex and vary significantly across states and localities. This variability can make it challenging to generalize findings and recommendations from a scoping examination to all programs and regions. Moffitt (2003) discusses the heterogeneity of welfare programs and the difficulty in creating uniform policies across different jurisdictions. Stigma and cultural factors may hinder recipiency by forming a complex and multifaceted set of hindrances. Stuber and Schlesinger (2006) explore the nuanced impact of stigma on welfare participation and emphasize the need for culturally sensitive approaches to policy design. While behavioral economics interventions, such as nudges and simplified processes, have shown promise, their effectiveness can vary significantly depending on context and implementation. Over-relying on these interventions is risky without considering deeper structural issues. Disparities in recipiency may reflect an intersectional dimension. Intersectionality is how various social categorizations, such as race, class, and gender, intersect to create overlapping disadvantage systems. Crenshaw (1991) introduces the concept of intersectionality and its importance in analyzing social issues.

Other factors that explain the low uptake rate include structural barriers and other inhibitors, such as eligibility criteria, informational problems, insufficient community participation, administrative hurdles, etc. Initial denials occur naturally. Other inhibitors include inadequate integration of information technology to connect different programs for the automated registration of eligible individuals. To successfully file a disability claim, one must be persistent. However, most disabled persons lack the resources, knowledge, or vigor to persist in navigating through bureaucratic obstructions to succeed in their claim. Conversely, those with sufficient resources and knowledge of program protocols but questionable disability or SSI claims may succeed.

Theory of Social Program Recipiency

Several theories help explain the factors influencing participation and access to benefits. They include planned behaviors, rational choice, economic incentive or behavioral economics, social determinants of health, institutional complexities, stigma, awareness and outreach, discrimination, and inequalities. The theory of planned behaviors (TPB) suggests that individual behavior is driven by intentions, which are influenced by attitudes, subjective norms, and perceived behavioral control. In social insurance recipiency, attitudes toward benefits, perceived social norms, and confidence in navigating the application process can affect participation. The rational choice theory posits that individuals decide by weighing the costs and benefits to maximize their utility. Regarding social insurance, potential recipients assess the perceived value of the benefits against the effort required to obtain them. The social determinant of health (SDOH) theory emphasizes the impact of social, economic, and environmental factors on individuals' health and well-being. Access to social insurance may be part of the broader determinants affecting economic stability and health outcomes. The institutional theory examines how formal and informal institutions (e.g., laws, regulations, cultural norms) influence behavior and decision-making. It suggests that institutional barriers and facilitators play a significant role in determining recipiency rates. Currie (2004) documents that automatic or default enrollment enhances take-up while administrative barriers hinder it; however, removing individual barriers has little effect, suggesting that one must address the whole bundle. The capability view submitted by Sen (1999) underscores an individual's capabilities to achieve well-being and participate in economic and social life. It emphasizes the importance of providing resources and opportunities that enable individuals to utilize their capabilities fully, including access to social insurance.

Research Significance

It is essential to comprehend the barriers that hinder the uptake rate from reducing poverty and the disparities between the impoverished and the destitute, marginalization, accomplishing programs' aspirations, augmenting fairness, permitting policymakers to appraise the financial costs more accurately, or the fiscal effects of welfare reforms. Reducing poverty and improving legitimate beneficiaries' financial strength will enhance their resilience to economic shocks. Analyzing the factors inhibiting DI and SSI utilization may bolster eligible individuals' rights while allaying policy apprehensions and strengthening programs' efficacy and effectiveness. Ineffectiveness in implementation prevents programs from achieving their goal of reducing poverty across sociodemographic groups. This study is timely as the implications of non-take-up, where individuals have yet to receive their full benefits, remain unclear.

Previous research has highlighted administrative complexity as a hindrance to participation. However, there is still a need for a more thorough analysis to understand how specific administrative procedures impact recipient rates in various social insurance programs. This study explores components of administrative complexity, such as application forms, documentation requirements, and bureaucratic interactions, to pinpoint precise obstacles and propose targeted simplification solutions. While recognizing the role of economic incentives in influencing participation, a void persists on how different benefit levels and perceived economic value impact demographic groups. The study explores ways to optimize economic incentives to enhance participation across diverse populations, considering income, employment status, and demographic characteristics.

Another significant persisting gap refers to how social stigma uniquely affects different groups and the mechanisms through which stigma discourages participation. Current literature underscores the importance of awareness and outreach, but the need for more thorough evaluations of various outreach strategies and their effectiveness persists. Limited research exists on institutional and systemic barriers contributing to disparities in social insurance participation among marginalized groups. While acknowledging behavioral economics principles, additional research is necessary to examine how specific behavioral interventions can enhance recipient rates in social insurance schemes. Integrating multiple theoretical frameworks is essential to understanding the factors influencing participation in social programs.

Data and Method

This research proceeds in two parts to assess hindrances to DI and SSI recipiency. The first part reviews the existing literature and contrasts U.S. results with those in the OECD countries. This approach brings together qualitative and quantitative data analysis, with an emphasis on qualitative analysis. This segment will feature comprehensive cross-country tables exhibiting the type of benefits, the name of the programs, the targeted population, the estimated participation, the time reference, and authoritative bibliographical references. Analyzing social insurance systems in other nations can help identify effective tactics and common hurdles that can guide U.S. policy. Lessons from various countries may provide insights on simplifying processes, boosting economic incentives, reducing stigma, enhancing outreach, overcoming discriminatory access, and intersectional policy design. By leveraging global best practices, policymakers can devise more effective strategies to promote participation and equity in U.S. social insurance programs.

The second part empirically estimates non-take-up rates in the U.S., using data from the Health and Retirement Survey (HRS) databank. It comprises two segments: The first focuses on identifying the factors influencing the take-up probability using probit regression with non-take-up of DI and SSI as distinct dependent variables. The factors assumed to affect take-up utility include single parents, households with children, income, employment status, family disability, educational attainment, sex, age, race, rural location, benefit size, duration, conditionality, attitudes toward Social Security, awareness, complexity, experiences of humiliation, intimacy, and participation in other government programs (such as Medicaid, Medicare, TANF, SNAP, UI, housing subsidy, and EITC). These variables serve as proxies for the needs or costs associated with claiming.

Policymakers should be concerned about the extent of non-take-up and the behavior behind it, along with the leakage of public resources to ineligible individuals (Fuchs 2007 and Kayser and Frick 2001). Low take-up of welfare benefits can undermine the redistributive effectiveness of welfare programs and bring into question their role as safety nets. Understanding the factors affecting the probability of non-take-up may fail to account for imperfect take-up while providing limited insights into the severity of the problem. If non-take-up is only partly voluntary, it creates fundamental inequities among similarly situated eligible individuals. These inequities may worsen when comparing non-take-up by eligible individuals to the receipt of benefits by ineligible ones. Imperfect take-up complicates the anticipation of social outcomes and estimating policy reform costs. Given the prevalence of non-take-up behavior, it is crucial to accurately incorporate it into economic simulation models to reflect income distribution and poverty incidence in society. To circumvent this, we will employ a Monte Carlo technique to simulate non-claimants from the population of eligible recipients. The HRS provides relevant characteristics to recognize eligible non-claimants. The modeling will progress in the following steps: (1) examine the population, (2) analyze requirements, (3) define permissible disabilities and income rules, (4) apply the subsidiarity principle when giving out benefits, (5) discuss data management and distinguishing between households who take up and do not take up benefits, and (6) evaluate beta error participants. We will subsequently show the descriptive non-take-up rates from our reference simulation model and analyze the discrepancies in non-take-up rates because of the alterations in the simulation model. We will analyze the influence of potential measurement and estimation errors in evaluating income and needs by employing constant rates of variation and fortuitous errors.

No simulation technique is entirely error-free. Monte Carlo simulations may yield biased non-take-up rates, while classical measurement errors overestimate both non-take-up and beta error rates. The challenge is how to correct this bias in estimating social benefit non-take-up. To adjust for this distortion, we can treat the observed measures as "true" and apply random variations to the measures of needs and disability, both separately and concurrently, under the assumption of independent errors. To overcome this challenge, we will generate 500 random errors for each measure and 500 sets of independent errors for all components, assuming the deviation of random or classical measurement errors from the "true" measure follows a normal distribution. We will graphically show the distributions of non-take-up rates and corresponding beta error rates before and after the post-simulation corrections. The beta error rate attests to the quality of the simulation model in combination with the corresponding variation in non-take-up rates, with high beta errors implying that the model is too restrictive. Analyzing the joint variations in beta error rates and non-take-up rates after several versions of the simulation model will yield a benchmark to evaluate the simulation model.

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What Are the Challenges in Accessing Supplemental Security Income for People with Disabilities?

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Significance

The purpose of this qualitative research study is to examine the obstacles that eligible disabled people experience, especially people of color, in applying for SSI or in appealing initial denials. Findings will yield recommendations for improving access to SSI. Approximately 6.5 million disabled individuals in the United States receive support from SSI (Office of Retirement and Disability Policy 2022). However, less than one-third of applicants were approved for benefits in 2020 (Social Security Administration 2022), and some eligible individuals self-select out of the program, because they do not apply or choose not to appeal an initial denial (Favreault 2021).

Qualifying for SSI is a lengthy process that often requires one or more appeals, which can delay receipt of benefits. One analysis of the disability benefits application process found that the conditional probability of being awarded benefits upon appeal was over 50% greater than at the point of initial application, but that for people who had to file one or more appeals, the median delay between applying for and receiving benefits increased from 4 months to 13 months (Benítez-Silva et al. 1999). Another study finds that as many as 60% of rejected applicants for disability benefits are disabled, three times the rate of benefit recipients determined by the same researchers to have been awarded benefits in error (Benítez-Silva et al. 2004).

Racial identity and racism are also specifically implicated in disability benefits take-up, and in disparities in receipt of disability benefits. Compared to beneficiaries of SSDI, including those who are receive both SSI and SSDI, SSI-only recipients are more likely to be people of color (Rupp & Riley 2011). Past work found that among applicants who are not represented by an attorney, Black claimants are significantly less likely to be awarded benefits than white claimants during the appeals process (Godtland et al. 2007).

Little research exists on the reasons that eligible individuals may choose not to apply for SSI, or why some applicants who are eligible but receive an initial denial of benefits do not pursue an appeal. Also, there has been limited research that uses primary qualitative data to explore the application and appeals processes from the perspective of eligible individuals. The proposed study addresses this gap and will contribute to SSA's ability to resolve barriers that limit participation of eligible individuals in SSI. The research questions include: (1) What are the perceptions of disabled people, specifically disabled people of color, towards the SSI application process? (2) What are the barriers that eligible disabled people experience in applying to SSI or appealing an initial denial? What are the specific barriers that eligible disabled people of color experience in applying to SSI or appealing an initial denial? (3) What improvements can be made to the SSI application process to better support disabled people in completing it?

Data

This project is collecting primary data via interviews with benefits counselors and staff from community-based organizations that support disabled people and focus groups and interviews with people with disabilities.

Methods

We are conducting semi-structured interviews with 10 benefits counselors, executive directors of independent living centers, and staff from other community-based organizations (CBOs) that support disabled people to ascertain the scope of the barriers to applying for SSI or appealing initial denials that their clients face. We are also conducting semi-structured interviews with 30 working-age disabled people who are eligible for SSI to document the barriers that they experience in applying for SSI or appealing initial denials. The interviews are being conducted over the phone or via video conferencing, depending on the participant's preference. Participants are being recruited through disability advocacy groups, community organizations, and social media platforms.

We are making specific efforts to include at least five professional staff from organizations that primarily serve racial and ethnic minority disabled people. We are recruiting 30 eligible disabled individuals, including people who have never applied for SSI and people who received an initial denial (and may or may not have appealed the decision). At least half of the individuals will be racial and ethnic minorities and at least a third will identify specifically as Black. Interviews will be conducted in Spanish and ASL, if needed. Accommodations will be provided to participants as needed and they will receive a $50 stipend for participating. We will use Dedoose software to assist with coding. Data will be analyzed using thematic analysis, which includes a process of generating initial codes, searching for themes, reviewing themes, and defining and naming themes to develop a thematic map.

We anticipate generating recommendations pertaining to both the application and the appeal processes. These recommendations may address the following areas, among others: accessibility of the application, wording of the application, format of the application, materials required for the application, training of Social Security staff members, knowing about the right to an appeal, timelines pertaining to the appeal process, the process of finding out about an initial denial, etc.

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Developing a Survey to Understand Barriers to Applying for Disability Insurance

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Introduction

Applications for SSDI and SSI benefits have been declining by more than expected for over a decade. There are few hypotheses for this decline. In this project, we try to understand true and perceived barriers to applying for benefits by surveying people about why they have or have not applied for disability benefits. We target two specific groups available to survey in large survey panels. First, we will identify adults with long-term disabilities. Second, we will identify adults who have children with long-term disabilities. While previous surveys have studied people's understanding of how SSDI and SSI work, we have a limited grasp of the barriers to applying for benefits expressed by people who have or have not actually applied for benefits. We will conduct multiple surveys on these groups to understand the importance of specific barriers.

We will use two strategies to understand these barriers. First, our surveys will directly ask about the reasons that people have not applied for disability benefits. Second, we will use embedded experiments to assess how information interventions and hypothetical changes to the programs impact application rates. This latter approach will provide direct evidence about the importance of information and other barriers in influencing disability application rates. In particular, we will have the opportunity to assess actual application rates among one of our samples in a follow-up survey after experimentally varying program information.

Little is known about how specific barriers impact disability application rates. In particular, there is little research on barriers facing parents of children with long-term disabilities. This work will provide needed evidence to inform policy about factors that might be impeding benefits from reaching households in need.

Data and Methods

The goal of this project is to understand what drives applications for disability benefits, and what the major barriers are that prevent people from applying.

Data

Standard survey panels typically do not have large enough samples to study the relevant populations for this project. We will use two different sets of panels. First, we will leverage panels constructed by Respondi to survey adults with long-term disabilities, stratified by whether they have ever applied for benefits. Respondi will also provide samples of parents with children with disabilities, which will likewise be stratified by whether the parents have previously applied for benefits. Respondi is a survey platform which has been frequently used by researchers (Alesina et al. 2023; Arin et al. 2021; Cattaneo et al. 2024; Dylong and Uebelmesser 2024; Liscow and Fox 2022; Liscow and Pershing 2022; Sander et al. 2023; and Schmelz & Bowles 2022). Respondi cultivates a high-quality sample of respondents through active online recruitment and validated authentication (e.g., they require individuals to opt in twice to be part of their survey pool). As part of the recruitment process, Respondi collects very detailed demographic information – up to 300 "touch points" – which enable the construction of nationally representative panels. Moreover, unlike typical convenience samples whereby individuals know the topic of the survey and select into responding, none of the respondents know the survey topic before participating, which reduces selection concerns.

In addition, the RAPID Survey Project, a large sample of parents and childcare providers constructed by the Stanford Center on Early Childhood, has agreed to let us field a set of questions about disability benefits for children. Started in response to the COVID-19 pandemic, the RAPID Survey Project contains a national survey of families with children under 6, particularly targeted to lower-income families. In addition to being a means to access this important population, a key advantage of RAPID is that we can survey the same respondents multiple times, and RAPID has agreed to let us conduct a follow-up survey.

Methods

Our survey will begin by asking Respondi respondents about whether they have a long-term disability or if they have a child with a long-term disability. Respondents with long-term disabilities, or who have children with long-term disabilities, will be asked about whether they have previously applied for disability benefits. In addition, we will ask if they were approved to receive such benefits if they applied. Respondents with long-term disabilities will also be asked questions to determine potential/actual eligibility for SSDI or SSI benefits, and the subsequent survey questions will be tailored to the program.

The respondents will then be separated into different surveys based on those who have never applied for long-term disability benefits versus those who have applied in the past. For those who have never applied, we will ask about the primary reasons for not applying, including (but not limited to): the hassles of applying, the complexity of application procedures, the waiting periods for benefit receipt (if applicable), a belief that they will not qualify, and so on.

After asking respondents to provide reasons for not applying, we will conduct our experiments to assess the importance of specific barriers in the decision to apply. A lack of knowledge about disability benefits is a frequent barrier to applying (Knapp and Perez-Arce 2022; and Messel et al. 2022). We will first test how improved knowledge of specific components of the programs would affect applications. We will randomize respondents into several experimental arms, and provide each arm with information about a particular component of the program, such as application approval rates, the lengths of waiting periods (for SSDI arm), and the possibility of becoming automatically eligible for or enrolled in Medicaid with SSI (for SSI arm). The control arm will not be provided with such information. After this information shock, we will ask respondents in the Respondi samples about the chances that they will apply for disability benefits within the next year. We will compare probabilities across arms to assess the importance of information on each program component in impacting disability application rates.

After respondents provide their probability of applying for benefits, we will present each experimental arm with a hypothetical change to the program component from their original information shock, and ask what their probability of applying for benefits would be under this hypothetical change. For example, respondents who were informed that SSDI has a two-year waiting period before receiving Medicare benefits will be asked what their probability of applying for benefits would be if SSDI beneficiaries were immediately eligible for Medicare upon receipt of cash benefits. We will then study how these probabilities change given these policy options. This approach allows us to study the scope for policy changes to affect application rates.

The same experimental treatments will be provided to the RAPID sample. However, we will not ask them to report their chances of applying for disability benefits. Instead, RAPID will provide an opportunity for us to re-survey the same parents. In the follow-up, we will ask whether they have applied for benefits. This experiment allows us to estimate the causal effect of the provided information.

For those who have applied for disability benefits in the past, we will ask specific questions about a large set of possible barriers they experienced when applying. We will stratify the results from these survey questions based on whether they eventually received benefits. For example, we will ask about the difficulties of specific parts of the application process, whether their actual benefit levels were higher or lower than they expected, and about the difficulties posed by the waiting periods. We will also ask about unmet needs. Finally, we will offer all respondents a chance to write about their experience applying for benefits.

Conclusion

This project will provide needed information on factors that are dissuading people with long-term disabilities or with children with long-term disabilities from applying for disability benefits. We will use experimental variation to study self-reported chances of applying for benefits and changes in actual application status.

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Which LTSS Financial Support Policies Are Preferred among Caregivers and Can They Reduce Racial/Ethnic Disparities in Retirement Security?

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Introduction

Family caregiving serves as the cornerstone of long-term services and supports (LTSS) care, especially within underserved communities, yet it poses significant challenges and often necessitates financial sacrifices from caregivers. Researchers, practitioners, and policymakers alike have proposed various options to alleviate this financial strain, but which options would be most beneficial to family caregivers of older adults remains uncertain. As the demand for LTSS continues to rise, it is important for researchers and policymakers alike to understand which policies could help alleviate retirement security burdens. Also important is uncovering how the preferences for policy alternatives vary across different sub-populations of family caregivers (e.g., working versus non-working, high- versus low-income, and different racial/ethnic groups). This project uses a mixed methods approach to understand which policy proposals would be most beneficial for different groups of caregivers.

Data and Methodology

To inform on these issues, we conducted focus-group interviews with a diverse array of LTSS family caregivers of older adults. These discussions were structured to elicit views on concrete caregiver support policies, with a focus on understanding how their lived experiences shape their perspectives and identifying which policies they perceive as most conducive to enhancing their retirement security. Virtual focus groups were conducted to maximize accessibility. Four focus groups were conducted, each 75 minutes, with 25 caregivers in total. Two groups were comprised of higher-income individuals (>$75,000) and two were lower-income (<$75,000).[1]

The quantitative portion supplements the interviews by estimating which racial/ethnic groups could benefit from these support policies and by how much. The analysis uses the *National Health and Aging Trends Study (NHATS)*, linked with the *National Study of Caregivers (NSOC)*, to calculate the probability that caregivers from different racial/ethnic groups face various financial challenges due to caregiving. Using those results, we can estimate the extent to

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[1] The average age across the 25 focus group participants was 50.3 years old (SD = 9.9, range 26-67). Overall, the sample was 80% female (n = 20) and 20% male (n = 5). A majority of respondents were from underserved communities including African American (40%), Hispanic or Latinx (8%), Pacific Islander or Native Hawaiian (4%), and Asian (4%). A plurality of the sample was white (44%). On average, 60% were employed full-time or part-time. The remaining 40% were retired or partially retired, or not employed outside the home. Approximately 52% of the sample made less than $75,000 annually. Most respondents were primary caregivers (64%), while 36% shared duties with others.

which each of the policies helps caregivers from different backgrounds.

Results

(A) Focus Group Discussion of Caregiver Support Policies

The following policies were explored with caregivers to assess their perceived helpfulness (that is, value) and to elicit views on each policy. The policies included: 1) paid family and medical leave or expanded paid sick leave; 2) direct payment from the government for providing family care; 3) tax credits for providing care; 4) caregiver credits toward Social Security benefits; 5) paid respite care; and 6) reimbursements for caregiver out-of-pocket expenditures.

(1) Paid Family and Medical Leave (FMLA) or Expanded Paid Sick Leave. While some states already have paid family leave, the proposed policy described to focus group members was most similar to the federal FMLA, which offers around 60% of wages for up to 12 weeks for workers caring for someone with a serious illness. Many respondents were aware of and noted the program's positive aspects but those who were not employed felt it wouldn't benefit them due to their non-working status. Concerns included the program's limitations, such as paid time accrual, benefit caps, the limited time that benefits are available, and relevance to certain employment types. Self-employed individuals questioned its relevance, and working caregivers were more likely to highlight the need for job protection.

(2) Direct Payment for Family Caregiving Services. Most participants showed great interest in being paid directly by the government for their family caregiving time. They emphasized the immediate relief such payments could provide, especially in urgent situations, and how it could ease balancing work and caregiving. Concerns about this type of program included anticipated delays in receiving payments, the temporary nature of support, and accessibility issues like eligibility criteria and lengthy approval processes. Disparities in regional availability were also noted as a limitation. Respondents suggested that it would be important to streamline approval processes and expand coverage to ensure equitable access to support services.

(3) Tax Credit for Caregiving Services. The next policy discussed was a tax credit for caregiving for an older adult, thereby reducing caregivers' income taxes. This policy interested fewer respondents but some still found it relevant. Participants noted it might not benefit them if they don't pay taxes or prefer immediate assistance. Some found direct government payments far

more helpful than a tax credit. Concerns about a tax credit approach included having to wait until tax season to receive the credit.

(4) Social Security Caregiver Credit Act. This policy involves counting caregiving time out of the labor force as "employment" for the purposes of accruing Social Security benefits.[2] Fewer participants showed interest in this policy in large part due to its focus on future, rather than immediate, financial needs. The fact that such a program could augment Social Security for caregivers unable to work outside the home was viewed positively. Higher income caregivers found this policy more helpful than lower-income earners. Again, some preferred immediate financial support over uncertain future benefits. Suggestions for strengthening such an approach included combining immediate support with long-term benefits to better address caregivers' financial needs.

(5) Paid Respite Care. Paid respite care involves payments to a provider to give caregivers a short-term break, either through home care services or short-term residential care.[3] A modest number of respondents showed interest, seeing potential benefits in reducing caregiver burden and allowing for temporary breaks. The benefits of such an approach included improved time management and opportunities for self-care. Concerns focused on the quality, availability, safety of respite care, and care recipient compliance. Overall, respondents found respite care helpful but emphasized the need for adequate payment to ensure high-quality providers.

(6) Reimbursement for Caregiving-Related Costs. This policy involves reimbursing caregivers for expenses like home modifications and assistive devices, such as covering the addition of ramps, building accessible bedrooms, or modifying cars for wheelchairs. Respondents saw significant benefits to such a policy, noting how these reimbursements could improve caregiving duties and quality of life. This policy was viewed as promising since such expenses are often not covered by insurance. While some didn't see immediate benefits for themselves, they recognized its potential for others. Concerns included the reimbursement process and the speed of receiving funds.

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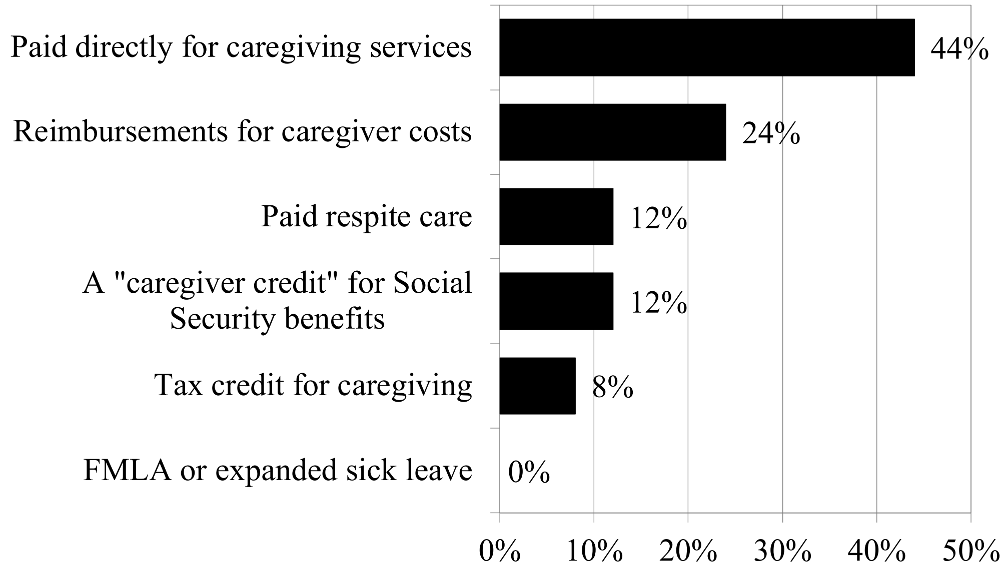
[2] There are several proposals that aim to help workers who have to drop out the labor force temporarily. Many are focused on providing parents who care for children credit but the Social Security Credit Act, which has been introduced in several recent legislative sections, would apply to caregivers who provide care for children or adults.

[3] The settings in which respite care is provided can vary by state. For example, Massachusetts has a grant that allows home and community-based services, such as certified home health agencies and day programs to provide respite care for caregivers. For more information see: https://www.mass.gov/info-details/respite-innovations-grant. Several states also provide adult day care services, which although not specifically respite care, can help caregivers get a break.

(B) Policy Priorities and Differences by Socio-Demographic Characteristics

Of the six policies described, being paid directly by the government for family caregiving was the most popular, followed by reimbursing caregiving costs (see Figure 1).

Figure 1. *Most Important Caregiver Support Policies*



Source: Focus group responses.

The policies that respondents found least important were almost a mirror image of the ones they found most important.[4]

While the most important and least important policies were highly consistent across sociodemographic groups, there were some variations. For example, higher-income caregivers clearly preferred direct payments for caregiving (28%), while lower-income caregivers were split between reimbursements for caregiving costs (20%) and direct payments (16%). Both non-white and white caregivers ranked direct payments highly, but non-white caregivers favored it much more (32% vs 12%). White participants were also just as likely to rank credit towards Social Security as their preferred policy as direct payments. The second most preferred policy among non-white participants, however, was having costs related to caregiving costs reimbursed (16%). Not surprisingly, primary caregivers preferred direct payments (32%) or reimbursements (16%).

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[4] None of the respondents selected direct government payment or reimbursement for caregiving costs as the "least important" policy. On the other hand, most respondents chose having paid family and medical leave or expanded paid sick leave as the least important (36%), followed by receiving a tax credit on income taxes (28%) and receiving credit toward Social Security (24%).

Non-primary caregivers also liked reimbursements (8%) but showed some interest in respite care as well (8%).

(C) Quantifying Challenges for Caregivers

One reason policy preferences vary across sociodemographic groups may be because the characteristics of caregivers and level of care they provide also vary across groups. Data from NHATs/NSOC show that Black and Hispanic caregivers are younger and much more likely to be the children rather than spouses of care recipients compared to their white counterparts. This means that a large share of them are under age 50; 34 percent of Black and 41 percent of Hispanic caregivers are under age 50 relative to 22 percent of white caregivers. In addition, Black and Hispanic caregivers are much more likely to provide high levels of care, with close to half of them providing more than 60 hours a month compared to 31 percent for white caregivers. As a result, Black and Hispanic caregivers are much more likely to be working part-time or have dropped out of the labor force despite being younger, which substantially impacts their lifetime earnings and their own financial security in retirement. Although over 40 percent of all caregivers incurred out-of-pocket costs for caregivers, Black and Hispanic caregivers, particularly those who provide more than 20 hours of care, are even more likely to face out-of-pocket costs. These quantitative results help highlight why direct payments or reimbursements were so popular among focus group participants, particularly those from diverse backgrounds.

Conclusion

Our focus group discussions showed that the policy perceived to make the most significant difference for caregivers was direct monetary compensation from the government, either by being paid for caregiving or through reimbursements for out-of-pocket costs. Conversely, the policy perceived as least beneficial was paid family leave or expanded sick leave. The responses align with our quantitative analysis, which shows that caregivers, particularly those from diverse backgrounds, incurred out-of-pocket costs for providing care and many had to cut back on work or leave the labor force altogether. Overall, these results provide valuable insights for policymakers on the most effective interventions for alleviating the financial burdens associated with caregiving.

Panel 6: Places Matter

Moderator

K. Steven Brown (Aspen Institute)

Panelists

“How Do People Who Reside in Rural Places Prefer to Communicate with SSA?”
Debra L. Brucker, Megan Henly, Stacia Bach, Kelly Nye-Lengerman, and Andrew J. Houtenville (University of New Hampshire)

“Assessing Underserved Communities Beneficiaries’ Communication Needs and Its Influence on Customer Experience and Satisfaction”
Dayo Oyeleye (Bowie State University)

“The Relationship between Local Characteristics and Disability Applications and Awards”
Barbara Butrica (Urban Institute), Stipica Mudrazija (University of Washington and Urban Institute), and Keisha Solomon (Howard University)

“How Workplace Matters for Health: New Evidence on Racial/Ethnic Disparities in Mortality in Urban and Rural America”
Jessica Halliday Hardie (Hunter College) and Frank W. Heiland and Rosemary T. Hyson (Baruch College)

How Do People Who Reside in Rural Places Prefer to Communicate With SSA?

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University of New Hampshire

Prepared for the 26th Annual Meeting of the Retirement and Disability Research Consortium
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Introduction

Our prior research, a scoping review that examined the communication preferences of populations served by government programs (Henly et al. 2023), has identified agency communication with rural populations as an area in need of more in-depth research. This prior research found that the mode of communication affects the public's knowledge and enrollment and that communication approaches that consider community-specific contexts are most effective. In addition, this research highlighted some of the unique barriers that might face people residing in rural areas, including lack of Internet access, no local government offices to visit in person, or a lack of transportation. Others have noted that people living in rural communities receive a larger share of their personal income from Social Security than people residing in less rural places and are disproportionately eligible for Old-Age, Survivors, and Disability Insurance (Michaud, Moore, and Wiczer 2019). This finding, too, lends importance to understanding how SSA can best support service to these types of communities.

Research Approach

To build off this prior research, our research team is conducting a community-engaged qualitative research project in rural areas of New Hampshire (NH) to answer the following questions: 1) What service-related <u>barriers</u> do individuals living in rural areas face when seeking government benefits, and how do these individuals <u>prefer to communicate</u> with SSA when seeking benefits (e.g., online, by telephone, in-person)? 2) How do these service-related barriers and communication preferences vary by sociodemographic groups (e.g., educational attainment, age) within rural populations? 3) How do service <u>perceptions</u> (e.g., satisfaction) and <u>outcomes</u> (e.g., wait times) vary by sociodemographic characteristics?

Our ultimate goal is to gather information to address the research questions outlined above from approximately thirty individuals in NH who meet the following criteria: 1) are at least 18 years of age; 2) primarily speak English at home; 3) reside in a rural county of NH; and 4) meet one of the following three descriptions: a) have a cognitive, communication, mental health, physical, sensory (hearing/vision) disability which limits their ability to work; b) are a family member of a person with intellectual and developmental disabilities who receives Social Security benefits; or c) are near or in retirement age.

Study Setting. As we are based in NH and our university and research institute have many connections with the disability and older adult local communities, we are conducting this study in NH. NH is a geographically small state in Northern New England with a population of nearly 1.4 million people. Seven of its 10 counties are classified as 'rural' and four of these do not have a local SSA field office. Trust in government is low among NH residents, ranging from 44% having trust in local government to only 14% having trust in the federal government in 2019 (Mallory 2024). About 19 percent of NH's population is aged 65 years and older and approximately 10% of working-age persons in NH have a disability. NH's population is predominantly white with 1.2 million people reporting as white alone, not Hispanic or Latino. NH has a slightly larger proportion of residents who are college educated (41%) than the nation as a whole (36%). Median incomes in NH are $15,000 more per year than the national median income ($89,992 compared to $74,755) (authors' calculations from 2022 ACS data).

Community Engagement Process. Before beginning the actual data collection phase of our study, we sought input from a dozen members of the community in NH, including persons with disabilities, family members of persons with disabilities, older adults, and other stakeholders to better inform our research questions, develop our focus group guides, and solicit recommendations for recruitment. This type of community-engaged approach, which involves members of the community in *all* stages of research, draws on approaches outlined in the literature on community-engaged studio approaches, community-based participatory research, and other community-engaged approaches (Daley et al. 2010; Harb and Taylor 2024; Israel et al. n.d.; and Joosten et al. 2015).

In this phase of the project, we aimed to share an overview of our project, a draft focus group guide that we had developed based on prior research (Henly et al. 2023), and our initial ideas about recruitment strategies with members of our target populations to solicit their input. We recruited members for this first phase of community input through our contacts at the University of New Hampshire (UNH). We met with 12 different members of the community in four meetings. While we did not have diversity by race/ethnicity for this phase of our project, we did have diversity in age, sex, and connection to the older adult and/or disability communities. The youngest person we spoke with was a 30-year-old male who had a disability. The oldest person who contributed input at this stage was a female in her 70s, who was also a family member of a person with a disability. Overall, we met with three people with disabilities, seven people who were family members of people with disabilities, and two people who were involved with disability advocacy or direct support professional roles. Of these 12, two were older adults as well as family members of people with disabilities. As mentioned, many of these people, who were familiar with SSDI and SSI, also had experience with other SSA benefits, including retirement and survivors' benefits, and thus represented an appropriate community for this study.

Of the four meetings, two were one-on-one meetings over Zoom. One meeting was hybrid, with one member of our research team attending in-person, one attending on Zoom, and nine attendees. One final person connected with us by phone. At each meeting, we first described our overall study aims and clarified that we were only seeking input on possible focus group questions and recruitment methods and that we could not use any information from these meetings as 'research results' as we were using this formative stage of community engagement to inform the development of our Institutional Review Board (IRB) materials. Each meeting lasted approximately 30-45 minutes. We reviewed the draft set of focus group questions that we had developed and solicited recommendations for improving the types and content of questions, adding additional questions, or removing some. Once the review and discussion were complete, we asked for suggestions about how we could best recruit people to participate in our in-person focus groups. Last, we asked participants if they would be willing to reconnect with us after we completed our focus groups to help discuss and provide input into interpreting our findings. Participants were not reimbursed by this study for their input at this phase.

We synthesized this community input to frame our final focus group protocol and recruitment strategies. These community members first suggested we simplify our questions. They also suggested that we place a strong emphasis on understanding how initial enrollment in an SSA program occurred, as it is important to understand how people even knew to apply for benefits. They reinforced the view that older adults and people with disabilities may have limited digital literacy as well as limited or no access to smartphones, computers, or printers. The community members reminded us that people are often not clear about what type of benefit they are receiving. They raised additional points about accessibility and accommodations and how this can impact enrollment or continued communication with SSA. Some members raised issues of trust. From a civic trust level, one mentioned that some people do not want benefits from the government. From a more general trust perspective, one mentioned that some people do not trust any online means of communication. They shared possible contacts for recruitment and some also (although unsolicited at this point) shared ideas for policy recommendations.
We submitted IRB materials to our institution's IRB in the Spring of 2024.

Research Participant Recruitment. After obtaining IRB approval, we worked with our UNH partners to assist us with our recruitment efforts to organize in-person focus groups in rural counties. To incentivize participation, we offered a $50 Visa gift card for participants, a fact that is highlighted in our marketing materials. We initially used primarily 'old school' types of recruitment as we were hoping to find people who were not on social media nor were connected to local advocacy groups. For this phase of recruitment, we e-mailed and mailed hard copy flyers to local contacts, including libraries, disability and older adult organizations, and senior centers. We also placed ads in local hardcopy newspapers. As recruitment using these types of processes was slow, we shifted our recruitment strategy to also use social media as of early-July. We also modified our IRB to allow for individual interviews (in-person, by phone, by Zoom) and for Zoom focus groups in addition to in-person focus groups.

The flyers and ads requested that participants who were interested in sharing their experiences in interacting with SSA and who met our inclusion criteria (as mentioned above) contact us (the research team) by telephone or e-mail so that we could arrange a time to call them back and go through a more in-depth screening process, using a script we had developed as part of our IRB package. The screening process that occurs by phone allows us to provide more details about our study and participation expectations and ensures that participants meet our inclusion criteria. During the screening, we also gather some demographic information and collect basic information about how people currently or have ever interacted with SSA. We are capturing this screening information in a spreadsheet so that we have full information about eligible candidates as we move to scheduling focus groups in particular parts of the state.
Since e-mail is included as a possible option that interested participants can use to contact us during this screening phase, we have had to screen out fictitious participants who have contacted us using bots (a computer application that automatically sends many e-mails from different e-mail addresses) or some other means. The monetary incentive makes screening for bots important. We have also faced challenges in that some people who have even initially expressed interest are wary of people (our research team) calling them back and asking for more information, given their concerns about possibly being scammed.

Data Collection. Our data collection is ongoing. We have been most successful at scheduling in-person focus groups at local organizations that had already scheduled events with our populations of interest. For example, in the latter weeks of July 2024, we are scheduled to hold focus groups at two rural locations that had already scheduled other events. Tacking our focus groups onto these events has been very successful in generating interest. For example, we are holding two focus groups, one immediately before and one immediately after a 'congregate lunch' and on location at a senior center. As another example, we are meeting a different advocacy group at the end of their regularly scheduled meeting at a restaurant and coordinating the attendance of group members at a focus group we have scheduled directly after their meeting, three miles away at a UNH Extension Office. As an alternative to these in-person focus groups, we have also scheduled a Zoom focus group for later in August that is beginning to generate interest.

We will video record each focus group (which will either be transcribed automatically via Zoom or will be downloaded from a video camera and uploaded to a secure transcription service). We will provide gift cards to participants at the conclusion of each focus group. Once we have conducted enough focus groups and/or interviews to capture our target sample size, we will conduct data analysis in nVivo. After our data collection wraps up and we have analyzed this qualitative data, we plan to circle back to our initial set of 12 community-engaged persons so that they can help us review and summarize the data and develop preliminary SSA-level and community-level policy options. We expect the results of this study to extend prior research that has examined federal agency communication with target populations in rural areas by providing new information that will be particularly relevant for agencies communicating with people with disabilities and older adults who reside in rural areas of the U.S.

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Assessing Underserved Communities Beneficiaries' Communication Needs and Its Influence on Customer Experience and Satisfaction

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Introduction

The U.S. Social Security Administration (SSA) achieved the highest score of any government agency on the Center for Plain Language's 2022 Federal Plain Language Report Card (e.g., SSA 2023). The Center evaluated 21 Executive Branch agencies, including all 15 cabinet-level departments, and graded each between an A+ and F- for writing quality and organizational compliance. The SSA received an **A+** for organizational compliance and an **A** for writing quality. However, results from a 2022-2023 SSA-funded research project (NB 23-12) indicate that beneficiaries in underserved and Black communities would prefer to receive SSA benefits information in "plain" language. Existing literature on "plain" language has not disaggregated findings by race or focused strictly on Black people. This project seeks to elicit Black people's understanding of what it means to communicate in "plain" language by examining whether the Center for Plain Language's 2022 Federal Plain Language Report Card ratings are consistent with the reality of Black people from underserved communities. This mixed methods project seeks to provide policymakers with some tangible approaches to improve service delivery, communication, and outreach with the goal of reducing racial and ethnic disparities in retirement preparedness and wealth more generally.

Significance of Project

The Plain Writing Act of 2010 requires that federal agencies use clear government communication that the public can understand and use (e.g., U.S. General Services Administration 2023). The goal of the Act is to ensure that users of federal agency services can find what they need, understand what they find, and use what they find to meet their needs. Results from an SSA funded research project (NB 23-12) to understand communication preferences of underserved communities, indicate that Black beneficiaries would like to receive information from SSA about their benefits in plain language. This finding is important because Black beneficiaries are more likely to report higher levels of distrust in the information they receive from SSA compared to other sources like financial advisors, banks, and family members (e.g., Rabinovich and Yoong 2016). The proliferation of other sources may give rise to choice overload and subsequent avoidance by underserved communities, which in turn may increase retirement planning delays and anxiety (e.g., Viceisza et al. 2022).

Utilizing a mixed methods approach to conduct research with the aim of assessing whether the SSA retirement benefit information received by Black people in underserved communities is perceived to be in plain language is the main purpose of this project. This project will provide pertinent information to policymakers on what could be done to improve service delivery, communication, and outreach with the ultimate goal of reducing disparities by race and ethnicity.

Mixed Methods Approach

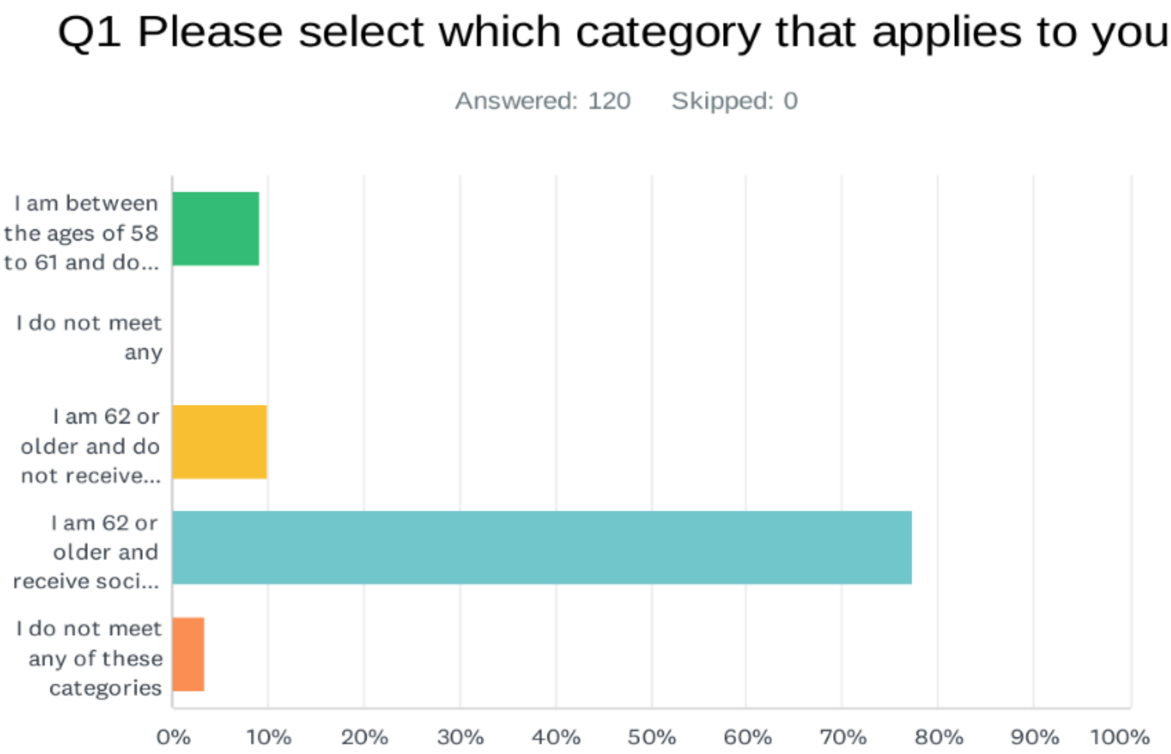
This project utilizes more than one method to validate and ascertain that the variance in the analysis of the data collected reflects accurate findings from the individuals who participated in the research and not solely on the research method used. This research used a combination of qualitative interviews/focus groups and quantitative survey/questionnaires methods to collect and study data that explored a firsthand view of Black beneficiaries' understanding of what "plain language" is and how that understanding can be used to improve SSA services to Black beneficiaries. In other words, if both methods are used separately, but in a logical sequence to validate each other, and are saying the same thing, then there must be an element of truth in the findings.

This project collected data from the focus group sessions to determine what questions will be asked in the survey instrument. After the focus groups, participants' feedback was evaluated to determine recurring themes that were used to create the survey instrument with the goal of identifying what is considered a shared understanding of plain language from a Black beneficiary's perspective.

Results

To gain a comprehensive understanding of the needs of these groups, a focus group consisting of 120 individuals (N=120) was conducted over four sessions (between March and April 2024). The research specifically targeted individuals aged 62 or older, who are either recipients or non-recipients of Social Security benefits. As illustrated in Figure 1, most of the focus group participants were aged 62 or older and were recipients of Social Security benefits.

Figure 1. *Age and Social Security Benefit Status*



In each focus group session, participants were asked five questions in no sequential order regarding what the beneficiaries / potential beneficiaries understood as plain language. The focus group sessions revealed a preference for tutorial videos or books that can provide information such as a job aid to illustrate a step-by-step approach on how to seek and understand information on a beneficiary statement. Transparency on how to calculate the amount beneficiaries receive was also suggested. Participants stated that having a quick reference guide on how beneficiary amounts are calculated on the beneficiaries' statement could foster building trust among Black people and SSA. Another barrier stated by the participants that deters them from seeking and getting information to better understand their beneficiaries' statement information is the mobility of getting to SSA offices, and the accessibility of having access to information via technology. Some participants suggested the utilization of seniors to be advocates in their community, which will foster trust building between the underserved community and SSA. The participants stated that professional development activities should be provided to SSA staff to enhance their customer service delivery approach. Feedback given in the sessions indicated that SSA staff are sometimes not courteous, impatient, and the information provided is not always consistent. Also, it was noticed that there were more female participants

(N=100) than male participants (N = 20), and the reason given for the gender difference is that men rely on women to seek information on SSA and bring it back to them. Based on the feedback received during the focus group session, a survey to gather feedback regarding their understanding to see if their statement was in plain language was developed and administered. Currently, 296 responses have been collected out of 350 targeted participants. Table 1 shows a sample of the survey questions.

Table 1. *Survey Questions*

7. How are you currently receiving retirement benefit information from SSA?	• Information mailed by the SSA to my home. • Public service announcements in the print media. • Public service announcements via the television or radio. • Public service announcements via social media (Facebook or Twitter). • Information posted in community spaces such as churches, libraries, and community centers. • Information provided by a SSA representative in person. • In a location such as a community center or local school, information provided at my place of work. • Web-based tutorials by the SSA (for example in the form of YouTube videos or other platforms). • Text Messaging. • My Social Security Portal.
8. Do beneficiaries find the information they need through the SSA communication of their preference with ease?	• Yes ○ If yes___can you explain in what way • No ○ If no___can you explain in why
9. Do beneficiaries understand the information they find?	• Yes ○ If yes___can you explain in what way • No ○ If no___can you explain in why
10. Does the information found by the beneficiaries meet their needs?	• Yes ○ If yes___can you explain in what way • No ○ If no___can you explain in why
11. How useful is the retirement benefit information received from SSA assist you in planning for retirement?	• Very useful • Somewhat useful • Not very useful • Not useful at all
12. How easy is it for you to understand the information about retirement planning from the retirement benefit information received?	• Very easy • Somewhat easy • Somewhat difficult • Very difficult

Conclusion

The findings from the mixed methods approach utilized will provide policymakers at SSA with some tangible insights on how to improve/enhance service delivery to the underserved communities' beneficiaries.

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The Relationship Between Local Characteristics and Disability Applications and Awards

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Introduction

The notion of place is central to the idea of social determinants of health and there has been an increased recognition, both by researchers and policymakers, of their critically important role in understanding the etiology of different diseases and health conditions (Mudrazija et al. 2020). For example, studies find factors such as the socioeconomic disadvantage of a neighborhood, residential instability, high crime, and poorly designed built environments to be linked systematically with worse health outcomes (Beard et al. 2009; Clarke et al. 2009; and Rachele et al. 2019), including work disability (Lane and Collie 2021), cognitive decline (Powell et al. 2020), and others. Particularly detrimental to health is a long cumulative exposure to adverse neighborhood conditions (Clarke et al. 2014).

Although disability determination is based on criteria that pertain to individuals, where people live is not random, and it is likely that place characteristics such as health insurance coverage, availability of health care services, unemployment rate, range of industries and occupations, quality of built environment, pollution, crime rate, physical safety, and availability of healthy food play an important role in who applies for and receives disability benefits, since they partly determine the likelihood of becoming disabled, the severity of disability, and access to health care to obtain medical documentation to support disability determinations. Looking at one such characteristic, the availability of SSA field offices, Deshpande and Li (2019) find that office closures lead to a substantial decline in disability applications and receipts in surrounding areas with a disproportionate impact on more socioeconomically disadvantaged populations.

In this paper, we assess various place-specific factors and their possible link with disability prevalence, Social Security Disability Insurance (SSDI) applications, and SSDI receipt. The findings will highlight the extent to which an individual applicant's health status is a function of the context of the place they live in and the extent to which different groups are differentially exposed to risks that lead to disablement and, subsequently, disability applications.

Data and Methods

The data for this analysis is based on the restricted-access Health and Retirement Study (HRS), which provides geographic identifiers that we use to merge tract-level data from the American Community Survey and from the National Neighborhood Data Archive (NaNDA). NaNDA is a repository of neighborhood data, available at census tract and zip code levels, that includes information on neighborhood-level characteristics such as socioeconomic and demographic information, urbanicity, broadband and internet access, number and type of establishments and organizations, health care services, crime, schools, parks, public transit stops, polluting sites, roadways, street connectivity, traffic volume, voter patterns, and more.

We pool data from the 2006-2014 waves of the HRS, which represents the years that we have a consistent and complete set of tract-level neighborhood characteristics. We then restrict the sample to adults ages 55 to 66—younger than the full retirement age—to capture those who would most likely apply for disability benefits.

Our key variables of interest are disability, SSDI receipt, place characteristics, and race/ethnicity. Disability is an indicator variable equal to one if a respondent reported having a disability (in the context of their current employment situation), a work-limiting health condition, memory/cognitive disease, or any functional limitation (including both limitations with activities of daily living [ADLs] and with instrumental activities of daily living [IADLs]). SSDI receipt is an indicator variable that records whether a respondent receives disability benefits. The current set of neighborhood characteristics includes: the proportion of open park lands; the per capita number of public transit stops, organizations providing elderly, disability, or vocational services (combined), organizations providing food, shelter, or emergency services (combined), violent crimes, law enforcement organizations, religious organizations, physicians, and liquor, tobacco, convenience, and gas station stores (combined); the percentage of residents without a high school diploma, receiving public assistance, who own a home, or who are professionals; and urbanicity. We considered including other place characteristics, but decided against them because they were strongly correlated with the current set. We created indicator variables for each neighborhood characteristic that equals one if it is in the top quartile of the distribution among all tracts in each year—indicating that a neighborhood has a "high" concentration of that particular characteristic.

We begin with descriptive analyses of differences in neighborhood characteristics by disability status and SSDI receipt. We then estimate regression models of disability and SSDI receipt that control for neighborhood characteristics, in addition to other factors likely correlated with these outcomes, including age (in years), gender (coded as one if the respondent is female), race and ethnicity (non-Hispanic white, non-Hispanic Black, Hispanic, and other non-Hispanic), educational attainment (no high school diploma, high school/GED, some college, and college degree), relationship status (married/partnered, divorced/separated, widowed, and never married), household income, and a period indicator (i.e., survey year). To account for the nesting of individuals within tracts, we estimate a multilevel logistic regression with one random intercept for individuals and another random intercept for the tracts they live in.

Results

Preliminary results in Table 1 show statistically significant differences in neighborhood characteristics by disability status and SSDI receipt among adults ages 55 to 66. Differences are substantially large for several characteristics. For example, those with disabilities and those receiving SSDI are more likely to live in neighborhoods with a high concentration of violent crimes, liquor, tobacco, convenience, and gas station stores, residents without a high school diploma, and residents receiving public assistance. These same neighborhoods also have a substantially high concentration of law enforcement organizations and religious organizations. On the flip side, those with disabilities and those receiving SSDI are substantially less likely to live in neighborhoods with a high concentration of homeowners and professionals. They are also less likely to live in urban areas.

In a regression of the likelihood of being disabled (Table 2),[5] the coefficients are statistically significant and the odds ratios are greater than 1 for neighborhoods with a high concentration of religious organizations, liquor, tobacco, convenience, and gas station stores, and residents without a high school diploma. The interpretation is that older adults in these neighborhoods are more likely to be disabled than those not in these neighborhoods. For example, older adults in neighborhoods with a high concentration of liquor, tobacco, convenience, and gas station stores are 22 percent more likely to be disabled than those in neighborhoods with a lower concentration of these stores. In addition, the coefficients are statistically significant and the odds ratios are less than 1 for neighborhoods with a high concentration of homeowners and professionals, and for non-urban neighborhoods. The interpretation is that older adults in these neighborhoods are less likely to be disabled than those not in these neighborhoods. For example, older adults in neighborhoods with a high concentration of homeowners are 32 percent less likely to be disabled than those in neighborhoods with a lower concentration of homeowners.

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[5] We only report results from the disability regression because the SSDI regression did not converge at the time of this summary. The SSDI regression results will be reported in the final paper and based upon the final model specification.

Discussion

Our preliminary analyses find evidence of differences in place characteristics by disability status and SSDI receipt. Our next step will be to examine whether specific place-based characteristics are causally linked with the prevalence of disability, SSDI/SSI applications, and SSDI/SSI awards. Given the endogenous nature of at least some neighborhood characteristics and work disability, sample selection issues (because only those who choose to apply for disability benefits can receive them), and the likely indirect impact of neighborhood characteristics on disability applications and award through their impact on work disability, it will be important that our modeling approach accounts for these complex links. Another important next step will be to examine whether there are systemic differences in the place-disability link by race and ethnicity. Given the pervasiveness and long history of residential racial segregation, these structural factors are particularly important for understanding racial and ethnic differences in the prevalence of disability, the need to rely on SSDI benefits to preserve a basic standard of living in the context of being unable to continue gainful employment, and the likelihood of applying for and receiving these benefits.

Table 1. *Percentage of Adults Ages 55-66 Living in Neighborhoods with a High Concentration of Neighborhood Characteristics, by Disability Status and SSDI Receipt*

	Disabled			SSDI Recipient		
Neighborhood Characteristic	Yes	No		Yes	No	
Open park land	21.6	24.9	***	21.5	24.1	***
Public transit stops	23.2	22.3	*	25.2	22.3	***
Elderly, disability, vocational services organizations	25.3	22.8	***	26.6	23.3	***
Food, shelter, emergency services organizations	8.0	7.2	**	9.9	7.2	***
Violent crimes	57.4	51.8	***	60.7	52.7	***
Law enforcement organizations	26.2	21.8	***	29.4	22.5	***
Religious organizations	28.0	21.6	***	34.6	22.4	***
Physicians	24.7	28.8	***	23.2	28.0	***
Liquor, tobacco, convenience, gas station stores	26.3	20.0	***	29.7	21.1	***
Residents without a high school diploma	28.9	16.5	***	35.9	18.6	***
Residents receiving public assistance	27.4	17.9	***	33.9	19.4	***
Homeowners	22.4	32.4	***	17.3	30.6	***
Professionals	17.5	30.7	***	11.8	28.3	***
Urbanicity	78.2	82.4	***	76.5	81.6	***

Notes: Sample includes 42,689 person-years. *** p<0.001; ** p<0.01; *p<0.05 indicates that differences are statistically significant.
Source: Authors' analysis of the HRS 2006-2016 waves.

Table 2. *Log-Odds Ratios from Multi-Level Logit of the Relationship Between Neighborhood Characteristics and the Likelihood of Being Disabled*

Neighborhood Characteristic	Odds Ratio
Open park land	1.001
Public transit stops	1.103
Elderly, disability, vocational services organizations	1.029
Food, shelter, emergency services organizations	1.146
Violent crimes	1.113
Law enforcement organizations	1.067
Religious organizations	1.354***
Physicians	0.892
Liquor, tobacco, convenience, gas station stores	1.224**
Residents without a high school diploma	1.367***
Residents receiving public assistance	1.073
Homeowners	0.679***
Professionals	0.778**
Urbanicity	0.754*

Notes: Sample includes 31,765 person-years. Model also controls for age, gender, race and ethnicity, educational attainment, marital status, household income, and survey year. *** $p<0.001$; ** $p<0.01$; *$p<0.05$.
Source: Authors' analysis of the HRS 2006-2014 waves.

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How Workplace Matters for Health:
New Evidence on Racial/Ethnic Disparities in Mortality in Urban and Rural America

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Motivation

Urban-rural mortality disparities emerged in the U.S. in the late 1980s and have increased steadily since then (Cosby et al. 2019), owing to higher levels of all-cause mortality in rural counties compared to urban counties (Singh and Siahpush 2014). At the same time, and despite recent upticks in 'deaths of despair,' Non-Hispanic White (hereafter "White") mortality rates remain lower than those of non-Hispanic Black (hereafter "Black") and American Indian or Alaska Native (AIAN), while mortality is lower among Latino/as and Asian/Pacific Islanders as a whole than among Whites (Woolf and Schoomaker 2019). Recent research has examined these two trends together, finding that rural-urban disparities are especially pronounced for Black and AIAN populations compared to Whites (Ferdows et al. 2020 and Probst et al. 2020).

Prior research has investigated the degree to which place- and race-based mortality disparities are explained by factors such as poverty and education (Cosby et al. 2019) but not the role of work. The U.S.'s comparatively modest social safety net means that work structures access to and use of health-promoting resources like insurance coverage, pensions, and earnings to an unusually high degree (Krueger and Burgard 2011). The connections between work and health go even further. On the positive side, prior research finds that higher status jobs are linked to lower mortality and work control is associated with better health (Burgard and Lin 2013). On the negative side, workers in some jobs are exposed to taxing physical labor and hazardous conditions (Clougherty, Souza, and Cullen 2010; Meyer, Castro-Schilo, and Aguilar-Gaxiola 2014). Job strain, schedule instability, and fear of losing one's job are associated with higher psychosocial stress (Burgard and Lin 2013 and Schneider and Harknett 2019).

Positive and negative work attributes are not distributed randomly across jobs nor across workers. Jobs in the U.S. have been increasingly divided into "good" and "bad" jobs, with "good jobs" offering stable and sufficient wages, job amenities, and job control while "bad jobs" pay poorly, do not include benefits, have unpredictable work schedules, and have low job control (Kalleberg 2000, 2009, 2013). Geographic factors matter in who works in "good" jobs both due to the type of work available in rural vs. urban areas and differences in state-level policies. Race matters because Black, Latino, and AIAN workers are more likely to be working in "bad" jobs, although variation by place and race simultaneously has not been examined. Taken together, the connections between work and health and the unequal distribution of good and bad jobs by place and race suggests that work may explain some degree of existing health disparities.

Work may also condition racial/ethnic mortality disparities in ways that go beyond traditional job characteristics and this may have bearing on rural-urban mortality differentials. Members of marginalized racial/ethnic groups who are outnumbered at work may experience elevated rates of work-based stressors (Mintz and Krymkowski 2010; Reskin, McBrier, and Kmec 1999; and Storer, Schneider, and Harknett 2020). Workers at the same location may garner different receptions in their work environment based on the racial/ethnic composition of the area surrounding the workplace. While no prior work has explored this, previous research has found correlations between exposure to segregated spaces throughout the day and health (Inagami, Cohen, and Finch 2007 and Kwan 2013). Further, because marginalized racial/ethnic groups face greater employment instability and lower chances of being promoted (Baldi and McBrier 1997; Castilla 2008; and Wilson and McBrier 2005), their current (cross-sectional) work conditions may understate the health impact of their longitudinal careers. Prior work has not examined the degree to which this variation may explain health disparities by race and place.

The research examines the degree to which the relative advantages offered by urban workplaces explain both urban-rural and racial mortality disparities. We argue that two processes are likely at play: urban workplaces may offer more positive job attributes with known connections to health, such as higher pay (even relative to cost of living), better health-promoting job amenities, and greater employment stability; and they may be organized in ways that reduce the stress experienced by minoritized workers. In the current paper, we estimate urban/rural disparities in mortality, accounting for firms, and then add explanatory variables indicating racialized wage disparities at the firm level. We also explore whether the explanations for urban and rural mortality risk vary in interactive models.

Theoretical Background

Our conceptual model draws from theories of structural racism and racialized organizations to understand how firms matter in shaping workers' health and mortality outcomes. Brown and Homan (2024) describe structural racism as multifaceted (reflected in numerous domains of life chances), interconnected (domain-specific disparities reinforce one another), and institutionalized (created and maintained through institutional practices). Structural racism at the state and local levels has been linked to health and mortality outcomes among minoritized groups, but this work has primarily examined the structural racism-health linkage at the macro level (Yearby 2018 and Yearby, Clark, and Figueroa 2022). In "A Theory of Racialized

Organizations," Ray (2019) posits that a meso-level approach (sandwiched in between macro- and micro-level forces) is key to understanding how racialization processes work. He argues that organizations are places in which structural racism manifests in complex and interlocking ways. Thus, the degree to which organizations allocate resources unequally by race/ethnicity is a potentially important and largely unstudied factor in racial/ethnic mortality disparities.

We posit that three manifestations of structural racism in firms hold the potential to link racial/ethnic mortality disparities to structural racism: racialized wage inequality, racial disparities in employment entrances and exits, and workforce racial composition. First, firms likely substantially differ in intra-firm racial/ethnic pay inequality (Carrington and Troske 1998). Given historic pay inequities (McCall 2001 and Parks 2012), educational disparities (Montgomery and Grzywacz 2022), and workplace discrimination (Reskin 2012), group pay disparities within firms are likely extensive, with Black, Hispanic, and AIAN workers making less than Asian and White workers in many contexts (Storer et al. 2020). Second, firms may differ in their levels of racial/ethnic employment stability inequality. For example, prior research demonstrates how Black workers are overrepresented among the first workers laid off or fired during economic downturns (Cajner et al. 2017; Couch and Fairlie 2010), leading to inequality. Third, workplaces are racially segregated relative to local labor markets (Ferguson and Koning 2018), and the resultant intra-workplace racial/ethnic composition likely has implications for worker treatment and exposure to stressors.

Data and Approach

We use the restricted Longitudinal Employer-Household Dynamics (LEHD) dataset, which contains detailed, longitudinal employment histories for 96% of all private-sector jobs [22] beginning in the early 1990s (exact year varies by state) to 2021 and amounting to hundreds of millions of individuals, and link it to the Census Numerical Identification file (Numident) which contains all-cause mortality indicators for the entire United States through 2022. We have been approved for LEHD data from 27 states[6] comprising an estimated 57% of the U.S. workforce. These rich datasets allow us to connect information on workers, employers, and mortality records in large-scale administrative data to answer important questions about the role

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[6] These states are: Arizona, California, Colorado, Connecticut, Delaware, Idaho, Indiana, Iowa, Kansas, Maine, Maryland, Massachusetts, Nebraska, Nevada, New Jersey, New Mexico, North Dakota, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Washington, and Wisconsin.

of work in place- and race-based mortality disparities. In analysis for this paper and presentation, we use combined data from three states, Colorado, Maryland, and South Carolina, focusing on workers in 2006 who were employed by a firm for at least two quarters and with at least 50 workers. Using that subset of the full LEHD data, we then use the Numident data to construct mortality records through 2022.

Mortality information is given as a dichotomous indicator of death (1) or not (0) in the observed period, which is combined with age when setting up the survival analysis, recognizing right-censoring in the mortality data. Our explanatory variables of focus are measures of urban/rural residence, worker race/ethnicity, and firm-level racial/ethnic wage disparities. Place of residence is coded as urban (1) or not (0), using the National Center for Health Statistics (NCHS) classification.[7] Racial/ethnic wage disparity is measured in four different ways. We first calculate firm-level wage variance explained by race/ethnicity (total racial/ethnic wage disparities) and each racial/ethnic group's standardized wage deviation from grand firm mean wages (group-specific racial/ethnic wage disparities). To assess whether the share of top earners in each racial/ethnic group is consequential, we also measure the group-specific absolute share of top earners for each racial/ethnic group (defining top earners as top 10% or 25% of firm-specific earners in each year) and the group-specific relative share of top earners, which divides each group's absolute share of top earners by the employee share in the same racial/ethnic group.

We estimate multi-level parametric survival-time models with firm random effects, a flexible framework that allows us to account for observed and unobserved components of our anticipated firm-level effects on workers' mortality risk. To document urban-rural differences in racial/ethnic mortality patterns and examine the potential contribution of firm-level racial/ethnic disparities, we estimate a series of models of worker survival as a function of race/ethnicity, urban/rural residence, and firm-level racial/ethnic wage disparity and work tenure (as a measure of exposure) at the baseline employer. Models are adjusted for individual characteristics related to health and mortality including gender, earnings (logged), and industry of baseline employer. To investigate urban-rural differences in the relationships, we test for interaction effects between urban/rural, race/ethnicity, and the wage disparity measures.

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[7] This classification scheme creates six categories, with the first four typically considered urban (large central metro, large fringe metro, medium metro, small metro) and the final two considered rural (micropolitan non-metro, non-core non-metro).

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Panel 7: Multigenerational Housing and Caregiving

Moderator

Stephanie Firestone (AARP)

Panelists

"How Are Household Living Arrangements Related to Retirement Expectations and Savings Across Race and Ethnicity?"
Jennifer Caputo (Westat)

"Coresident Grandparents' Mortality Risk by Race/Ethnicity"
Hongwei Xu (Queens College), John R. Logan (Brown University), and Todd K. Gardner (U.S. Census Bureau)

"Do Shared Households Reduce or Increase Housing Cost Burden among Older Adults?"
Hope Harvey (University of Kentucky), Kristin L. Perkins (Georgetown University), and Lucas Taulbee (University of Kentucky)

"Who Pays for Elder Care? An Analysis of the Burden on Caregivers and Families"
Jessica Forden and Teresa Ghilarducci (The New School) and Siavash Radpour (Stockton University)

How Are Household Living Arrangements Related to Retirement Expectations and Savings Across Race and Ethnicity?

Jennifer Caputo
Westat

Prepared for the 26th Annual Meeting of the Retirement and Disability Research Consortium,
August 7-9, 2024

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Background

As U.S. households become increasingly diverse, a growing proportion of adults approaching retirement age lives with more than one generation of adults or alone (Anderson et al. 2023 and Caputo and Cagney 2023). However, we know relatively little about how living arrangements are related to retirement outcomes, including timing expectations, Social Security wealth, and savings. Research also has yet to explore whether implications of living arrangements for retirement outcomes differ across race and ethnicity, one of the most robust predictors of both (e.g., Francis and Weller 2021 and Cohn et al. 2022). Addressing these gaps in research, this study examines how living with an adult child or alone is related to retirement timing expectations and savings among White, Black, and Hispanic adults aged 50-61.

While married individuals are at a clear advantage when it comes to retirement security (e.g., Zissimopoulos et al. 2015), the literature supports conflicting possibilities about how living with an adult child—with or without a spouse—might impact retirement. On the one hand, sharing living costs with adult children may help parents save money, as suggested by research showing lower poverty rates in multigenerational households (Cohn et al. 2022). Parents who live with adult children may thus expect that they can retire earlier and accumulate greater retirement wealth. On the other hand, a variety of research suggests that contemporary growth in multigenerational households is driven by financial hardships of children (e.g., Lei and South 2016 and Newman 2012). Sharing a home with an adult child to help support them financially may have negative implications for retirement outcomes. Consistent with this possibility, Maroto (2017, 2019) found that parents' financial assets declined when they lived with adult children. Prior work suggests less equivocal expectations regarding how living alone may impact retirement. A large body of research documents negative social, health, and economic implications of living alone in mid- to later life (e.g., Mutchler et al. 2023 and Victor et al. 2000). Adults who live alone, without other family or friends to help shoulder the burden of household costs, may accumulate less retirement savings and expect to work longer.

The prevalence and predictors of living arrangements vary across racial and ethnic background, which may shape their potential impact on retirement outcomes. Racial and ethnic minority adults are significantly more likely to live in a multigenerational household than White peers (Cohn et al. 2022). Studies often point to greater shared economic needs as the primary driver of these patterns (e.g., Kamo 2000; Lei and South 2016; and Reyes 2022). Because minority families may have overall fewer financial resources to share with each other, potential benefits of living with a child for retirement security may be more limited. However, research also suggests that racial and ethnic minority families are more likely to share a home out of personal preference (Kamo 2000 and Lei and South 2016) and that resource transfers are more reciprocal and less downstream in multigenerational minority than White households (Kahn et al. 2013, 2017 and Reyes 2022). Thus, it is also possible that living with adult children will have a more positive relationship to retirement outcomes for racial and ethnic minority parents than White parents. In addition, although Hispanic adults are less likely to live alone than White peers, single person households are more prevalent among Black adults, partly due to lower marriage rates (Marsh et al. 2007 and Liu 2024). To the extent that living alone in adulthood is more normative and expected among Black adults, it may have fewer negative implications for retirement outcomes. Conversely, living alone has the potential to compound well-documented racial and ethnic inequalities in retirement security (e.g., Francis and Weller 2021; Munnell et al. 2021).

Data and Methods

Data to investigate these different possibilities come from the 1998-2020 waves of the Health and Retirement Study (HRS), an ongoing, biennial panel study of U.S. adults aged 50+ (Juster and Suzman 1995). The HRS began in 1992 with a cohort born from 1931-1941, and new birth cohorts are regularly added. The analysis sample for each year includes adults who were below early retirement age, working for pay, and in contact with at least one child. Sample sizes vary for each outcome, since many respondents are missing data on one or more. The base sample for 1998 includes 4,463 respondents; 78% were non-Hispanic White, 14% were non-Hispanic Black, and 8% were Hispanic. Those in the "other" racial/ethnic category or missing data on non-time-varying covariates are not included in the analysis sample.

Time-varying dummy variables capture living arrangements each year. Those living with a spouse only—the most common living arrangement among this age group (e.g., Liu 2024)—are the reference category. Other mutually exclusive living arrangement groups are: living with a spouse and an adult child, living with an adult child only, and living alone. The study examines four time-varying retirement outcomes. First is planned retirement age, which comes from a question asking respondents the year they plan to retire and ranges from age 51-92. Second is a measure of self-reported probability of working after age 65, which ranges from 0-100. Fourth and fifth are predicted Social Security wealth percentile assuming a claim age of 62[8] and current employer DC plan balance percentile, which both range from 1-100. To account for other characteristics that may shape links between living arrangements and retirement, the analysis controls for year, age, gender, nativity status, education, and time-varying self-rated health, income, number of children, and presence of other household members.

The analysis employs mixed effects linear and logistic regression to estimate multivariate relationships between living arrangements and retirement savings and expectations across race and ethnicity. These multilevel models nest observations at the twelve different survey waves within respondents. They include fixed effects, which indicate the mean within-individual effect of a variable over time, and person-specific random effects, which indicate between-individual variance. In the interest of brevity, results presented here focus on fixed effects.

Results

Figure 1 shows descriptive differences in living arrangements across race/ethnicity in 1998 and 2020. At both time points, Black and Hispanic respondents were less likely to live in a household with a spouse only and more likely to live with an adult child with or without a spouse than White peers. Black respondents were also more likely to live alone at both times.

Figure 1: *Living Arrangements Across Race and Ethnicity*

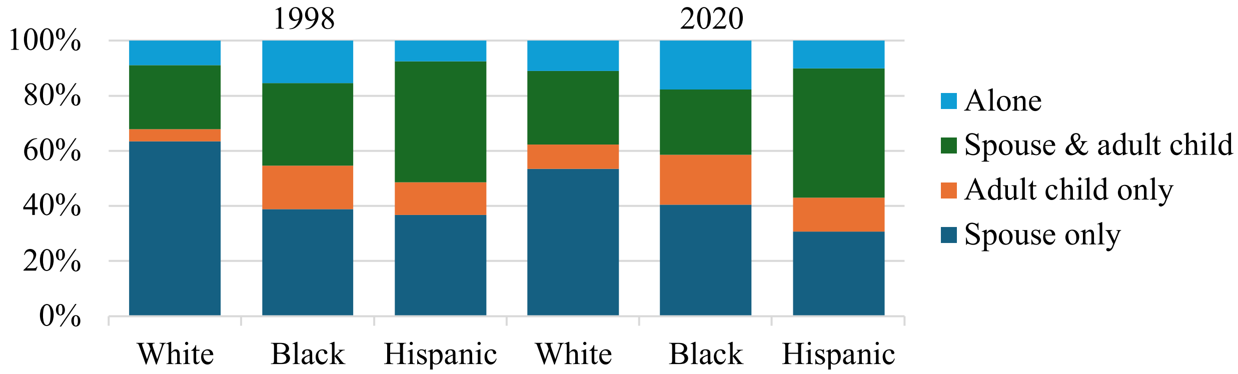

Table 1 presents abbreviated results from mixed effects models regressing retirement outcomes on household living arrangements and race/ethnicity. It shows that on average, Black and Hispanic respondents planned to retire earlier, reported lower probability of working after age 65, and had less prospective Social Security wealth and less DC savings than White peers.

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[8] HRS researchers calculated predicted Social Security wealth for individuals who have not yet claimed benefits using respondent self-reported earnings and administrative records (see Fang 2024 for more information).

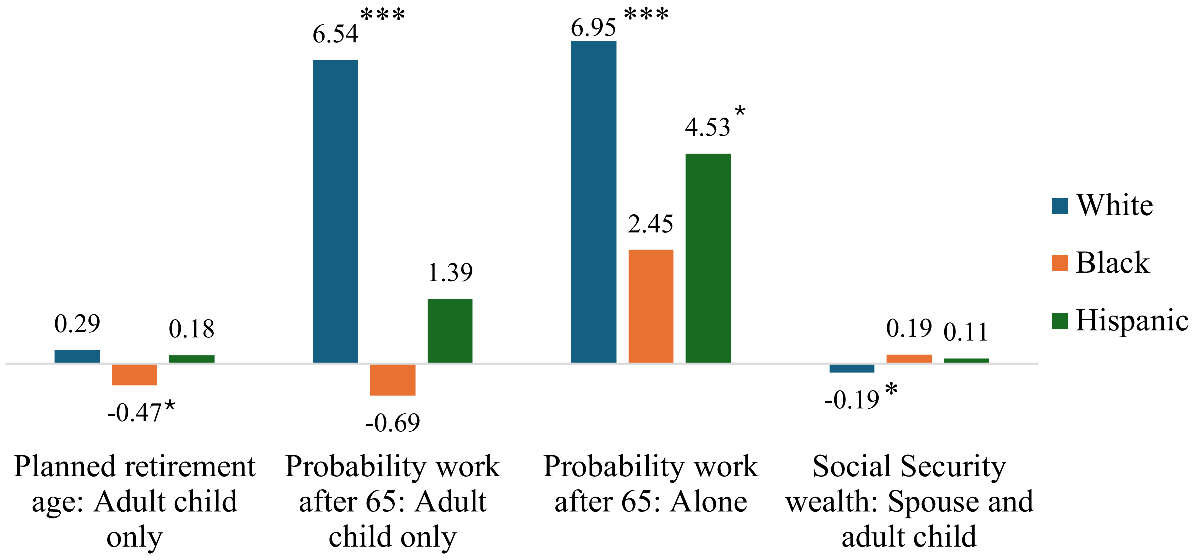
Compared to respondents who only lived with a spouse, those who lived with a spouse and adult child had lower DC savings. Parents who lived with an adult child only reported greater probability of working after 65. In addition, those living alone planned to retire later and reported greater probability of working after 65 than those who lived with their spouse only.

Table 1: *Fixed Effects Coefficients from Mixed Effects Models Regressing Retirement Outcomes on Household Living Arrangements and Race/Ethnicity, 1998-2020*

	Planned retirement age (N=9,481)	Probability work after 65 (N=13,323)	Social Security wealth % (N=13,950)	DC savings % (N=5,090)
Race/ethnicity (Ref.: White)				
Black	-1.018***	-9.600***	-4.579***	-6.151***
Hispanic	-.410*	-3.916***	-7.794***	-3.044***
Living arrangements (Ref.: Spouse only) ^				
Spouse and adult child	-.080	-.126	-.109	-1.830**
Adult child only	.053	3.830***	.214	.303
Alone	.379**	5.709***	.134	1.521

Notes: All models include controls for age, time, gender, foreign-born, years of education, and time-varying self-rated health, household income, number of children, and presence of non-spousal, non-adult child household members. *=p<.05, **=p<.01, ***=p<.001, ^= Time-varying covariate

Figure 2: *Fixed Effects Coefficients for Retirement Outcomes Across Race and Ethnicity*



*=p<.05, **=p<.01, ***=p<.001

Interaction analyses revealed several racial/ethnic differences in how living arrangements were related to retirement outcomes, summarized in Figure 2. These findings show that living with an adult child predicted lower planned retirement age among Black parents, but not White or Hispanic peers. In addition, living with an adult child did not predict greater probability of working after 65 for Black adults, and the positive impact of living alone on self-reported probability of working after 65 was only significant among White adults. Last, living with an adult child and spouse was negatively related to Social Security wealth for White adults only.

Discussion

Taken together, I interpret the findings as providing further support for research highlighting the benefits of marriage for economic security in mid- to later-life. Adults who lived with a spouse were more likely to expect that they would retire on time and at younger ages over a historical period of almost two decades. Although those living with both a spouse and adult child reported lower DC plan balances, supplemental analyses[9] including spousal DC savings show no difference between married people who lived with or without an adult child. The results also suggest that living with an adult child only or alone may have some disadvantages for retirement outcomes. However, these patterns differ across race and ethnicity. Overall, negative implications of living with an adult child for retirement expectations only appear to be present for White parents, while Black parents living with an adult child planned to retire somewhat earlier than same-race peers who lived only with a spouse. In addition, living alone predicted higher probability of working after 65, while living with both an adult child and spouse predicted lower prospective Social Security wealth for White respondents only. These patterns are largely consistent with prior research suggesting that diverse living arrangements—particularly multigenerational households—have more positive health, social, and economic well-being implications for minority families, among whom they are more normative, expected, and preferred (e.g., Caputo and Cagney 2023; Kamo 2000 and Reyes 2022).

Although further research is needed, these findings suggest that social policies that support or encourage marriage or re-marriage in midlife, as well as those that limit the prevalence of living alone, may have positive implications for adults' confidence that they can retire on-time as they approach retirement age. Such policies may include expanded housing options, programmatic incentives, and community living programs. In further analyses, I will explore additional methods to account for differential selection into living arrangements to shed further light on the causal direction of these patterns.

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[9] Available from the author by request.

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Coresident Grandparents' Mortality Risk by Race/Ethnicity

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Introduction

In America, it used to be unconventional for grandparents to live with grandchildren in the same households. Coresident grandparents did not attract much academic or public attention until the late 1990s when the Census Bureau estimated that the number of children under age 18 living in grandparent-maintained households increased from 2.3 million in 1980 to 3.9 million in 1997 (Bryson and Casper 1999) due to such factors as increases in poverty, single parenthood, drug abuse, child abuse and neglect, and incarceration (Minkler 1999). Concerned about this trend, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 required the Census Bureau to collect data on caregiving grandparents (Simmons and Dye 2001). Later estimates showed that the number of grandparents living with grandchildren increased by 22% from 5.8 million in 2000 to 7.1 million in 2011-2013 (Livingston 2013 and Florian and Casper 2015), and then declined slightly to 6.7 million in 2021 (Anderson, Buck, and Hayward 2024). Aside from their rising number, coresident grandparents are shouldering the burden of providing care to their grandchildren. It was estimated that, for example, more than 2.7 million coresident grandparents were primary caregivers to their grandchildren in 2011 (Livingston 2013), although this number fell to 2.1 million in 2021. During the same period, however, the proportion of coresident grandparents who spent 5 years or more being primary caregivers to their grandchildren increased from 39.3% (Ellis and Simmons 2014) to 49.3% (Anderson, Buck, and Hayward 2024).

Living with and caring for grandchildren affect grandparents' physical health, psychosocial health, and economic condition in various ways (Minkler and Fuller-Thomson 2001; Minkler et al. 1997; Luo et al. 2012; and Chen and Liu 2012). In the United States, earlier studies reported negative health effects of caring for grandchildren. In particular, extensive and custodial grandparenting has been associated with poor health outcomes including elevated depressive symptoms (Blustein, Chan, and Guanais 2004 and Minkler et al. 1997), lower life satisfaction (Szinovacz, DeViney, and Atkinson 1999), and more functional limitations (Minkler and Fuller-Thomson 2001). However, these health disadvantages may have been preexisting rather than the consequences of grandparenting (Hughes et al. 2007; Arpino and Bordone 2014; and Di Gessa, Glaser, and Tinker 2016b, 2016a). Recent studies have also suggested that the health implications of caring for grandchildren vary by grandparents' race and ethnicity (Choi 2020 and Chen et al. 2015).

This study examines the association between coresident grandparenting and mortality, with a focus on the racial-ethnic variation in this association. We focus on one particular type of coresident grandparenting known as custodial grandparents or grandparents raising grandchildren in the literature (Bryson and Casper 1999; Ellis and Simmons 2014; Livingston 2013; Fuller-Thomson, Minkler, and Driver 1997; Minkler and Fuller-Thomson 2000; Anderson, Buck, and Hayward 2024; and Florian and Casper 2015). Such grandparents are responsible for the basic needs of their grandchildren, regardless of their legal guardianship status. Many potential pathways link intergenerational caregiving to grandparents' health; some are positive, whereas others are negative. On one hand, grandparents experience role strain (Goode 1960) when they are unable to fulfill the obligations of intergenerational caregiving due to limited resources or inadequate coping strategies. The role strain of intergenerational caregiving takes many forms, ranging from physical to psychological and from relational to financial. On the other hand, according to the role enhancement theory (Moen, Robison, and Dempster-McClain 1995), providing care to grandchildren may promote grandparents' emotional, psychological, and social well-being, which in turn are protective against biological health risks.

We expect the association between coresident grandparenting and mortality to vary by race/ethnicity because different groups have different family norms, cultural expectations, and economic survival strategies with respect to grandparenting. In general, non-Hispanic white grandparents value more of their own privacy, independence, and self-reliance, and have a stronger preference for nuclear family households over multigenerational households, compared with racial-ethnic minorities (Cohen and Casper 2002 and Kamo 2000). Therefore, they tend to live independently from adult children and grandchildren over the life course, and to avoid interference with parents' authority over their children (Casper and Bianchi 2002). In contrast, rooted in a tradition of surrogate parenting, black grandparents are culturally accustomed to take a stronger, more authoritative role in providing support, guidance, and discipline to their grandchildren (Jimenez 2002). Therefore, they may be better adept at coping with the stress and strains of caregiving roles and receive stronger support from relatives, friends, and community networks, compared with their white peers. Hispanic and Asian Americans are more likely to embrace multigenerational living and intergenerational caregiving for extended family solidarity and cultural obligations known as familism and filial piety, respectively (Glick and Van Hook 2002 and Casper et al. 2016). Hispanic and Asian American grandparents are also more likely to be immigrants and face such challenges as language barriers and adjustment to a new life in America. They may prefer to live in multigenerational households maintained by adult children and to care for grandchildren so that the adult children (especially daughters or daughters-in-law) can work full-time. In other words, Hispanic and Asian American grandparents may willingly choose to live with and care for grandchildren in parent-headed multigenerational households as a resource-pooling strategy in response to economic hardship. Such living arrangements also allow Hispanic and Asian American grandparents to adopt a coparenting style of grandchild care and share caregiving burdens with adult children (Fuller-Thomson and Minkler 2007 and Tang, Jang, and Mulvaney 2019), as opposed to the authoritative role of surrogate parents played by black grandparents in skipped-generation households.

Data and Method

This study draws on two main data sources: the 2000 Census long-form sample and the Social Security Administration's Numerical Identification file (SSA Numident). The former captures basic demographic and socioeconomic information for about 17% of all U.S. residents as of the 2000 Decennial Census. The SSA Numident captures all interactions individuals have with the SSA related to Social Security Numbers (SSNs), including SSN applications, claim records, and death information, among others (Finlay and Genadek 2021). Using restricted-access data from these two sources, we link person records from the 2000 Census long-form sample to their records in the Numident file. Our analytical sample is restricted to participants who were 50 years and older at the time of the 2020 Census and who were non-Hispanic whites, non-Hispanic blacks, Hispanics, or Asian Americans.

We employ Cox proportional-hazard models to estimate the association between coresident grandparenting and all-cause mortality. We measure the risk of all-cause mortality as time to death in days from April 1 of 2000, the Census Day when participants were supposed to complete their Census long forms, to December 31 of 2019. We classify each participant into one of six groups according to his/her coresident grandparenting status measured in the 2000 Census long-form sample: (1) individuals who did not live with any grandchildren under 18 years old in the same house; (2) non-custodial coresident grandparents who lived with their grandchildren but were not primary caregivers of the coresident grandchildren; and (3-6) custodial coresident grandparents who lived with and were primary caregivers of their grandchildren for varying durations of time, ranging from less than 1 year to 5 years or more.

Results

Table 1 reports the frequency distributions of coresident grandparenting status, stratified by race/ethnicity, in 2000. In total, about 5.5% (N = 4,013,770) of the adults aged 50 years and older were coresident grandparents. Among them, only about 37.4% (N = 1,500,902) were custodial caregivers of their grandchildren. However, there were substantial differences in the prevalence of coresident grandparents across racial/ethnic groups. Coresident grandparents were much more common among Hispanics (17.7%), Asians (15.4%), and blacks (13.6%) than among whites (3.3%). Among coresident grandparents, blacks were most likely to be custodial caregivers (48.4%) than not (51.6%), followed by whites (39%) and Hispanics (29.6%), whereas Asians were least likely to be custodial caregivers (17.6%) than not (82.4%). Regardless of race/ethnicity, it was most common for custodial coresident grandparents to spend 5 years or more taking care of their grandchildren than any other shorter duration of time. Nevertheless, black coresident grandparents spent a much longer time being responsible for the basic needs of their grandchildren than any other racial/ethnic group. For example, more than half (57.9%) of black custodial coresident grandparents provided primary care to their grandchildren for 5 years or more, whereas only 37.8% of their Asian peers did so.

Table 2 reports the signs and statistical significances of hazard ratios estimated from the Cox models. An upward arrow indicates a hazard ratio that is greater than one (i.e., a higher hazard of death), while a downward arrow represents a hazard ratio that is smaller than one (i.e., a lower hazard of death). Compared with those who were not coresident grandparents, Model 1 shows substantial racial/ethnic variations in the association between coresident grandparenting and mortality after adjusting for age, gender, and state fixed effects. Among whites, coresident grandparents experienced significantly higher risks of mortality, regardless of whether they were custodial caregivers or not, or how long they provided custodial care to their grandchildren. For both blacks and Hispanics, there was a nonlinear relationship between coresident grandparenting and mortality. Compared with their peers who were not coresident grandparents, black non-custodial coresident grandparents had a significantly higher hazard of death, and so did black long-term (5 years or more) custodial coresident grandparents. However, black coresident grandparents who spent two years or less taking care of their grandchildren experienced significantly lower risks of mortality. Hispanic coresident grandparents who were not custodial caregivers or who only spent two years or less taking care of their grandchildren also experienced significantly lower risks of mortality, but the long-term (5 years or more) custodial caregivers had a significantly higher hazard of death. For Asians, being a coresident grandparent was anything but detrimental to their longevity. Asian coresident grandparents who were not custodial caregivers or who spent 1-4 years taking care of their grandchildren experienced significantly lower risks of mortality. Asian long-term (5 years or more) custodial coresident grandparents also had a lower risk of mortality, although the coefficient was not statistically significant in Model 1.

After controlling for household structures, socioeconomic status, acculturation, and disability in Model 2, the associations between different coresident grandparenting status and mortality changed substantially for blacks and Hispanics, but not much for whites and Asians. Regardless of the duration of providing custodial care to grandchildren, being a coresident grandparent was still associated with a significantly higher risk of mortality for whites, but a significantly lower risk of mortality for Asians. For blacks, being a non-custodial or a long-term coresident grandparent was no longer significantly associated with an elevated risk of mortality. In fact, spending 5 years or more as a custodial coresident grandparent was associated with a significantly lower risk of mortality for blacks, compared with their peers who were not coresident grandparents. For Hispanics, none of the associations between different coresident grandparenting status and mortality found in Model 1 was statistically significant anymore.

Conclusions

Our regression estimates show substantial racial/ethnic variations in the association between coresident grandparenting and mortality. Living with and raising grandchildren is consistently associated with higher risks of mortality for non-Hispanic white grandparents, but reduced risks of mortality for Asian American grandparents. The changes of signs and statistical significances between Models 1 and 2 suggest that black coresident grandparents might experience higher mortality risks because of their disadvantages in household structures, socioeconomic status, acculturation, and disability. Similarly, Hispanic coresident grandparents might experience higher or lower risks of mortality because they had certain advantages or disadvantages in other demographic, socioeconomic, cultural, and health domains, but not due to coresident grandparenting per se. Future reforms of old-age support and childcare policies could benefit from incorporating both racial/ethnic disparities in socioeconomic resources and different cultures of intergenerational relationships.

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Table 1. *Coresident Grandparenting Status among U.S. Adults Aged 50 Years and Older*

	Total	White	Black	Hispanic	Asian
All adults aged 50 years and older					
Not coresident grandparents (%)	94.5	96.7	86.4	82.3	84.6
Coresident grandparents (%)	5.5	3.3	13.6	17.7	15.4
Total weighted N of individuals	72,896,636	59,549,368	6,557,716	4,623,761	2,165,791
Among coresident grandparents					
Not custodial caregiver (%)	62.6	61.0	51.6	70.4	82.4
Custodial caregiver (%)	37.4	39.0	48.4	29.6	17.6
Subtotal weighted N of individuals	4,013,770	1,967,372	894,628	817,522	334,248
Among custodial coresident grandparents					
Caregiver < 1 year (%)	17.2	18.6	12.5	20.0	22.5
Caregiver 1-2 years (%)	18.8	20.1	15.6	19.8	22.2
Caregiver 3-4 years (%)	15.0	15.6	14.0	14.6	17.6
Caregiver 5 years or more (%)	48.9	45.7	57.9	45.7	37.8
Subtotal weighted N of individuals	1,500,902	766,838	433,327	241,835	58,902

Source: Public-use microdata from the 5% weighted sample of the 2000 U.S. Census.

Table 2. *Cox Proportional Hazard Models of the Associations between Coresident Grandparenting and Mortality during 2000-2019: U.S. Adults Aged 50 Years and Older in 2000*

	White		Black		Hispanic		Asian	
Independent variables in 2000	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2
Coresident grandparenting status (ref: not coresident grandparent)								
Non-custodial coresident	↑***	↑**	↑**	↓	↓***	↓	↓***	↓***
Custodial coresident <1 year	↑***	↑***	↓*	↓***	↓*	↓	↓	↓
Custodial coresident 1-2 years	↑***	↑***	↓*	↓***	↓*	↓	↓**	↓*
Custodial coresident 3-4 years	↑***	↑***	↑	↓	↑	↑	↓*	↓*
Custodial coresident >=5 years	↑***	↑***	↑***	↓*	↑*	↑	↓	↓*
Basic demographics								
Age (mean-centered)	↑	↑***	↑***	↑***	↑***	↑***	↑***	↑***
Age (mean-centered) squared	↓***	↓***	↓***	↓***	↓***	↓***	↓***	↓***
Male (ref: female)	↑***	↑***	↑***	↑***	↑***	↑***	↑***	↑***
Household structures								
Married (ref: not married)		↓***		↓***		↓***		↓***
Household head (ref: not)		↓***		↓***		↑		↑***
Number of people in household		↑***		↑***		↓***		↑
Socioeconomic status								
Education (ref: < high school)								
High school		↓***		↓***		↓***		↓**
Some college		↓***		↓***		↓***		↓***
College or above		↓***		↓***		↓***		↓***
Employed (ref: unemployed)		↓***		↓***		↓***		↓***
Income-to-poverty ratio		↓***		↓***		↓***		↓***
Renter (ref: homeowner)		↑***		↑***		↑***		↑***
Acculturation								
Citizenship (ref: born citizen)								
Naturalized citizen		↓***		↓***		↓***		↓***
Not citizen		↓***		↓***		↓***		↓***
Speaking English at home (ref: not)		↑***		↑***		↑***		↑***
Health status								
Disabled (ref: not)		↑***		↑***		↑***		↑***
State fixed effects	YES		YES		YES		YES	
Weighted N of individuals (rounded)	53,000,000		5,473,000		3,759,000		1,795,000	

Notes: ↑ hazard ratio > 1; ↓ hazard ratio < 1. * $p < .05$; ** $p < .01$; *** $p < .001$.
Source: Restricted data from the weighted 2000 U.S. Census long-form sample linked to the 2019 Numident file.

Do Shared Households Reduce or Increase Housing Cost Burden among Older Adults?

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Introduction

Older adults are at the forefront of the affordable housing crisis in the United States. Among both renters and homeowners, adults over age 65 are the group second most likely to be burdened by housing costs, right behind young adults under age 25 (Fenelon and Mawhorter 2020). In recent years, rapid growth in the population of older adults and increased income inequality within this population has left a record number of older households vulnerable to housing affordability challenges (Joint Center for Housing Studies 2019). Housing affordability challenges have far-reaching impacts on well-being; older adults who are burdened by housing costs spend less on other necessities, like healthcare and food (Joint Center for Housing Studies 2020). This project advances research on economically vulnerable older adults by examining how shared households (defined as those that include any adult besides the householder and householder's romantic partner) may buffer older adults against housing affordability challenges or compound these challenges. Drawing on data from the Survey of Income and Program Participation (SIPP), we examine the extent to which shared households provide a financial safety net for older adults. This summary focuses on two research questions: (1) What share of older adults live in shared households and what types of shared households do they live in? (2) Do shared households reduce or increase housing costs, and housing cost burden, among older adults?

Motivation

A large and growing share of older adults – 20% as of 2017 – live in intergenerational shared households. The share is even higher among Black, Hispanic, and Asian older adults: 27% of Black, 40% of Hispanic, and 40% of Asian adults aged 65 to 79 live in intergenerational shared households, compared to 14% of White adults aged 65 to 79 (Joint Center for Housing Studies 2019). Because shared households are a common arrangement for older adults, especially non-White older adults, it is important to consider how these arrangements may impact the housing cost challenges older adults commonly face. By examining how rent/mortgage and utility costs are shared and how this varies based on household characteristics, we provide insight into one tangible way older adults may benefit from, or be disadvantaged by, residence in shared households. Shared households may reduce older adults' housing costs if other household members contribute to housing costs. Alternatively, older adults in shared households may subsidize other household members and receive little financial benefit themselves.

Although a growing literature focuses on the rising number of intergenerational households formed by parents and adult children (Kahn et al. 2013 and Ruggles 2007), we know far less about older adults residing with other extended family and with nonrelatives, and about how the safety net role of shared households varies across household types. Another innovation of our analysis is that we examine how older adults' contributions towards housing costs vary by their householder status. Our results inform our understanding of the impact of social support receipt and obligations on older adults' economic security, and particularly on racial, ethnic, and gender disparities. If providing housing to others increases hosts' housing costs, it may contribute to disparities in housing affordability. Failing to account for the support that older adults receive from shared households may lead us to underestimate disparities in housing needs.

Data and Methods

We use the 2014-2022 panels of the SIPP to examine shared housing among older adults (age 65 and over). The SIPP allows us to identify household composition and whether the older adult is the homeowner/renter or is living in someone else's home. Another key advantage of the SIPP is that it identifies income sources for all individuals, which household members paid for basic utilities and/or mortgage or rent, and the amount paid by each of these individuals. We categorize older adults into one of seven household types. With the SIPP household relationship matrix, we identify whether each older adult is living in: 1) a nonshared household, 2) an intergenerational household as a host (sharing their home with their adult child or parent), 3) an other extended family household as a host (sharing their home with a grandchild, niece/nephew, sibling, etc.), 4) a non-kin household as a host (sharing their home with a non-relative adult who is not their romantic partner), 5) an intergenerational household as a guest (sharing the home of their child or parent), 6) an other extended family household as a guest (sharing the home of a grandchild, niece/nephew, sibling, etc.), or 7) a non-kin household as a guest (sharing the home of a non-relative who is not their romantic partner).

We use weighted proportions to describe the share of older adults who live in shared households and describe the types of households in which they live. To estimate whether living in shared households increases or reduces housing costs for older adults, we first match older adult hosts in shared households with older adults living in nonshared households based on these characteristics: age, income, net worth, health, gender, disability status, race/ethnicity, nativity, educational attainment, relationship status, employment status, housing subsidy, residence in a metropolitan area, and region of residence. Then, we use our nonshared matches to model housing costs as a function of the characteristics listed above. We use this model to predict the hypothetical nonshared housing costs for older adults who are currently hosts in shared households as a function of their characteristics. Finally, we calculate the difference between the predicted nonshared housing costs and observed shared housing costs. We repeat this analysis for older adult guests: matching guests in shared households to older adults living in nonshared households followed by a prediction of housing costs among the matched nonshared sample.

Table 1. *Older Adults' Household Types*

	Share of all older adults	Share of hosts	Share of guests
Shared household	0.23		
Host	0.17		
Intergenerational	0.13	0.77	
Other relative	0.03	0.16	
Nonrelative	0.01	0.06	
Guest	0.07		
Intergenerational	0.05		0.74
Other relative	0.01		0.17
Nonrelative	0.01		0.09
Nonshared household	0.77		
Observations	38,873	6,443	2,600

Source: Individuals 65 years old or older. Month 12, Wave 1 of the 2014- 2022 SIPP panels. Weighted by individual-level SIPP weight.

Results

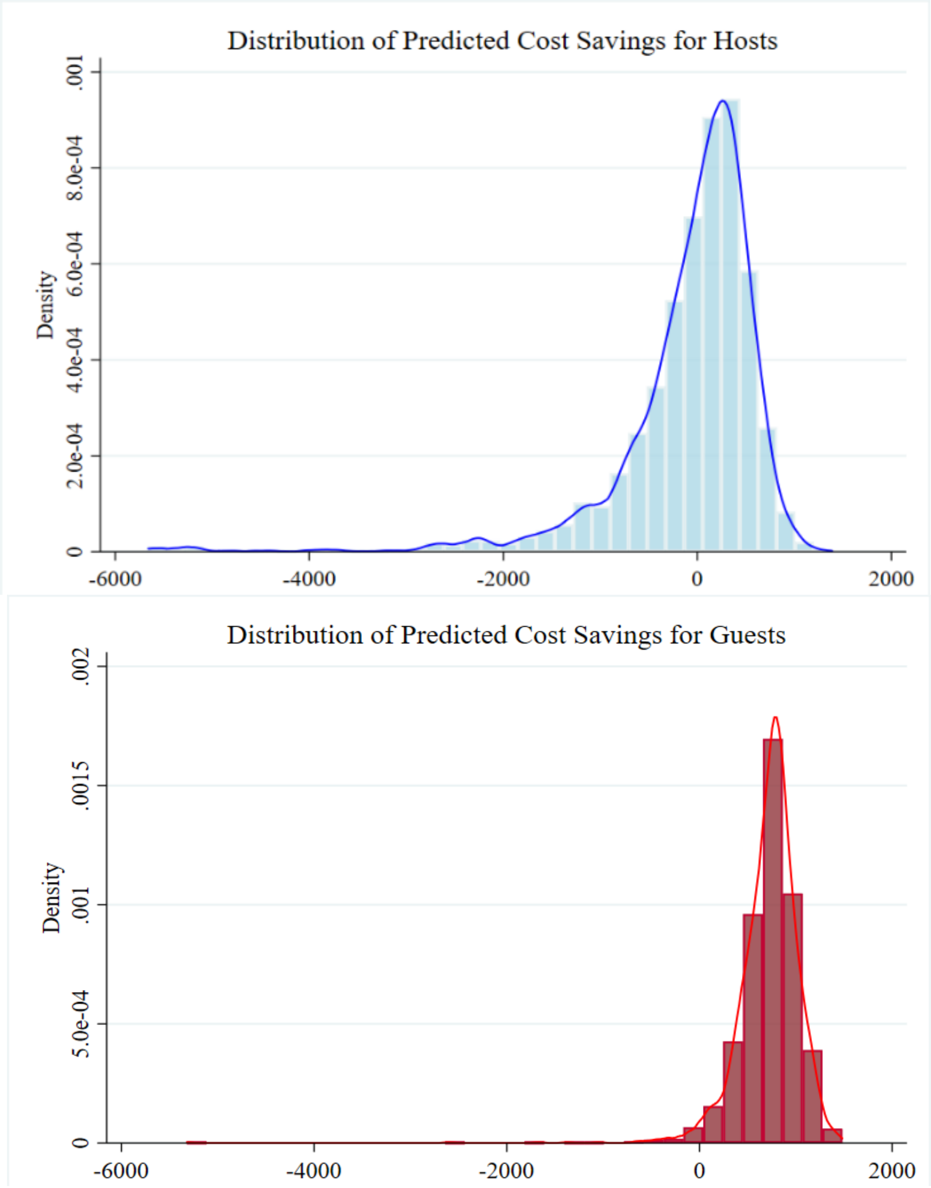
Overall, 23% of older adults live with another adult who is not their romantic partner (see Table 1). We disaggregate this sample by householder status; 17% of older adults are the lease- or mortgage-holder and *host* other adults in their homes, while 7% of older adults are *guests* sharing others' homes (that is, they are in a shared household and are not the lease- or mortgage-holder or the romantic partner of the lease- or mortgage-holder). We find that intergenerational shared households, which include older adults who live with their parents or adult children, are the most common type of shared household among older adults (77% of hosts, 74% of guests). We classify older adults who live with grandchildren, siblings, adult nieces and nephews, and other relatives who are not their parents or children as living in other relative households (16% of hosts, 17% of guests). Finally, nonrelative shared households are those in which older adults live with an adult who is not their romantic partner and not a relative (6% of hosts, 9% of guests).

Our estimate of whether hosting in a shared household increases or reduces older adults' housing costs uses a matched sample of hosts and older adults in nonshared households. We find that hosts spend approximately $74 a month more, on average, than they would if they were not sharing a home. As Figure 1 shows, however, the distribution of the difference between observed costs among hosts and predicted costs in a nonshared arrangement spans from negative to positive. The median savings among hosts is approximately $95 a month. We plan to examine the characteristics of hosts whom we predict save money by hosting, those whom we predict have a similar housing cost regardless of arrangement, and those for whom we predict hosting costs that exceed what they would spend in nonshared arrangements. The results for guests are much more straightforward. Figure 1 (right) shows the distribution of cost difference between observed costs among guests and predicted costs in a nonshared arrangement. The vast majority of the distribution is positive, meaning that we predict that nearly all guests in our sample are saving money by sharing a household. On average, we predict guests save $724 a month by sharing a home. The median cost savings among guests is $759 a month.

Conclusion

Our goal in this summary is to describe household sharing among older adults and assess whether sharing a household provides a housing safety net. We find that 23% of older adults live with another adult who is not their romantic partner. The vast majority of these shared household arrangements involve intergenerational relationships: older adults who host their parents or adult children or who live in the homes of their parents or adult children. Smaller shares of older adults host adult grandchildren, other relatives, and non-relatives or live in the homes of adult grandchildren, other relatives, or non-relatives. Our results reveal that the financial benefits to living in shared households accrue primarily to older adults who are guests in others' homes (see Figure 1 on the next page). We estimate that guests save over $700 a month by living in someone else's home. If guests are contributing financially to the housing cost, they are contributing far less than we would expect them to pay if they lived alone. Hosts, on the other hand, have higher housing costs, on average, than older adults in nonshared households, yet our results suggest that there is much more variation in the cost difference between hosting and nonshared arrangements than we observed for guests. We predict some hosts save money by hosting additional adults in their homes, but some hosts spend considerably more per month than they would in a nonshared arrangement. Our descriptive analyses improve our understanding of the composition and financial impacts of shared households for older adults and provide a foundation for future research assessing the advantages and disadvantages of these arrangements for both hosts and guests.

Figure 1. *Predicted Costs minus Observed Costs among Hosts (top) and Guests (bottom)*



Source: Individuals 65 years old or older who are hosts (left) or guests (right) in shared households during month 12, Wave 1 of the 2014-2022 SIPP panels.

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Who Pays for Elder Care? An Analysis of the Burden on Caregivers and Families

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Introduction

Expected population aging will lead to increasing eldercare needs and place strain on the ability of smaller middle and younger generations to meet increased demand (Caplan 2023; Mather and Scommegna 2024; Houde and Melilo 2009; Anderson et al. 2012; and Dall et al. 2013). Care in the U.S. is largely provided by unpaid family and friends, with 41.8 million adults providing care to an older adult in 2019 ("Caregiving in the U.S." 2020). Many adult children spend both time and money to provide that care. Using data from the Health and Retirement Study, we present a descriptive profile of elders who need care, those who receive care, and who pays for it with money or time. We then examine the impact of eldercare on labor supply using the American Time Use Survey (ATUS). Our preliminary results show that:

- Need and receipt of care varies substantially between demographic groups by gender, race and ethnicity, educational attainment, and marital status.
- Few family caregivers are paid for their care labor, but financial transfers from family to pay for care are relatively uncommon.
- Intergenerational and extended family caregiving are particularly important for Black and Hispanic elders, as well as those with lower educational attainment.
- The effects of caregiving on labor force participation (LFP) vary depending on the frequency of caregiving; only daily caregiving is associated with reduced LFP.

Profile of Care Need and Receipt

Care need and receipt are not uniform and can depend on a variety of factors. Low earners have greater risks of requiring long-term care due to disparities in health and disability by socioeconomic status (Isaacs et al. 2021 and Johnson and Favreault 2021). Severity of disability is also a factor in whether one receives care. Adults with severe care needs are more likely to receive care (73%) than those with milder difficulties (60%) (Table 1).[10] For both mild and severe care need levels, women are more likely than men to receive care and Black and Hispanic adults are more likely to receive care than white adults (Table 1). These disparities may

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[10] "Mild need" is defined as having difficulty with one or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs). "Severe need" includes those with two ADL difficulties. ADLs are routine, self-care tasks that most healthy individuals can perform daily without assistance, including walking across a room, eating, getting dressed, getting in and out of bed, using the toilet, and bathing. IADLs, in comparison, are necessary activities that allow a person to continue living independently, including grocery shopping, managing money, making phone calls, taking medication, and preparing meals.

also be driven by the higher likelihood of women (12%) and Black (18%) and Hispanic (16%) elders over age 50 to have severe needs, compared to men (8%) and white elders (8%).[11]

Table 1. *Percentage of Adults Who Receive Some Care by Severity of Need*

	Everyone 51+	Mild Need	Severe Need
Total	13%	60%	73%
Male	11%	55%	67%
Female	15%	64%	78%
White	12%	59%	73%
Black	19%	62%	74%
Hispanic	19%	64%	78%
Less than HS	30%	72%	81%
HS/GED	14%	58%	72%
Some College	12%	57%	72%
BA degree +	7%	54%	66%

Source: Health and Retirement Study 2018 (wave 14), RAND longitudinal file combined with core HRS section files. "Mild need" is defined as having difficulty with one or more activities of daily living (ADLs) or instrumental activities of daily living (IADLs). "Severe need" includes those with two ADL difficulties.

Within educational attainment, care receipt is greatest for those with lower educational attainment (Table 1), in part because educational attainment is a proxy for socioeconomic status and those in lower income and wealth groups are more likely to be below Medicaid eligibility income and wealth limits. While private long-term care insurance can provide protection, it is often inaccessible and expensive. Even among those with private insurance, roughly a quarter allow their policies to lapse, often due to cognitive impairments that make the need for insurance covered long-term care pressing (Friedberg et al. 2017).

Table 2. *Percentage of Adults with Severe Need Who Pay for Care Out of Pocket, with Insurance, and from Family and Friend Help, by Gender and Race (2018)*

	Everyone	Male	Female	White	Black	Hispanic
Pays for care	36%	39%	34%	37%	34%	30%
Avg monthly payment	$1,152	$1,402	$1,066	$1,281	$842	$813
Insurance/Medicaid/Medicare pays	14%	12%	15%	11%	15%	24%
Family/friends help pay	1%	0%	1%	1%	1%	2%

Source: Health and Retirement Study 2018 (wave 14), RAND longitudinal file combined with core HRS raw files, individual-level weights. Sample includes adults 51+ who have difficulty with two or more activities of daily living (ADLs). Average monthly out-of-pocket expenses are calculated conditional on paying for care. Percentages do not add up as individuals may pay for care through a variety of means.

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[11] Authors' calculations using 2018 Health and Retirement Study data.

While formal care may be financed through Medicaid, private insurance, or savings, families may instead "finance" care through unpaid caregiving from friends and family. But time spent on care creates opportunity costs that result in intergenerational transfers away from younger generations to older adults for adult children and grandchildren caregivers. Past research on intergenerational transfers focuses heavily on downstream transfers, such as those from parents or grandparents to children, with far less focus placed on upstream transfers.

Table 3. *Percentage of Adults with Severe Need Who Receive Care by Gender and Race (2018)*

	Everyone	Male	Female	White	Black	Hispanic
Receives no care	27%	33%	22%	27%	26%	22%
Receives formal care:	39%	35%	40%	43%	32%	28%
From an organization	5%	5%	4%	5%	4%	4%
From an institution employee	19%	19%	19%	24%	13%	7%
From a paid helper	16%	14%	18%	15%	15%	20%
Receives family & friend care:	63%	59%	66%	63%	63%	70%
From a spouse	40%	60%	29%	42%	35%	40%
From a daughter	34%	19%	43%	31%	39%	44%
From a son	21%	18%	23%	22%	21%	19%
From a grandchild	9%	6%	11%	6%	18%	13%
From other family	4%	4%	5%	2%	11%	5%
From other social relationships	13%	9%	14%	14%	12%	8%

Source: Health and Retirement Study 2018 (wave 14), RAND longitudinal file combined with core HRS raw files, individual-level weights. Sample includes adults 51+ who have difficulty with two or more activities of daily living (ADLs). Percentages do not add up as individuals may receive care from multiple sources.

Our descriptive analysis shows that most adults rely on unpaid family and friend care (63%), with 24% receiving care from a daughter and 21% receiving care from a son. Only spousal care is more common at 40% (Table 3). When looking by educational attainment, individuals with higher attainment are more likely to receive formal care and lower educational attainment groups are more likely to receive family care. Intergenerational and extended family caregiving are particularly important for older adults with no college education, as well as for Black and Hispanic older adults (Table 3).

Effects of Caregiving on Labor Supply

Care needs affect family caregivers, often women, who reduce work hours or drop out of the labor force because of their caregiving responsibilities. Older literature on the effects of eldercare on labor force participation are mixed (Bolin et al. 2008; Heitmueller 2007; Pavalko & Artis 1997; Ruhm 1996; Ettner 1996; Moen et al. 1994; and Wolf and Soldo 1994), but recent research is starting to agree that caregiving results in lower labor force attachment (Maestas 2023; Bertogg 2020; Moussa 2019; Lee et al. 2015; Skira 2015; Butrica and Karamcheva 2014; Crespo & Mira 2014; Van Houtven et al. 2013; and Johnson and Sasso 2006). The literature, however, typically uses older data, or relies on more recent Health and Retirement Study (HRS) data which do not include younger caregivers in the 25-49 age range. Caregivers ages 25-49 account for nearly 40% of unpaid caregivers to adults between 2011-2018 in the ATUS.

Using ATUS data, we examine the effect of unpaid caregiving to an older adult on labor force participation by caregiving frequencies (daily, several times a week, or once a week or less). It is difficult to empirically determine whether individuals work less due to caregiving or whether those who already do not work are more likely to provide care at greater rates. The probability of becoming a caregiver is also not random; adults from populations who are more likely to provide care may also already be less likely to work. To account for the non-random assignment of being a caregiver, we use inverse probability weighting with regression adjustment (IPWRA).

We then additionally restrict our sample to adults who are identified as working full-time or part-time in their last month of the Current Population Survey (CPS), which occurs 2-5 months prior to the ATUS questionnaire.[12] The sample restriction reduces potential overestimation of the effect of caregiving by excluding individuals who are likely to be a caregiver because they already do not work. We control for age, gender, race and ethnicity, educational attainment, marital status, year, and usual hours worked.

Table 4. *Estimated Average Treatment Effects for Different Caregiving Frequencies on Labor Force Participation (2011-2018)*

Average Treatment Effects	Coefficient	z	P>z
Labor Force Participation			
Daily care vs. no care	-0.019	-2.17	0.030
Several times a week care vs. no care	-0.001	-0.22	0.827
Once a week or less care vs. no care	0.008	2.27	0.023

Source: Authors' estimates using pooled 2011-2018 American Time Use Survey data.

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[12] The ATUS is a random subsample selected from households in their eighth and final month of the CPS.

Our preliminary results show that the effects of caregiving on labor supply are only significant for labor force participation. Daily caregiving is associated with reduced labor force participation, while caregiving once a week or less is associated with slightly higher labor force participation (Table 4). The positive effect for less frequent caregivers is unexpected and may reflect added worker effects. Adults may work more when the family member in need of care reduces their labor supply or in response to increased medical and care costs (Coile 2004).

We did not find hours of work to be responsive to caregiving among those who continue working. However, the statistically insignificant results for hours worked likely reflect the limited data availability on hours of work. We cannot accurately examine changes in work hours between the CPS and ATUS surveys as we do with labor force participation given that the ATUS only resurveys participants about their work hours if their job has changed between CPS and ATUS surveys. Work hours are otherwise carried forward from the last CPS interview.

Care needs and caregiving both have serious impacts on older households' finances, as well as to immediate and extended family members. Intergenerational impacts are particularly relevant for lower socioeconomic status elders as they are more likely to receive unpaid care from adult children and grandchildren, as well as extended family care (Table 3).

The effects of reduced labor force participation for caregivers extends beyond lost income and include compounded losses in potential savings, potentially lower Social Security benefits after retirement, and not qualifying for OASI and SSDI if caregivers do not accumulate sufficient work credits (Wakabayashi and Donato 2006 and Butrica and Karamcheva 2018). Policies that increase the availability of affordable formal care or that address the negative economic effects of caregiving may help. Such policies could include providing Social Security work credits to caregivers or expanding Medicaid eligibility for long term services and supports.

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Panel 8: New Perspectives on Poverty

Moderator

H. Luke Shaefer (University of Michigan)

Panelists

"Poverty According to a Pilot Principal Poverty Measure"
Rosemary T. Hyson and Sanders Korenman (Baruch College) and Ingrid Gould Ellen (New York University)

"The Color of Wealth in Chicago: Wealth Disparities Among Older Residents by Race and Ethnicity"
Malcolm V. Williams and Susann Rohwedder (RAND), Suparna Bhaskaran and Darrick Hamilton (The New School), and Jessica Hayes (RAND)

"Racial Disparities in Older Adults' Economic Security when Experiencing Chronic Health Conditions: Insights from Electronic Health Records, Wage Earnings, and Credit Data"
Cäzilia Loibl, Stephanie Moulton, Donald Haurin, and Joshua Joseph (The Ohio State University), Kendall Moody (Howard University), Adam Perzynski and Douglas Einstadter (Case Western), Madison Hyer and Matthew Pesavento (The Ohio State University), and Stephania Miller-Hughes (Meharry Medical College)

"Why Does Old-Age Poverty Persist?"
Barbara Butrica and Richard W. Johnson (Urban Institute) and Christopher Tamborini (U.S. Social Security Administration)

Poverty According to a Pilot Principal Poverty Measure

Rosemary T. Hyson and Sanders Korenman
Baruch College, CUNY and CUNY Institute for Demographic Research

Ingrid Gould Ellen
NYU Wagner School of Public Service and Furman Center for Real Estate and Urban Policy

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Overview of the Principal Poverty Measure

A National Academies of Sciences report (NAS 2023) recommended major revisions to the Supplemental Poverty Measure (SPM). This project is the first to our knowledge to implement and conduct analyses of poverty using both the housing and medical care revisions of the report's recommended measure, the Principal Poverty Measure (PPM). The PPM would transition the SPM from a measure of the ability to attain a specified level of expenditure on food, clothing, shelter, and telephone & internet services towards one that measures the ability to afford basic needs according to policy standards such as (the equivalent of) a benchmark health insurance plan as established by the Affordable Care Act (or, for Medicare recipients, a Medicare Advantage plan), a home that rents for HUD's Fair Market Rent (FMR) and, in our pilot PPM, a diet consisting of the USDA's Thrifty Food Plan.

The PPM's health revisions build on the Health Inclusive Poverty Measure (HIPM; Korenman and Remler 2016; NAS 2023, chapter 3), adding a health insurance need to the threshold and, for those with health insurance benefits, an insurance value to resources. The PPM also limits SPM subtractions from resources for out-of-pocket payments for premiums, cost sharing and other medical expenses. The PPM housing revisions (NAS 2023, chapter 5) replace the three-tier housing threshold (renters, owners with and without a mortgage) with a single housing need based on HUD's Fair Market Rents (FMRs). Using HUD guidelines, the number of people in a household determines the "needed" home size (number of bedrooms), and the threshold housing need equals the FMR associated with that home size. Like the SPM, the PPM caps the resource value of housing assistance, though at the revised threshold housing need. For homeowners, the PPM adds to resources an estimate of the implicit rental income (housing services) from an owned home, implemented as the FMR minus average out-of-pocket costs (property taxes, maintenance, insurance and mortgage interest) associated with the needed home.[13]

The NAS (2023) report did not recommend changes to the threshold food need. However, in the absence of new equivalency scales, our pilot PPM replaces the SPM threshold

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[13] Our pilot PPM implementation used the American Housing Survey (US Census Bureau 2021) to estimate average homeowner costs according to the needed number of bedrooms and household's mortgage status, Census division, and metro/non-metro location. For links to data for the project, see references: Robert Wood Johnson Foundation (2024); USDA (2022; 2021); US Department of Housing and Urban Development (2024); and US Census Bureau (2023).

food need with SNAP maximum allocations, based on the USDA Thrifty Food Plan, consistent with the policy-based housing and health threshold needs.[14] Our pilot PPM uses the SPM threshold need value for Clothing, Telephone, Internet, and "Other" (unspecified) necessities.

Pilot PPM Implementation Results

For a 2-parent, 2-child household, the threshold housing need differs modestly between the SPM and PPM; but differences for small households are large, due to the different scale economies used in the FMR and the SPM housing need estimates (Table 1; see also Burns 2024).[15] The SPM equivalence scales for housing are those used to adjust the entire SPM threshold; the PPM scale is specific to housing, based on rental prices by home size.

Table 1. *Mean Housing Needs, SPM & PPM, Single-SPM-Unit Renter Households, 2022*

Household composition	**SPM ($)**	**PPM ($)**	**PPM/SPM Ratio***
(1) One 65+ adult	7,661	12,529	1.61
(2) Two 65+ adults	11,258	14,770	1.28
Ratio (1)/(2)	0.68	0.85	NA
(3) Two adults, two children	16,602	16,437	0.98
Ratio (1)/(3)	0.46	0.76	NA
Ratio (2)/(3)	0.68	0.90	NA

* The PPM/SPM ratio is the mean of the PPM/SPM ratios taken at the household level, not the ratio of means.
Source: Hyson, Korenman, and Ellen (2024a).

Therefore, the SPM procedure understates housing needs for groups that tend to live in smaller households, such as those aged 65 and older. Further, the SPM caps housing assistance values at the threshold housing need (Renwick and Garner 2020), reducing SPM estimates of housing assistance impacts on poverty, particularly for smaller households (discussed below).

Table 2 shows thresholds and their components for the SPM and pilot PPM, for renters and homeowners. For renters, the mean SPM threshold is $31,333, and for owners, $30,111 (row 7), due to the lower SPM threshold for owners without mortgages. Adding a health insurance need increases the average threshold by between $17,000 and $23,000 (row 6). Yet HIPM poverty rates (not shown) are only 2 to 3.5 points higher than SPM rates since the

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[14] The NAS report called for further research on this approach to defining food needs (pp. 35-36). Hyson, Korenman and Ellen (2024a) present additional results for a pilot PPM version that retains the SPM food need.

[15] Hyson, Korenman and Ellen (2024a; 2024b) present results for 2020-2022. We focus here on 2022 for brevity, and since poverty rates and impact estimates for 2020 and 2021 were heavily influenced by pandemic era transfers.

insurance need is mostly met by insurance benefits[16], though 15 points higher for the uninsured (39.7% vs. 24.7%) due to their unmet health insurance needs.[17]

The average PPM (FMR) housing need is two to three thousand dollars greater than the SPM (SU) housing need (row 3), though that differs by location and household size. The higher PPM housing need for renters is partly offset by the PPM's higher rental assistance valuation (row 8). Homeowners' implicit net rental income adds $9,000 to their PPM resources. Average food needs are slightly lower according to the PPM than SPM (row 1). Together (row 9), food and housing revisions raise the PPM poverty rate for renters to 26.2% (vs. a HIPM rate of 24.5%, not shown) but decrease the rate for homeowners to 6.3% (vs. a HIPM rate of 8.9%, not shown).

Table 2. *Poverty Threshold Components ($), Thresholds ($), and Rates (%), Single-SPM-unit Households, 2022 (means except where indicated)*

		Renters		**Owners**	
	Threshold components	SPM	PPM	SPM	PPM
1	Food (F or SNAP)	8,594	8,187	9,132	8,689
2	Clothing (C)	1,237	1,237	1,314	1,314
3	Shelter & Utility (SU or FMR)	14,733	16,989	12,470	15,548
4	Telephone & Internet (ti)	1,891	1,891	2,010	2,010
5	Other (O)	4,878	4,878	5,184	5,184
6	Health insurance (HI)	NA	17,516	NA	22,835
7	**Poverty threshold***	**31,333**	**50,698**	**30,111**	**55,580**
8	Rental assistance or owner's implicit rental income	768	1,207	NA	9,107
9	**Poverty rates (%)**	**21.0**	**26.2**	**7.6**	**6.3**

*SPM threshold = (F + C + SU + ti + O); PPM threshold = (SNAP + FMR + C + ti + O + HI). HIPM threshold = (F + C + SU + ti + O); the HIPM and PPM also add a value for government or employer health insurance benefits to resources, and cap the SPM subtraction for out-of-pocket spending. HIPM poverty rate = 24.5% for renters and 8.9% for owners.
Source: Hyson, Korenman and Ellen (2024a; 2024b).

Differences in poverty rates among groups between the pilot PPM and SPM are driven by five main factors: 1. Differences in uninsurance rates across groups; 2. Higher housing costs at the 40th percentile of the local rent distribution (FMRs), relative to the SPM geographic adjustment, in selected places, like Northeast center cities; 3. Differences between the PPM

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[16] The capping of the subtraction for medical out-of-pocket spending in the HIPM and PPM modestly reduces poverty rates relative to SPM (not shown).

[17] Korenman, Remler and Hyson (2018) added estimates of the insurance value of free care to the uninsured to HIPM resources for a study of New York. NAS (2023, p. 52) called for additional research on free and reduced-price care.

(FMR) and SPM housing scale economies (affecting the housing need and, via capping, the value of housing assistance); 4. Difference between the scale economies in the PPM (SNAP) food need and the SPM food need (F); and 5. for homeowners, the PPM implicit rental income.

Table 3 shows poverty rates. For renters, PPM poverty rates among children and Hispanics are higher than SPM rates (rows 2 and 10); compared to the Midwest, PPM poverty rates are higher than SPM poverty rates in the South due to higher uninsurance rates, and in the Northeast and West, due to higher rents (rows 14-17); and PPM poverty rates for single-parent renters are much higher than SPM rates (row 20). For homeowners, implicit (net) rental income reduces the PPM rate below the SPM rate for nearly every group, the main exception being the uninsured, whose unmet insurance needs leaves their PPM rate 8.8 percentage points higher than their SPM rate (row 9). The PPM rate is reduced most relative to the SPM rate for groups likely to own their homes outright, particularly persons aged 65+ (row 4). Disability benefit recipients in owned homes have lower PPM than SPM rates (row 22-23).

Table 3. *Poverty Rates for Persons in Single-SPM-Unit Households, 2022 (%)*

			Renters		**Owners**	
			SPM	**PPM**	**SPM**	**PPM**
1	**All persons**		21.0	26.2	7.6	6.3
2	**Age**	<18	24.4	32.2	6.1	5.8
3		18-64	18.8	23.7	6.9	6.0
4		65+	26.7	27.4	11.0	7.4
5	**Health insurance**	Employer	7.0	8.2	2.3	1.5
6		Direct Purchase	24.3	35.0	13.8	12.8
7		Medicaid	33.1	38.4	18.0	14.0
8		Medicare	28.0	27.7	12.1	8.0
9		Uninsured	32.0	54.1	18.4	27.2
10	**Racial/ Hispanic identification**	Hispanic	27.3	37.2	11.1	10.3
11		NH White	15.8	18.1	6.5	5.2
12		NH Black	23.4	27.6	10.2	7.9
13		NH Asian	17.0	22.2	7.4	5.4
14	**Census region**	Northeast	20.7	26.7	6.8	5.1
15		Midwest	17.6	20.2	5.6	4.5
16		South	22.6	28.6	9.0	7.8
17		West	21.2	26.3	7.7	6.1
18	**Family structure (selected)**	1 adult, 0 kids	22.3	24.9	15.3	11.9
20		1 adult, 1+ kids	33.8	40.3	17.3	14.1
21		2 adults, 2 kids	14.8	20.5	3.7	2.9
22	**Disability benefit recipients**	Ages 18-64	27.0	27.3	14.7	11.1
23		Ages 65+	27.7	23.4	12.5	7.4

Source: Hyson, Korenman and Ellen (2024a; 2024b).

Table 4 shows selected impact estimates of transfer programs for renters only.[18] The SPM and PPM impact estimates appear similar, with two exceptions. First, the PPM shows very large impacts of health insurance benefits on poverty that the SPM cannot (Remler, Korenman and Hyson 2017). And the PPM finds larger anti-poverty impacts of housing benefits than the SPM, especially for those ages 65+ (11.6 vs. 6.6 percentage points). The large PPM housing impacts result from: 1. A larger PPM than SPM housing need for smaller households; 2. The consequent increase in the capped value of housing benefits, and 3. The relatively large proportion of older renters that receive housing assistance (Hyson, Korenman and Ellen 2024a).[19] Although far smaller than the impacts of Social Security and Medicare, these social insurance programs are nearly universal among older persons, while housing assistance is income-tested. For children, tax credits (ETIC & ACTC), housing assistance and especially Medicaid have substantial poverty impacts.

Our pilot PPM analyses demonstrate the feasibility of implementing the PPM's housing and medical care recommendations and reinforce the call for continued research on equivalence scales for poverty thresholds (NAS 2023, pp. 98-99). The results also suggest that SPM methods may have obscured the substantial anti-poverty impacts of housing assistance for older renters.

Table 4. *Poverty Impacts, Persons in Single-SPM-Unit Renter Households, 2022 (% points)*

	All Ages		**Children**		**Seniors**	
	SPM	**PPM**	**SPM**	**PPM**	**SPM**	**PPM**
Social Security	7.3	7.2	2.4	2.2	39.8	40.6
EITC & ACTC	4.1	3.3	9.0	7.1	0.4	0.2
SNAP	2.7	2.3	4.2	3.9	2.8	1.6
SSI	1.5	1.6	0.8	0.8	3.1	3.2
Housing subs/public housing	2.8	4.0	3.2	4.1	6.6	11.6
Medicaid	NA	9.0	NA	15.0	NA	1.6
Medicare	NA	6.4	NA	1.6	NA	36.8
Poverty rate	21.0	26.2	24.4	32.0	26.7	27.4

Source: Hyson, Korenman and Ellen (2024a; 2024b).

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[18] These are static or accounting impacts of programs on poverty rates (e.g., Shrider and Creamer, 2023; Table B-7). They equal the change in poverty that results when the value of a benefit or program is subtracted from resources, with no other changes (i.e., ignoring behavioral changes resulting from loss of benefits).

[19] There is a parallel implication for homeowners of the larger PPM housing need for small households since their implicit rental income equals the housing need minus mean homeowner costs (Hyson, Korenman and Ellen 2024b).

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The Color of Wealth in Chicago: Wealth Disparities Among Older Residents by Race and Ethnicity

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Introduction

In the U.S., the average Black and Hispanic or Latino household owns about 15% to 20% as much net wealth as the average White household (Aladangady and Forde 2021). An in-depth understanding of the barriers to wealth accumulation among people of color could shed light on the financial vulnerability that extends to advanced ages.

The Chicago metropolitan area is the third largest in the U.S., with 9.5 million residents, including Whites (52%), Latinos (22%), and African Americans (16%) as the three largest racial and ethnic groups (U.S. Census 2018). However, the Chicago region is one of the most segregated, both economically and by race and ethnicity, and Chicago's African American and Latino residents generally have worse wealth indicators, such as lower homeownership rates, compared to Whites (Acs, Pendall, Treskon, and Khare 2017 and Brown, Montes, and Hassani 2019). A detailed analysis of wealth disparities and its correlates in Chicago by nuanced race and ethnicity categories holds the promise to identify important barriers to wealth accumulation among people of color.

This project is analyzing unusually rich and freshly collected data on the "Color of Wealth" (COW) from the Chicago area, the third largest metropolitan area in the U.S. The population of Chicago is not only very diverse, but also one of the most segregated, both economically and by race and ethnicity. The Chicago COW data were designed and collected in collaboration of The New School (PI: Darrick Hamilton) and RAND (PI: Malcolm Williams) with funding and substantive input from the Chicago Community Trust.

In this project we are leveraging the unique combination of comprehensive and detailed economic measures with rich information on households' current and past circumstances to study wealth disparities by race, ethnicity and socioeconomic status in Chicago. An important focus will be to identify barriers to wealth accumulation among older people of color, recognizing that economic circumstances and barriers to advancement vary greatly within groups of people of color, for example, by whether their families arrived in this country recently. We will study potential drivers of wealth disparities throughout life using the rich information on family income and demographics, immigration history, and childhood circumstances, among others. Prior research identified large differences in income as an important source of wealth inequality. We will aim to identify factors that contribute to income inequality, considering a wide set of variables (family structure, health, employment and job-related factors, parental background variables, transfers, incarceration history, etc.).

Methods

The data for this project is Chicago Color of Wealth (C-COW), 2022 survey. C-COW employed sophisticated sampling methods to maximize analytic power for comparisons of Latino ethnicity sub populations; its survey methods were adapted to facilitate comparisons with the Panel Study of Income Dynamics (PSID).

Recruitment for the C-COW study employed address-based probability sampling, combined with innovative methods to oversample racial and ethnic groups (non-Hispanic African American and Hispanic individuals including those of Mexican and Puerto Rican ancestry) in order to maximize the analytic power for comparisons of Chicago households by race and ethnicity. The final data set contains 1,626 completed interviews; and the median age is 48, with about 60% of the sample aged between 40 and 75. The questionnaire had six modules. The income and asset modules closely followed the PSID design, including follow-up questions in case of non-response to economic questions. In addition, the survey queried detailed demographics (7-category detailed race/ethnicity, immigration status, education (own, spouse, parents), health, childhood conditions), financial fragility (e.g., food insecurity, difficulties paying bills, use of expensive forms of credit), transfers (received and given, both intervivos and inheritance), attitudes and social engagement. The final data set has about 300 economic variables (income, assets, housing, including bracket information in case of initial non-response), and 560 variables in total.

The first task has been to process the raw data, including imputations of missing values in economic variables, and to construct income and asset summary measures. Next, we analyze disparities in wealth holdings and income (composition and amounts), by age bands and race and ethnicity and other demographic characteristics. Analyses of amounts focus on medians because of the skewed distribution of income and wealth variables. When we present results, the level of detail of reported descriptive statistics is adapted to sample size in order to obtain interpretable results. We plan to use multivariate regressions of asset ownership (housing, risky assets, debt) and of asset amounts (e.g., total assets, non-housing in logs or median regression), controlling for age, and detailed demographic indicators, such as family and household structure, immigration history, childhood conditions, transfers to and from others, neighborhood characteristics, and many more. To find contributors to income inequality we will study employment-related disadvantage (health limiting ability to work, earnings, whether job offers health or pension benefits, etc.). We have completed descriptive analyses of the entire sample and are close to completing descriptive analyses on a restricted sample of older persons. If the sample will allow, our goal will be to assess persons 65 years of age and older.

Results

The Color of Wealth data oversampled racial and ethnic minority populations. Table 1 highlights the race of respondents by the key racial and ethnic subpopulations. The largest race group represented was White non-Hispanics. The smallest was people who identified as Puerto Rican. Black non-Hispanic respondents made up one fifth of the sample. There were important differences in education, marital status, homeownership, and income (Table 2).

Table 1. *Chicago Metro Region-Color of Wealth in Chicago Respondents*

	Number of Respondents	% of Sample
Black	307	20%
Mexican (foreign-born)	115	8%
Mexican U.S. born	204	13%
Puerto Rican	70	5%
White	819	54%
Total	1,515	100%

Source: Color of Wealth in Chicago Survey Respondents for the Chicago Metro Region which includes the city of Chicago and 10 counties: Cook County, DeKalb County, DuPage County, Grundy County, Kane County, Kankakee County, Kendall County, Lake County, McHenry County, and Will County.

White non-Hispanic respondents, compared to other racial and ethnic groups, were most likely to have at least a bachelor’s degree, own a home, and had the highest income at $92,000. Mexican respondents who were foreign born were least likely to have at least a bachelor’s degree but most likely to be married. Black respondents were least likely to own a home and had the lowest family income of all racial and ethnic groups.

Table 2. *Demographic and Socioeconomic Status Characteristics by Race/Ethnicity in Chicago Metro Area, Census Data and Color of Wealth in Chicago Data*

	Bachelor's Degree or Higher	Married	Home Ownership	Median Family Income
Black	28%	28%	34%	$36,500
Mexican (foreign born)	9%	67%	57%	$55,000
Mexican (U.S. born)	26%	48%	58%	$65,000
Puerto Rican	28%	41%	50%	$68,000
White	45%	52%	72%	$92,000

Source: Color of Wealth in Chicago Survey Respondents for the Chicago Metro Region which includes the city of Chicago and 10 counties: Cook County, DeKalb County, DuPage County, Grundy County, Kane County, Kankakee County, Kendall County, Lake County, McHenry County, and Will County.

Among all participants, credit cards are the most prevalent type of noncollateralized consumer debt (Table 3). Respondents who were Mexican (U.S. born) and Black (29% and 30%, respectively) were more likely to have medical debt than White families (18%).

Table 3. *Percentage of Families Having Various Types of Unsecured Debt*

	Credit Card Debt	Student Loans	Medical Debt	Legal Debt	Loans from Relatives	Other	Total Non-Tangible Debts (Median)
Black	50%	45%	30%	8%	15%	7%	$17,000
Mexican (foreign born)	61%	20%	26%	3%	11%	1%	$8,000
Mexican (U.S. born)	57%	28%	29%	4%	13%	8%	$14,000
Puerto Rican	63%	20%	21%	4%	10%	2%	$8,000
White	44%	23%	18%	5%	6%	3%	$15,000

Source: Color of Wealth in Chicago Survey Respondents for the Chicago Metro Region which includes the city of Chicago and 10 counties: Cook County, DeKalb County, DuPage County, Grundy County, Kane County, Kankakee County, Kendall County, Lake County, McHenry County, and Will County.

In addition, U.S. born Mexican and Black families were most likely to use payday lending (13 percent and 18 percent, respectively), followed by Puerto Rican families at 11 percent (Table 4).

Table 4. *Payday Loan Usage Among Families in Chicago Metro Areas*

	Percent
Black	18%
Mexican (foreign-born)	7%
Mexican (U.S. born)	13%
Puerto Rican	11%
White	6%

Source: Color of Wealth in Chicago Survey Respondents for the Chicago Metro Region which includes the city of Chicago and 10 counties: Cook County, DeKalb County, DuPage County, Grundy County, Kane County, Kankakee County, Kendall County, Lake County, McHenry County, and Will County.

There were important differences in total assts and net worth by race and ethnicity (Table 5). Black respondents had the lowest of both among all racial and ethnic groups, White respondents had nearly 3 times the total assets of the next highest racial and ethnic group, and about 5 times net worth.

Table 5. *Total Assets and Net Worth*

	Total Assets	Net Worth
Black	$20,000	$0
Mexican (foreign born)	$26,000	$6,000
Mexican (U.S. born)	$128,000	$40,500
Puerto Rican	$125,000	$24,000
White	$325,000	$210,000

Source: Color of Wealth in Chicago Survey Respondents for the Chicago Metro Region which includes the city of Chicago and 10 counties: Cook County, DeKalb County, DuPage County, Grundy County, Kane County, Kankakee County, Kendall County, Lake County, McHenry County, and Will County.

Discussion

The results so far highlight important differences by race and ethnicity. We plan to complete the descriptive analyses of older persons in the sample prior to the presentation on August 7. At this stage of analyses, it will be difficult to draw broader conclusions.

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Racial Disparities in Older Adults' Economic Security when Experiencing Chronic Health Conditions: Insights from Electronic Health Records, Wage Earnings, and Credit Data

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Introduction

As many as 80% of Americans have a chronic health condition by age 65. This study focuses on type 2 diabetes mellitus (hereafter “diabetes”), a common, costly chronic health condition and federally-protected disability (EEOC 2023). Over the past 20 years, the number of adults diagnosed with diabetes has more than doubled to 38.4m (11.6% of population). About 12.7% of Black adults are diagnosed with diabetes, compared to 11.0% of White adults (CDC 2023). Black adults with diabetes are almost three times more likely to be hospitalized for short-term complications and two times more likely to have disabling complications including diabetic retinopathy, lower limb amputation, stroke, renal failure, and major cardiovascular disease than White adults (Hill-Briggs et al. 2022). In this study, we ask: How does access to financial resources associate with diabetes control and complications? To what extent do differences in financial resources associate with heterogeneity in diabetes control by race?

Our first aim is to construct a new panel data set that links individual-level clinical diabetes patient data with quarterly wage earnings and credit data. A small but growing number of studies, most focused on cancer, have linked clinical health data with credit panel data; but none have included employment information (Dobkin et al. 2018; Gupta et al. 2018; and Shankaran et al. 2022). These frequent-interval, administrative data are critical to understanding how financial resources from different sources associate with changes in diabetes control over time.

Our second aim describes the association of financial resources with diabetes control and complications. Research on the social determinants of health and diabetes show that non-medical factors account for 40% of health outcomes (CHR&R 2023). In diabetes frameworks (WHO, HHS, and KFF), economic stability is the most important non-medical factor. Our focus on employment income, credit access, and debt use on diabetes outcomes will inform the understanding of pathways of economic factors that contribute to diabetes inequities (Hill-Briggs et al. 2021). We examine how the magnitude of changes in wage income, credit access, and debt levels associate with diabetes control and disability-related complications, informing SSA about evolving risks to the economic security of future beneficiary cohorts.

Our third aim examines heterogeneity in the relationship between financial resources and diabetes control by race, gender, and income. Survey data find that Black patients with diabetes show a 1.2 to 1.4 higher likelihood to report financial hardship from medical bills (Caraballo et al. 2020 and Mszar et al. 2020). Employment difficulties, credit constraints, and debt accumulation may translate more strongly into diabetes complications for Black than White adults (Gaskin et al. 2014 and Jencks et al. 2019).

Data and Methods

We use several new and unique datasets for this analysis, combining data on adults ages 50 and older in Ohio from 10/1/2017 to 12/31/2021 (17 calendar quarters). For the here presented, preliminary analyses, the first data source is electronic health records of patients with diabetes indicators from The Ohio State University (OSU) Wexner Medical Center from both inpatient and outpatient encounters. The second data source is credit panel data from Experian, one of three national credit bureaus with detailed individual and account level information. The third data source is individual-level wage earnings and unemployment insurance claims for adults employed in the state of Ohio through the Ohio Longitudinal Data Archive. While our data are limited to one state, Ohio ranks among the 10 states with the highest diabetes prevalence (ODH 2023). Ohio mirrors the nation with regard to age, gender, and race distribution.

For our first aim, we transferred and merged two of the three quantitative data sources, electronic health records from one provider, the OSU Wexner Medical Center, and credit panel data from Experian. We matched 93% of the diabetes patient sample to quarterly, individual-level credit data, n=133,545 observations. We coded patients diagnosed with diabetes in three categories each quarter: “controlled” (HbA1c: <7.00%, 52% of the sample), “uncontrolled” (HbA1c: 7.00% to 8.99%; 35% of the sample), and “severely uncontrolled” (≥9.00%; 13% of the sample).

For our second aim, we first describe credit and debt characteristics of patients across the three diabetes categories at baseline, which we define as the first observation of a patient with diabetes in our data, using means comparison tests. We then use multinomial logistic regression to regress the three diabetes categories on credit score, as the focal measure from credit data, for the full sample as well as subsamples of Black and White patients with diabetes.

$$\mathrm{T2DM}_{i,t+n} = \beta_0 + \beta_1\mathrm{Credit}_{i,t} + \beta_2\mathrm{Demog}_{i,t} + \beta_3\mathrm{T2DM}_{i,t} + \beta_4\mathrm{QTR}_{i,n} + \beta_5\mathrm{T}_{i,n} + e_{i,t} \quad (1)$$

where the outcome $\mathrm{T2DM}_{i,t+n}$ is an indicator of diabetes control. Quarter t is the first observation of diabetes in the data and t+n is the nth period of observation of diabetes. Predictor variables are credit score ($Credit_{i,t}$), demographic characteristics ($Demog_{i,t}$), $QTR_{i,n}$ is the number of quarters between the first and the n-th observation, and T is a dichotomous measure of quarterly time trends.

Preliminary Results

Descriptive means comparison statistics show that patients with controlled diabetes differ from patients with uncontrolled and severely uncontrolled diabetes in many ways. Table 1 reports means differences in credit access and debt measures, collected at the first observation of a patient (baseline). The levels of diabetes control are measured at subsequent quarters.

Generally, individuals with worse diabetes control have lower access to credit and problematic debt levels at baseline in our sample. The greatest differences are observed when comparing patients with controlled diabetes to patients with severely uncontrolled diabetes, with significant differences for 13 of the 15 variables, at $p<0.05$. Credit and debt values at baseline for those who are subsequently in the severely uncontrolled group range within 0.75 and 2.0 times of the controlled group. Patients with severely uncontrolled diabetes report lower credit scores, less available revolving credit, higher auto loan balances, higher amounts of derogatory debt, higher debt amounts in collections, including non-medical and medical collections at baseline, and report more often charge-offs, bankruptcy, and foreclosure, at $p<0.05$. The credit access of patients with severely uncontrolled diabetes is lower at baseline, when compared to patients with controlled diabetes, as documented in lower total debt, lower mortgage debt, and lower revolving (credit card) debt. We do not find a difference for student debt and personal installment loans at baseline for the two groups of patients with diabetes.

Patients with uncontrolled diabetes differ from patients with controlled diabetes for nine of the 15 variables. Their credit and debt values at baseline are typically between those of patients with controlled and severely uncontrolled diabetes. They range within 0.95 and 1.2 times of the controlled group. Exceptions are the highest auto loan and personal installment loan balances of all three diabetes groups (see Table 1).

Table 2 shows demographic characteristics at baseline. Compared to patients with controlled diabetes, a higher number of patients with severely uncontrolled diabetes are Black, Hispanic, in the 50-59 and 60-61 age groups, and are enrolled in managed health care plans, Medicaid, other health insurance, or no health insurance. Patients with severely uncontrolled diabetes are less often White or Asian, age 62 and older, female, and in Medicare health insurance plans (see Table 2).

Tables 3 and 4 compare Black and White patients with diabetes at baseline, regardless of subsequent level of diabetes control. At the first observation of a patient, Black patients with diabetes differ in all but one (auto loan balances) from the credit and debt variables of White patients with diabetes. The values reflect limited access to credit as well as higher problematic debt balances. For example, non-medical debt in collection is 1.4 times higher and student loan debt is 1.35 times higher among Black patients with diabetes compared to White patients with diabetes. In contrast, Black patients have lower mortgage, revolving credit, and installment loan balances compared to White patients. We also observe stark demographic differences with Black patients with diabetes reporting younger ages, are more often female and of Hispanic ethnicity, on Medicaid or without health insurance.

Across these descriptive data, we find that the financial situation of Black patients with diabetes at baseline (across the diabetes spectrum) is on average about as vulnerable as the financial situation of patients with severely uncontrolled diabetes at baseline (ratio: 1.02). In contrast, the financial situation of White patients with diabetes at baseline (across the diabetes spectrum) is reflective of the more stable financial situation of patients with controlled diabetes (ratio: 1.06) (see Tables 3 & 4).

Table 5 provides preliminary results of multinominal regressions of the three levels of diabetes control on an overall credit measure (credit score) and selected demographic control measures. For the full sample, we find that the risk ratio for a 100-unit increase in credit score is 0.957 for being in the uncontrolled vs the controlled diabetes category. The result indicates a slight, but significant decrease in risk for being in the uncontrolled diabetes group. The risk ratio for a 100-unit increase in credit score is 0.754 for being in the severely uncontrolled vs the controlled diabetes category, indicating a substantial decrease in risk for being in the severely uncontrolled diabetes group. The results for the subsample of White patients with diabetes, in Panel 2, mirror the results for the full sample. For the subsample of Black patients with diabetes, in Panel 3, the risk ratio of uncontrolled vs controlled diabetes is weaker, at $p<0.05$. The risk ratio for a 100-unit increase in credit score is 0.801 for being in the severely uncontrolled (vs the controlled diabetes category), indicating a lesser decrease in risk for being in the severely uncontrolled diabetes group for the subsample of Black patients with diabetes (see Table 5).

Next Steps

The next steps in this project will add several important dimensions to these results. First, we are in the process of almost doubling the sample size by adding data from a large Northeast Ohio medical center, the MetroHealth System in Cleveland. These data will increase the robustness of the current models and allow us to confidently investigate subsamples by race, gender, and income. Second, we recently received approval to merge-in individual-level wage earnings and unemployment insurance claims data from the Ohio Department of Jobs and Family Services. These important demographic measures will allow us to describe wage earnings and periods of unemployment for patients with diabetes. We will also include indicators of high-cost borrowing, account for the COVID-19 pandemic by testing interaction specifications, and ZIP code characteristics, including poverty and unemployment rates. Third, we will test continuous measures of HbA1c, binary measure of diabetes control, and indicators of disability-relevant complications, and identify patients with prediabetes (5.70% to 6.49%). Fourth, we will investigate the role of a number of key medical risk factors in the relationship of credit and debt with diabetes control, such as BMI, smoking, blood pressure, LDL cholesterol, hospital overnight stays, and emergency room visits, following medical literature (Wong et al. 2013). Fifth, we will conduct qualitative interviews to complement these rich quantitative data, allowing us to probe how different types of financial resources, and lack thereof, may contribute to diabetes management (Morgan et al. 2002 and Addo and Beverly 2022).

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Table 1. *Descriptive Statistics - Credit and Debt Measures are at the Quarter Of 1st Observation of a Patient (Baseline); Hba1c Measurements Are in a Quarter After Baseline*

	(1) Diabetes controlled HbA1c<7% (reference category)	(2) Diabetes uncontrolled HbA1c: 7.00-8.99%	(3) Diabetes severely uncontrolled HbA1c: ≥9.00%	(4) Total diabetes sample
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Credit Score (300-850)	707 (107)	698*** (108)	651*** (108)	697 (109)
Any revolving credit available	0.68	0.66***	0.53***	0.65
	(0.47)	(0.47)	(0.49)	(0.47)
Total mortgage debt	$43,950	$41,770***	$32,650***	$41,730
	($91,620)	($91,870)	($103,930)	($93,460)
Total revolving debt	$5,490	$5,410	$4,350***	$5,320
	($13,660)	($12,430)	($9,740)	($12,790)
Total student debt	$4,370	$4,280	$4,510	$4,360
	($23,090)	($21,980)	($21,690)	($22,530)
Total auto debt	$5,850	$6,400***	$6,080*	$6,070
	($11,700)	($13,020)	($11,850)	($12,200)
Total personal installment debt	$1,510	$1,850***	$1,420	$1,620
	($9,290)	($20,830)	($8,170)	($14,320)
Total debt	$60,020	$58,650*	$47,750***	$57,960
	($103,070)	($105,840)	($113,050)	($105,450)
Total derogatory debt	$2,300	$2,360	$3,600***	$2,490
	($13,050)	($11,870)	($14,410)	($12,850)
Total collections	$579	$609*	$1,072***	$653
	($2,188)	($2,083)	($2,957)	($2,274)
Total non-medical collections	$348	$373**	$615***	$391
	($1,578)	(1,494)	($1,786)	($1,580)
Total medical collections	$232	$237	$457***	$263
	($1,428)	($1,354)	($2,238)	($1,535)
Charge-off in previous year	0.05	0.06***	0.09***	0.06
	(0.22)	(0.23)	(0.28)	(0.23)
Bankruptcy in previous year	0.01	0.01	0.01***	0.01
	(0.08)	(0.08)	(0.10)	(0.08)
Foreclosure in previous year	0.002	0.002	0.003*	0.002
	(0.05)	(0.05)	(0.06)	(0.05)
N observations	69,701	46,571	17,273	133,545
	(52.19%)	(34.87%)	(12.93%)	(100.00%)

Note: * $p<0.05$, ** $p<0.01$, *** $p<0.001$, observations of controlled diabetes serve as reference group for means comparison t-tests.
Source: Calculations of the authors.

Table 2. *Descriptive Statistics – Demographic Measures are at the Quarter of 1st Observation of a Patient (Baseline); Hba1c Measurements are in a Quarter After Baseline*

	(1) Diabetes controlled HbA1c <7.00% Mean (SD)	(2) Diabetes uncontrolled HbA1c 7.00-8.99% Mean (SD)	(3) Diabetes severely uncontrolled HbA1c ≥9.00% Mean (SD)	(4) Total sample Mean (SD)
Race				
--White	0.71 (0.46)	0.72*** (0.45)	0.66*** (0.47)	0.70 (0.46)
--Black	0.23 (0.42)	0.22*** (0.41)	0.28*** (0.45)	0.23 (0.42)
--Asian	0.03 (0.17)	0.03** (0.16)	0.02*** (0.13)	0.03 (0.16)
--Native	0.00 (0.05)	0.00 (0.05)	0.00 (0.05)	0.00 (0.05)
--Multiple Races	0.00 (0.06)	0.01** (0.07)	0.01 (0.07)	0.00 (0.07)
--Race Missing	0.03 (0.16)	0.03** (0.17)	0.03* (0.17)	0.03 (0.17)
Ethnicity				
--Hispanic	0.01 (0.11)	0.02*** (0.13)	0.02*** (0.13)	0.02 (0.12)
--Not Hispanic	0.98 (0.14)	0.98* (0.15)	0.98** (0.15)	0.98 (0.15)
--Ethnicity Missing	0.01 (0.09)	0.01* (0.08)	0.01 (0.09)	0.01 (0.08)
Age	65.12 (9.27)	64.15*** (9.29	61.36*** (8.72)	64.30 (9.29
--50-59	0.30 (0.46)	0.35*** (0.48)	0.48*** (0.50)	0.34 (0.47)
--60-61	0.07 (0.26)	0.08** (0.27)	0.08*** (0.28)	0.08 (0.26)
--62-66	0.20 (0.40)	0.19*** (0.40)	0.18*** (0.38)	0.20 (0.40)
--67-69	0.11 (0.31)	0.10*** (0.30)	0.08*** (0.28)	0.10 (0.31)
--70-71	0.07 (0.26)	0.06*** (0.24)	0.04*** (0.19)	0.07 (0.25)
--72+	0.24 (0.43)	0.21*** (0.41)	0.14*** (0.34)	0.22 (0.41)
Female	0.52 (0.50)	0.48*** (0.50)	0.49*** (0.50)	0.50 (0.50)
Health insurance coverage				
--Managed care	0.35 (0.48)	0.37*** (0.48)	0.37*** (0.48)	0.36 (0.48)
--Medicare	0.49 (0.50)	0.45** (0.50)	0.37*** (0.48)	0.46 (0.50)
--Medicaid	0.09 (0.29)	0.10*** (0.30)	0.17*** (0.37)	0.10 (0.30)
--Other health insurance	0.06 (0.24)	0.07** (0.26)	0.07*** (0.26)	0.07 (0.25)
--No health insurance	0.01 (0.11)	0.01** (0.12)	0.03*** (0.17)	0.02 (0.12)
No. quarters since baseline (1-17)	4.67 (4.69)	5.27*** (4.86)	4.54** (4.72)	4.86 (4.76)
HbA1c at baseline (%)	6.50 (1.15)	7.80*** (1.31)	9.63*** (1.95)	7.36 (1.70)
N observations	69,701 (52.19%)	46,571 (34.87%)	17,273 (12.93%)	133,545 (100.00%)

Notes: * $p<0.05$, ** $p<0.01$, *** $p<0.001$, observations of controlled diabetes serve as reference group for means comparison t-tests; "Other health insurances" includes Bureau of Disability, Columbus Free Clinic, Drug Advocacy Program, Victims of Crime and other government health insurance, including Bureau of Workers Compensation, Veterans Administration.

Source: Calculations of the authors.

Table 3. *Descriptive Statistics for White and Black Patients with Diabetes - Credit and Debt Measures are at the Quarter of 1st Observation of a Patient (Baseline)*

	(1) White patients with diabetes Mean (SD)	(2) Black patients with diabetes Mean (SD)
Credit Score (300-850)	716 (104)	630*** (100)
Any revolving credit available	0.69 (0.46)	0.51*** (0.50)
Total mortgage debt	$45,990 ($99,430)	$25,680*** ($61,510)
Total revolving debt	$5,790 ($13,910)	$3,820*** ($8,550)
Total student debt	$3,260 ($18,590)	$7,810*** ($31,700)
Total auto debt	$6,070 ($12,500)	$6,210 ($11,350)
Total personal installment debt	$1,910 ($16,750)	$1,020*** ($5,250)
Total debt	$62,320 ($111,710)	$41,990*** ($75,320)
Total derogatory debt	$2,040 ($11,670)	$3,850*** ($14,620)
Total collections	$530 ($2,161)	$1,081*** ($2,608)
Total non-medical collections	$283 ($1,438)	$758*** ($1,918)
Total medical collections	$246 ($1,515)	$323*** ($1,670)
Charge-off in previous year	0.04 (0.21)	0.10*** (0.30)
Bankruptcy in previous year	0.01 (0.07)	0.01*** (0.12)
Foreclosure in previous year	0.002 (0.05)	0.003* (0.05)
N observations	93,973 (75.07%)	31,197 (24.93%)

Notes: * $p<0.05$, ** $p<0.01$, *** $p<0.001$, observations of White patients with diabetes serve as reference group for means comparison t-tests.
Source: Calculations of the authors.

Table 4. *Descriptive Statistics for White and Black Patients with Diabetes - Demographic Measures are at the Quarter of 1st Observation of a Patient (Baseline)*

	(1) White patients with diabetes Mean (SD)	(2) Black patients with diabetes Mean (SD)
Age	64.88 (9.28)	62.98*** (9.14)
--50-59	0.31 (0.46)	0.40*** (0.49)
--60-61	0.07 (0.26)	0.08*** (0.27)
--62-66	0.19 (0.39)	0.19 (0.39)
--67-69	0.10 (0.31)	0.09*** (0.28)
--70-71	0.07 (0.25)	0.05*** (0.22)
--72 and older	0.23 (0.42)	0.17*** (0.37)
Female	0.46 (0.49)	0.60*** (0.48)
Ethnicity		
--Hispanic	0.01 (0.07)	0.004*** (0.06)
--Not Hispanic	0.98 (0.10)	0.99*** (0.08)
--Ethnicity Missing	0.01 (0.07)	0.003*** (0.05)
Health insurance coverage		
--Managed care	0.36 (0.48)	0.32*** (0.46)
--Medicare	0.46 (0.49)	0.46 (0.49)
--Medicaid	0.07 (0.25)	0.17*** (0.38)
--Other health insurance	0.08 (0.28)	0.01*** (0.12)
--No health insurance	0.01 (0.10)	0.02*** (0.15)
No. quarters since baseline (1-17)	4.76 (4.75)	5.09*** (4.77)
HbA1c at baseline (%)	7.32 (1.65)	7.49*** (1.85)
N observations	69,701 (52.19%)	17,273 (12.93%)

Notes: * p<0.05, ** p<0.01, *** p<0.001, observations of White patients with diabetes serve as reference group for means comparison t-tests; “Other health insurances” includes Bureau of Disability, Columbus Free Clinic, Drug Advocacy Program, Victims of Crime and other government health insurance, including Bureau of Workers Compensation, Veterans Administration.

Source: Calculations of the authors.

Table 5. *Multinomial Regression Results of Regressing the Three Categories of Diabetes Control on Credit Score and Control Measures; Reference Category Is Observations with Controlled Diabetes (Hba1c<7%)*

	Diabetes uncontrolled HbA1c: 7.00-8.99% RRR (SE)	Diabetes severely uncontrolled HbA1c: ≥9.00% RRR (SE)
Panel 1:	Full sample	Full sample
Credit Score (100 units)	0.957*** (0.010)	0.754*** (0.013)
Demographic controls	Yes	Yes
Quarter fixed effects	Yes	Yes
N observations / patients	133,545 / 37,887	
Chi2 statistic	5973.5	
Panel 2:	White patient sub-sample	White patient sub-sample
Credit Score (100 units)	0.961** (0.012)	0.751*** (0.015)
Demographic controls	Yes	Yes
Quarter fixed effects	Yes	Yes
N observations / patients	93,973 / 27,863	
Chi2 statistic	4146.6	
Panel 3:	Black patient sub-sample	Black patient sub-sample
Credit Score (100 units)	0.947* (0.023)	0.801*** (0.030)
Demographic controls	Yes	Yes
Quarter fixed effects	Yes	Yes
N observations / patients	31,197 / 7,957	
Chi2 statistic	1479.4	

Notes: RRR=Relative risk ratios; * p<0.05, ** p<0.01, *** p<0.001, Demographic controls include age categories, race (full sample only), ethnicity, gender, % HbA1c at baseline, number of quarters since baseline observation.
Source: Calculations of the authors.

Why Does Old Age Poverty Persist?

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Introduction

Despite steady real growth in average OASDI benefits, the poverty rate remains stubbornly persistent. The poverty rate for adults ages 65 and older rose slightly from 9.9 percent in 2000 to 10.3 percent in 2021 (Creamer et al. 2022), while the real value of the average benefit increased about 25 percent (SSA 2022).

Using administrative earnings and benefits records linked to multiple waves of the *Current Population Survey* (CPS), this study examines how employment and earnings histories, benefit claiming age, and immigration shape Social Security retirement benefits and poverty outcomes and how those relationships vary with gender and race/ethnicity.

Background

Despite the complications that often arise in measuring poverty (Blank and Greenberg 2008; Citro and Michael 1995; and Meyer and Sullivan 2012), the evidence suggests that many older adults experience economic hardship. People in their 70s are about three times as likely as younger adults to experience poverty for 5 or more years over a 10-year span (Sandoval, Rank, and Hirschl 2009). At some point between ages 60 and 90, nearly half of people ages 65 and older will have incomes that fall short of 125 percent of the federal poverty level (FPL) (Rank and Hirschl 1999). Risks are especially high for women, those without a high school education, unmarried people, and people of color (Lu, Shelley, and Liu 2021). Many studies have found that old-age poverty is associated with widowhood (Gillen and Kim 2009 and Holden, Burkhauser, and Feaster 1988), although more recently women's longer work histories and higher educational levels have reduced poverty for this group (Munnell, Sanzenbacher, and Zulkarnain 2020). In addition, people who experienced poverty at some point in their midlives can expect to spend about half of their retirement years in poverty (Vartanian and McNamara 2002).

In 2022, about 1 in 10 (10.2 percent) adults ages 65 and older had incomes below the FPL. Although this rate implies that 8.2 million older adults lacked enough income to cover basic living needs, it signifies a sharp reduction in poverty at older ages since 1959, when the poverty rate for adults ages 65 and older stood at 35.2 percent. The sharp decline in the old-age poverty rate between 1959 and 2000 is generally attributed to a substantial expansion in Social Security benefits during the 1960s and 1970s (Engelhardt and Gruber 2004). Since 2000, however, the poverty rate has not changed much for older adults, generally fluctuating between 9 and 10 percent. The poverty rate at ages 65 and older is about the same as the poverty rate at ages 18 to 64 but substantially lower than the poverty rate for children younger than age 18. The child poverty rate was lower than the old-age poverty rate until the mid-1970s, when child poverty began to rise as households headed by single mothers, many with limited incomes, proliferated. The poverty rate for children fell sharply between 1993 and 2000 as employment among mothers with young children surged and wages grew. Poverty among people younger than 65 generally increases during economic slowdowns (such as the 2007-2009 Great Recession and its aftermath), as employment and earnings fall. The old-age poverty rate varies less with economic conditions because relatively few older adults depend on employment for their income.

Poverty rates at older ages vary with personal characteristics (Table 1). Older women are more likely to live in poverty than older men, and people ages 75 and older are more likely to live in poverty than people in their late 60s and early 70s. The old-age poverty rate is higher for people of color than for white people, with older Black and Hispanic people about twice as likely to experience poverty as older non-Hispanic white people. People who are not married—divorced, separated, widowed, or never married—are more than twice as likely to experience poverty as married people. The poverty rate among never married women ages 85 and older reached 30.6 percent in 2022. Poverty rates are also especially high among older people with limited education and personal care limitations and those who are not US citizens.

Social Security significantly reduces poverty among older adults (Engelhardt and Gruber 2004 and Romig 2022) and enables many to live independently (McGarry and Schoeni 2000). However, some workers never receive meaningful Social Security benefits (Whitman, Reznik, and Shoffner 2011), and others receive benefits less than 100 percent of the FPL (Favreault 2010). The decline in SSI (Favreault 2020) means that those with sub-poverty Social Security benefits often have no other source of income support.

To understand better the persistence of poverty at older ages and provide information that could help policymakers craft proposals to reduce it, this study examines the trends and determinants of this poverty, the characteristics of older people experiencing poverty, and the role of lifetime earnings histories and Social Security in protecting older people from poverty.

Data

The project uses administrative earnings and benefit records matched to the CPS Annual Social and Economic Supplement. Earnings records have been matched to the 1994-2021 CPS interviews, and Summary Earnings Records run from 1951-2021. Pooling the CPS survey data, we assemble a database of adults born from 1931-1951, for whom we can track lifetime earnings from ages 20-70 and the timing of their Social Security claiming through age 70.

Methods

The analysis focuses on the official poverty measure. We measure poverty (income less than 100 percent of the FPL), deep poverty (less than 50 percent of the FPL), and near poverty (100-125 percent of the FPL). We also experiment with relative measures of economic hardship, such as income that falls below 25 percent of the national average wage.

We report poverty rates and show how they vary by race and ethnicity, gender, age, educational level, marital status, and living arrangements. The analysis reveals the relative importance of Social Security, SSI, other government transfers, earnings, and income from assets, and shared living arrangements in keeping older adults out of poverty. We show how outcomes have shifted across birth cohorts, highlighting the decline in SSI benefits at older ages and the role of that decline in the persistence of old-age poverty.

Given the importance of Social Security in protecting older people from poverty, the project also focuses on the receipt of only limited Social Security benefits. The analysis examines two benefit measures – retired worker benefits only and retired worker benefits plus any spousal or survivor benefits – and classifies people into the following groups: less than 50 percent of FPL, 50-99 percent of FPL, and 100-125 percent of FPL. For each group, we show the distribution of years of covered employment and Social Security claiming age and report immigration status and age entering the US, access to spousal/survivor benefits, receipt of DI benefits, and the racial/ethnic, gender, and educational composition.

We are estimating probit models of the probability that older adults experience poverty. Predictors would include years of covered employment, average annual indexed earnings when employed, immigrant status, receipt of auxiliary benefits and DI benefits, benefit claiming age, and demographic characteristics (race/ethnicity, gender, age, marital status, education level). The models would interact claiming age and earnings histories with demographic characteristics to determine if their impacts differ with race and ethnicity, gender, and birth cohort.

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Table 1. *Composition of the Population and Percentage with Income below the FPL, Adults Ages 65 and Older*

	Percentage of the population	Poverty rate (%)
All	100.0	10.2
Gender		
Men	45.4	9.0
Women	54.6	11.2
Race and ethnicity		
Asian	5.3	12.6
Hispanic	9.4	16.9
Indigenous	0.5	14.1
Non-Hispanic Black	9.8	17.5
Non-Hispanic white	74.2	8.2
Other, including mixed race	0.8	11.9
Education		
Not high school graduate	10.3	22.5
High school graduate	31.1	12.1
Some college	25.8	9.1
Bachelor's degree or more	32.8	5.3
Marital status		
Married	57.6	5.8
Divorced or separated	15.1	16.6
Widowed	20.5	14.1
Never married	6.7	21.6
Age		
65-69	31.8	9.6
70-74	26.9	9.2
75-84	30.8	10.5
85 and older	10.4	13.9
Women ages 85 and older, by marital status		
Married	1.3	7.6
Divorced or separated	0.6	19.2
Widowed	4.2	17.5
Never married	0.2	30.6
Citizenship status		
Born in the United States	85.6	9.6
Naturalized citizen	11.2	12.8
Noncitizen	3.2	16.6
Overall health status		
Excellent or very good	37.4	5.8
Good	37.7	10.4
Fair or poor	24.9	16.4
Personal care limitation		
No	94.6	9.5
Yes	5.4	22.6

Source: Authors' estimates from the 2022 Current Population Survey Annual Social and Economic Supplement.

Panel 9: Precarious Work

Moderator

Siavash Radpour (Stockton University)

Panelists

"Precarious Work and Perceived Workplace Ageism as Structural Barriers in Racial/Ethnic and Gender Disparities in Expected Full-Time Employment Past Age 62"
Duygu Başaran Şahin (RAND Corporation) and Frank W. Heiland and Na Yin (Baruch College and CUNY Institute for Demographic Research)

"What Factors Are Associated with Successful Work among Social Security Disability Insurance Beneficiaries?"
Gina Livermore, Jody Schimmel Hyde, and Bernadette Hicks (Mathematica)

"What Informs SSI Recipients' Work-Related Decision-Making?"
Katie Savin (California State University, Sacramento) and Nev Jones (University of Pittsburgh)

"Has Remote Work Improved Employment Outcomes for Older People with Disabilities?"
Siyan Liu and Laura D. Quinby (Boston College)

Precarious Work and Perceived Workplace Ageism as Structural Barriers in Racial/Ethnic and Gender Disparities in Expected Full-Time Employment Past Age 62

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Introduction

While Americans dream about retiring early to enjoy more leisure time and pursue personal interests without the constraints of a full-time (FT) job, the reality for many who retire early is less ideal. Withdrawal from the labor force before reaching full retirement age (FRA, 66-67) comes with significant economic challenges and risks including insufficient retirement savings, limited access to health care, and reduced Social Security Old Age retirement benefits (due to early take-up and lower lifetime contributions). Many who retire before FRA may not do so entirely by choice but find themselves in this situation due to difficult employment and health circumstances.

This project investigates the importance of precarious work and workplace ageism as structural barriers to a financially secure retirement where individuals can work until, and claim benefits, at their FRAs. We provide novel evidence from middle-aged workers surveyed in the Health and Retirement Study (HRS) on how precarious employment and workplace ageism affect expectations of working FT past age 62. We test whether these factors are barriers to employment at older ages and whether they differentially affect racial/ethnic minorities and women.

Previous Studies and Main Hypothesis

Precarious work has become more common (Donnelly 2022). It is defined as work that is “uncertain, unstable and insecure” with limited benefits and protections, and a higher risk of work that employees are responsible for (Kalleberg and Vallas 2018:1). Groups with pre-existing disadvantages and women are more likely to engage in precarious employment (Cubrich and Tengesdal 2021 and Ross and Bateman 2019). Precarious work has been shown to be detrimental for health (e.g., Benach et al. 2014). As poor health is a key predictor of premature withdrawal from the labor force (e.g., Cahill et al. 2012), we hypothesize that due to their disproportionate representation in precarious and low-paying jobs, older workers from racial/ethnic minority backgrounds might have shorter working lives than older workers who identify as White.

There is evidence that older non-Hispanic Black and Latinx workers have higher odds of perceiving the workplace as ageist than their non-Hispanic White counterparts and that blue-collar workers are more likely to perceive the workplace as ageist than white-collar workers (Basaran Sahin 2023). Because racial/ethnic minority groups often hold low-paying jobs which are also likely to be lower skill blue-collar jobs, investigating workplace ageism along with precarious work may offer a new explanation for the racial/ethnic disparities in retirement expectations. While self-reported measures of discrimination can be noisy and subjective, they are often the only measures available and can provide important signals (e.g., Pascoe and Richman (2009) show that perceived racial/ethnic discrimination increases stress and negatively affects physical and mental health).

We hypothesize that precarious work and ageist workplaces contribute to early retirement, thereby potentially exacerbating racial/ethnic and gender inequalities in old-age income security.

Data, Measures and Methods

Using HRS data from 2004-2020, we estimate a series of multivariate regressions predicting workers' self-reported likelihood of working FT beyond age 62 (henceforth: "Pr(FT past 62)"). Respondents are asked: "What do you think the chances are that you will be working full-time after you reach age 62?" Answers vary from 0% (certain to not be working FT past 62) to 100% (certain to work FT past 62). Following Donnelly (2022), we use three indicators of precarious work: Part-time (PT) employment, job insecurity and insufficient work hours. We define anyone who works less than 35 hours as a PT worker. For job insecurity we use: "What are the chances that you will lose your job during the next year?" Lastly, respondents who answer "yes" when asked if they would like to increase their hours worked with pay are defined as workers with insufficient hours.

We create three dummies to capture degrees of precarious employment ("no precarious work" is the reference in regressions) based on "yes" to 1, 2, or all 3 measures above. Perceived workplace ageism is measured using two dummies (=1 if "agree/strongly agree;" 0 otherwise) based on: "In decisions about promotion, my employer gives younger people preference over older people" and "My co-workers make older workers feel that they ought to retire before age 65."

Our analytic sample is workers aged 51-61 from the HRS baby boomer cohorts. Cases with missing data are excluded. Table 1 provides descriptives of our final sample (N=4,393 person-year observations). Table 2 presents exploratory OLS regression results. The coefficients represent %-point changes in the Pr(FT past 62) associated with unit increases in the respective independent variables. We test our main hypothesis by examining how the relationships between race/ethnicity, gender and Pr(FT past 62) change as we control for exposure to precarious employment and ageist workplaces. All models also adjust for age, age^2, marital status, and foreign born. Some models add educational attainment and self-reported health status to examine robustness and mechanisms.

Preliminary Findings and Next Steps

Across Models 1-6 (Table 2), we find that, on average, Non-Hispanic Blacks and Hispanics are significantly less likely to expect to be working full-time past age 62 compared to Non-Hispanic Whites and women report a slightly lower chance of working past 62 than men, all else equal. There is strong evidence that workers currently in more precarious employment are less likely to expect to work FT past age 62. For example, based on Models 3 & 4, on average, workers for whom all three indicators of precarious employment apply (PT employment, job insecurity and insufficient hours) report a 14%-points lower likelihood that they will work FT past 62 compared those without any precarious work characteristics. Individuals currently in work environments perceived as age discriminatory—based on co-workers who pressure individuals to retire before age 65—are 8 to 10 percentage points less likely to see themselves working full time past age 62. However, comparing across Models 1-4, there is no evidence that the lower Pr(FT past 62) for NH Blacks, Hispanics, and women can be explained by precarious employment or perceived ageism. Educational attainment, on the other hand, partly explains the differences by race/ethnicity (Model 4 vs. 5). Tests for interactions effects did not provide any support that the relationship between precarious work and Pr(FT past 62) is moderated by race/ethnicity or gender.

Our next steps include analyzing the cumulative impact of extended exposure to precarious work and workplace ageism. We will also study additional characteristics that relate to precarity, including low wages, lack of benefits, and lack of schedule control. Additionally, we will look more closely at mediators (mechanisms) and moderators (incl. occupation type) and will evaluate the robustness of the results above by conducting longitudinal analyses and estimating zero-one-inflated beta regressions that separately model focal points that exist at 0% and 100% in the data.

Preliminary Conclusions

We provide new insights into precarious work and workplace ageism as contributing factors to earlier-than-ideal retirement. Preliminary results suggest that middle-aged workers in precarious employment or with co-workers who pressure older employees to retire before 65 are significantly less likely to see themselves working FT past age 62. This is consistent with the idea that precarious work and workplace ageism present structural barriers to extend employment into old age and, in turn, put those affected at greater economic uncertainty in retirement.

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Table 1. *Sample Descriptives (Unweighted)*

	Mean / %	Std. dev.	Min	Max
Self-reported probability of working full-time after age 62	56.71	35.06	0	100
Breakdown of self-reported probability of working				
0 % chance	11.65			
1-49 %	21.07			
50%	15.70			
51-75 %	11.29			
76-99 %	22.76			
100 % chance	17.52			
Perceptions of workplace ageism				
Agrees with pressure to retire statement	14.92	0.36	0	1
Agrees with preference for young statement	19.86	0.40	0	1
Precarious job indicators				
Respondent's self-reported probability of losing job =>50 %	20.41		0	1
Wants to increase work hours	36.68		0	1
Part-time worker	11.58		0	1
Breakdown of precarious work indicators				
No to all indicators	47.54			
Yes to 1 indicator	38.07			
Yes to 2 indicators	12.54			
Yes to 3 indicators	1.84			
Demographic characteristics				
Age	55.76	2.39	51	61
Race/ethnicity			1	4
NH White	47.75			
NH Black	27.01			
NH Other Race	7.72			
Hispanic	17.52			
Gender (female)	54.25		0	1
Education			1	4
less than HS	10.33			
high school	25.24			
some college	26.47			
college or more	37.96			
Marital status			1	4
married/partnered	64.45			
separated/divorced	22.21			
widowed	3.53			
never married	9.81			
self-reported physical health (1=poor 5=excellent)	3.38	0.96	1	5
Total N (person-years)		4,393		

Table 2. *OLS Regressions: Predictors of the Probability (in %) of Working FT Past Age 62*

Predictors of Prob(Working FT past 62)	**Model 1**	**Model 2**	**Model 3**	**Model 4**	**Model 5**	**Model 6**
race/ethnicity (ref: NH White)						
NH Black	**-14.545*****	**-14.262*****	**-13.808*****	**-13.835*****	**-13.100*****	**-12.855*****
	(1.654)	(1.656)	(1.644)	(1.645)	(1.642)	(1.641)
NH Other Race	**-2.328**	**-1.972**	**-1.646**	**-1.699**	**-2.226**	**-1.959**
	(2.557)	(2.544)	(2.517)	(2.515)	(2.497)	(2.490)
Hispanic	**-9.441*****	**-9.124*****	**-8.328*****	**-8.318*****	**-5.854****	**-5.170***
	(2.165)	(2.173)	(2.178)	(2.178)	(2.198)	(2.192)
female (ref: male)	**-3.144***	**-2.787***	**-2.906***	**-2.863***	**-3.109***	**-3.133***
	(1.369)	(1.366)	(1.352)	(1.354)	(1.343)	(1.342)
age	**-14.700**	**-15.282**	**-16.079**	**-15.953**	**-16.380**	**-16.803***
	(8.551)	(8.554)	(8.521)	(8.531)	(8.497)	(8.461)
age squared/100	**14.011**	**14.551**	**15.291***	**15.196***	**15.595***	**15.955***
	(7.659)	(7.662)	(7.633)	(7.642)	(7.611)	(7.579)
marital status (ref: married/partnered)						
separated/divorced	**5.076****	**5.380*****	**5.315****	**5.333*****	**5.425*****	**5.630*****
	(1.636)	(1.629)	(1.615)	(1.617)	(1.604)	(1.600)
widowed	**0.948**	**1.262**	**1.343**	**1.361**	**2.641**	**3.073**
	(3.370)	(3.381)	(3.352)	(3.360)	(3.298)	(3.321)
never married	**-0.195**	**0.054**	**0.467**	**0.557**	**0.811**	**1.072**
	(2.314)	(2.297)	(2.279)	(2.276)	(2.223)	(2.238)
foreign-born (ref: born in the U.S.)	**-4.984***	**-4.598***	**-3.697**	**-3.714**	**-3.197**	**-3.383**
	(2.012)	(1.999)	(1.983)	(1.984)	(1.963)	(1.958)
precarious work status (ref: no precarious work)						
yes to 1 indicator		**1.263**	**1.515**	**1.581**	**2.373**	**2.604***
		(1.293)	(1.290)	(1.292)	(1.296)	(1.290)
yes to 2 indicators		**-5.125****	**-4.379***	**-4.274***	**-2.941**	**-2.150**
		(1.836)	(1.836)	(1.835)	(1.834)	(1.838)
yes to 3 indicators		**-14.022*****	**-13.998*****	**-13.873*****	**-12.542*****	**-11.734*****
		(3.578)	(3.507)	(3.506)	(3.480)	(3.456)
perceived workplace ageism						
strongly/agrees with "pressure to retire"			**-10.500*****	**-9.744*****	**-8.763*****	**-8.232*****
			(1.553)	(1.647)	(1.655)	(1.651)
strongly/agrees with "preference for young"				**-1.938**	**-2.114**	**-1.914**
				(1.486)	(1.486)	(1.487)
education (ref: less than high school)						
high school					**5.411***	**5.151***
					(2.372)	(2.369)
some college					**9.928*****	**9.155*****
					(2.393)	(2.396)
college and more					**11.614*****	**10.533*****
					(2.396)	(2.416)
self-reported physical health (1-poor 5-excellent)						**2.545*****
						(0.660)
R-squared	0.046	0.052	0.063	0.064	0.074	0.078
F statistic	13.864	13.325	16.602	15.588	15.555	15.655

Notes : *N* =4,393 (person-years). All models include a constant term. Robust Standard Errors in parentheses. *** p<.001, ** p<.01, * p<.05.

What Factors Are Associated with Successful Work among Social Security Disability Insurance Beneficiaries?

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Prepared for the 26th Annual Meeting of the Retirement and Disability Research Consortium
August 7-9, 2024

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Background

Promoting employment among Supplemental Security Income (SSI) and Social Security Disability Insurance (DI) beneficiaries has long been a goal of the Social Security Administration (SSA). Despite supports and provisions that allow beneficiaries to keep cash benefits while they test their ability to return to work, relatively few work and earn enough to leave the program. During their first 15 years in the program, only about 3.5 percent of DI beneficiaries earn above the SSA substantial gainful activity (SGA) level long enough for SSA to terminate their benefits.[20] About half of such beneficiaries eventually return to disability benefits (SSA 2020), citing poor health as a primary reason (Shenk and Livermore 2021).

Though at any given time, only about 2 percent of DI beneficiaries have recently worked above SGA, rates of SGA-level earnings vary substantially by personal characteristics (Baker et al. 2023). For DI beneficiaries, the highest rates of SGA-level earnings are among those who believe they are not limited by a health condition (4 percent), and are younger than age 40 (4 percent), able to perform their pre-disability job (12 percent), and aware of the DI program provision allowing beneficiaries to keep their Medicare coverage after losing DI benefits because of earnings (4 percent). Compared with other recently employed DI beneficiaries, those with earnings above SGA are younger, entered the DI program more recently, and are more likely to be nonwhite, more likely to have attended college, and less likely to have a representative payee.

Purpose of the Study

Research to date offers little information about the reasons why beneficiaries who initially work above SGA do not sustain earnings at that level long enough to leave the disability program. To shed light on this topic, this study is using the 2017 and 2019 National Beneficiary Surveys (NBS) to examine the experiences of a cohort of SSI and DI beneficiaries who worked above SGA for at least three consecutive months during the six months before they were interviewed in 2017. Using the NBS sample naming convention, we refer to such beneficiaries as *successful workers*. We are able to assess whether these successful workers remained employed in the short term (at the 2017 interview) and, for the subset included in the NBS

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[20] In 2024, SSA defines SGA as monthly earnings above $1,550 for nonblind individuals. When DI beneficiaries continue to work above SGA after exhausting the DI trial work period and extended period of eligibility, SSA terminates cash DI benefits. Those who obtained Medicare coverage before benefit termination may remain eligible for Medicare for at least 93 months after completing the trial work period.

longitudinal sample, we can also assess their employment status two years later (at the 2019 interview). The study will add to what is known about beneficiaries who are successful workers by assessing:

- differences between successful workers who were employed at the 2017 interview and those who were not in terms of their personal characteristics, health, and knowledge of SSA work supports;
- differences between successful workers employed at the 2017 interview who did and did not remain employed two years later (at the 2019 interview) and the reasons for stopping work among those who did so; and
- the extent to which changes in health, overpayment experiences, and other factors from 2017 to 2019 are associated with employment status in 2019.

Data and Methods

The study uses data from SSA's 2017 and 2019 NBS public use files. All NBS rounds use a nationally representative sample of SSI and DI beneficiaries ages 18 to 64 participating in the programs as of June of the calendar year before each survey. The 2017 NBS was the first NBS round to also include a large sample of successful workers (about 4,600). A subset of the successful workers who were employed at the 2017 interview (about 2,100) were reinterviewed in the 2019 NBS. Both NBS rounds collected extensive information about beneficiaries' characteristics, health status, employment experiences, and knowledge of SSA work supports. The files include administrative data that help describe successful workers, including time on the disability rolls and history of benefit suspension.

Using the NBS data, we are developing descriptive profiles that compare the characteristics of successful workers who were and were not employed at the 2017 interview. For the successful workers who were employed at the 2017 interview, we are documenting their employment status two years later (at the 2019 interview) and examining the differences between those who were and were not employed at that time. We are assessing the point-in-time differences between the groups, as well as differences in changes over time for those in the longitudinal sample using descriptive and multivariate methods.

Preliminary Findings

The preliminary findings we discuss in this summary focus on successful workers in the DI program (those eligible for DI only or eligible for DI and SSI concurrently). Table 1 shows selected characteristics that differed significantly between successful workers who were and were not employed at the time they were interviewed in 2017. Though all had worked at least three months during the six months before their NBS interview, about 20 percent had stopped working by the time they were interviewed.

Table 1. *Selected Characteristics of DI Beneficiaries Who Were Successful Workers, by Employment Status at 2017 Interview*

Characteristic	All	Employed	Not employed	*p*-value*
Unweighted number	3,286	2,625	661	
Weighted number	200,520	161,227	39,293	
Weighted percentage	100	80.4	19.6	
Reason for limitation (%)				0.000
Psychiatric condition	21.9	19.7	30.5	
Intellectual disability	1.3	1.4	0.9	
Musculoskeletal condition	17.7	17.0	20.2	
Sensory disorder	5.6	6.1	3.3	
Other or unknown	32.5	32.0	34.6	
No condition limits activities	21.1	23.7	10.4	
General health (%)				0.000
Excellent/very good	20.8	23.3	10.4	
Good/fair	60.4	61.5	56.3	
Poor/very poor	18.8	15.2	33.3	
Can perform pre-disability job (%)				0.000
Yes	19.6	21.9	10.0	
No	38.7	36.0	50.0	
Not applicable (no pre-disability job)	41.7	42.1	40.1	
Aware of extended period of Medicare eligibility	49.1	50.0	45.5	0.096
Benefits ever suspended (%)	59.4	61.7	50.0	0.000
Benefits suspended in past year (%)	43.0	43.9	39.4	0.083

*The *p*-value is for a test of the difference between successful workers employed and not employed at 2017 interview using a two-sided t-test for binary variables and a chi-squared test for categorical variables.
Source: 2017 and 2019 NBS.

Short-Term Employment Success. Compared with the 20 percent of initially successful workers who were no longer employed at the 2017 interview, the 80 percent who remained employed between sampling and interview were more likely to report that no condition limits their activities, were less likely to report being limited by a psychiatric condition, reported better general health, were more likely to indicate they could perform their pre-disability job, and were somewhat more likely to know that they could keep their Medicare coverage after losing their DI benefits. One-half or more of both groups had ever experienced a benefit suspension because of earnings; those who remained employed were more likely to have experienced such suspensions. Successful workers who were and were not employed at the 2017 interview did not differ significantly in their other characteristics, including age, race, ethnicity, time in the DI program, and knowledge of the DI trial work period and program rules regarding SGA.

Estimates from a regression model predicting the likelihood of employment at the 2017 interview indicate that there is no significant relationship between a recent loss of DI benefits (in the past year) and the employment status of successful workers at interview after holding other characteristics constant. The most important variables for predicting employment at the 2017 interview are those relating to the health condition causing limitation and ability to perform the pre-disability job. All else equal, those reporting psychiatric conditions had a predicted likelihood of being employed that is 25 percentage points lower than beneficiaries reporting no limiting conditions and those with musculoskeletal conditions had one that is 19 percentage points lower. Those who could perform their pre-disability job had a predicted likelihood of employment that is 12 percentage points higher than those who either could not perform that job or never had a job before disability onset. Though these effects on the predicted likelihood of employment seem large, it is important to note that, overall, about 80 percent of the recent successful workers remained employed at the time of the 2017 interview.

Longer-Term Employment Success. Members of the successful worker sample who were employed at the 2017 interview were eligible for the two-year follow-up survey in 2019. At the 2019 interview, 74 percent of these successful workers were employed. On average, those who were and were not employed in 2019 did not appear to be different from each other in terms of most of their 2017 personal and health characteristics. By 2019 however, there were substantial differences in the health status of successful workers who did and did not remain employed. Among the once successful workers who were no longer employed, declines in health status between the 2017 and 2019 interviews are evident. For example, the percentage reporting that no condition limited their activities declined from 19 to 14 percent, rates of reporting general health as poor or very poor increased from 21 to 32 percent, and the rates of reporting limitations of activities or instrumental activities of daily living increased from 49 percent to 54 percent. Although 22 percent of these once successful workers reported they could perform their pre-disability job in 2017, just 7 percent reported having that ability in 2019.

Discussion

The findings provide some insights into the factors associated with DI beneficiaries working and sustaining earnings above the SGA level. Health status and changes in health status play an important role. Those with psychiatric and musculoskeletal conditions appear significantly less likely to maintain employment in the short term, suggesting that they might require more or different kinds of support to remain successfully employed.

Loss of DI benefits, though common among successful workers, was not associated with their continued employment in the short term, after holding other characteristics constant. This might be because most successful workers (66 percent, not shown) expected the benefit suspension. And given that these beneficiaries still chose to work above SGA, the loss of benefits appears not to have curbed their willingness to remain employed. However, beneficiaries' understanding that they can keep their Medicare coverage after their DI benefits cease is an important predictor of successful work, suggesting that education about the Medicare-related provisions of the DI program is important to supporting employment.

Future Analyses

As work on the study proceeds, we plan to conduct multivariate analyses to assess the relative importance of different characteristics in predicting the likelihood that successful workers remained employed in the longer-term (at the 2019 interview). Of particular interest are beneficiaries' knowledge of program rules, benefit suspension experiences, race, and ethnicity. The regression models will control for other personal characteristics (for example, age, education, impairments, ability to perform pre-disability job, program, time spent in the disability programs). We also will explore whether job characteristics and alternative measures of health status are associated with the likelihood that successful workers remain employed.

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What Informs SSI Recipients' Work-Related Decision-Making?

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Background

A significant body of research demonstrates that people who participate in Social Security's Supplemental Security Income (SSI) rarely return to the workforce in their lifetimes (Anand and Ben Shalom 2018 and She and Livermore 2007). Simultaneously, a substantial proportion of adults with disabilities, including those receiving SSI, would prefer to return to work were adequate supports in place (see Bush and Tassé 2017; Fossey and Harvey 2010; Kumin and Schoenbrodt 2016; and McQuilken et al. 2003). Indeed, across multiple qualitative studies carried out by the co-PIs, collectively involving over 120 SSI beneficiaries, the majority described feeling "stuck" on benefits, despite their desire to engage in the labor market. Participants cited a combination of barriers including employer racism and ableism, dependence on interlocking benefits, financial insecurity, and administrative burden. Addressing significant gaps in the literature, this study's aims are to: (1) Investigate the contexts and socio-structural factors, including racial, class, and disability identity, underlying the SSI employment-related decisions of individuals; (2) Identify potential educational and/or employment-related supports and resources or lack thereof that may have shaped this decision-making; and (3) Develop a thick understanding of how poverty, particularly racialized poverty, influences the risk aversion with regard to returning to work after benefit receipt.

In their qualitative research with SSI/DI beneficiaries, Olney and Lyle (2011) note the limiting effects of social welfare policies on using work incentive programs, a phenomenon they name "the benefits trap." For example, earning exactly up to the substantial gainful activity (SGA) level is a concern for many beneficiaries who quickly learn that a small miscalculation by SSI or slight employer overpayment could result in their losing eligibility. This outcome sets off a domino effect of benefits that strips the individual of their health insurance (Medicaid), which also pays for any in-home support services – the program that allows disabled people who require assistance with activities of daily living to live in their communities rather than a nursing home (Batavia and Beaulaurier 2001; Caplan 2014; O'Day and Killeen 2002; Olney et al. 2014; Olney and Lyle 2011; and She and Livermore 2007). Thus, while up to 90% of working-age people on SSI/DI express a desire to work, less than 1% of them actually transition back into the workforce (Olney 2011).

SSA collaborates with local departments of rehabilitation to promote two programs intended to fill this need of easing people on disability benefits back to work: the Plan to Achieve

Self-Support (PASS) program for people on SSI to save money towards achieving employment-related goals and the Ticket to Work (TTW) program for people on SSI or SSDI to access jobs and create a plan to transition into work. TTW attempts to alleviate beneficiaries' concern about losing medical insurance and disability benefits by providing a nine-month period when people can both receive benefits and earn any amount of money as well as a 60-month period of eligibility for Medicaid/Medicare after initial earnings. Despite these programs, actual return to work and transition off of benefits remained less than 1% (Dekkers-Sánchez et al. 2011 and Franche et al. 2005). This is true even when current evidence based supports are offered, e.g., supported employment in SSA's Mental Health Treatment Study (MHTS) and other employment demonstration projects (see Mann and Wittenburg 2012). The MHTS, for example, which focused on SSDI recipients with serious mental illness, did not increase the proportion of workers earning above the SGA threshold (Drake et al. 2013), while the Accelerated Benefits (AB) demonstration found no sustained impacts on employment (Bailey and Weathers 2014).

Several qualitative studies provide nuance to the portrayal of TTW use found in the low program participation rates alone. They find that people do have an interest in returning to work and consider that working would be an improvement in quality of life over life on SSI/DI, however the interlocking benefits that they depend upon are hard to replace through employment (Olney et al. 2014; Olney and Lyle 2011; and Whittle et al. 2017). Further, research has found that mistrust of SSA extends to work programs such as TTW, and that fear of losing benefits is a strong deterrent to attempting work trials (Livermore 2003 and Olney 2007). Finally, some recipients report that the supported employment services they are offered are often the problem insofar as they fail to facilitate access to living wage jobs, positions with sufficient perceived dependability/sustainability, and/or career mobility (Jones et al. 2024).

While the extant literature speaks to the impact (and participant fears regarding) SSI work incentives and potential misalignment between vocational rehabilitation strategies and individual goals, significant gaps remain in our understanding of: (1) the ways in which race and other forms of structural disadvantage shape both the administrative burden of work-related rules and the navigation of available supports; (2) the role of anticipated discrimination (potentially involving race, class and disability) in shaping perceptions of the risks associated with exiting SSI; (3) how fears regarding overpayment and the redetermination process shape decisions about pursuing/not pursuing work; and (4) participants' risk-benefit calculus as it pertains to perceived likelihood of earnings and employer healthcare access with sufficient dependability to outweigh disability benefit reductions, program exit and/or the risk of a negative redetermination.

Methods

We used qualitative methods to explore how individuals receiving SSI engage in employment-related decision-making across two geographical sites. In-depth semi-structured interviews were designed to explore underlying factors and contexts that influence decisions about workforce participation and the impact of these decisions on household income. Using purposive sampling, we stratified sub-samples by ethno-racial group and age of disability onset.

Parallel research methods were conducted across two demographically distinct cities - Pittsburgh, PA and Sacramento, CA, with data collection involving broader catchment areas surrounding these cities. Pittsburgh is a former ‘Rust Belt’ steel town in Northern Appalachia, with a substantial Black community (approximately 23% of the population); racial inequity is pronounced, with high levels of neighborhood segregation, and a disproportionate burden of steel, coal and manufacturing related environmental pollution (Anand and Ben-Shalom 2018 and She and Livermore 2007). Surrounding areas include more rural Appalachian towns with significant pockets of white poverty; Pittsburgh is only one hour north of the West Virginia border, one of the poorest states in the nation and with the highest proportion of SSI beneficiaries in the US (Gettens et al. 2018). Sacramento and the surrounding Central Valley have large Latinx, Asian and Southeast Asian communities. The largest Sikh population in the nation is in the Central Valley, and large groups of Hmong, Afghani, and Ukrainian immigrants have also settled in the area. Despite its proximity to California’s Bay Area, the Central Valley lags behind the rest of the state in economic opportunity.

After conducting 30-40 in-depth qualitative interviews at each site, audio recordings will be transcribed and coded in the Atlas.Ti software package. Using both inductive and deductive techniques, researchers at each site will code the interviews and compare preliminary findings.

Community Involvement & Impact

All members of the study team, including the co-PIs and graduate assistants / research coordinators identify as disabled. Almost all members of the team have direct (personal) or family experience of SSI/SSDI receipt. In addition to this deep integration of disability perspectives, the study includes a strong ‘member checking’ component: following completion of the interviews and preliminary analysis, the team will hold a series of feedback sessions with all original participants, encouraging them to challenge or help refine these findings and leveraging their insights to strengthen the final analysis. The team has partnered with disability rights attorney/advocate Rebecca Vallas, CEO of the National Academy of Social Insurance. Ms. Vallas will help the team refine the research protocols to maximize public policy relevance. She will also help identify areas for manuscripts and more public-facing products such as Op-Eds and non-academic commentaries, as well as other forms of dissemination.

Preliminary Findings

Preliminary findings after completing approximately ⅔ qualitative interviews and engaging in initial qualitative coding and reflective memoing processes suggest multi-layered, structural factors that impact SSI recipients' approach to employment-related decision-making, including factors related to compliance costs of administrative burden; socioeconomic background and differing perceptions of financial risk; and experience with employment.

For currently or previously employed SSI recipients, the fluctuating nature of many disabilities and health conditions was cited as a source of chronic uncertainty and potential insecurity. For example, multiple participants noted that they could work, but only during periods of doing or feeling well. These periods were described as temporary, leading to fears that if they worked full-time and lost benefits but then relapsed, they would find themselves in an untenable situation, unable to pay bills without a safety net to fall back on.

Still others sought out jobs with limited hours and pay primarily to stay within SSI limits; in some cases, describing positions explicitly created to maintain employees' eligibility. For example, one participant in a peer support role explained, *"they created the job, the position that we all have around the fact that we're almost all on SSI."* For those who wanted to work but could not afford to lose their benefits (direct and indirect), doing just the right amount of work (maximizing earnings and minimizing losses) was described as requiring considerable effort.

Participant narratives suggest multiple ways in which socioeconomic background, as well as family and network socioeconomic status, influence work (and work-related) decision-making. For example, fears centered on potential loss of housing or essential housing subsidies were absent from the narratives of participants who lived with family members, while often prominent among those with no other source of housing. Moreover, the relationship between benefits of multiple kinds and employment is complex: earnings not only affect SSI eligibility, but also subsidized housing, including Section 8 vouchers, SNAP and other benefits. Calculations of risk and benefit are thus more difficult for individuals with more attenuated social networks and socioeconomic resources, especially those who need to account for the potential impacts of additional earnings across multiple systems, and with the precarity that loss of or reduction of any of these benefits might lead to.

Socioeconomic background also influences school and work trajectories in multiple ways which ultimately impact work-related decisions, for example through early family support for education (or the lack thereof), family's capacity to advocate for their children's needs in school, and support for the pursuit of career goals in early adulthood. For at least some participants, the combination of family poverty and lack of education (in general and specifically regarding disabilities) created huge barriers to the pursuit of independence. For example, one blind participant emphasized the starkly negative views of his parents towards disability, and the psychological and structural work involved in fighting to attend school and live on his own:
[My parents] thought I was blind. A blind person really can't do much. That a blind person stays at home while being taken care of. Right now, I'm trying to prove them wrong. I'm moving out….I tried my best to keep the same expectations that I have now, but I've been really let down sometimes. I've had my phases where I'm down. I'm like, "No, I don't want to do this anymore." But then I just came back up. It was really, really hard when nobody really believed in me.

Among participants with an express interest in working, many described barriers related to inflexibility, disability- and race-based discrimination, and poor working conditions. One person, for example, described the demoralization of a Department of Rehabilitation-mediated work placement which did not even allow sufficient bathroom breaks: "*I had an accident at the job because they didn't want me to go to the bathroom…I just want to go to the bathroom when I have to go. I'm not trying to go to the bathroom every five minutes…Yeah. Just like we're working slave trade. And we all ain't in there Black. I was the only-- like two of us. Everybody else was different nationalities. But you can't do that…So they end up letting me go.*"

Many others described outright skepticism on the part of potential employers about their ability to work, and discrimination during hiring. As one participant noted*: it's funny they always say, "We're an equal opportunity, blah, blah, blah." But then when you go, they don't hire you. They get funny. "How are you going to do the job? You can't see."*

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Has Remote Work Improved Employment Outcomes for Older People with Disabilities?

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Introduction

As the economy recovered from the severe but short pandemic recession, the shift to remote work remained widespread.[21] This shift may be particularly beneficial for people with disabilities, who may struggle to convince employers that their productivity merits necessary workplace accommodations or who may find it too expensive or time consuming to commute.[22] Preliminary evidence seems to support the hypothesis that remote work has played an important role. The employment rate for older people with disabilities in the *Current Population Survey* (CPS) rebounded more rapidly after the pandemic than for other older individuals, even rising above pre-pandemic levels in late 2021 and early 2022 (see Figure 1). Remote work, however, may not be the only factor contributing to this positive outcome. First, a higher share of the working-age population now reports a disability in the CPS, so the recent increase in the employment rate could be driven by a rise in relatively mild impairments.[23] Second, this period was also notable for an extremely tight labor market, which particularly benefits historically marginalized workers, including those with disabilities.[24]

The goal of this study is to identify how remote work – as opposed to the confounding factors – has contributed to the rise in the employment rate of older (51-64) individuals with disabilities, the age group most likely to enter DI.[25]

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[21] A growing literature suggests that workers prefer remote work (Adrjan et al. 2021; Barrero, Bloom, and Davis 2021; and Hansen et al. 2023).

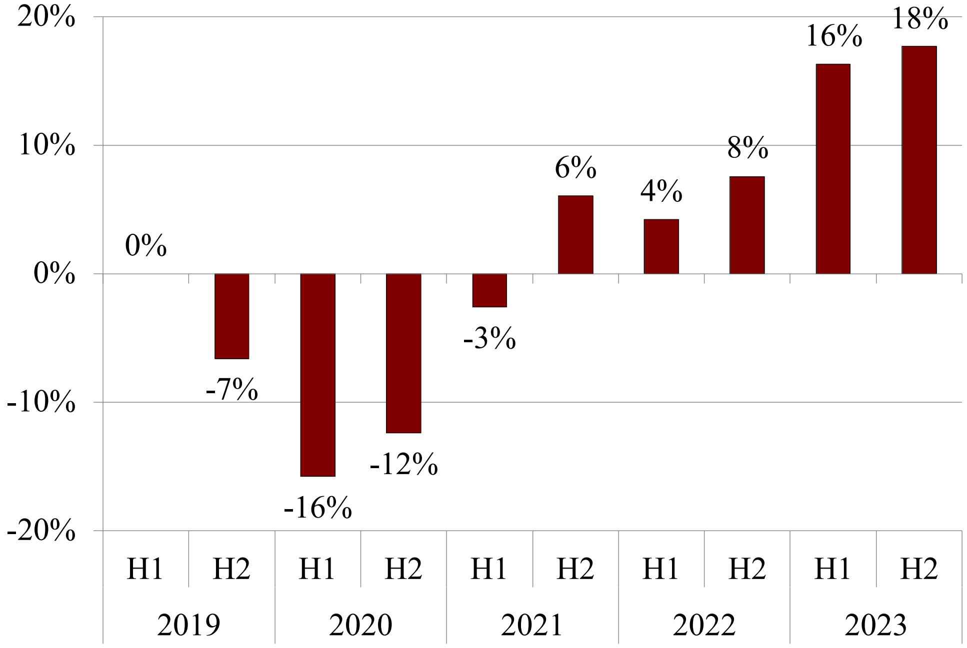
[22] Examples of accommodations include sight-assistive computing technology, wheelchair accessible facilities, or a private office to reduce noise. In principle, the Americans with Disabilities Act prohibits employers from discriminating in hiring, but evidence abounds on employer bias against workers with disabilities (for example, see Ameri et al. 2018).

[23] See Ne'eman and Maestas (2023) and Guo and Krolikowski (2024) on the rising prevalence of disability. One possibility is that the CPS is picking up instances of "long COVID" (Carfi et al. 2020, Deitz 2022, and Bull-Otterson et al. 2022). Long-COVID impairments are often temporary and may not be severe enough for DI eligibility (Cabrera et al. 2021 and Del Brutto et al. 2022). Another possibility is that people whose impairments were previously mild developed more severe disabilities during COVID (Kavanagh et al. 2022; Schur, Rodgers, and Kruse 2021; Shenk et al. 2022; and Yuan et al. 2022).

[24] Domash and Summers (2022).

[25] Center on Budget and Policy Priorities (2021) and Office of the Chief Actuary, Social Security Administration (2022).

Figure 1. *Percentage Change in the Employment-to-Population Ratio among Individuals Ages 51-64 with Disabilities, Relative to the First Half of 2019 (H1)*



Note: Bars reflect changes in semiannual averages relative to the employment-to-population ratio in the first half of 2019.
Source: Authors' calculations from the U.S. Census Bureau, *Current Population Survey* (2018-2024).

Data and Methodology

The analysis, which is based on the *Health and Retirement Study* (HRS), proceeds in two stages. The first stage simply documents how the employment rate for older workers with disabilities in teleworkable occupations has risen from 2018 to 2022 compared to those in non-teleworkable occupations.[26] Occupations are classified as "teleworkable" if the share of jobs in that occupation that can be done remotely exceeds 26 percent according to Dingel and Neiman (2021).[27] If remote work has had an impact, then we would expect the increase in the employment-to-population ratio of people in teleworkable jobs to be much larger than the increase for those whose jobs are not amenable to remote work.

This naïve comparison, however, does not consider the potentially confounding effects of the rising prevalence of disability and tight labor market. Hence, the second stage uses two

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[26] We consider self-reported work-limiting conditions in the HRS as disabilities. We use the 2018 and 2022 waves of the HRS to compare outcomes before and after the pandemic. Most respondents in the 2020 wave (the height of the pandemic) reported a large drop in employment followed by a quick recovery.

[27] Alternative classifications yield similar results.

regression equations to control for worker health and the tight labor market in addition to basic demographics.

The first regression estimates the likelihood of being employed in a teleworkable occupation for older workers with disabilities, accounting for these other factors:

$$\begin{gathered}\mathit{Employment\ rate\ in\ teleworkable\ occupations} = \\ f(\mathit{health}, \mathit{labor\ market\ tightness}, \mathit{demographics}, \boldsymbol{year\ 2022}) \qquad (1)\end{gathered}$$

where $health$ is a series of variables capturing the severity of the worker's disability, including identifiers for major health conditions and difficulties with Activities of Daily Living (ADLs) or Instrumental Activities of Daily Living (IADLs), and $labor\ market\ tightness$ is a monthly measure calculated as the number of job openings relative to job seekers in the *Job Openings and Labor Turnover Survey* (JOLTS) at the industry level.[28] Of particular interest, $year$ 2022 is one of a set of year dummy variables with 2018 as the omitted baseline year; the coefficient of year 2022 indicates how the employment rate in 2022 compared to 2018 – the omitted value.[29] Likewise, a second regression estimates how the likelihood of being in a non-teleworkable occupation has changed over time:

$$\begin{gathered}\mathit{Employment\ Rate\ in\ non\ teleworkable\ occupations} = \\ f(\mathit{health}, \mathit{labor\ market\ tightness}, \mathit{demographics}, \boldsymbol{year\ 2022}) \qquad (2)\end{gathered}$$

If remote work has an important effect on the employment rate – after accounting for worker health and labor market tightness – then the coefficient on $year$ 2022 should be much larger in the teleworkable employment regression (equation 1) than in the non-teleworkable employment regression (equation 2).

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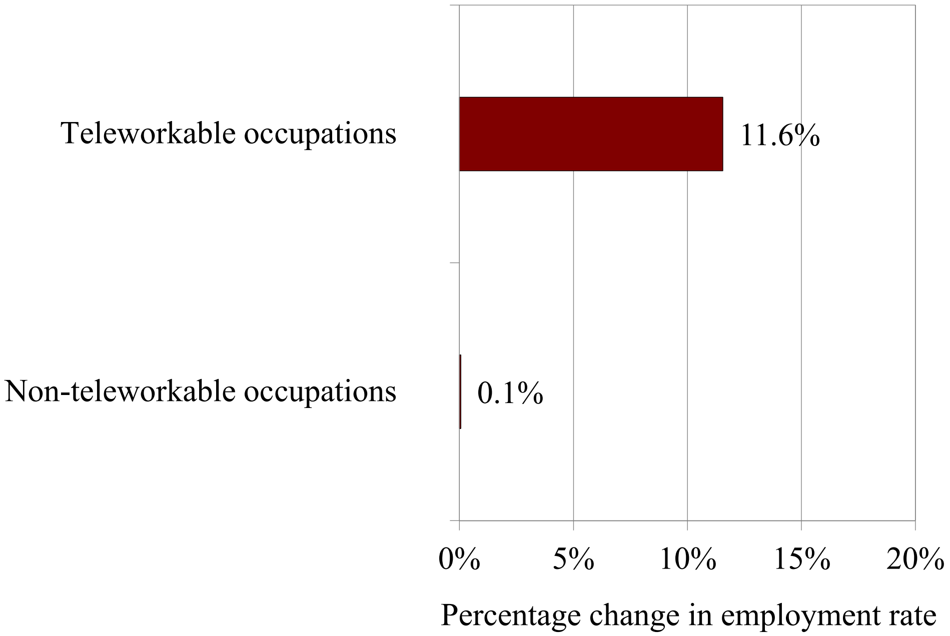
[28] The regression also includes indicators for employment status two and four years ago. To improve the precision of our estimates for the labor market tightness and demographic control variables, the regression sample also includes individuals without a work-limiting condition and extends back to 2012.

[29] The impact of remote work on employment is estimated by the interaction of the year dummy variables with an indicator for having a work-limiting disability.

Results

As a point of comparison with the CPS data in Figure 1, Figure 2 shows the HRS results without controlling for health or labor market tightness. Consistent with the CPS data, the employment rate in teleworkable occupations grew 11.6 percent between 2018 and 2022, while it did not change in non-teleworkable occupations.

Figure 2. *Post-Pandemic Employment Gain for Individuals Ages 51-64 with Disabilities, by Occupation, 2022 vs. 2018*



Source: Authors' estimates from the University of Michigan, *Health and Retirement Study* (2018-2022).

The regression results show that remote work remains an extremely important factor even after controlling for worker health and labor market tightness (see Figure 3). The fact that the point estimates barely change suggests that the two potentially confounding factors have not played a meaningful role in increasing employment for older people with disabilities.[30]

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[30] Supporting this interpretation, we do not find a shift towards individuals with relatively mild impairments for older people with disabilities. And despite recent loosening of the labor market, the employment rate for older people with disabilities remains at 2023 levels.

Figure 3. *Regression-Adjusted Post-Pandemic Employment Gain for Individuals Ages 51-64 with Disabilities, by Occupation, 2022 vs. 2018*

Note: Solid bars are statistically significant at the 5-percent level.
Source: Authors' estimates from the University of Michigan, *Health and Retirement Study* (2018-2022).

Conclusion

The shift to remote work following COVID may have improved job prospects for people with disabilities, as productivity-enhancing accommodations are often already present in the home and travel for work is limited or non-existent. Consistent with this view, nearly all of the post-pandemic employment gain for older people with disabilities has been concentrated in teleworkable occupations, and that pattern holds even after controlling for the rising prevalence of disability and the concurrent tight labor market. Hence, remote work seems to help older workers with disabilities stay in the labor force, and likely improves the finances of the Social Security Disability Insurance (DI) program through reduced applications for DI benefits.

Yet, the extent to which these dynamics will persist over the long run remains an open question. The analysis in this paper corresponds to a period when remote work was particularly widespread. The availability of remote work may decline as the labor market eases back toward more normal conditions. And, the labor supply of older workers with disabilities might also decline as the impact of unusual pandemic-era economic and policy conditions – including the temporary closure of Social Security field offices – subsides. Hence, the role of teleworkable jobs for people with disabilities should remain a topic of interest.

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Panel 10: Intended and Unintended Consequences of Policy Reform

Moderator

Phillip Beatty (National Institute on Disability, Independent Living, and Rehabilitation Research)

Panelists

"Will Auto-IRA Savings Disqualify Vulnerable People from Benefit Programs?"
Karolos Arapakis and Laura D. Quinby (Boston College)

"Supplemental Security Income and Social Security Disability Insurance Utilization by American Indians and Alaska Natives – the Effects of Medicaid Expansions and Long COVID"
Randall Akee (University of California, Los Angeles) and Emilia Simeonova (Johns Hopkins University)

"Barriers to Accessing Healthcare Services Among Denied SSI/DI Applicants"
Jocelyn Marrow (Westat)

"Structural Barriers to Receipt of Income and Health Insurance among Adults with Disabilities"
David M. Cutler (Harvard University and NBER), Marema Gaye (Harvard University), Ellen Meara (Harvard University and NBER), and Rand Obeidat (Bowie State University)

Will Auto-IRA Savings Disqualify Vulnerable People from Benefit Programs?

Karolos Arapakis and Laura D. Quinby
Boston College

Prepared for the 26th Annual Meeting of the Retirement and Disability Research Consortium
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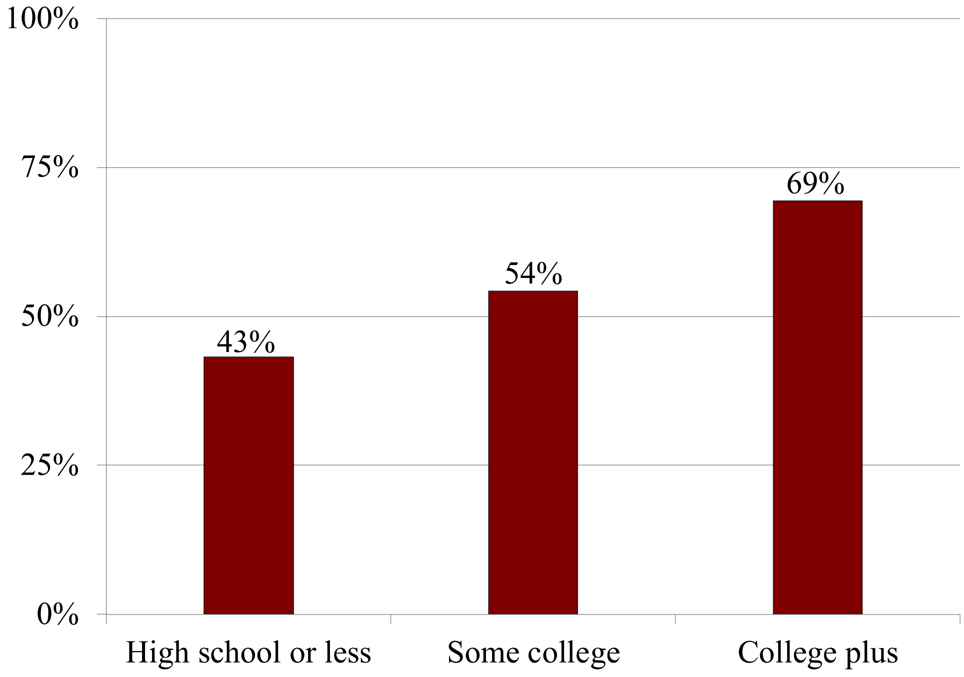
Introduction

Around 30 percent of retired households are solely reliant on Social Security for income, with many ending up on safety net programs such as Medicaid.[31] One reason for the lack of supplemental retirement saving is that only about half of private sector workers are covered by an employer-sponsored plan at any given time, and few workers save without them. Although the coverage gap particularly affects lower-wage workers without a college degree, a substantial share of even college graduates lack employer coverage at any given moment (see Figure 1).

Figure 1. *Share of Prime-Age Workers (25-54) Covered by an Employer-Sponsored Retirement Plan, by Education, 2018*



Source: Authors' calculations from the *Survey of Consumer Finances* (2019).

In recent years, eight states have launched auto-IRA programs that require employers without a plan to auto-enroll their workers in a Roth IRA, and eight more states are planning to launch their programs soon. Most of the existing auto-IRA programs follow a very similar model: participant contributions are initially set at 5 percent, but workers can change the rate or opt out at any point. The first $1,000 of contributions is invested safely, with additional contributions defaulted into a target date fund. And, because the accounts are designed as Roths,

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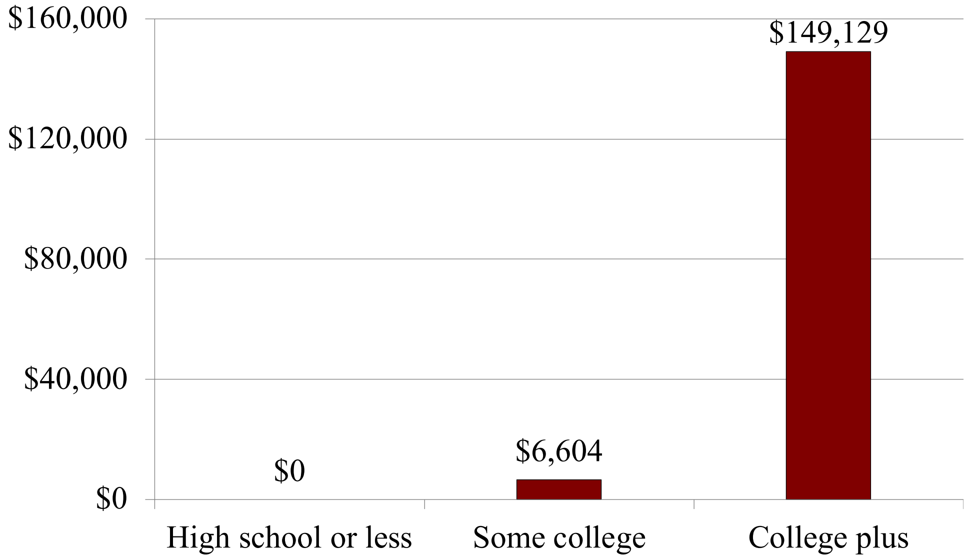
[31] See Biggs, Munnell, and Chen (2019) or Dushi and Trenkamp (2021) for analyses on resources in retirement.

workers can always withdraw their contributions with no penalty. Auto-IRAs have the potential to benefit all types of workers, but they are particularly helpful for those left out of employer-sponsored plans: less-educated, living paycheck-to-paycheck, and more likely to be non-White.

Although studies have begun to document participant outcomes in the nascent auto-IRAs, less attention has been paid to their interaction with other safety net programs.[32] Of particular concern, Medicaid includes a household asset test for those over 65. The rules vary by state and the type of Medicaid services, but financial assets cannot exceed $3,000 in most cases. IRA wealth is typically included, and where it is excluded, withdrawals often count toward the limit.[33] In practice, this asset test screens out college graduates, who frequently reach retirement with significant resources in a 401(k) or traditional IRA (see Figure 2).[34] But auto-IRAs target workers with less education, who are currently served by Medicaid. Auto-IRA participants with assets in excess of the Medicaid thresholds may either miss out on receiving means-tested benefits or be forced to draw down their savings to preserve access.[35]

Figure 2. *Median Household Assets in DC Plans at Ages 51-56, by Education (2019 Dollars)*



Notes: Estimates are for Late Boomers. DC plans include employer-sponsored plans, such as 401(k)s, and IRAs.
Source: Authors' estimates from the *Health and Retirement Study* (1992-2022).

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[32] Belbase, Quinby, and Sanzenbacher (2020); Chalmers et al. (2022); Quinby et al. (2020); and Scott and Blevins (2020). Some proponents argue that auto-IRAs will improve state finances by reducing spending on means-tested programs (see, for example, Econsult Solutions 2018; Trostel 2017; and Schifflet and Harvey 2017).

[33] Musumeci, Chidambaram, and Watts (2019). SSI counts IRA wealth in its asset limit and withdrawals as income.

[34] The methodology for estimating retirement savings in the *Health and Retirement Study* is described in Gok, Chen, and Quinby (2024). Income from a defined benefit plan counts towards the Medicaid income limit.

[35] Chetty, Friedman, and Saez (2013) and Saez (2010) show how low earners adjust earnings to qualify for programs.

Hence, this project explores whether low- and middle-income households are at-risk of losing Medicaid because of their auto-IRA savings. Specifically, we ask: how much auto-IRA savings would future households have if a national program had launched in 2019?[36]

Data and Methodology

The analysis involves a hypothetical simulation based on households in the 2019 *Survey of Consumer Finances* (SCF) and proceeds in three steps. The first step is to project lifecycle employment and earnings for households in the SCF. Employment is estimated using a logit regression where the probability of being employed in future year *t* is a function of age, gender, education, race, and their interactions. Then employed individuals are assigned earnings based on the median for current workers with similar characteristics.

The second step is to determine which employed individuals have employer-plan coverage. Since the results turn out to be quite sensitive to this determination, the analysis is conducted under two assumptions. The first approach assigns individuals' 401(k) coverage randomly each year, based on age-specific probabilities that vary according to gender, education, and race (the "intermittent coverage scenario"). Intuitively, this approach assumes that individuals switch jobs every year and have some chance of obtaining employer coverage at each job change.[37] In contrast, a second approach assigns individuals' lifetime 401(k) coverage randomly, at the beginning of one's working life, based on the average coverage rate for prime-age workers of similar gender, education, and race (the "continuous coverage scenario"). Conceptually, this approach assumes that some workers always have an employer plan while others always lack one and are instead in the auto-IRA.[38]

The third step of the analysis is to simulate auto-IRA balances. The analysis assumes that each individual who is not covered by an employer plan is eligible for the auto-IRA, and makes a one-off decision to stay auto-enrolled or to opt out. The probability of opting out is set at 30 percent, which reflects the opt-out rates reported by the live auto-IRAs.[39] The employee contribution rate is set at 5 percent of earnings.[40] Participants make stochastic withdrawals with

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[36] An unresolved question is whether automatic enrollment will spur lower-income households to take on more debt. See Beshears et al. (2024) for a thorough discussion of this issue.

[37] This approach understates disparities across socioeconomic (SES) groups because most simulated individuals end up with some employer coverage over the course of their working life.

[38] This approach overstates disparities across SES groups as, in practice, some workers cycle in-and-out of coverage.

[39] For fact sheets on participation in auto-IRAs, see: https://crr.bc.edu/project-page/closing-the-coverage-gap.

[40] Auto-IRAs preclude employer matching contributions by design.

a probability of 20 percent each year. When participants make a withdrawal, they remove $2,000 from their account, consistent with behavior in the live programs.[41] The first $1,000 of contributions is held in cash; amounts in excess of $1,000 are invested in a target date fund.[42]

Results

Table 1 shows results from the simulation at ages 51-56 for a cohort of younger individuals (ages 21-25 in 2019). The first column displays the share of workers projected to ultimately end up with a positive auto-IRA balance. In the intermittent coverage scenario, most workers end up with some auto-IRA savings, although 30 percent opt out (small differences by education are driven by withdrawals). However, because participants cycle in-and-out of the program, median ending balances are moderate: $25,371 for those with no more than a high school degree, $27,595 for those with some college, and $22,304 for those with a college degree (column 2). The last column shows that the balances would be larger if participants were not also using the accounts for precautionary savings throughout their work lives.

Table 1. *Simulation Results at Ages 51-56 for Workers Ages 21-25 in 2019, in 2019 Dollars*

Education	Share with a balance at ages 51-56	Among those with balances (median): Balance after withdrawals	Balance assuming no withdrawals
		Assuming intermittent coverage	
High school or less	67%	$25,371	$43,654
Some college	70	27,595	50,110
College plus	72	22,304	41,150
		Assuming continuous coverage	
High school or less	44%	$68,964	$94,937
Some college	36	76,880	99,373
College plus	25	104,719	126,126

Source: Authors' estimates from the *Survey of Consumer Finances* (2019) and data from live auto-IRA programs.

The story is different in the continuous coverage scenario. Here, fewer workers end up with positive balances – 44 percent of those with a high school degree or less, 36 percent of those with some college, and only 25 percent of college graduates. Yet, because participants

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[41] Quinby et al. (2020).

[42] The analysis assumes that stocks return 7 percent and bond returns 4 percent per year. In terms of fees, the auto-IRA is assumed to charge $24 dollars and 0.45 percent of total assets per year. The target-date fund also charges a fee of 0.59 percent. While consistent with the fee structure of current state programs, fees would likely be lower in a national program operating at scale (Aubry 2024).

spend their full careers in the program, they accumulate sizeable balances: $68,964 for individuals with a high school degree, $76,880 for those with some college, and $104,719 for college-educated workers. Both the intermittent and continuous coverage scenarios are based on extreme assumptions, so the most likely amounts would fall somewhere between these two scenarios.

Conclusion

State auto-IRA programs aim to help low and moderate earners without an employer retirement plan build savings. However, the programs' interaction with means-tested safety-net programs such as Medicaid has not been discussed. This study starts the conversation by simulating what households might have saved in an auto-IRA had a national program launched in 2019. Although the results are sensitive to underlying assumptions, the analysis suggests that workers without a college degree, who are most likely to utilize other safety net programs, would accumulate meaningful new savings over the course of their working lives.

Ultimately, assessing whether this new savings will disqualify vulnerable households from other benefit programs is a judgement call beyond the mechanics of the model. Under current Medicaid policy, households with moderate auto-IRA savings – under $100,000 for instance – will have a strong incentive to spend down their balances to qualify. Alternatively, states could adapt their Medicaid asset tests to disregard all, or some portion of, auto-IRA savings. Future research could help policymakers make this decision by studying how retired participants spend down their savings in practice.

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Supplemental Security Income and Social Security Disability Insurance Utilization by American Indians and Alaska Natives – the Effects of Medicaid Expansions and Long COVID

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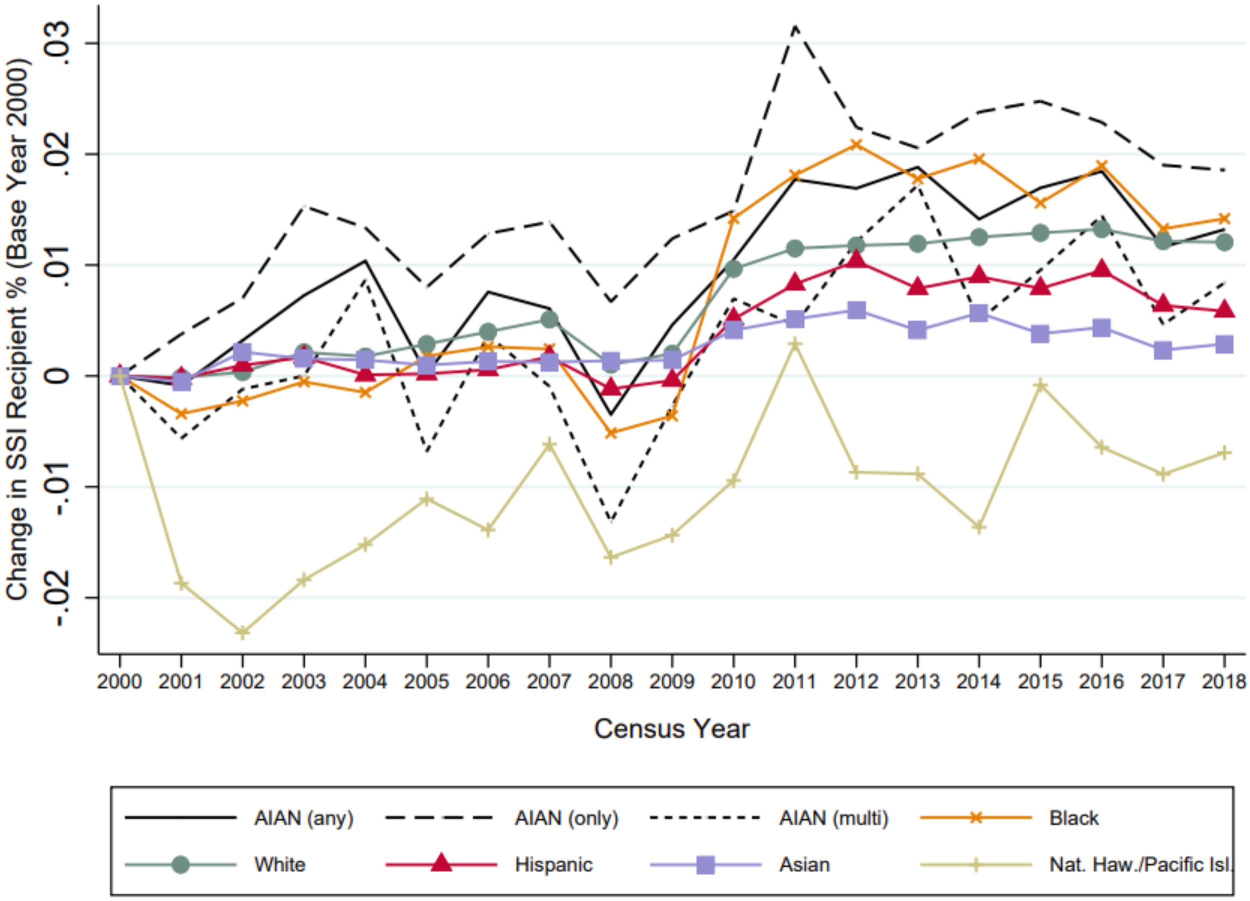
Prepared for the 26th Annual Meeting of the Retirement and Disability Research Consortium
August 7-9, 2024

The research reported herein was pursuant to a grant from the U.S. Social Security Administration (SSA), funded as part of the Retirement and Disability Research Consortium. The findings and conclusions expressed are solely those of the authors and do not represent the views of SSA, any agency of the federal government, University of California, Los Angeles, Johns Hopkins University, or the NBER Retirement and Disability Research Center.

According to self-reports in the American Community Survey (ACS), participation of American Indian and Alaska Native (AIAN) individuals in the Supplemental Security Income (SSI) program is twice as high as that of the rest of the population. The year-on-year increase in SSI among single-race AIANs has also been the highest since the turn of the century, as evident in Figure 1. Little is known about the determinants of SSI and Social Security Disability Insurance in the AIAN population. The interaction between health, public health insurance eligibility and generosity, and participation in social insurance programs is not well understood in this population. Public policy changes and external shocks, such as the disparate effects of the COVID epidemic on the health status across race, are particularly likely to affect utilization of the safety net by socially and economically disadvantaged groups, such as rural AIAN populations.

Figure 1. *Changes in Self-reported Participation in SSI*



Sources: Stoddard (2021), authors' calculations using the Decennial Census and the American Community Survey.

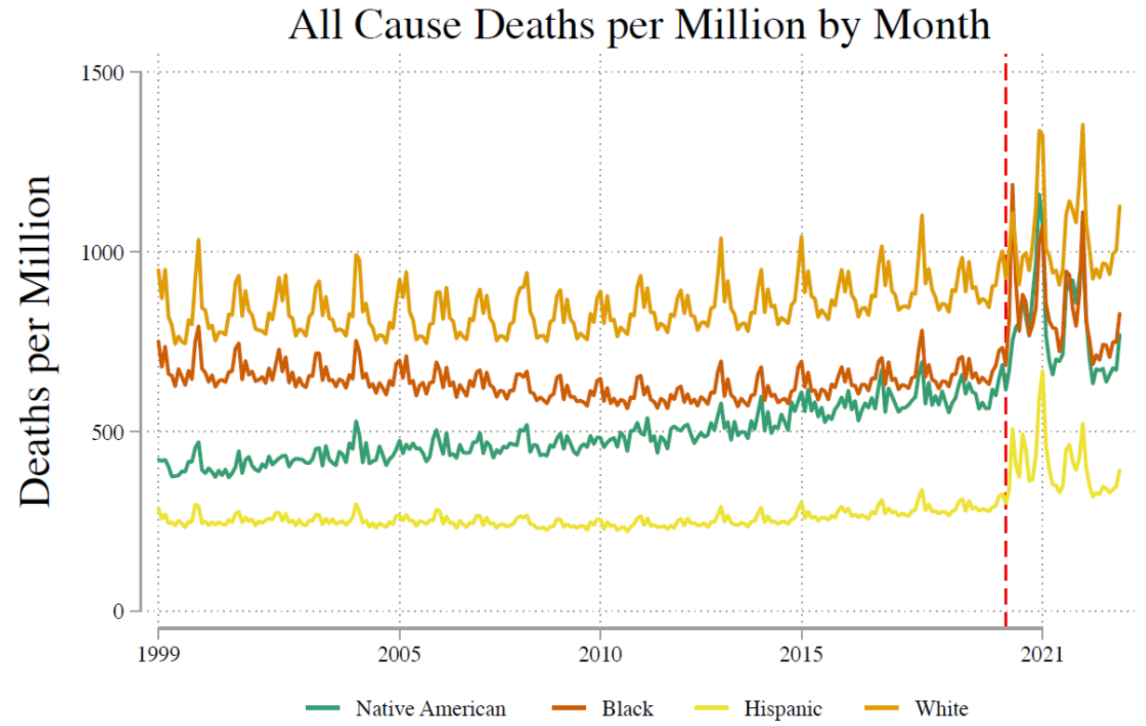
We use 22 years of Medicaid and Medicare data ('99 -'21) to examine the determinants and trends in utilization of SSI and SSDI among eligible individuals of AI race. Our data include Medicaid and Medicare demographic and utilization files for all AIs as well as a 1-in-5 sample for all others.

A number of previous studies have investigated the relationship between SSI and public health insurance (Medicaid or Medicaid-like substitutes) (e.g., Yelowitz 2000; Baicker et al. 2013; and Maestas et al. 2014). In the case of AIAN specifically, Burns and Dague (2017) show that state Medicaid expansions reduced AIAN participation in SSI, possibly because expanding eligibility ensured that individuals could access public insurance without qualifying for a disability. The first goal of this research is to test whether Medicaid Expansions under the Affordable Care Act (ACA) affected AIAN participation in SSI and SSDI as measured in Medicare and Medicaid data.

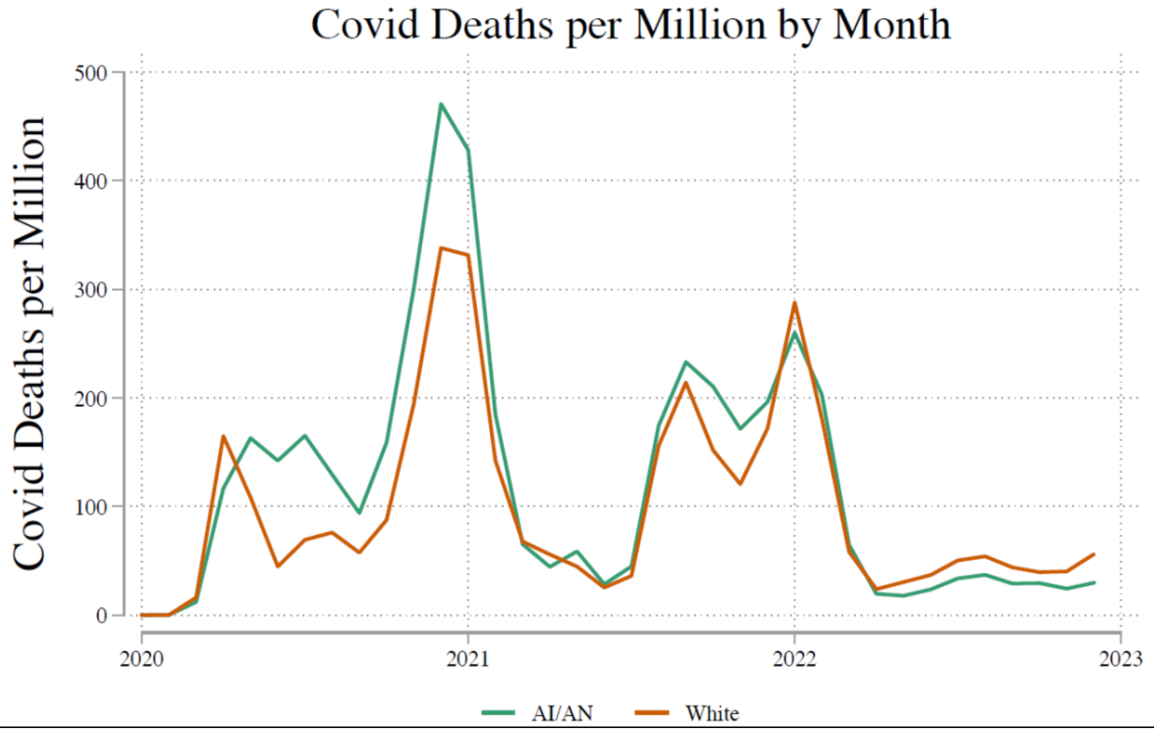
During the COVID-19 pandemic, American Indians experienced unusually high rates of infection and death. According to the Kaiser Family Foundation, AIAN were about fifty percent more likely to experience a COVID infection than non-Hispanic whites, and had the highest age-adjusted infection rates in the periods September-December 2020 and July-December 2021. In prior research, we have shown that AIs were more likely to utilize the emergency department and inpatient services when presenting with an acute COVID infection. They were also more likely to die from COVID than whites, even when we compare populations covered by Medicaid and thus eligible for publicly funded health insurance (Wang et al. forthcoming). In Figure 2 below we confirm our findings on mortality using nationally representative data.

Figure 2. *All-cause and COVID Mortality by Race*

Differences in Mortality by Race



Differences in COVID Deaths AIAN vs White



Source: CDC, Vital Statistics.

The top panel of Figure 2 shows all-cause mortality by race between 1999 and 2021, not adjusted by age. The data are from the national vital statistics mortality files (CDC 2024). The dotted vertical line indicates the beginning of the COVID period. While white and Hispanic mortality experience little change, there is a marked decrease in mortality for Black Americans and an increase in mortality for AIAN until the COVID era. During the COVID period, Black and AIAN mortality increased substantially more than white mortality. In the bottom panel, we zoom in on differences between AIAN and white COVID-related mortality during the 2020-2023 time period. During the initial three COVID waves in 2020 and 2021, AIAN mortality significantly exceeds white mortality.

The large differences in the incidence of COVID infection and mortality raise a particularly important question about a potential locus of disparities in outcomes centered around the incidence of Long COVID, the associated social and economic effects in this population, and impacts on the usage of the social safety net. So far, we have uncovered little research on the incidence of Long COVID in the AIAN population. A related diagnosis code (ICD 10) was only recently created and has not been consistently used in Medicare data.

Using data from the US Census Pulse survey, Louie and Wu (2024) report similar rates of reported Long COVID across Black, Hispanic and White races, with slightly lower incidence for Asians. Data for AIAN were not available, but they also find inequalities by socio-economic status, with people from higher SES backgrounds reporting lower rates than those from lower SES. The second main goal of this research is to trace the incidence of SSI and SSDI in individuals with a COVID diagnosis of AIAN origin and the rest of the population, using Medicare and Medicaid data. We have determined that we could not utilize Long COVID ICD codes, however COVID incidence is well-recorded in outpatient and inpatient encounters. Coupled with additional diagnosis codes, such as codes related to cardio-vascular and neurological disorders, post-COVID diagnosis, we can proxy for the incidence of post-COVID complications and the correlation with SSI receipt. We also examine the relationship between COVID, SSI/SSDI receipt, and mortality across racial and ethnic groups.

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Barriers to Accessing Healthcare Services Among Denied SSI/DI Applicants

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Introduction

This project for the Retirement and Disability Research Consortium examines the healthcare usage of denied SSI/DI applicants who listed a psychiatric condition as their primary impairment and who enrolled in a clinical trial of an employment intervention for people with serious mental illness. Our qualitative findings from the evaluation of the clinical trial suggested that, before enrollment, participants struggled to obtain health services to treat, manage, and document multiple chronic conditions. The findings from this study will illuminate a key barrier to filing an application representative of their impairment: access to healthcare to document, manage, and treat their mental health and chronic physical impairments. The presentation will describe the background motivating this study because the results of the project are not yet available. We expect to have results by next March.

Un- and undertreated health conditions were not the only unmet needs experienced by the denied applicants enrolled in our study. Analysis showed multiple health and social barriers. At the time of enrollment in the study, participants reported experiencing crises related to unmet social and health needs including housing instability, lack of reliable transportation, and substance use. They reported multiple medical problems along with symptoms of psychiatric disorders. Participants were hesitant to use the community mental health and social services offered to them.

Background

The Supported Employment Demonstration (SED) was a random-controlled trial of Individual Placement and Support (IPS) supported employment funded by SSA and implemented and evaluated by Westat. Along with IPS supported employment, the SED provided a package of care management and mental health services. Thirty sites with documented high-fidelity IPS provided services to unsuccessful SSI/DI applicants who applied with a primary psychiatric impairment and indicated that they wanted to seek or maintain employment. The hypothesis of the demonstration was that evidence-based clinical and rehabilitative services provided early in the disability application process would increase employment and clinical recovery over a comparable sample of applicants who were provided “care as usual”, which, in this case, means they were not provided services through the study, but they were free to seek services and care outside the study (Riley et al. 2021).

The demonstration ran from 2017 until 2020. In total, we randomized 2,960 participants across two treatment groups and one comparison group. Participants were recruited from the catchment areas of 1 of 30 community mental health or social service organizations. They received 36 months of services at their local site (Riley et al. 2021).

Evaluation Methods

For this presentation, we rely on multiple sources of data collected during implementation. These include the Monthly Service Use Checklist on which providers record treatment-arm participants' service use; in-depth interviews with providers singly and in group discussions; focus groups with participants; person-centered, in-depth interviews with participants in all three study arms; and survey responses of participants at baseline (Marrow et al. 2020).

Results

At enrollment, the average age of participants was 36.1. Females comprised more than half of enrollees. Eighty-one percent of all participants were unemployed at enrollment with a median household income below the poverty line in the 30 days before enrollment. Whites accounted for 48 percent of enrollees; Blacks for 28 percent (Borger et al. 2021; Marrow et al. 2022 and Taylor et al. 2022).

Participants (n=1,842) reported mental health problems on the Colorado Symptom Index (CSI), with approximately half experiencing symptoms consistent with anxiety (71%) (post-traumatic stress disorder, 48%), mood disorders (61%), and personality disorders (65%) (Borger et al. 2021). Borger et al. found at baseline that 81 percent of participants reported symptoms consistent with at least one mental health condition and one general medical condition on the Composite International Diagnostic Interview (CIDI) (Kessler and Ustun 2004). Thirty-eight percent (38%) reported at least one symptom of psychosis (Borger et al. 2021).

Unsurprisingly, when asked about the mental health problems of SED participants, service providers echoed results of these assessments. SED providers observed that participants exhibited symptoms of anxiety, especially post-traumatic stress disorder (PTSD), depression, and personality disorders. SED providers at sites that specialized in intensive community-based mental health treatment frequently noted that SED participant case profiles were different than those of their usual clientele in that SED participants exhibited more anxiety, PTSD, and personality disorders than psychosis.

Providers and participants reported that anxiety interfered with the employment of the latter: causing problems on the job, but also making it difficult to search for work. Participants reported that anxiety affected their cognition to the point where they were ineffective workers; others battled anxiety daily simply leaving the house. Providers felt that many participants experienced chronic traumatic stress as a response to high exposure to interpersonal violence due to unstable housing, family disruption, and distressed neighborhoods. Participants' descriptions of their PTSD tended to highlight experiences of violence and abuse in their childhood.

Participants experienced chronic (and frequently) severe physical health problems. On average, each participant reported 3 general medical conditions indicating widespread multiple morbidities. The top four conditions were back pain, obesity, hypertension, and lung conditions. There were a range of impairments, including heart failure, stage four cancer, uncontrolled diabetes, multiple sclerosis, etc. Sixty-three percent of participants described chronic back pain; 49 percent reported height and weight indicating obesity; 33 percent reported hypertension and 33 percent reported a lung condition. On the Physical Short Form-12 survey (PSF-12), physical health-related quality of life was 1 standard deviation below the norm (Borger et al. 2021).

Participants also reported numerous barriers in accessing health services. Findings revealed that some participants struggled with obtaining health services to treat, manage, and document multiple chronic conditions before their SED enrollment (Marrow et. al. 2020). Without adequate treatment and documentation of their health conditions, applicants may not be able to demonstrate impairments serious and chronic enough to preclude employment at the level of substantial gainful activity.

For providers, addressing medical problems were new challenges. Staff repeatedly told us that this was out of their scope of practice, or as one said, "pretty close to the edge." However, staff rose to the challenge as best they could by coordinating primary and specialty care for participants; collecting low-cost referrals for participants who needed primary care and specialty services; and helping participants set up doctor appointments and then taking them to the appointments. Some sites requested and received specialized training on topics such as fibromyalgia or chronic pain.

Employment specialists learned to tailor employment services for people with physical limitations. For example, they searched for jobs that did not require employees to stand all day. They also worked with participants and their employers to secure accommodations for physical limitations. They sought reimbursements from the study for items to help participants manage pain, such as supportive shoes, cushioned mats on which to stand, back and knee braces, walkers, compression socks, and canes, among others.

Survey results showed improved self-reported health over the three years of the study for all participants, including those randomized to the control condition. However, the SED did not appear to improve the self-reported health of treatment-arm participants above participants in the control condition (Taylor et al. 2020).

RDRC Project Significance

The Social Security Administration is taking action to address systemic barriers to program participation (SSA 2022). This project is intended to assess whether lack of treatment for impairments and concomitant lack of documentation of impairments is a barrier to successful applications.

Findings from this study will illuminate a key barrier to applying for SSI/DI among applicants who report a mental impairment: access to healthcare adequate to document, manage, and treat the multiple, chronic physical and mental impairments applicants report. If applicants have impairments sufficient to preclude employment at the level of substantial gainful activity, but can neither treat nor document them, they cannot effectively access SSA's DI/SSI programs. We will be able to assess the extent to which barriers to healthcare access vary in magnitude or aspect by race, ethnicity, and sex.

Community engagement with service providers who assisted denied applicants with healthcare will enumerate practical strategies that may assist low-income, disadvantaged applicants with accessing healthcare, as well as more completely meet the requirements of their disability applications. We will also be able to suggest potential options for SSA to consider that may facilitate applicants obtaining proper treatment and documentation.

Specific Aims

This project will assess the extent to which participants received treatment for their impairments, whether some impairments were more likely to be treated than others, and whether self-reported health improved among those treated. It will also assess the magnitude of improvement in self-reported health by health impairment and intensity of treatment to identify which impairments were most likely to improve during the three-year study period, and whether receipt of treatment was correlated with improvement.

We will quantify the magnitude of barriers to healthcare access by examining baseline health and mental health services usage to assess the extent to which usage addressed the health conditions reported on the baseline survey (and any conditions that may have subsequently developed).

In-depth interviews with professionals who work with SSI/DI applicants and focus groups with former SED providers about treatment will further describe access problems and illuminate barriers to treatment access and uptake. Mixed-methods analysis will include secondary analysis of baseline and quarterly survey data from the 2,960 SED participants over three years, interviews with professionals who work with individuals applying for disability income (for example, claimant representatives and benefits counselors) and focus groups with former SED providers.

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Structural Barriers to Receipt of Income Support and Health Insurance among Adults with Disabilities

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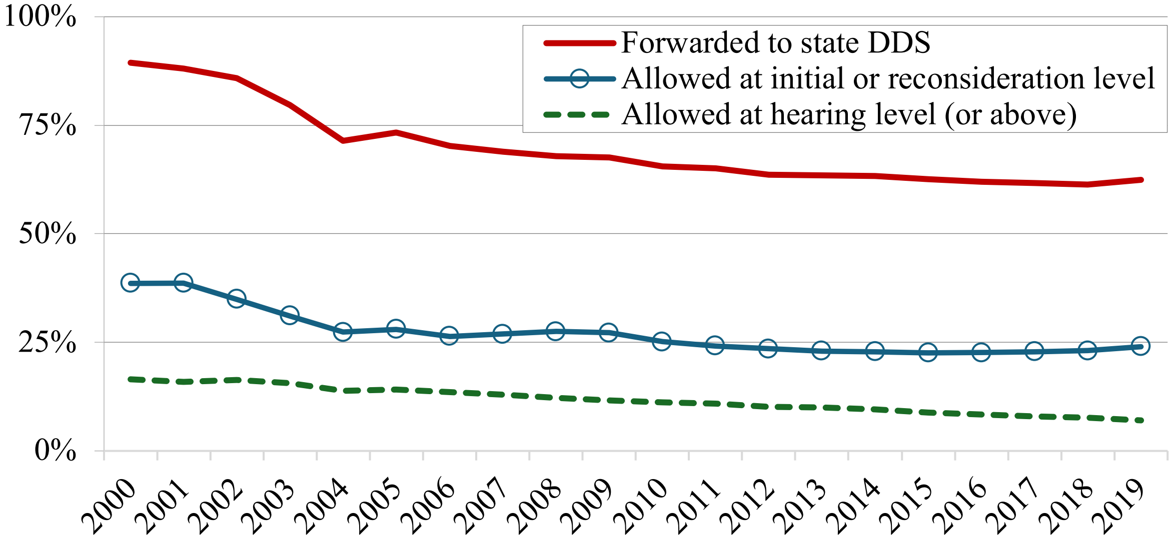
Applications for Social Security Disability Insurance (SSDI) have been declining over the last 15 years. Total applications received by local SSA field offices increased from 1.2 million in 2000 to 2.8 million in 2010, but they began declining in 2011, reaching 2.0 million by 2019. SSDI awards also rose from nearly 700,000 in 2000 to over 1 million in 2010, then declined to 630,000 by 2019. Several factors may explain this decline. Starting in 2010, the SSA Appeals Council made efforts to streamline decisions made at the hearing level by administrative law judges (Maestas 2019 and Ray and Lubbers 2014), which may have contributed to more consistent approval rates at the appeals level. Additionally, a wave of SSA field office closures between 2000 and 2014 led to a 10% drop in applications and a 16% decrease in new awards in areas with an office closure (Deshpande and Li 2019), and office closures in response to the COVID-19 pandemic highlight the potential barriers at the initial application stage.

The impact of these changes on the racial and ethnic composition of SSDI applicants and awardees, and the area-level characteristics of new awardees, remains unclear. This study uses publicly available data from SSA and data on new SSDI enrollees from Medicare enrollment files to answer two questions: (1) How have outcomes of SSDI applications changed over time and along each decision-making point (or adjudicative level) in the application process? and (2) Do changes in application outcomes impact the composition of new SSDI awardees?

To receive disability benefits, an applicant must first apply at their local SSA field office, where the application undergoes a technical review. If workers do not meet non-medical criteria regarding earnings limits, quarters of work, or related reasons, their claim may receive a technical denial and would not be forwarded to their state disability determination service (state DDS). Applications forwarded to the state DDS receive an initial medical decision. Among applications that receive an unfavorable medical decision, the decision can be appealed for a reconsideration. Applications rejected after reconsideration can be appealed and considered by an administrative law judge at the hearing level or above.

Between 2000 to 2019, applications that were approved, or “allowed”, across all adjudicative levels fell from 55% to 31%. Figure 1 shows trends in the percentage of applications that were allowed at each adjudicative level, and these trends illustrate that the percentage of allowed applications declined at all adjudicative levels. The percentage of applications forwarded to the state DDS fell by one-third from 89% in 2000 to 62% in 2019.

Figure 1. *Percentage of All Applications Forwarded or Allowed at Each Adjudicative Level*



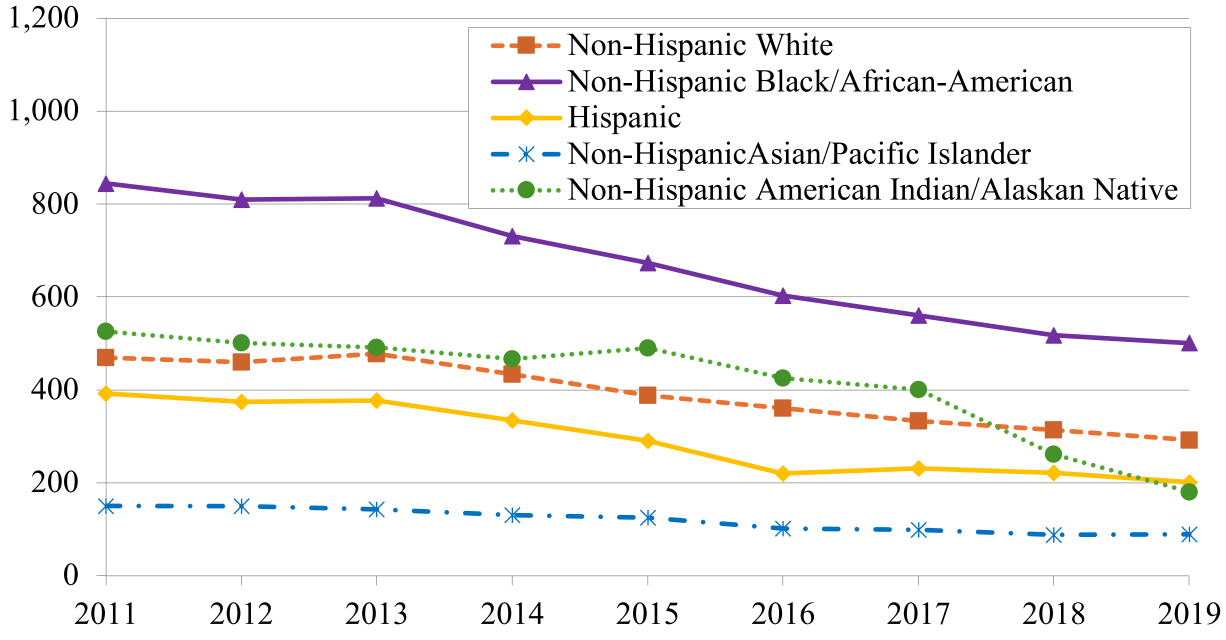
Notes: Includes SSDI-only and concurrent SSDI/SSI applications. DDS=Disability Determination Service. *Sources*: SSA Annual Statistical Supplement Tables 60-63, and authors' calculation based on technical denials, allowances, and applications in that year.

Furthermore, the proportion of denials arising from a technical denial (i.e., applications not forwarded to the state DDS) more than doubled during this period from 25% to 55%. Applications allowed at the initial or reconsideration level have also fallen, from 39% to 24%, and applications allowed at the hearing level or above also fell from 16% to 7%. Altogether, the rate of allowed applications has fallen by more than 40%, driven by an increase in technical denials and a decrease in allowed applications at higher adjudicative levels.

To understand how the decline in allowance rates impacted the composition of new SSDI awardees, we used the Medicare Master Beneficiary Summary File (MBSF) to identify new SSDI awardees, as individuals newly receiving disability benefits are automatically enrolled into Medicare after a 29-month waiting period (5 months after disability onset plus 24 months of receiving disability benefits). We grouped new awardees based on their race and ethnicity (Non-Hispanic White, Non-Hispanic Black/African-American, Hispanic or Latino, Non-Hispanic Asian/Pacific Islander, and Non-Hispanic Native American/Alaskan Native) using the Research Triangle Institute (RTI) code in the MBSF. We also grouped new awardees based on zip-code level characteristics from the American Community Survey (ACS), where beneficiaries were grouped into zip-code quartiles based on the percentage of foreign-born population in the zip code who speak English well/very well, the percentage of the zip-code population with college-level education, and the percentage of the zip-code population with income above the federal poverty limit (FPL). Finally, we grouped awardees based on the rural-urban commuting area (RUCA) category of their zip code (rural area, small town, micropolitan area, or metropolitan area). We calculated the rate of new SSDI beneficiaries per 100,000 population in each group, stratified by age, and assessed absolute and relative changes in new SSDI awardees over time. The results described below will focus on rates of new awardees among 45-54-year-olds between 2011-2019[43], although trends for other groups are similar.

Figure 2 shows the rate of new SSDI awardees per 100,000 45-54-year-old population by awardee race and ethnicity. Between 2000 and 2019, the rate of new awardees per 100,000 45-54-year-old population declined by 38% among Non-Hispanic White adults, 41% among Non-Hispanic Black/African American adults and Non-Hispanic Asian/Pacific Islander adults, 49% among Hispanic adults, and 66% among Non-Hispanic American Indian/Alaskan Native adults. Additionally, Non-Hispanic Black/African American and Non-Hispanic American Indian/Alaskan Native adults experienced the largest absolute decline of 344 new awardees per 100,000 45-54-year-old population.

Figure 2. *Number of New SSDI Awardees per 100,000 Population, by Race/Ethnicity*



Sources: MBSF, 2011-2019 (for new awardee counts); ACS 5-year estimates, 2011-2019 (for population counts).

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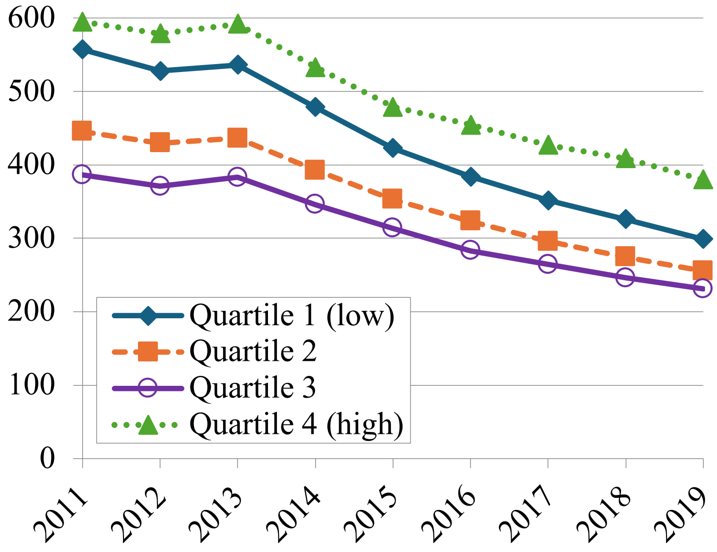
[43] We focus on these years because data on zip-code level characteristics before 2011 are unavailable.

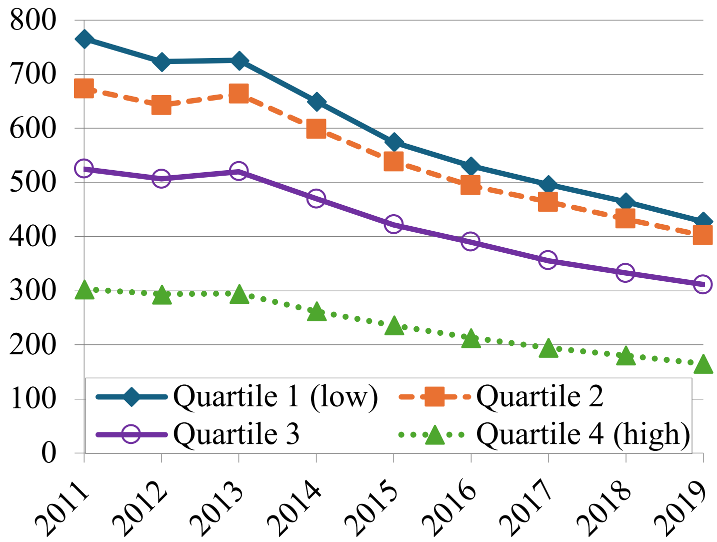
Figure 3 shows the rate of new SSDI awardees by quartiles based on the percentage of the foreign-born population in the zip code that speaks English well. All quartiles experienced similar declines in the rate of new awardees. Figure 4 shows the rate of new awardees by quartiles based on the percentage of the zip-code population with college-level education. The absolute decline in new SSDI enrollees was 2.5 times larger in quartile 1 (areas with the lowest share of individuals with college-level education) relative to quartile 4 (areas with the highest share of individuals with college-level education), though relative declines were similar. Figure 5 shows the rate of new SSDI awardees by quartiles based on the percentage of the zip-code population with income above the FPL. The absolute decline in new SSDI enrollees was three times larger in quartile 1 (areas with the lowest share of individuals with income above the FPL) relative to quartile 4 (areas with the highest share of individuals with income above the FPL), though relative declines were also similar. Prior work suggests that SSDI beneficiaries are more likely to

Figure 3. *Number of New SSDI Awardees per 100,000 Population, by Zip-Code Quartiles of % Foreign Born Population Who Speak English Well*



Sources: MBSF, 2011-2019 (for new awardee counts); ACS 5-year estimates, 2011-2019 (for population counts and zip-code quartiles).

Figure 4. *Number of New SSDI Awardees per 100,000 Population, by Zip-Code Quartiles of % of Population with College Education*

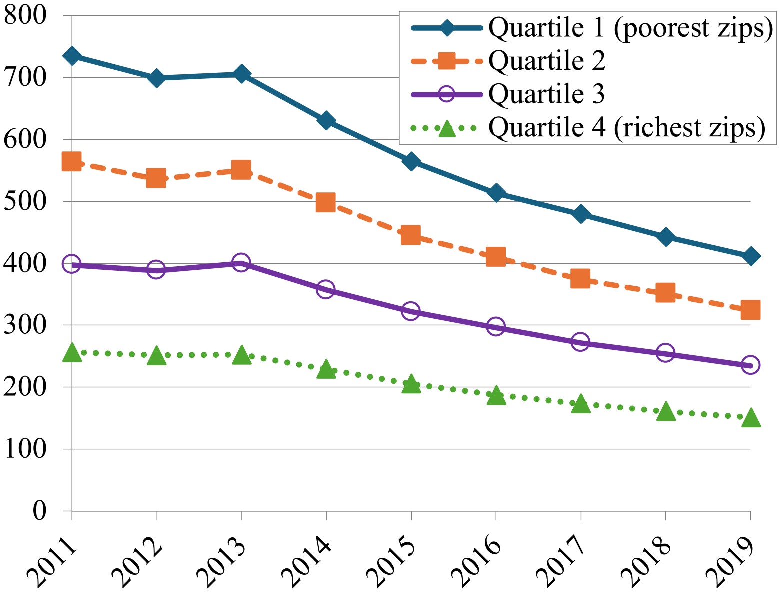


Sources: MBSF, 2011-2019 (for new awardee counts); ACS 5-year estimates, 2011-2019 (for population counts and zip-code quartiles).

have less than college education and be in the bottom income quintile (Favreault, Johnson, and Smith 2013), thus a decline in new awardees in areas with lower income and educational attainment may be expected. Figure 6 shows the rate of new SSDI awardees by RUCA category, and each category experienced similar declines in new awardees.

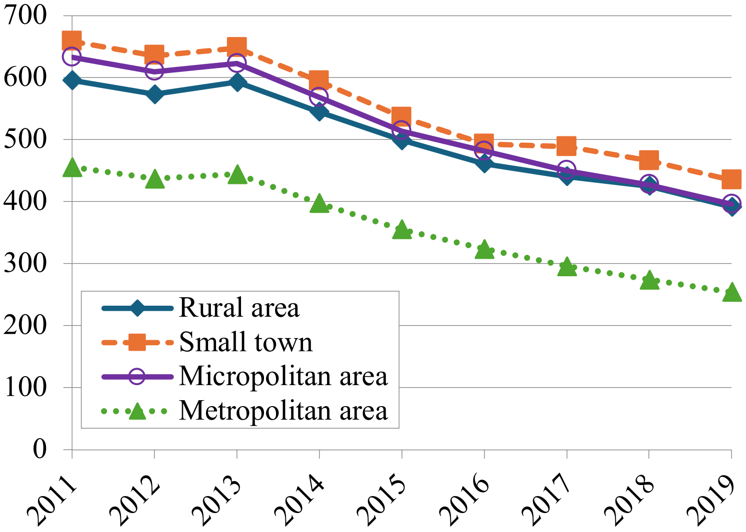
To conclude, there was a rise in the rate of technical denials and a drop in the allowance rate at higher adjudicative levels in the SSDI application process from 2000-2019. Individuals of racial and ethnic minoritized groups saw the largest declines in new awards. Areas with higher proportions of awardees with low income and less than college education also saw large absolute declines, which may reflect their substantial representation in the SSDI population. However, awardees in zip codes with a higher share of non-English speaking population and awardees in non-metropolitan areas did not appear to be disproportionately impacted.

Figure 5. *Number of New SSDI Awardees Per 100,000 Population, by Zip-Code Quartiles of % of Population with Income Above Federal Poverty Level*



Sources: MBSF, 2011-2019 (for new awardee counts); ACS 5-year estimates, 2011-2019 (for population counts and zip-code quartiles).

Figure 6. *Number of New SSDI Awardees per 100,000 Population, by Zip-Code RUCA Category*



Sources: MBSF, 2011-2019 (for new awardee counts); ACS 5-year estimates, 2011-2019 (for population counts); USDA ERS zip code to RUCA category crosswalk (for zip-code RUCA categorization).

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Panel 11: The Legacy of COVID-19

Moderator

Priyanka Anand (George Mason University)

Panelists

"Pathways and Persistence of Labor Force Transitions during COVID-19"
Maria Casanova (California State University, Fullerton) and David Knapp (University of Southern California)

"Medium-Term Effects of COVID-19 on Disparities by Race and Income"*
Raj Chetty and Nathan Hendren (Harvard University), John Friedman (Brown University), and Michael Stepner (University of Toronto)
** Summary not available because the results were embargoed from public circulation at the time of printing.*

"COVID-19 in Adults with Disabilities: Disparities in Prevalence, Health Care Access and Use and Employment Outcomes"
Zoë McLaren and Nancy A. Miller (University of Maryland, Baltimore County)

"How Might COVID-19 Affect Future Employment, Earnings, and OASI Claiming?"
Gary V. Engelhardt (Syracuse University)

Pathways and Persistence of Labor Force Transitions during the COVID-19 Pandemic

Maria Casanova
California State University, Fullerton

David Knapp
University of Southern California

Prepared for the 26th Annual Meeting of the Retirement and Disability Research Consortium
August 7-9, 2024

The research reported herein was pursuant to a grant from the U.S. Social Security Administration (SSA), funded as part of the Retirement and Disability Research Consortium (RDRC). The findings and conclusions expressed are solely those of the authors and do not represent the views of SSA, any agency of the federal government, California State University, Fullerton, University of Southern California, or the University of Michigan Retirement and Disability Research Center.

Introduction

The COVID-19 pandemic resulted in a significant reduction in labor force participation (BLS 2023). Among the cohort of workers over age 55, transitions out of the labor force were greatest among low earners, women, nonwhites, and non-college-educated individuals (Davis 2021). While the participation rates of prime-age workers have largely returned to pre-pandemic levels, those of older individuals have not, remaining substantially lower (Figure 1). These career disruptions may have lasting effects on the economic security of older workers and potentially exacerbate pre-existing disparities across groups.

Our project is divided into two parts. The first part, which is described in the current document, provides a comprehensive analysis of labor force exits during the pandemic. Specifically, we explore how the overall likelihood of exiting the labor force, the likelihood of exiting through specific pathways such as retirement, disability, or other reasons, as well as the likelihood of becoming temporarily laid-off changed for older workers during the pandemic period. The focus on temporarily laid-off workers is important because, even though they are considered part of the labor force by the official statistics, many fail to re-enter the workforce. If individuals experiencing temporary layoffs have a greater risk of permanently leaving the labor force, then a greater volume of temporary layoffs during the pandemic may explain part of the sharp reduction in labor force participation over the age of 55.

The second part of the project focuses on assessing the persistence of pandemic-induced labor force exits. Because the Health and Retirement Study (HRS) data that we use in the analysis are only available until 2022-2023, we cannot directly observe the duration of labor force separations exceeding two or three years. To address this, we will estimate models of labor force reentry using pre-pandemic data. The models will allow us to predict which separations from the labor force are likely to be permanent and to estimate the duration of those that are not.

By combining the first part's estimate of the share of labor force exits attributable to the pandemic with the re-entry probabilities and duration separations estimated in the second part, we can project the long-term impacts of the pandemic on individuals' economic well-being. Throughout both parts of the study, we examine whether the estimated effects vary across sex, race/ethnicity, and rurality. The findings derived from this analysis can inform efforts to promote economic security in old age and enhance our understanding of disparities across demographic groups.

Data

The results presented in this summary use data from the RAND HRS (version 1992-2020). The analyses for the rest of the project will be performed using supplemental COVID-19 information available from HRS for wave 15 (2020-2021) as well as data from the 2022 HRS wave. We will also use the Harmonized COVID-19 data in development from the Gateway to Global Aging Data covering the COVID-19 supplement to wave 15 and the 2021 leave-behind questionnaire, as well as the HRS detailed geographic linkage file to link state-level COVID-19 policy information (HRS Contextual Data Resource; Oxford University's government response tracker).

The RAND-HRS considers seven labor force statuses, namely full-time work (1), part-time work (2), unemployment (3), partial retirement (4), retirement (5), disability (6), and not in the labor force for other reasons (7). We categorize individuals from categories (1) to (4) as being part of the labor force, and those in categories (5) to (7) as not in the labor force. Labor force exits are defined as a transition from the labor force in period $t-1$ to not in the labor force in period t. Between 2000 and 2020, we observe 25,805 labor force transitions for men and 27,808 for women.

We classify workers as temporarily laid-off when they report having been temporarily laid-off from their job and expect to return to that job.

Methods

We estimate separate linear probability models for men and women to analyze the determinants of: (a) all labor force exits, (b) exits into retirement only, (c) exits into disability only, (d) other exits (not due to retirement or disability), and (e) the likelihood of becoming temporarily laid off in wave t. We model these outcomes as follows:

$$\text{Outcome}_{it} = \beta_T' X_t^T + \beta_P' \, X_{i,t-1}^P + \beta_J' X_{i,t-1}^J + \ \beta_{SS}' X_t^{SS} + \varepsilon_{i,t}$$

where the vector X^T includes indicators for interview waves; X^P includes personal characteristics such as age, labor force status, whether health limits work, marital status, race/ethnicity, and education; X^J contains job characteristics such as indicators that the job is physically demanding or requires computer use, firm size, job tenure, and health insurance coverage; and X^{SS} contains measures of Social Security eligibility, such as whether the respondent is newly eligible for early or unreduced benefits since the previous wave, or currently eligible for those benefits. β_T, β_P, β_J, and β_{SS} are vectors of coefficients, and ε is a random error term.

To assess whether any of the explanatory variables considered above are significantly associated with pandemic exits, we also estimate an extension of the model above where we interact an indicator for the pandemic interview wave with personal and job characteristics and Social Security eligibility.

Results

Pathways Out of the Labor Force during COVID-19

Our analysis shows that the likelihood of men exiting the labor force in 2020 was significantly higher than in the previous 4 interview waves (2012-2018), as shown in Figure 2. The likelihood of women exiting the labor force was not significantly different than those from earlier waves (Figure 3).

Focusing on specific pathways out of the labor force, we find that neither the probability of retirement nor that of retiring through disability in 2020 is significantly different from those from previous waves for men or women. However, the probability of exiting the labor force for reasons other than retirement or disability is significantly higher in 2020 for both men (Figure 4) and women (Figure 5).

Finally, the likelihood of becoming temporarily laid off spikes in 2020 for both men (Figure 6) and women (Figure 7).

Factors Associated with Pandemic Labor Force Exits

Focusing on the coefficients of interactions between the pandemic wave indicator and controls, we can assess which observables are associated with labor force exits and temporary layoffs in 2020.

For men, greater age and a college education decreased the probability of labor force exit during the pandemic, while having a health condition that limited their ability to work in the previous period increased it. Women were less likely to exit the labor force in 2020 if they were older or partially retired in the previous wave, and more likely if they were employed in the previous wave or worked in firms with more than 50 workers.

Temporary layoffs during the pandemic were less likely for men who had health insurance coverage through their own job in the previous period and more likely for those who had a health condition that limited their ability to work in the previous wave, or whose job in the previous wave was physically demanding. For women, pandemic-induced layoffs were less likely if they had not completed high school, if they had a job that required working with computers most of the time in the previous wave, and if they had health insurance coverage through either their own job or that of their spouse in the previous wave. Instead, pandemic-induced layoffs were more likely for women of older ages, those who were partially retired in the previous wave, and those whose job tenure was between 2 to 10 years.

Overall, we find that job-related factors such as employer-provided health insurance and jobs requiring computer use were associated with a lower probability of workers being laid off during COVID-19 relative to other periods. Worse health in the previous period increased both the likelihood of exiting the labor force and becoming laid off for men.

Previous studies had reported that the individuals who left the labor force during the pandemic were more likely to be low earners, women, nonwhites, and non-college-educated individuals. Those studies focused on the characteristics of individuals leaving the labor force during the COVID-19 period but, crucially, did not compare them with individuals leaving the labor force in earlier times.

In our analysis, we found that Black men, Hispanic men and women, and individuals who were not previously employed full-time, had less education, or worse health, were generally more likely to exit the labor force or be temporarily laid off *in all interview waves*. However, we found no evidence that the relative likelihood of leaving the labor force or becoming laid off during COVID-19 was different from previous periods for any race or ethnicity. This was also true with education, with one exception being that women who had not completed high school were less likely to be laid off during COVID-19, possibly because they were more likely to perform essential jobs.

Conclusion

A substantial number of US individuals left the labor force during the COVID-19 pandemic. Since then, the labor force participation rate of those under 55 years of age has largely recovered, but that of individuals aged 55 and older remains below pre-pandemic levels.

Using data from the HRS, we find significantly higher labor force exits for men during the pandemic, with weaker findings for women. Analyzing different exit pathways shows that pathways out of the labor force matter, as retirement and disability exits were not statistically different in 2020 than in previous waves, while other exits were significantly higher for both men and women.

We find some evidence to suggest that other explanatory factors may be related to labor force exits and temporary layoffs during the pandemic. Characteristics that are suggestive of higher-quality and more flexible jobs, such as those that provide health insurance coverage or require the use of computers, were associated with lower rates of job separation (either through labor force exit or layoff) than in previous waves, while worse health and having a physically demanding job increased the relative probability of job separation.

We found little support for the hypothesis that racial and ethnic minorities and the least-educated individuals were relatively more likely to separate from their job during the COVID-19 period than in previous times. This does not mean that there were no disparities in labor force exits and layoffs during the pandemic, but rather that the extent of previous disparities remained relatively constant over time. Moreover, increased disparities may still be identified by the second part of our project, where we will study the re-entry behavior of individuals who separated from their jobs during the pandemic.

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Figures

Figure 1. *U.S. Labor Force Participation Rate for Individuals Aged 55 and Older Using Data from the HRS and CPS*

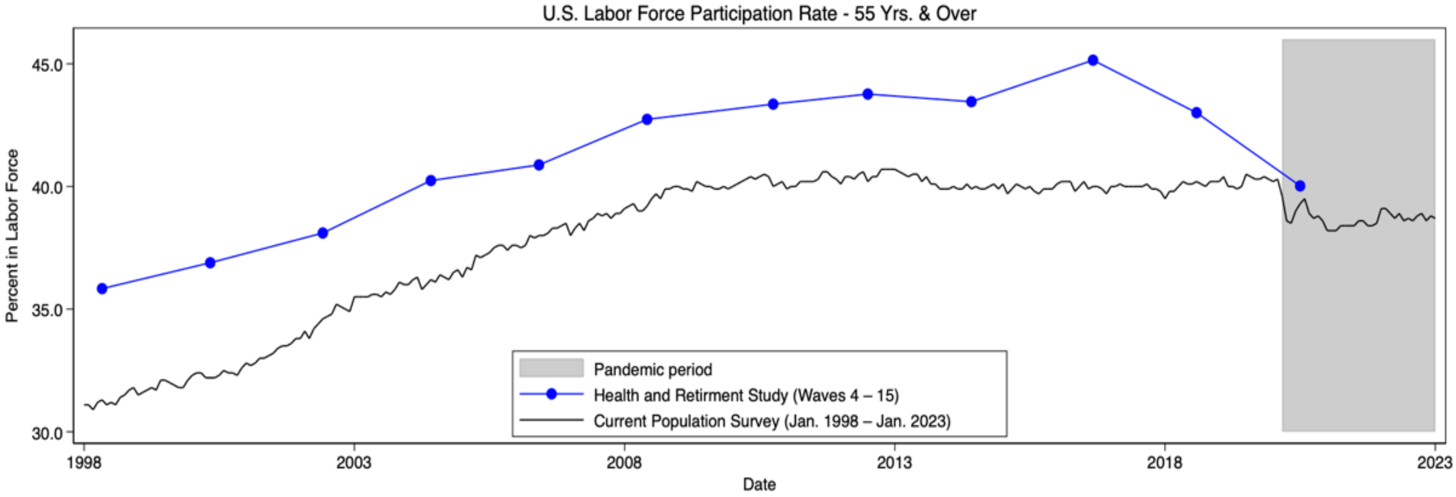


Figure 2. *Trend in Probability of Labor Force Exit by Year for Men*

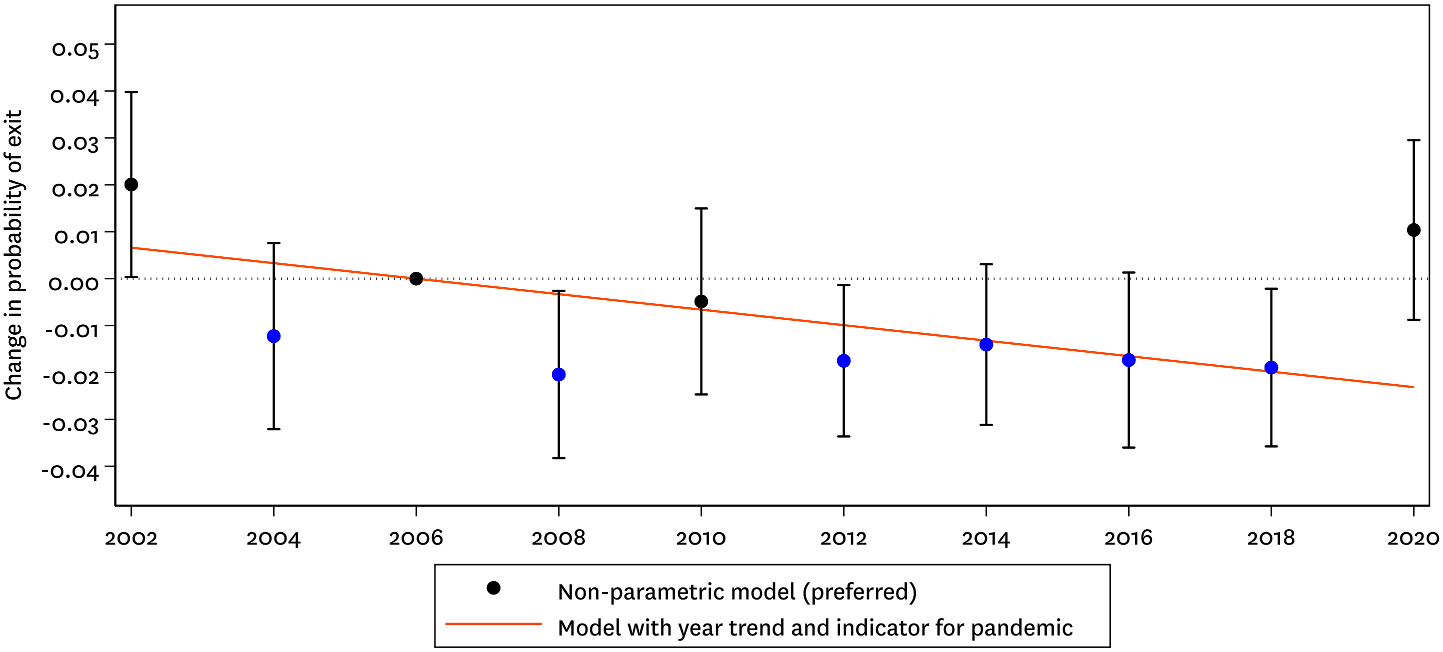


Figure 3. *Trend in Probability of Labor Force Exit by Year for Women*

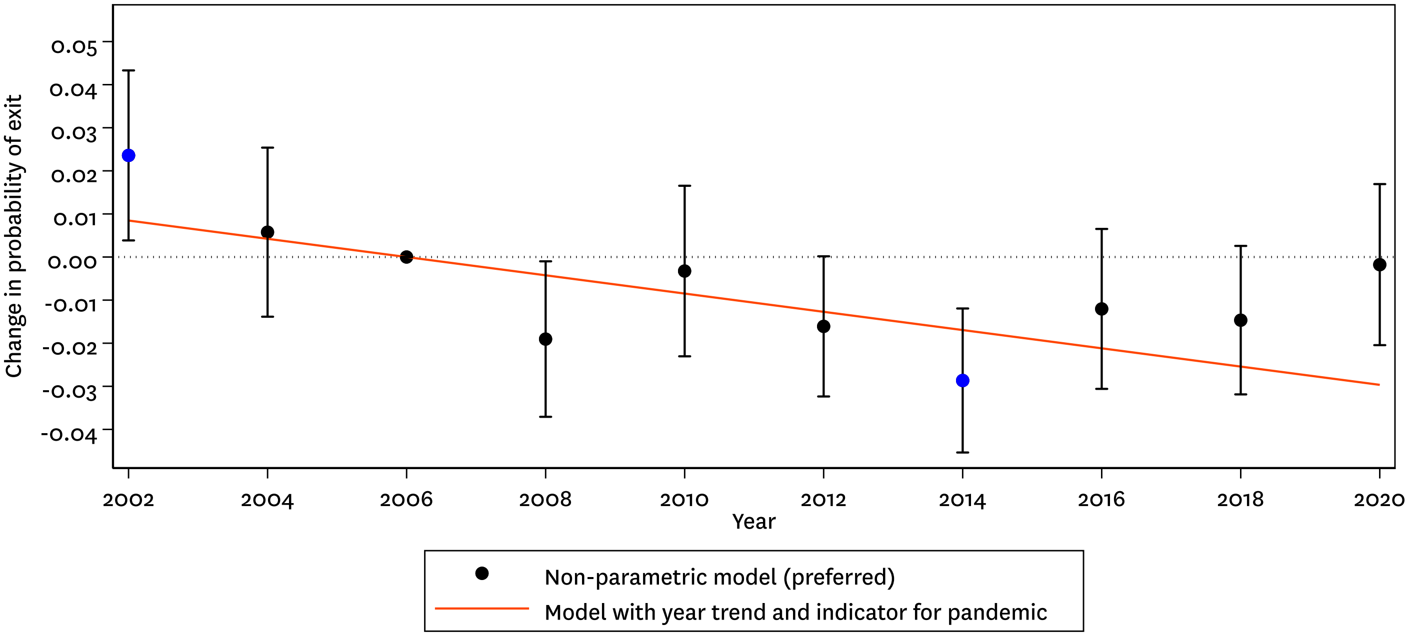


Figure 4. *Trend in Probability of Labor Force Exit for Other Reasons (not Retirement or Disability) by Year for Men*

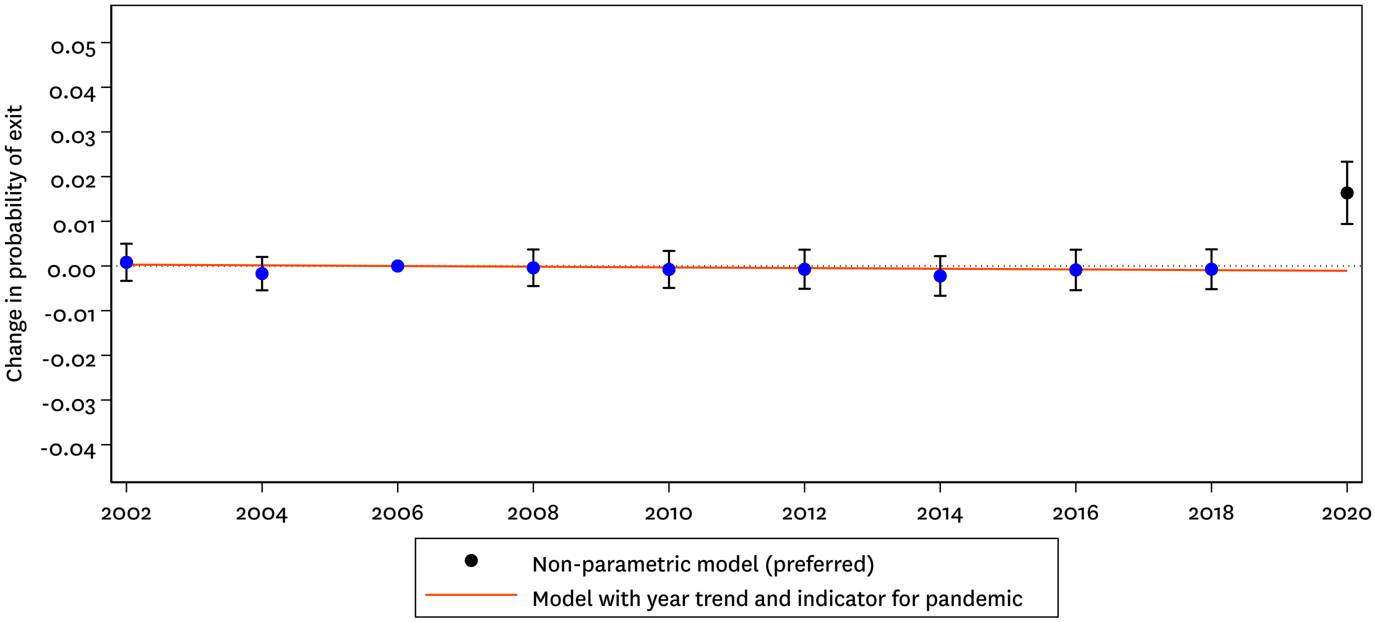


Figure 5. *Trend in Probability of Labor Force Exit for Other Reasons (not Retirement or Disability) by Year for Women*

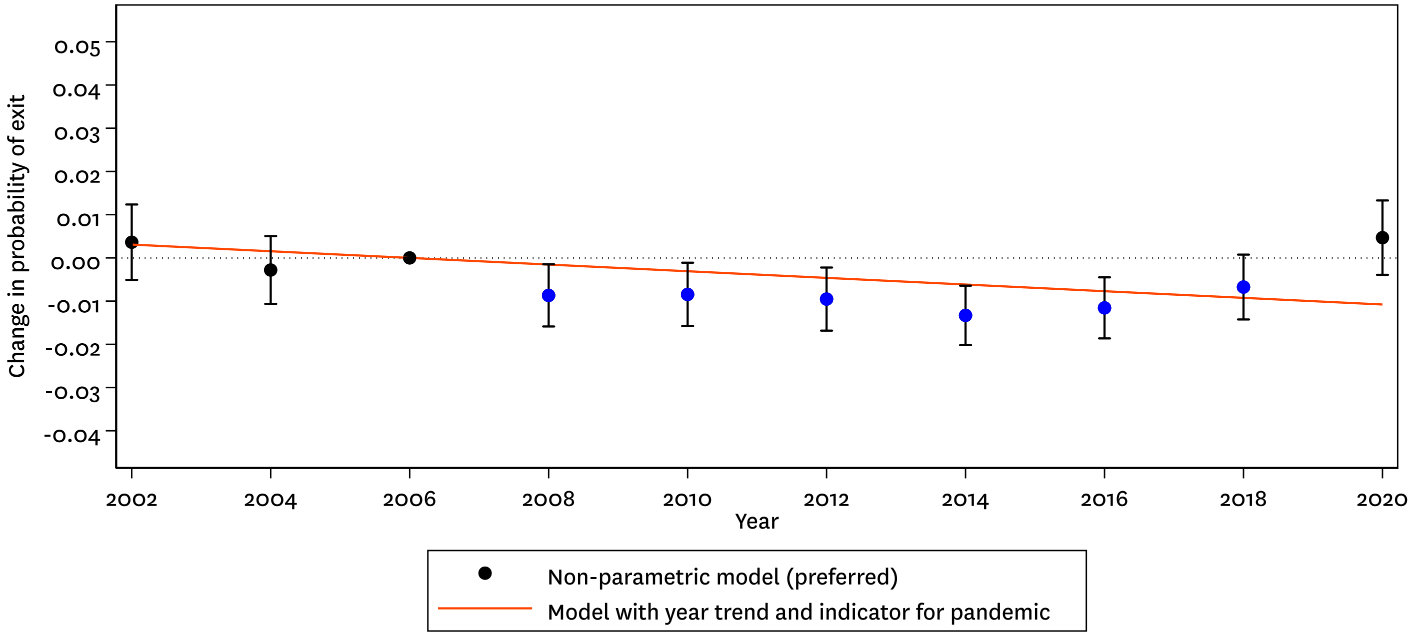


Figure 6. *Trend in Probability of Becoming Temporarily Laid Off by Year for Men*

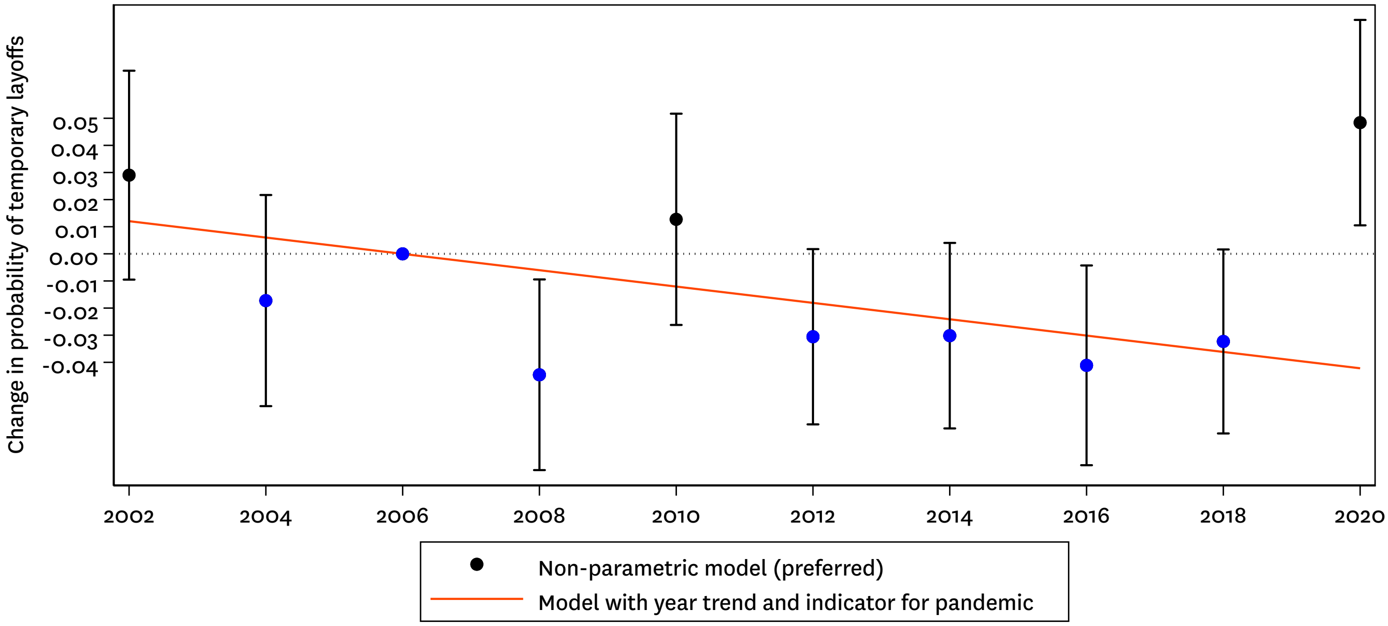
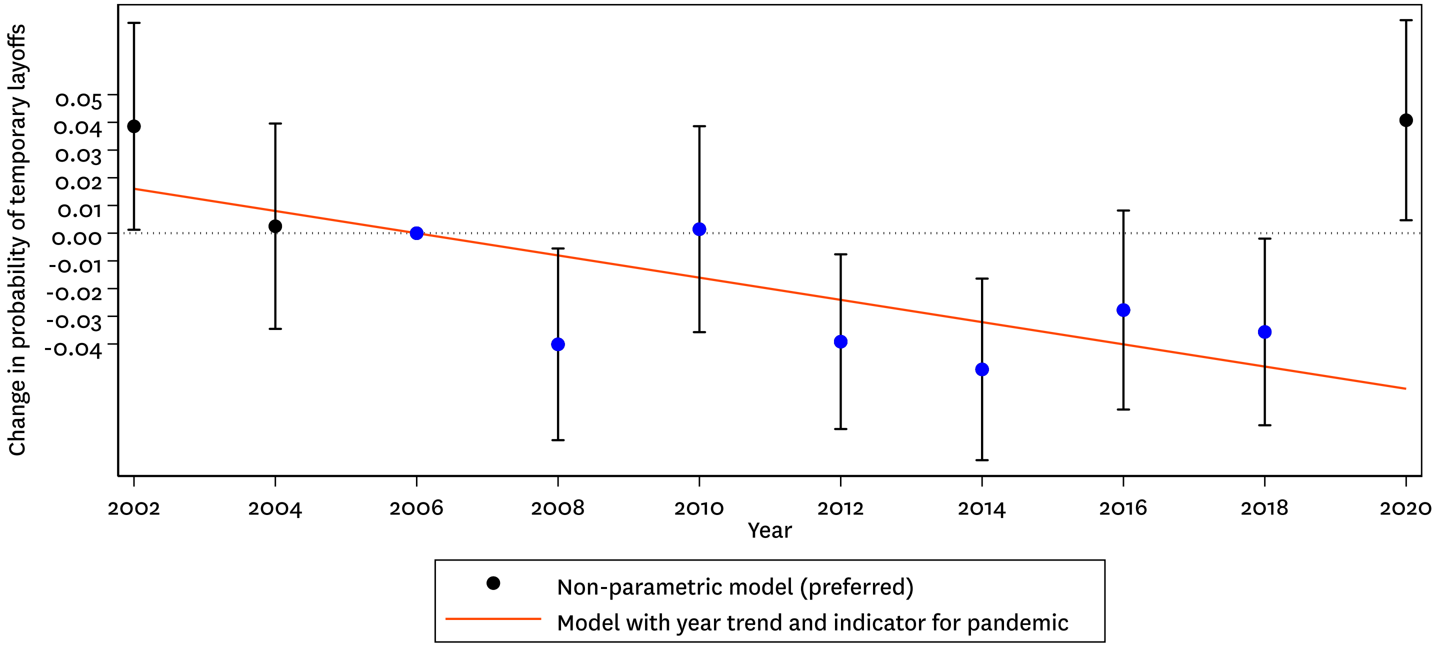


Figure 7. *Trend in Probability of Becoming Temporarily Laid Off by Year for Women*



COVID-19 in Adults with Disabilities: Disparities in Prevalence, Health Care Access and Use and Employment Outcomes

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Introduction

Approximately 25% of adults in the US experience a disability, according to the Centers for Disease Control and Prevention's (CDC's) Disability Health Data System (CDC 2022). Minority and lower socioeconomic status (SES) individuals are disproportionately affected by disabilities. Disability prevalence is higher for the Black population (25%) than the White (20%) or Hispanic populations (16.7%) (Okoro et al. 2018). Houtenville and colleagues (2022) found individuals with disabilities to have attained less education than those without a disability, with 14.6% and 6.6% respectively not earning a high school degree. Only 19% of individuals with disabilities compared to 41.9% of people without disabilities have earned a B.A. or more. A higher percentage of people with disabilities live in poverty than those without a disability, 23.2% versus 11.1% respectively.

Previous work has shown that individuals with disabilities receive fewer preventive and treatment services than individuals without disabilities (Ahmed et al. 2009; Chevarley et al. 2006; Dillard et al. 2022; Iezzoni et al. 2008; and Yee et al. 2018). Individuals with disabilities report greater unmet needs for medical care (Iezzoni, Frankt and Pizer 2011 and Mitra, Findley and Sambamoorthi 2009) and are more likely to report health care costs as a barrier to care (CDC 2019; Chevarley et al. 2006; and Lee, Hasnain-Wynia and Lau 2012).

Individuals with disabilities who are a racial or ethnic minority or of lower SES may face additional barriers to access. Having a usual source of care is an access to care measure (Agency for Healthcare Research and Quality 2023). Miller et al. (2014a) found racial and SES disparities among adults with disabilities related to a usual source of care, with working-age and older minority adults as well as lower SES adults more often having a place rather than a person as a usual source of care. Black adults with disabilities had a higher relative risk of emergency department use, compared to White adults with disabilities, in part due to differences in health insurance. Emergency department use decreased with increasing income (Miller et al. 2014b).

The COVID-19 pandemic has disproportionately impacted individuals with disabilities (Mitra and Turk 2022; Pendergrast and Monnat 2022; and Shakespeare, Ndagire and Seket 2021). For example, data from the National Well-Being Survey found that working-age adults with activities of daily living (ADL) disabilities were more than twice as likely to have experienced COVID-19, compared to those without ADL disabilities (Pendergrast and Monnat 2022). They also were more than six times as likely to experience a COVID-19 hospitalization and twice as likely to report a negative health impact from COVID-19. These disparate impacts can be attributed to a higher risk of poor outcomes, decreased access to routine care, and the adverse impacts of efforts to mitigate the pandemic (Shakespeare, Ndagire and Seket 2021).

COVID-19 continues to create a new cohort of persons with disabilities within the disability community among those who experience a range of persistent symptoms following a SARS-CoV-2 infection including physical and cognitive symptoms, functional disability and post-intensive-care symptoms (CDC 2022). As of July 2021, post-COVID condition can be considered a disability under the Americans with Disabilities Act and it was designated with the ICD-10-CM Diagnosis Code in October 2021 (CDC 2022). Post-COVID condition is defined by CDC and the World Health Organization as a "broad range of symptoms (physical and mental) and symptom clusters that develop during or after COVID-19, continue for >=2 months (i.e., 3 months from the onset of illness), have an impact on the patient's life, and are not explained by an alternative diagnosis" (Soriano et al. 2021). The population affected by post-COVID disability is likely substantial given that, as of April 2024, almost half of adults 18 and older in the US had experienced COVID, with 30% reporting symptoms of Long COVID (Household Pulse Survey, June 2024). Comprehensive assessment of the short- and longer-term impacts of COVID-19 and Long COVID on people with disabilities is therefore needed (Mitra and Turk 2022, pg. 1).

Although there is work examining COVID prevalence as well as health care access and use among adults with disabilities (Mitra and Turk 2022; Pendergrast and Monnat 2022; and Shakespeare, Ndagire and Seket 2021), this work has largely focused on individuals with specific conditions (e.g., individuals with functional limitations) (Pendergrast and Monnat 2022), often drawing on convenience samples (Mitra and Turk 2022). To extend this literature, we will use nationally representative data from the National Health Interview Survey (NHIS) to assess the short- and longer-term health and employment impacts of COVID-19 and Long COVID for adults with disabilities. We begin our work with a review of the literature regarding what is known about the prevalence of COVID-19 among individuals with disabilities.

Methods

We searched social science and health databases, included CINAHL Plus, Health Source - Nursing/Academic Edition, Health Source, Consumer Edition, JSTOR, Medline/Pubmed, and Web of Science. We also conducted hand searches in journals that included *Disability and*

Health Journal, Journal of Disability Policy Studies, Medical Care, Medical Care Research and Review, Health Affairs, Health Services Research, Dialogues in Health, and American Journal of Public Health. Then, we conducted hand searches of bibliographies included from eligible articles identified in the articles above. Our search string for electronic databases consisted of keywords related to disability, COVID-19, and prevalence. After searches were conducted using the procedures outlined above, collected articles were consolidated into a database and screened for duplicates and publishing language. From there, articles were screened based on title and abstract, and then reviewed by full-text. Then, relevant journals were screened dating back to the beginning of the pandemic in 2020 through May 2024. The references of the selected articles were screened for eligible articles.

The following criteria were used to select studies for analysis in this review:

1. Type and year of publication: Published in a peer-reviewed journal 2020-May 2024;
2. Study Design: Quasi-experimental design that includes a prevalence or incidence number or a case rate of COVID-19 infection or Long-COVID among individuals with disabilities relative to a comparison group;
3. Population: Individuals with disabilities and COVID-19 in the United States; and
4. Issue of interest: COVID-19 infection and/or Long COVID incidence, prevalence or case rate among individuals with disabilities, relative to individuals without disabilities.

Findings

We found nine peer-reviewed manuscripts that met the above inclusion criteria. Of these nine manuscripts, four focused on individuals with intellectual and developmental disabilities (IDD) (Formica et al. 2024; Karpur et al. 2022; Landes et al. 2020; and Landes et al. 2021), one was specific to individuals with serious mental health disorders (Wang et al. 2021), one focused on individuals with functional limitations (Pendergast and Monnat 2022), one compared Medicare beneficiaries who were eligible due to disability (Social Security Disability Insurance [SSDI]) relative to age eligible (Yan et al. 2022), and two used survey questions capturing a range of disabilities (e.g., mobility, vision) (Friedman 2022 and Miller et al. 2021).

With regard to data sources, Karpur et al. (2022) and Yan et al. (2022) examined private insurance and Medicare claims data respectively, while Wang and colleagues (2021) drew data from electronic health records. Survey data, including the Census Bureau Household Pulse Survey (Friedman 2022), the National Well-Being Survey (Pendergast and Monnat 2022) and the

2021 Porter Novelli Public Services Fallstyles Survey (Miller et al. 2023) were used in three studies. Studies focused on individuals with IDD in New York drew on provider and state Department of Health data (Formica et al. 2024 and Landes et al. 2020) while the study conducted in California drew from publicly available data from the Department of Developmental Disability Services and publicly available state data (Landes et al. 2021).

Six of nine studies found individuals with disabilities to be more likely to experience COVID-19. Landes et al. (2020) compared the case rate for individuals with IDD residing in group homes to the general population, finding a case rate of 7,841/100,000 and 1,910/100,000 respectively in the early months of the pandemic. Formica et al. (2024), drawing from the same data sources but for the first year of the pandemic, also reported a higher case rate for individuals with IDD (20,350/100,000) relative to the general population (8,700/100,000). Pendergast and Monnat (2022), using survey data and a measure of ADL difficulty reported a weighted prevalence of 30.5% for those with an ADL difficulty and 16.4% for those without an ADL difficulty. In multivariate analyses, those with an ADL difficulty had 2.11 times the odds of those without with regard to experiencing COVID-19. Medicare beneficiaries initially eligible through SSDI had a case rate of 10,978/100,000 relative to 3,148/100,000 for beneficiaries who were age eligible (Yan et al. 2022). Friedman (2022) found 19.3% of individuals with a self-reported disability (e.g., cognitive, mobility) reporting a COVID-19 diagnosis relative to 16.7% without a disability, drawing from Household Pulse Survey data. They also had a higher odds of reporting COVID-19 in an adjusted model with a significant odds ratio of 1.2. Wang et al. (2021) focused on the experience of individuals with serious mental disorders, finding higher odds for individuals with depression (10.43), schizophrenia (9.89), bipolar disorder (7.69), and ADHD (7.31) relative to those without a mental health disability.

Although Karpur et al. (2022) and Landes et al. (2021) reported a lower diagnosis for individuals with Autism Spectrum Disorders (ASD) (Karper et al. 2022) and IDD (Landes et al. 2021), there was considerable heterogeneity. For example, across all individuals with IDD receiving services in California the case rate was 831/100,000, relative to 2,085/100,000 in the general population. However, the case rate was 19,031/100,000 for those with developmental disabilities receiving services in an intermediate care facility. Karpur and colleagues reported a prevalence of 0.90% for individuals with ASD, compared to a prevalence of 2.04% overall. Individuals with an intellectual disorder and related conditions (but not ASD) had a prevalence of

2.21%. Although Karpur and colleagues focused on individuals with ASD, they included additional disabilities, finding a COVID-19 prevalence of 2.51% for individuals with depressive disorders and 2.7% for anxiety disorders. Miller and colleagues (2023) found no significant difference in a self-reported COVID-19 diagnosis among those with one of six ACS disability questions (e.g., cognitive, vision, work-limiting). However, they did not analyze specific types of disabilities, which, given the preceding heterogeneity, suggests there may have been disparate impacts for individuals with certain disabilities.

Next Steps

To extend the existing literature, we are using data from the NHIS that is nationally representative of U.S. civilian, noninstitutionalized households and has been conducted annually since 1957. In 2019, the NHIS began collecting data through in-person interviews with approximately 27,000 adults annually. Though the 2019 response rate was 61.1%, new sampling weights were introduced to address nonresponse bias. Black, Hispanic, and Asian populations are oversampled to allow for more precise estimates in these populations.

In 2022, the NHIS began including questions specific to COVID-19 and post-COVID condition. Respondents are asked whether a doctor or other health professional has told them they have coronavirus or COVID-19, whether they have taken a test for COVID-19, and the severity of symptoms they experienced. They are also asked whether they have had any symptoms lasting three months or longer that they did not have prior to having COVID-19, with prompts for symptoms. Respondents are asked whether they are currently experiencing these symptoms. Beginning in 2023, respondents have been asked whether these long-term symptoms reduce their ability to carry out day-to-day activities compared with the time before they had COVID-19 and the severity of symptoms. The NHIS also collects information on health and disability, sociodemographic and health insurance information, chronic conditions (presence and duration), health status, health behaviors, health care access and utilization, and employment.

We will use these data to estimate the prevalence of COVID-19 and post-COVID condition for adults with and without disabilities. We will construct a disability measure, following Altman and Bernstein (2008), that we have used in previous research (Miller et al. 2014a) to capture mutually exclusive measures of *basic activity limitations* only (i.e., sensory, physical, cognitive and mental health), and *complex activity limitations* only (i.e., functional and work-related), as well as a combined measure.

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How Might COVID-19 Affect Future Employment, Earnings, and OASI Claiming?

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This project examines how COVID-19 has affected the health of mid- and late-career Americans, as well as their employment, earnings, and OASI claiming since the onset of the pandemic. This includes how it might impact employment, earnings, and participation in the future. COVID may have affected health through two main channels. The first is direct: infection may have led to an array of post-acute and chronic conditions that limit the ability to work, so-called long COVID. The second is indirect: the pandemic led to disruptions in the supply of healthcare that may have delayed or prevented required care. Indeed, recent evidence suggests that these supply disruptions have led to increased mortality.

The project is in three parts. The first is primarily descriptive. This effort includes documenting the extent to which individuals have been affected by long COVID and supply-related health care disruptions and identifying differences by race, ethnicity, sex, education, marital status, age, and pre-pandemic earnings, employment, and health status. The second estimates the impact of these changes in health on employment, earnings, OASDI claiming, and work expectations. The third part uses the estimates to frame a general discussion of how long COVID and supply-induced health effects might impact future employment, earnings, and OASI claiming. The focus of my remarks for the RDRC meeting will be on preliminary findings from the second part, in general, and the role of chronic inflammation as a progenitor to long COVID, in particular.

Long COVID is characterized by one or more symptoms that persist roughly three months or more after acute infection. These commonly can be fatigue, muscle weakness, and trouble breathing, but may also present in a variety of organ systems. It may prevent or otherwise limit an individual from returning to work or other daily activities. Self-reported prevalence based on data from the U.S. Census Bureau’s Household Pulse Survey indicate that 15.7% of American adults between the ages of 50 and 75 ever had long COVID as of June 2024, and 4.8% currently suffer from long COVID.

Simple comparisons of the likelihood of employment of individuals who self-report long COVID symptoms versus those who do not typically show that long COVID is correlated with substantive reductions in employment. For example, in the most recent Pulse data, those 50 to 75 years old with long COVID were 3.4 percentage points less likely to be employed. Whether these correlations are causal is a key research and policy question and is complicated by the fact that long COVID is not randomly assigned across adults. Indeed, long COVID symptoms are very heterogeneous. Individuals who develop it may be systematically different from those who do not in other ways also related to their labor force participation.

One objective of this project is to get unbiased causal estimates of the impact of long COVID on employment. To do so, I exploit rich longitudinal data on health and employment before, during, and after the pandemic from the Health and Retirement Study (HRS), a nationally representative survey of individuals 50 and older, interviewed every two years until they die. The 2020 and 2022 HRS waves asked questions from which I measure whether an individual had an acute COVID infection. I also measure whether the individual had post-acute/chronic symptoms based on the following questions:

> “Did you ever have symptoms? (People with COVID-19 may experience fever chills, a cough, shortness of breath or difficulty breathing, fatigue, body aches, headache, new loss of taste or smell, sore throat, congestions or runny nose, nausea/vomiting, diarrhea.)”

followed up by

> “Do you continue to have health problems related to your experience with COVID-19?”

The 2020 wave was administered between March 2020 and May 2021; the 2022 wave was administered between March 2022 and September 2023. These data are supplemented by additional information on acute and post-acute conditions from the HRS’s *Perspectives on the Pandemic* supplement, which was administered in the spring and fall of 2021, respectively. In combination, the HRS provides longitudinal data at multiple points from essentially the beginning through the end of the pandemic on the same individuals.

The first stage of the empirical analysis uses these data on a sample of 50 to 75 year olds—the key age range for retirement and OASDI claiming decisions—to estimate the individual’s pandemic infection status: had an acute infection, had post-acute symptoms, or was never infected. Infection status is modeled as a function of demographic characteristics (age, sex, race, ethnicity, marital status, and education), region, pre-pandemic health status, the timing of the HRS interview with respect to the stage of the pandemic, and the transmissibility of the novel coronavirus at that stage. Transmissibility was measured as the weighted-average R0 of the virus for the HRS interview week based on the CDC’s estimates of the proportion of variants in circulation that week in the individual’s Census division.

Pre-existing health conditions were measured from the 2018 HRS wave, which was administered from April 2018 through June 2019. The medical conditions included whether the individual had arthritis, heart disease, diabetes, high blood pressure, lung disease, stroke, Alzheimer's or related dementia, or suffered from psychiatric conditions, respectively. Other health measures included were whether the individual smoked, was clinically obese (based on BMI), and their CESD depression score. Added to these was a measure of C-Reactive Protein (CRP) gathered from blood samples taken in 2016. There is a lengthy medical literature linking chronic inflammation and immune dysregulation to the likelihood of developing post-acute COVID symptoms. CRP is a standard clinical measure of inflammation.

Therefore, the first stage models the likelihood of infection status as a function of pre-existing health conditions, including the extent to which the immune system was latently dysregulated prior to the arrival of the novel coronavirus. The central mechanism is that infection of a person so primed increases the likelihood of post-acute symptoms in a way that is unrelated to what otherwise would have been the individual's labor force attachment in the absence of the pandemic. The first-stage maximum likelihood multinomial probit estimates indicate a strong relationship between pre-pandemic inflammation and the likelihood of long COVID: after controlling for differences in demographics, transmissibility, region, pandemic stage, and pre-pandemic medical and behavioral risk factors, a doubling of pre-pandemic CRP increases the probability of experiencing long COVID by 10%.

The second stage then estimates the causal impact of long COVID on the likelihood the individual is employed post-pandemic (as measured in the 2022 HRS wave), using the probability of long COVID based on pre-pandemic latent chronic inflammation calculated in the first stage. The resulting maximum likelihood probit estimates indicate that experiencing long COVID reduces the likelihood of post-pandemic employment by 5-8 percentage points. Almost 40% of 50 to 75 year olds were employed in 2018, prior to the pandemic. Therefore, the 5-8 percentage point reduction in employment from long COVID is a substantive economic reduction in work for the affected individuals.

Presenter: Rebekah Carpenter, Florida State University

Title: Occupational Exposures and Cancer Diagnosis among Older Workers Prior to Full Retirement Age

Abstract: A critical barrier to financial security in later life includes early departure from the labor force prior to reaching full Social Security Administration claiming age, or full retirement age (FRA). Cancer is among the most common health conditions that individuals are diagnosed with during the last phase of their working career (after age 50), and may be influenced by working conditions, which are likely to disproportionately impact Black older workers. This project evaluates the association between occupational environment exposures and cancer diagnosis prior to reaching FRA based on birth date and how the cancer-related consequences of these exposures vary based on race (i.e., Black versus White older workers). Results show that, on average, no occupational environment exposures are associated with an increased risk of cancer diagnosis. However, 10 occupational exposures are associated with significant odds of cancer diagnosis (after age 50) prior to FRA among Blacks but not among Whites. These results show that Blacks are disproportionately likely to experience elevations in cancer risks as a consequence of their occupational environments relative to Whites. This suggests that Black older workers may be more likely to be in jobs that place them at higher risk of cancer even within the same occupations as their White counterparts. Future research will evaluate the extent to which older workers diagnosed with cancer during this life stage experience job disruptions and how these job disruptions differ by race.

Presenter: Somalis Chy, Washington University in St. Louis

Title: Work Credit Accumulation and SSDI Eligibility among Young Adults

Abstract: Social Security Disability Insurance (SSDI) is an important type of social insurance that protects workers against the risk of income loss due to work-limiting disabilities. One of the SSDI eligibility criteria is a set of credits based on age and work history. However, the current work credit eligibility structure has been static and might not reflect changes in labor force engagement as a result of changing demographic trends. In particular, these trends include the extended age range of young adulthood and the multiple employment disruptions they experience while making major life transitions, such as completing secondary education, getting married, and becoming parents. Little is known about the relationships between SSDI credit eligibility under the current program structure, young adults' labor force engagement, and any potential disparity in SSDI credit eligibility across ages. Using the Panel Study of Income Dynamics (2005-2018), this study follows 2,345 young adults for at least 10 years and estimates the proportion of those who met the SSDI credit eligibility criteria at each age between 18-34. The findings indicate that the share of SSDI-eligible young adults is highest at age 25 at 71 percent, while around 29 percent are deemed ineligible, even when needed. Then, using regression analyses, this study examines differences in the probability of being SSDI-eligible by educational attainment and the differences by sex and race/ethnicity within each level of education after accounting for a vector of controls. The results illustrate the potential limitations of SSDI for young adults, and how program rules related to the eligibility structure may better support the well-being of workers.

Presenter: Emma Flanagan, University of Wisconsin, Madison

Title: Extending Recertifications: Pandemic SNAP Waivers' Impacts on SNAP Enrollment

Abstract: The Supplemental Nutrition Assistance Program (SNAP) aims to address food insecurity by supplementing grocery budgets for households with limited incomes. As a universal means-tested program, it is particularly effective in automatically responding to economic downturns. Following the onset of the COVID-19 pandemic in March 2020, SNAP enrollment dramatically increased, and federal legislation allowed for adaptations to SNAP participation requirements through state-level waivers. These waivers created flexibility in administering SNAP benefits to households, such as simplifying application and recertification processes. This study uses state-level variation in the termination of these waivers to examine how these policy changes impacted SNAP enrollment during the COVID-19 pandemic. Understanding the impacts of these waivers sheds light on the role of policy, rather than economic conditions, in shaping SNAP enrollment outcomes. Further, it offers insight into how temporary decreases in administrative burdens shape program participation, which is important as SNAP promotes food security among households with limited resources.

Presenter: Taylor Franklin, American University

Title: Only Spot a Few Blacks the Higher I Go: Occupational Segregation and the COVID-19 Pandemic

Abstract: This project examines whether there exists a link between occupational segregation by race and labor market outcomes during the COVID-19 pandemic. We estimate the extent to which workers who were employed in occupations with higher concentrations of Black workers were more likely to indicate a change in employer, a change in hours employed, or a change in earnings during the pandemic. The results show that Black workers employed in occupations with higher concentrations of Black workers are more likely to indicate a reduction in hours and earnings compared to White workers employed in occupations with similar concentrations of Black workers during the pandemic. These results do not exist between Hispanic and White workers when comparing individuals employed in occupations with similar concentrations of Hispanic workers. Considering that short-term unemployment, long-term unemployment, or a reduction in earnings can affect future Social Security payments, racial differences in labor market outcomes are directly related to SSA programs and may have lasting impacts on individuals during older ages.

Presenter: Hyun Ju Kim, University New Hampshire Institute on Disability

Title: Who Will Benefit from the 2024 ABLE Age Adjustment Act?

Abstract: This study explores different characteristics in asset and savings behavior of Supplemental Security Income (SSI) recipients by three disability onset age groups: before age 26, ages 26-45, and age 46 and older. The focus is placed on the second age group who can be new potential users of Achieving Better Life Experience (ABLE) savings accounts as the eligibility criteria expands in 2026 to include SSI recipients who experienced disability onset before the age of 46 (currently age 26). Using the 2014 Survey of Income and Program Participation (SIPP) merged with the 2014 Social Security Supplement Data, this study finds that the current work status of SSI recipients is significantly associated with having any savings accounts which is a proxy for ABLE accounts. Predicted values from the linear probability models indicate that SSI recipients who report bothering, work-limiting, and work-preventing health issues between ages 26 and 45 have lower likelihoods of having savings accounts (66-80 percent) than other age groups (over 87 percent). This suggests a low rate of participation for new eligible users of ABLE accounts as this age group becomes eligible in 2026 through the ABLE Age Adjustment Act.

About the RDRC Centers
and SSA Funding Opportunities

CENTER *for*
RETIREMENT
RESEARCH
at BOSTON COLLEGE

Mission

The Center produces first-class research and forges a strong link between the academic community and decision-makers in the public and private sectors around an issue of critical importance to the nation's future. Since its inception in 1998, the Center has established a reputation as an authoritative source on all major aspects of the retirement income debate.

Research

The Center's research covers any issue affecting individuals' income in retirement. Our main areas of research are Social Security, employer-sponsored retirement plans, financing retirement, healthcare costs, and working longer. The Center's work goes beyond economics. We seek to understand the human behavior behind individuals' decisions so that we can craft solutions that work in practice, not just in theory.

Grant Programs

The Center sponsors the Sandell Grant and Dissertation Fellowship Programs in retirement and disability research. These programs, funded by the U.S. Social Security Administration, provide opportunities for junior or non-tenured scholars and Ph.D. candidates from all academic disciplines to pursue cutting-edge projects on retirement or disability policy issues.

Squared Away Blog

The Center's popular personal finance blog translates complex academic research and financial information into an accessible form. The blog aims to help everyone – policymakers, financial service providers, and the public – better understand the factors that shape households' money management from college through mid-career and into retirement.

Find the Center online:

https://crr.bc.edu

@RetirementRsrch

MICHIGAN RETIREMENT AND DISABILITY RESEARCH CENTER
UNIVERSITY OF MICHIGAN

About MRDRC

The MRDRC promotes high quality research on retirement, disability, and Social Security policy; communicates findings to the policy community and the public; enhances access to relevant research data; and helps to train new scholars. MRDRC serves the public and policy community as an authoritative source of information on a range of issues related to retirement income security.

Read more about our research priorities, view current projects, and download more publications on our website, mrdrc.isr.umich.edu. All publications may be printed directly from the website.

Join the MRDRC mailing list to receive research publication updates, newsletters, and notice of events and training opportunities.

Contact us:

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LinkedIn: www.linkedin.com/in/mrdrcumich

Website: mrdrc.isr.umich.edu

This center is sponsored by a cooperative agreement with the Social Security Administration.

NBER | RDRC

Research

Social Security is the foundation of retirement and disability income support in the United States. The age-qualified OASI program, health-qualified SSDI program, and means-based SSI program together provide income streams totaling $1.4 trillion annually to over 70 million beneficiaries, or over 20 percent of the U.S. population. Most of the other 80 percent of Americans can anticipate benefits from one or more Social Security programs at some point in their lifetimes, based on their own work history, the work history of a spouse or parent, or from SSI. Thus, Social Security is imbedded in the social and economic fabric and lifecycle planning of nearly every American household.

Despite its breadth of social insurance coverage, there are distributional variations, disparities, structural barriers, and other inequities in program accessibility and impact on people of different socioeconomic, health, race/ethnicity, gender, sexuality, education, and other circumstances. To learn about these issues, the focus of research in the current 2024-2028 phase of the NBER-RDRC is to better understand the variations, inequities, and disparities in accessibility and impact of Social Security, and thereby, to inform future decisions about Social Security policy and administration.

Training and Partnerships

RDRC Fellowships. The RDRC supports pre-doctoral fellows and post-doctoral fellows who are developing a research agenda on issues relating to Social Security and the wellbeing of Social Security beneficiaries. While fellowship research may address any issue in this area, fellows are expected to include in their studies how Social Security differentially affects people with different circumstances and life experiences.

Mentored Research in Racial Health Disparities. This RDRC program, based at Howard University and Hunter College, mentors advanced undergraduate or master's degree students in research on the determinants of racial health disparities in SSI. A key component of the mentored experience is to examine a possible determinant of racial health disparities by linking our aggregated health outcomes data (by race/ethnicity) from Medicaid claims to other publicly available databases.

Capacity Building Workshops and Project Mentoring. Our HBCU/MSI partnership with Spelman College includes the sponsorship of an annual capacity-building workshop to familiarize HBCU/MSI researchers with datasets useful for retirement and disability research. The RDRC also supports investigators who would benefit from additional mentoring in developing project proposals, applying for RDRC project funding, and conducting independent studies through the NBER-RDRC.

To Learn More

NBER-RDRC Website

www.nber.org/retirement-and-disability-research-center

Fellowship Opportunities

www.nber.org/calls-fellowship-applications

NBER Bulletin on Retirement and Disability

www.nber.org/brd

NEW YORK
RETIREMENT
AND DISABILITY
RESEARCH CENTER

Mission

The NYRDRC connects and engages a diverse range of scholars, students, researchers, advocates, and policymakers to spark collaboration and improve Social Security and related programs. The NYRDRC seeks to better understand those excluded from social insurance programs and ultimately reduce barriers to entry by improving and adapting social safety net policies.

Research

Through our deep ties to communities across New York City, we combine community-based participatory research strategies with quantitative and qualitative analysis to investigate emerging issues to inform policy changes and address complex issues. We focus on several themes related to aging and disability, including the impact of climate change, retirement financial security, old age job security, social security service barriers and needs among specific population groups (e.g., formerly incarcerated older adults, LGBTQ+ community, recent immigrants), intergenerational transfers and their implications for old age health risks and income security, and caregiving, including family and social support.

Training & Events

Our goal is to cultivate a diverse, new generation of researchers that are equipped with the skills and knowledge needed to tackle the complex challenges related to Social Security programs. In addition to our research initiatives, we host a Summer Research Internship Program for undergraduates, a Community Outreach Fellowship for graduate students, a Research Fellows Program for doctoral candidates, and an annual Academy for journalists and policymakers where we translate research to policy.

Find NYRDRC online

https://www.nyrdrc.org/

https://www.facebook.com/NYRDRC

https://x.com/NYRDRC

CUNY Institute for
Demographic Research
at CUNY Baruch College

Brookdale Center for
Healthy Aging
at CUNY Hunter College

Schwartz Center for
Economic Policy Analysis
at The New School

RETIREMENT AND DISABILITY RESEARCH CONSORTIUM

Promoting Equity in Retirement, Disability, and Health

The Retirement and Disability Research Consortium (RDRC): Promoting Equity in Retirement, Disability, and Health is a collaboration between four institutions: the University of Maryland, Baltimore County, Heller School of Social Policy and Management at Brandeis University, the University of Baltimore, and Westat. Our RDRC supports interdisciplinary research, evaluation, data development, and training and education on retirement and disability policy.

Our RDRC collaborators bring a wealth of experience and expertise in retirement and disability policy to the RDRC. Our extensive academic research portfolio and interests, together with our collaborative work with SSA and other federal and state agencies catering to the needs of individuals with disabilities of all ages, position us as a valuable resource for this initiative.

Three themes capture the focus and intent of our current research agenda. The first theme is equity in access to Social Security retirement for under-recognized and underserved segments of society. The second theme concerns the intersection of health and access to healthcare and equitable SSI/DI program participation. The third theme is disparities in SSI/DI program access and participation.

Our RDRC also supports a training program intended to diversify and increase the field of early-career research scientists and policy analysts focusing on retirement, disability, and health through an innovative, transdisciplinary, multi-site training and education collaboration. Our training activities include an undergraduate mentored summer research program housed at UMBC and the University of Baltimore, both MSIs, and dissertation grants and support for research on retirement, health, and disability.

As part of our overall dissemination efforts, our RDRC is building a community-based network of partners and collaborators to support the development of Center research projects and products that inform researchers, policymakers, providers, advocates, and the general public.

Website: https://rdrc.umbc.edu/

Retirement and Disability
Research Center
UNIVERSITY OF WISCONSIN–MADISON

Mission

The University of Wisconsin-Madison Retirement and Disability Research Consortium Center (UW-RDRC) is an applied research program which develops evidence that assists policymakers, the public, and the media in understanding issues in Social Security, retirement, and disability policy, especially related to economically vulnerable populations. Our Center incorporates a diversity of viewpoints and disciplines, is committed to the training and development of emerging scholars and generates research findings that are used in policy and practice.

Research

The research agenda of the UW-RDRC is designed to understand the impact of Social Security programs on people at every stage of the life course, from low-birthweight babies, through students, young families, and into older people, and even end-of-life care. Our Center explores topics that are important for SSA and the broader field, and leverages the strengths of the UW-RDRC, our research community, and our partners. Our main research themes applied to topics of Social Security programs, beneficiaries, and social program interactions include *Systematic Poverty*; *Material Hardships*; *Net Wealth, Debt, and Housing*; *Caregiving*; and *Causes and Consequences of Health Inequality*.

Training Programs

The UW-RDRC conducts training of scholars and junior faculty, especially students from underrepresented backgrounds and from a range of disciplines, on issues relevant to SSA policy and practice. The Extramural Mentored Fellowships on Poverty, Retirement, And Disability Research program strives to provide mentorship and research opportunities for emerging researchers in the area of retirement and disability research. The Junior Scholar Intensive Training (JSIT) and the Social-Insurance Undergraduate Research (SURF) programs are unique training models in collaboration with Howard University and San Diego State University. The UW-RDRC vision is to develop a cohort of scholars who will become tomorrow's project investigators.

Resources & Dissemination

The UW-RDRC hosts quarterly webinars and the *Financial Findings Podcast.* These translational and accessible resources feature UW-RDRC researchers and highlight the implications of research for policy, practice, and relevance for the general public.

Find the UW-RDRC online:

UW RDRC https://rdrc.wisc.edu/

@uw_rdrc

Retirement & Disability Research Funding Opportunities

For undergraduate students only

- **Social Insurance Undergraduate Research Fellowship (SURF)**
  University of Wisconsin-Madison Retirement and Disability Research Center partnering with Howard University and San Diego State University
  A 4-week, in-person program that provides undergraduates with an introduction to social insurance, social safety net policies, and related research. Participants receive a $3,000 stipend.
  Annual application period: February–March
- **Undergraduate Fellowship** (UMass Boston students only)
  Center for Retirement Research at Boston College
  Full-time paid summer research assistantships in a variety of disciplines that combine hands-on research experience with one-on-one mentoring from senior center researchers.
  Annual application period: October–January

For undergraduate students or masters candidates

- **Summer Research Training and Assistantship**
  New York Retirement & Disability Research Center
  Paid summer research training and assistantship that combines in-depth seminars and workshops led by senior faculty members at the center with individualized mentoring to help gain practical, hands-on research experience.
  Annual application period: March–May
- **Undergraduate & Masters Summer Research Fellowship Program**
  University of Maryland, Baltimore County Retirement and Disability Research Consortium
  Introduces participants to Social Security Administration (SSA) programs and provides mentorship on research projects.
  Annual application period: April–May

For graduate students (masters, doctoral, or post-doctoral) through junior-level faculty

- **Extramural Mentored Fellowships**
  University of Wisconsin-Madison Retirement and Disability Research Center partnering with the Institute for Research on Poverty
  $45,000 stipend (up to 3) for non-tenured junior faculty, post-doctoral researchers, or those in dissertator status to support poverty research related to retirement and disability policies and programs.
  Annual application period: December–February
- **Junior Scholar Intensive Training (JSIT)**
  University of Wisconsin-Madison Retirement and Disability Research Center partnering with Howard University
  Provides training and mentoring to develop research ideas and initial research proposals relevant to SSA. Workshop-completed proposals may be eligible for small grants or other support. Training, course materials, travel, lodging, meals and incidentals will be covered for successful applicants. Participants are eligible to apply for a $5,000 research award after the workshop.
  Annual application period: November–February
- **Masters & Doctoral Student Research Grant Program**
  University of Maryland, Baltimore County Retirement and Disability Research Consortium
  Provides grant support and mentoring to conduct research on retirement and disability issues.
  Annual application period: November–December

For doctoral candidates

- **Dissertation Fellowship Program**
  Center for Retirement Research at Boston College
  $28,000 fellowship (up to 2) for doctoral candidates writing dissertations on retirement and disability topics.
  Annual application period: October–January
- **Doctoral Student Mentored Pilot Studies Program**
  University of Maryland, Baltimore County Retirement and Disability Research Consortium
  Grant support and mentoring for doctoral students to conduct pilot studies and/or write academic papers on retirement and disability issues.
  Annual application period: November–December
- **Pre-Doctoral Fellowship Program**
  National Bureau of Economic Research
  $27,927 stipend (up to 2) for full-time PhD candidates to conduct retirement- and disability-relevant research; also provides limited funds for tuition, health insurance, research expenses, and travel.
  Annual application period: October–December

For junior scholars (recent PhD recipients)

- **Post-Doctoral Fellowship Program**
  National Bureau of Economic Research
  $90,000 stipend (up to 2) for new PhDs and early career researchers to conduct retirement and disability research; also covers health insurance and provides limited funds for research expenses and travel.
  Annual application period: October–December
- **Small Grant Program**
  University of Wisconsin-Madison Retirement and Disability Research Center partnering with the Institute for Research on Poverty
  Up to $45,000 grants to support poverty research related to retirement and disability policies and programs.
  Annual application period: December–February
- **Steven H. Sandell Grant Program**
  Center for Retirement Research at Boston College
  $50,000 grants (up to 2) to pursue cutting-edge projects on retirement and disability issues
  Annual application period: October–January

All eligible persons are welcome to apply.

We strongly encourage applications from women, minorities, people with disabilities, and veterans.

ssa.gov/policy/about/research-funding.html

Biographies for Speakers, Moderators, Poster Session Participants, and RDRC Center Directors

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Olugbenga Ajilore is a senior advisor for rural development at the United States Department of Agriculture. Prior to his current role, he was a senior economist at the Center for American Progress and a former associate professor of economics at the University of Toledo. His expertise includes regional development, macroeconomic policy, and issues in diversity and inclusion. He has testified before Congress and has been featured in *The New York Times, The Wall Street Journal,* and *The Washington Post.* He holds a Ph.D. in economics from Claremont Graduate University and a bachelor's degree from the University of California, Berkeley.

Dr. Priyanka Anand is an associate professor in the Department of Health Administration and Policy at George Mason University. Her research examines the social safety net and social insurance programs, with a particular focus on disability policy and paid leave. Her work has been supported by the Washington Center for Equitable Growth, the Social Security Administration, and the Center for Retirement Research at Boston College. She has published in journals such as the *Journal of Health Economics,* the *American Journal of Health Economics,* and *Health Services Research.* Before joining George Mason, Dr. Anand was a senior researcher at Mathematica Policy Research. Dr. Anand received her Ph.D. in economics from Yale University.

Kate Bahn is the chief economist and senior vice president at the Institute for Women's Policy Research (IWPR). Prior to joining IWPR, Kate served as the director of research of WorkRise, a research-to-action network hosted by the Urban Institute, and as a chief economist and the director of labor market policy at the Washington Center for Equitable Growth. She was also an economist at the Center for American Progress and served as the executive vice president and secretary for the International Association for Feminist Economics. Her research areas include gender, race, and ethnicity in the labor market; care work; and monopsonistic labor markets. Bahn has testified before Congress, and her commentary has been featured on *Bloomberg, Marketplace, NPR, MSNBC, AP News,* and other media outlets. She received her B.A. from Hampshire College and her Ph.D. in economics from The New School for Social Research.

Duygu Başaran Şahin is a T32 Postdoctoral Research Fellow at the RAND Center for the Study of Aging. Trained as a sociologist and demographer, she specializes in population aging, age discrimination, later-life employment, and health disparities research with a focus on racial and ethnic inequalities. She is currently conducting research on three areas: perceived workplace ageism among older workers during the COVID-19 economic crisis; financial fraud knowledge among the older population; and cognitive functioning disparities by sexual orientation among middle-age and older adults. Duygu has extensive experience in using the Health and Retirement Study. She holds a B.A. in sociology from Galatasaray University (Istanbul/Turkey), an M.A. in health, population and social policy from Ecole des Hautes Etudes en Sciences

Sociales (Paris/France) and a Ph.D. in sociology from The CUNY Graduate Center. Duygu is a former research fellow at the CUNY Institute for Demographic Research and a current researcher with the NYRDRC.

Phillip Beatty is the Director of the Office of Research Sciences within the National Institute on Disability, Independent Living, and Rehabilitation Research. Dr. Beatty's Federal experience includes the U.S. Senate Committee on Health, Education, Labor, and Pensions and the Grants Management Advisory Council within the Administration for Community Living. He has co-authored 20 peer-reviewed publications while at the National Rehabilitation Hospital Center for Health and Disability Research.

Suparna Bhaskaran is the Director of Research Partnerships at the Institute on Race, Power and Political Economy at The New School and oversees the Color of Wealth Chicago project at the Institute. Suparna has experience working in the academy, government, and community organizations. She works at the intersections of feminist, queer, diasporic, race and transnational studies. She was a policy researcher in the Just Public Finance Program at the Othering and Belonging Institute (University of California, Berkeley). She served as a health policy researcher in Ohio Governor Ted Strickland's administration. She has taught in gender and sexuality studies programs at Antioch College, Agnes Scott College, and the Ohio State University; and in the Public Policy Program at the John Glenn College of Public Affairs at the Ohio State University. She has numerous publications, including the *book Made in India: Decolonization, Queer Sexualities, Transnational Projects.* She is a co-founder of OPAWL: Building AAPI Feminist Leadership, a grassroots member-led community organization dedicated to social and economic justice, building power, community, and progressive leadership for Asian and Asian American and Pacific Islander women and nonbinary people in Ohio. Suparna organizes with community groups in the Midwest that work on immigrant and refugee rights, popular education, and transnational multi-issue multigenerational politics. Dr. Bhaskaran has a B.A. in sociology and a Ph.D. in anthropology.

Mark Brennan-Ing, Ph.D., is the Director of Research and Evaluation at the Brookdale Center for Healthy Aging at Hunter College, the City University of New York. Their research focuses on psychosocial issues affecting people aging with HIV and older sexual minority and gender diverse adults. They are Past-President of the State Society on Aging of New York (SSANY), a Fellow of the Gerontological Society of America (GSA), and a Fellow of Division 44 (Psychology of Sexual Orientation and Gender Diversity) of the American Psychological Association (APA). They were the Principal Convener for GSA's HIV/AIDS and Aging interest group, and 2016 Chair of the APA's Committee on Sexual Orientation and Gender Diversity. Dr. Brennan-Ing's work has been recognized by the Hunter-Brookdale Center on Aging, Pride Senior Network, and the New York State Office for the Aging. In 2017, they received SSANY's Walter M. Beattie Award. They were the lead editor of *Older Adults with HIV* (2009) and the 2016 volume, *HIV and Aging: Interdisciplinary Topics in Gerontology and Geriatrics*, which received a "High Commendation" from the British Medical Association, and *Aging with HIV in Sub-*

Saharan Africa: Health and Psychosocial Perspectives (2022). They have authored over 100 peer-reviewed articles, chapters, and books.

Lydia X. Z. Brown is the National Disability Institute's (NDI) Director of Public Policy. They bring nearly 15 years of experience as a committed advocate, community organizer, and policy expert at the nexus of disability rights and disability justice. Lydia has spoken and consulted internationally and throughout the U.S. on a range of topics at the intersections of disability, race, class, gender, and sexuality, and has published in numerous scholarly and community publications. Their work has often focused on interpersonal, state and corporate violence, deprivation and exploitation targeting disabled people at the margins. Previously, Lydia served as Policy Counsel at the Center for Democracy & Technology, focusing on disability rights and algorithmic bias; Director of Policy, Advocacy, & External Affairs at the Autistic Women & Nonbinary Network; Justice Catalyst Fellow at the Bazelon Center for Mental Health Law; and Chairperson of the Massachusetts Developmental Disabilities Council. Outside of their work at NDI, Lydia teaches at Georgetown University and serves as Co-President of the Disability Rights Bar Association, board member of the National Lawyers Guild and founding board member of the Alliance for Self-Direction and Disability Rights. They also serve as an advisor for the Transgender Law Center's Disability Project, the Nonbinary & Intersex Recognition Project and Disability Rights Maryland. Lydia is the founder of the Autistic People of Color Fund, which advocates for disability, racial, and economic justice with a focus on building generative economies and just transition.

K. Steven Brown is the Director of Insights and Evidence for the Aspen Institute Financial Security Program (FSP). His professional work has focused on understanding the structural factors that impact wealth-building and inclusive economic opportunity. Prior to Aspen, he was a director at the Washington Center for Equitable Growth and served on assignment to the U.S. Department of the Treasury, where he supported their equitable research and policy implementation efforts. He also spent several years at the Urban Institute, where he helped stand up the Office of Race and Equity Research and authored numerous briefs and reports on racial wealth gaps, disparities in employment opportunities, economic mobility metrics, and advancing equity through data. His research and perspective have been cited in *The Washington Post, CNN, Marketplace, NPR,* and *Vox.* He holds a bachelor's degree from Princeton University and a master's degree in sociology from Harvard University, where he was also an inequality and social policy doctoral fellow at Harvard Kennedy School.

Debra L. Brucker is a research associate professor at the University of New Hampshire's Institute on Disability and a member of the National Academy of Social Insurance. She studies the economic, health, and social well-being of persons with disabilities, older adults, and other vulnerable populations as well as the in-kind, income assistance, and social insurance programs that support these populations. Her current research explores the impact of Long COVID on employment for people with disabilities, examines the barriers that rural adults experience when communicating with SSA, and develops new conceptualizations of food insecurity that are relevant to certain sub-populations of people with disabilities, including persons with physical limitations and persons with intellectual and developmental disabilities. Dr. Brucker earned her B.A. in psychology and criminal justice and her Master of Public Administration degrees from the University of Delaware. She earned her Ph.D. in urban planning and public policy from Rutgers University.

Barbara Butrica is a senior fellow at the Urban Institute, with more than two decades' experience researching the economics of aging, including older workers, pensions and retirement plans, Social Security, and retirement security. Her recent studies have examined the role of debt on labor force participation and Social Security benefit claiming; the retirement prospects of workers in alternative work arrangements; how caregiving affects work and retirement savings; the impact of the Social Security, pension, and tax systems on work incentives at older ages; the effect of the Great Recession on 401(k) participation and contributions; and strategies for improving the employment prospects of low-income incumbent older workers. She is an elected member of the National Academy of Social Insurance and was an appointed member of the advisory board serving the Wider Opportunities for Women's Elder Economic Security Initiative. Before joining Urban, Butrica held positions as an analyst at Mercer Human Resource Consulting and an economist at the Social Security Administration. She has a B.A. from Wellesley College and a Ph.D. from Syracuse University, both in economics.

Jennifer Caputo is a senior research associate at Westat and an interdisciplinary social scientist. Much of Dr. Caputo's research focuses on understanding the social determinants of older adults' mental and physical health and well-being. She is the principal investigator of a National Institute on Aging-funded project that uses data from the Health and Retirement Study to investigate longitudinal links between family relationships and cognitive impairment. She has also worked on projects examining the health impacts of family caregiving, multigenerational living arrangements, paid work, and widowhood. At Westat, her work includes supporting the New Applicant Survey for the Social Security Administration, helping to design the survey instrument, design and conduct exploratory and cognitive interviews, and write technical reports and memos. Dr. Caputo holds a Ph.D. in sociology from Indiana University. Before joining Westat, she held postdoctoral research positions at the University of Chicago and the Max Planck Institute for Demographic Research in Germany.

Rebekah Carpenter is a fifth-year doctoral candidate in the Department of Sociology at Florida State University. Her research explores how work and other social factors shape health and well-being outcomes, like financial security, over the life-course.

Dr. Maria Casanova is an associate professor of economics at California State University, Fullerton, where she teaches graduate and undergraduate courses on applied microeconometrics, program evaluation, and labor economics. Her research spans several topics within the economics of aging, ranging from retirement and saving decisions to the costs that cognitive decline and dementia impose on individuals, caregivers, and societies. A strand of her research examines how these issues impact older Hispanic populations, highlighting unique challenges and disparities compared to the broader U.S. population.

Makini Chisolm-Straker, MD MPH, was a 2022-2023 White House Fellow appointed to the Office of the Commissioner at the Social Security Administration. While at SSA, her portfolio included disability justice, economic mobility, housing (in)security, and racial and gender equity work. The team she worked with conducted a qualitative study examining the structural contributors to disability in the U.S.; the study team included the first federal technical working group (TWG) to be fully comprised of lived experience experts who were paid for their TWG activities. Prior to the White House Fellowship, Dr. Chisolm-Straker served in Africa, Southwest Asia, the Caribbean, Central America, and the U.S. as an emergency medicine physician and engaged in invisible populations public health research using community-based participatory research principles. A leader in U.S. trafficking response efforts, Dr. Chisolm-Straker has co-edited two seminal textbooks on U.S.-based labor and sex trafficking and reparative domestic policy, and helped develop the country's public health framing of anti-trafficking action. After the White House Fellowship, Dr. Chisolm-Straker worked at Yale University's Gilder Lehrman Center for the Study of Slavery, Resistance, and Abolition as a Visiting Associate Professor in the History Department; her focus is on policy-based reparations for U.S. Blacks and decolonization.

Somalis Chy is a postdoctoral research associate at the Brown School at Washington University in St. Louis. She recently graduated with a Ph.D. in human ecology, concentrating on consumer behavior and family economics, from the University of Wisconsin-Madison. She is a family economist primarily interested in the dynamic relationships and decision-making processes of low-income American families and young adults. Her research focuses on how these groups navigate the intricate balance between paid employment, family responsibilities, and household finances, along with their interactions with public social policies. She utilizes large public survey data and various econometric methods to study labor market participation, household division of labor, and income security among families and individuals. Additionally, her research evaluates the impact of family-related issues on financial, social, health, and material hardships, as well as inequalities within and between families and young adults. She is also conducting ongoing research on family caregiving, with a specific focus on the challenges faced by socioeconomically disadvantaged family caregivers, including access to work-family policies (such as paid family leave) and employment-tied benefits.

Marc A. Cohen is the director and clinical professor at the Gerontology Institute at the University of Massachusetts Boston. Previously, Cohen was the chief research and development officer and former president and co-founder of LifePlans, Inc., a long-term care research and risk management company that works with both the public and private sector on issues related to the financing and delivery of long-term services and supports. Over his 30-year career, Cohen has conducted extensive research and analysis on a variety of public policy issues affecting the financing and delivery of long-term care services and has promoted public-private partnerships in helping to address the nation's challenges. He has testified before Congress, the Bipartisan Policy Center, and other organizations on issues related to long-term care financing and private insurance. He served on Governor Deval Patrick's Task Force on Long-Term Care Financing for the Commonwealth of Massachusetts and most recently he served on the Steering Committee of the Long-Term Care Financing Collaborative, which recently published its recommendations for improving the nation's financing of long-term care. Cohen has published widely in scientific journals and his work has been quoted extensively. He has been interviewed by *The New York Times, Wall Street Journal,* and *Time Magazine* as a thought leader on issues affecting elder care financing.

Courtney C. Coile is Provost and Lia Gelin Poorvu '56 Dean of the College as well as the Stanford Calderwood Professor of Economics at Wellesley College. She is the co-director of the NBER Retirement and Disability Research Consortium Center and a member of the Committee on Population at the National Academies of Sciences, Engineering, and Medicine. Coile is the co-director of the NBER International Social Security Project, a collaboration between researchers in a dozen countries to explore why workers in the U.S. and other developed economies are retiring later and how much of this trend can be explained by social security reforms. Her research focuses on the economics of aging and health, particularly retirement and disability policy, and has been published in academic journals, in the co-authored book *Reconsidering Retirement: How Losses and Layoffs Affect Older Workers* (Brookings Institution Press), and in the *Social Security and Retirement Programs Around the World* series (University of Chicago Press). Coile received her A.B. from Harvard College and her Ph.D. from the Massachusetts Institute of Technology.

J. Michael Collins is the Faculty Director of the University of Wisconsin-Madison Retirement and Disability Research Consortium Center (UW-RDRC) and has served as the director and lead PI for the UW-RDRC from 2018 through 2024. Collins is the Fetzer Family Chair of Consumer Finance and a professor at the La Follette School of Public Affairs. Collins is the author of over 60 published articles in peer-reviewed journals, as well as the editor of the book *A Fragile Balance: Emergency Savings and Liquid Resources for Low-Income Consumers* and a textbook, *Financial Capability for Helping Professionals.* He is one of the creators and leading experts on financial coaching and the applications of financial coaching with economically vulnerable populations. Collins also has extensive experience managing field studies to test how programs impact the financial security and well-being of individuals across the lifespan. In 2017, Collins was awarded the inaugural national Ketchum Prize by the Financial Industry Regulatory Authority (FINRA) Investor Education Foundation for his work to "make demonstrable improvements to financial capability in the United States through research, education, or public communications." Collins has led over $21 million in research projects since 2008. Collins directed the Social Security Administration Financial Literacy Research Consortium site in Wisconsin from 2009 to 2012. In 2024, Professor Collins was the recipient of the Robert G. F. and Hazel T. Spitze Land Grant Faculty Award for Excellence. In 2018, he was named a H.I. Romnes Faculty Fellow, a prestigious designation at UW-Madison. Collins's research focuses on using research methods to establish causality. He has led field studies with a variety of entities including school districts, banks and credit unions, as well as state agencies. Collins frequently serves as a subject matter expert on program design and evaluation, as a reviewer for leading journals, as well as a consulting for granting agencies internationally. Collins worked with the Consumer Financial Protection Bureau on the development of the Financial Well-Being Scale, the Center for Financial Service Innovation's Financial Health Indicators, the Financial Diaries

Project, the Financial Consumer Agency of Canada and many other public and private entities. Beyond academia, Collins founded PolicyLab Consulting Group, a research consulting firm, and co-founded SpringFour, a financial technology company specializing in facilitating payments. He also worked for NeighborWorks America and the Millennial Housing Commission. Collins holds a Ph.D. from Cornell University, an M.P.P. from Harvard University's John F. Kennedy School of Government, and a B.S. from Miami University.

Danielle Dickens, Ph.D., is an associate professor in the Department of Psychology at Spelman College. Dr. Dickens earned her B.A. in psychology from Spelman College, and her M.S. and Ph.D. from Colorado State University in Applied Social and Health Psychology. As a Black feminist social psychologist, her program of research focuses on identity development and identity formation of Black women, and how they navigate higher education and the workplace, such as experiences with salary negotiations. Dr. Dickens has received research funding from agencies such as the National Science Foundation, the American Psychological Foundation, and Goldman Sachs. She received the 2019 Teaching of Psychology of Women Award and the 2020 Psychology of Black Women Foremothers Mentorship Early Career Award. She is an associate editor of *Psychology of Women Quarterly.* Dr. Dickens teaches undergraduate courses in psychology of women, research methods, and psychology of racism and is the co-author of the textbook, *Psychology of Black Womanhood* published by Rowman & Littlefield. In all, her teaching and research aims to contextually position and understand the lived experiences of Black women in the U.S., to identify effective strategies to reduce inequalities, and improve their career development and mental and behavioral health outcomes.

Dr. Wendy M. Edmonds is an assistant professor in the College of Business at Bowie State University, the oldest Historically Black College and University in Maryland. She is Chair of the Followership Learning Community at the International Leadership Association – the largest followership research and practitioner group in the world. She is the first researcher to conduct focus group studies with survivors of the 1978 Jonestown Massacre that occurred in Guyana. It was that life changing event which fueled her interest in "toxic followership" and the various perspectives of leader-follower relationships. Recognized internationally as a scholar-practitioner in followership, an emerging field of study in organizational leadership, Dr. Edmonds is the author of *inTOXICating FOLLOWERSHIP*. Her most recent research focuses on the lived experiences of victims of domestic violence in relation to followership and the impact of spirituality.

William R. Emmons, Ph.D., has been speaking and writing about the economy, banking and bank regulation, financial markets, housing, household finance, and economic policy for more than 30 years. His media exposure includes live interviews on national and local radio and television networks (*NPR, PBS, Bloomberg Radio, Scripps TV,* local media outlets) and dozens of news articles highlighting his research (*Wall Street Journal, New York Times, Washington Post, Bloomberg, Reuters, American Banker, Forbes, Time,* etc.). Dr. Emmons advised three Federal Reserve Bank of St. Louis presidents during his 27-year career at the St. Louis Fed. He also served as lead economist for the Bank's Center for Household Financial

Stability and for the Supervision, Credit and Learning Division. Dr. Emmons is president of the Gateway Chapter of the National Association for Business Economics (NABE), serves as a board member of the Missouri Main Street Connection (MMSC), and is an adjunct lecturer at the Olin Business School at Washington University in St. Louis. Dr. Emmons holds a Ph.D. in finance from the J.L. Kellogg Graduate School of Management at Northwestern University and received bachelor's and master's degrees from the University of Illinois at Urbana-Champaign.

Gary V. Engelhardt is a professor of economics in the Maxwell School of Citizenship and Public Affairs at Syracuse University, and a faculty associate in the Syracuse University Aging Studies Institute. His specialties are in the economics of aging, household saving, pensions, Social Security, taxation, and housing markets. Engelhardt's current research focuses on three areas: the impact of Social Security on economic well-being in retirement; the impact of population aging on housing markets; and the evaluation of field experiments in household saving and financial behavior. He is an associate editor of the *Journal of Pension Economics and Finance*, and teaches graduate and undergraduate courses in public economics, applied econometrics, and program evaluation. Engelhardt holds a B.A. in economics from Carleton College and a Ph.D. in economics from the Massachusetts Institute of Technology.

Andrew D. Eschtruth is the deputy director of the Center for Retirement Research at Boston College. He directs the Center's communication activities, including publications, press relations, and social media. Mr. Eschtruth also manages relationships with the government, foundation, and corporate communities, and speaks to a variety of audiences on retirement-related topics. He is the co-author (with Charles D. Ellis and Alicia H. Munnell) of *Falling Short: The Coming Retirement Crisis and What to Do About It* (Oxford University Press, 2014). Before joining the Center in 1999, Mr. Eschtruth was a senior research analyst with the U.S. Government Accountability Office (GAO) specializing in Social Security, federal fiscal policy, and the economic implications of an aging population. While at the GAO, Mr. Eschtruth served on a special assignment as an aide to the Chairman of the Senate Finance Committee. Mr. Eschtruth earned his B.A. from the University of Michigan and an M.A. in public policy from Duke University.

Ruth Finkelstein is an aging policy expert focusing on older workers and those left behind by public benefits and services. She is currently the Executive Director of the Brookdale Center for Healthy Aging, as well as a Professor of Public Health at Hunter/CUNY. She is an activist scholar who engages communities in research and translates aging research and concepts to policy-makers. Among her award-winning initiatives are Age-Friendly New York City and Age Smart Employer. She has a past life in HIV and drug policy, as well as a doctorate in health policy from the Johns Hopkins School of Public Health, an M.A. in anthropology from Case Western Reserve and a B.A. from the University of Michigan.

Stephanie Firestone is a senior strategic policy advisor for health and age-friendly communities at AARP International. In this role, she collaborates with international organizations such as the World Health Organization (WHO), where she is the liaison between the WHO Global Network of Age-friendly Cities and Communities and AARP's Network of Age-friendly Communities. She also works with WHO colleagues in developing plans for the Decade of Healthy Ageing initiative (2020-2030), including ways that AARP's experience with Disrupt Aging can inform planning for the Global Campaign to Combat Ageism. Stephanie also collaborates with organizations such as the American Planning Association, the Global Planners Network, and the American Society on Aging to advance the art of planning for aging in the U.S. and internationally. Stephanie shares and exchanges good practices with age-friendly colleagues around the world and provides consultation to cities seeking to become more age-friendly, such as The Hague in the Netherlands and Sharjah in the United Arab Emirates – the first Arab city in the world to join the global age-friendly network. She holds a master's in urban planning from the University of Virginia and a B.A. in communications from the State University of New York.

Emma Flanagan is a doctoral student in the human development and family studies program in the School of Human Ecology at the University of Wisconsin, Madison. Her research largely surrounds families' experiences navigating public social safety net programs. She conducts qualitative research with the Baby's First Years study and has been involved in several community-based studies. She draws upon both qualitative and quantitative methods in her three dissertation papers, which focus on how delivery mechanisms of social benefits shape families' experiences and outcomes. Emma is the 2024-2025 Institute of Research on Poverty Dissertation Research Fellow.

LesLeigh Ford is an associate director in the Office of Race and Equity Research at the Urban Institute. She regularly leads and contributes to research- and policy-focused projects that explore sources of and solutions to racial inequities. Her research has focused on a range of topics, including philanthropic and federal grantmaking, programs, and practice; economic mobility; and health policy. Ford holds a B.A. from the University of Michigan, an M.Ed. in education policy and management from the Harvard Graduate School of Education, and a Ph.D. in sociology from Duke University.

Jessica Forden is a researcher at the Schwartz Center for Economic Policy Analysis (SCEPA) at The New School for Social Research and an incoming Ph.D. student in The New School's economics department. Her research interests include the political economy of aging, with a specific interest in aging, caregiving, labor markets, and eldercare. Prior to joining SCEPA, she was a senior manager of research for the Impact Lab at the TIME'S UP Foundation and a senior associate at the Roosevelt Institute. Her past work has explored issues in labor, gender and racial inequality, and public policy more broadly, including work on monopsony labor markets, occupational segregation, and the economic effects of paid leave policies. Jessica received her bachelor's in economics from Wellesley College, and her master's degree in economics from The New School.

Taylor Franklin is a Ph.D. student in the public policy and administration program at American University. Her research interests include the effects of policy on labor market outcomes and inequalities. Specifically, her recent work focuses on moderators of stimulus payment effects and racial gaps in entrepreneurship and employment. Taylor holds a B.S. in economics from the University of Wisconsin – La Crosse, where she received the Undergraduate Research and Creativity grant for her honors thesis on the links between cultural indicators and gender gaps in entrepreneurship. Before pursuing a Ph.D., Taylor worked in survey research project management at the University of Michigan's Institute for Social Research.

Marema Gaye is a Ph.D. candidate in health policy from Harvard University. Marema graduated from Arizona State University in 2014 with a B.S. in economics and a B.A. in business with a concentration in global politics. She received her M.A. in global development economics from Boston University in 2016. Previously, Marema worked as a research associate in the Negotiations, Organizations, & Markets Unit at Harvard Business School and as a research project and data assistant in the Department of Health Policy and Management at the Harvard T.H. Chan School of Public Health. Her research interests include the delivery and financing of behavioral health care and the social determinants of mental health.

Teresa Ghilarducci is the Bernard and Irene Schwartz Chair of Economic Policy Analysis and the Director of the Schwartz Center for Economic Policy Analysis (SCEPA) at The New School for Social Research. She is also the co-director of the New York Retirement and Disability Research Center, a new center within the Social Security Administration's Retirement and Disability Research Consortium. She has written and lectured extensively on pension issues, including the award-winning book *Labor's Capital: The Economics and Politics of Employer Pensions*. Dr. Ghilarducci's most recent books include *Work, Retire, Repeat*, *The Uncertainty of Retirement in the New Economy* and *When I'm 64: The Plot Against Pensions and the Plan to Save Them and Rescuing Retirement* with Tony James. Dr. Ghilarducci was the 2006-2008 Wurf Fellow at Harvard Law School and she serves as a public trustee for the Health Care VEBAs for UAW Retirees of General Motors and for the USW retirees for Goodyear. She has also served on the Pension Benefit Guaranty Corporation's Advisory Board from 1996 to 2001 and on the Board of Trustees of the State of Indiana Public Employees' Retirement Fund from 1996 to 2002.

christian gonzález-rivera is the Director of Strategic Policy Initiatives at the Brookdale Center for Healthy Aging. He translates research into policy, builds strategic partnerships, and communicates Brookdale's policy priorities. Previously, he spent seven years as a senior researcher at the Center for an Urban Future, focusing on workforce development and older adults' policy. His work highlighted the needs of NYC's diverse older adult population. He also researched housing policy at NYU's Furman Center and managed research at the Greenlining Institute. Christian is a past president of the State Society on Aging of New York and a fellow of the Sterling Network. Named one of NYC's 40 Under 40 Rising Stars by City and State in 2016, his work has been widely covered in major media outlets. He holds a B.A. from Columbia University and a master's in urban planning from NYU Wagner.

Nanette Goodman is the former Research Director of the Burtin Blatt Institute (BBI) at Syracuse University. She has over 20 years of experience conducting quantitative and qualitative research on disability policy issues in the U.S. and in low-and moderate-income countries. Through the lens of public policy development, she focuses on the economic disparities between people with and without disabilities in their financial stability, use of financial services and the extra costs of living with a disability. Prior to taking on her role at BBI, Ms. Goodman was the Research Director at the National Disability Institute and Daniels and Associates LLC, a Research Associate at the Center for Inclusive Policy, a Senior Policy Advisor at the Office of Disability Employment Policy, and a Research Associate at the Cornell University Institute for Policy Research. She has written book chapters, published in peer-reviewed journals, prepared reports for the National Council on Disability, and developed policy white papers.

Dr. Vernon Grant was born and raised in Browning, MT and is an enrolled member of the Blackfeet Nation (*Amp-ska-pi-pikuni*). Dr. Grant holds an interdisciplinary Ph.D. in exercise science and community health from the University of Montana and is currently an assistant research professor in the Center for American Indian and Rural Health Equity at Montana State University. Dr. Grant's current funding is a K01 from the National Heart, Lung, and Blood Institute at NIH titled, "Developing, Implementing, and Evaluating a Mixed-Methods Community-Based Participatory Research Sleep Intervention in Families with K-1st Grade Children Living on the Blackfeet Indian Reservation." Dr. Grant has dedicated his career to serving Indian country and conducting research that helps and benefits Indian people.

Jevay Grooms is an assistant professor of economics at Howard University. She is an applied microeconomist with research areas of interest that lie at the intersection of public economics, health economics, and studies of poverty and inequality. Her overall research agenda is to study the impediments to adequate healthcare delivery and health outcomes of underserved and vulnerable populations with the keen intent to understand how poverty and the legacy of wealth inequality have contributed to health disparities among racial and ethnic minorities. She has a Ph.D. in economics from the University of Florida.

Jessica Halliday Hardie is a professor of sociology at Hunter College and the CUNY Graduate Center. Hardie is a mixed methods researcher who studies race, class, and gender inequality in education and work, family processes and relationships, and the life course. Her research contributes to scholarship on how institutions – particularly work, school, and family – structure access to resources and have consequences for individuals' health and well-being. Hardie holds a B.A. in conflict and social change from Wellesley College, a master's in science of teaching from Pace University, and an M.A. and Ph.D. in sociology from the University of North Carolina at Chapel Hill.

Darrick Hamilton is a university professor, Henry Cohen Professor of Economics and Urban Policy, and founding director of the Institute on Race, Power, and Political Economy at The New School. Considered one of the nation's foremost public intellectuals, Professor Hamilton has been profiled in *The New York Times*, *Mother Jones, Bloomberg's Business Week,* and *The Wall Street Journal*. Professor Hamilton was named a Freedom Scholar by the Marguerite Casey Foundation and the Group Health Foundation. He has been involved in crafting policy proposals that have garnered media attention and inspired legislative proposals at the federal, state, and local levels, including baby bonds, guaranteed income, and a federal job guarantee. He has testified before several Senate and House committees, including the Joint Economic Committee and the Senate Banking Committee. He was born and raised in the Bedford-Stuyvesant section of Brooklyn, New York. He is a graduate of Oberlin College and received a Ph.D. in economics from the University of North Carolina.

Dr. Jeffrey Hemmeter is the Acting Deputy Associate Commissioner in the Office of Research, Demonstration, and Employment Support at Social Security. He helps design, conduct, and oversee research, evaluation, and policies related to disability and return to work initiatives. Dr. Hemmeter's research focuses on children, transition-age youth, and Supplemental Security Income (SSI). He has worked on several Social Security demonstrations, evaluations, and studies; including as the Social Security lead on the Promoting Readiness of Minors in SSI evaluation. Dr. Hemmeter earned his Ph.D. in economics from the University of Illinois, Urbana-Champaign.

Miriam Heyman, Ph.D., is a research scientist at the Lurie Institute for Disability Policy, where she serves as Project Manager for the National Research Center for Parents with Disabilities. Miriam received a Ph.D. in applied developmental and educational psychology from Boston College, where she focused her studies on individuals with disabilities and their families. Her research reflects a lifespan approach to disability and mental health; her research has explored characteristics of the early childhood home and family environment that promote positive development for children with disabilities, the development of executive functioning and adaptive functioning, the early childhood education context, the influence of toxic stress on developmental outcomes, factors that predict positive employment outcomes for adults with intellectual disabilities, community living experiences and outcomes for adults with disabilities, and the experiences of parents with diverse disabilities. Miriam is also an adjunct faculty member at Boston College, where she teaches undergraduate and graduate courses in psychology.

Dr. Cicely K. Johnson is a medical sociologist and a research associate at the Brookdale Center for Healthy Aging, Hunter College, in New York City. She specializes in community-based research, focusing on health disparities and prevention through collaborations with community organizations and businesses, faith-based institutions, and medical centers. Prior to coming to Brookdale, Dr. Johnson was with Hunter College's Center for Cancer Health Disparities Research for six years, where she explored associations between cancer and aging in minority communities. Her work under the Hunter College/Temple University U54 Partnership included studies supported by a pilot award and an NIH Diversity Supplement. Previously, she was Director of Research and Programming at HOPE Center Harlem, and Associate Executive Director for Research and Training at the Arthur Ashe Institute for Urban Health. Dr. Johnson has taught sociology, psychology, and criminology courses at several colleges and universities over the past 13 years. She holds extensive experience in community-based participatory research and health disparities intervention programs. Currently, she is examining barriers to accessing social security across race, class, gender, sexual orientation, and gender identity under the auspices of the New York Retirement and Disability Research Center.

Richard W. Johnson is a senior fellow in the Income and Benefits Policy Center at the Urban Institute, where he directs the Program on Retirement Policy. His current research focuses on older Americans' employment and retirement decisions, long-term services and supports for older adults with disabilities, and state and local pensions. His recent studies have examined job loss at older ages, occupational change after age 50, employment prospects for African Americans and Hispanics over age 50, and the impact of the 2007-2009 recession and its aftermath on older workers and future retirement incomes. He has also written extensively about retirement preparedness, including the financial and health risks people face as they approach retirement, economic hardship in the years before Social Security's early eligibility age, and the adequacy of the disability safety net. Johnson's long-term services and supports research focuses on financing options and uses DYNASIM, Urban's dynamic microsimulation model, to project demand for services under current and alternative policies. His other major research thread involves state and local pension plans. He recently directed a team of researchers evaluating public pension plans in all 50 states and the District of Columbia, and he is examining how reforms might affect public-sector employees. Johnson, who writes and speaks frequently about income and health security at older ages, earned his A.B. from Princeton University and his Ph.D. from the University of Pennsylvania, both in economics.

Suhas Kellampalli is a Participatory Action Research (PAR) Researcher who is, in collaboration with the Southeast ADA Center, conducting interviews with community members to understand how the intersectionality of disability with other identities affects employment outcomes. He identifies as an individual with a disability himself and is deeply connected to the disability community. Suhas works as a peer advocate at a Center for Independent Living in Birmingham, AL called Disability Rights and Resources. He is concurrently pursuing a B.S. in neuroscience and an MPH in biostatistics and epidemiology at the University of Alabama, Birmingham. Suhas has additional research experience through the University of Michigan Family Medicine Department's MDisability Summer Internship Program, where he assisted on a mixed methods research project and is also currently working to implement an exploratory global health study on access to healthcare for people with disabilities in India.

Dr. Kilolo Kijakazi served as Acting Commissioner of the Social Security Administration (SSA) for two and half years (from July 2021 through December 2023). She is now serving as Principal Senior Advisor to Commissioner Martin O'Malley. During her tenure as Acting Commissioner, Dr. Kijakazi focused on major operational challenges facing the agency, including reaching agreement with SSA's labor unions to prepare for reentry and reopen over 1,200 offices across the country. She was asked to take office at a time when the agency was on track to hit its lowest staffing level in 25 years, while needing to serve an increasing number of beneficiaries and customers. Dr. Kijakazi focused on rebuilding the workforce, including using limited funding from Congress to conduct a hiring surge. She focused SSA on reducing administrative burdens for the public and advancing equity across its programs and services. To set the agency on a path of continued improvement, she established SSA's first Office of Native American Partnerships and first Office of Transformation. Prior to her appointment as Acting Commissioner, Dr. Kijakazi joined the Biden-Harris Administration in January 2021 as Deputy Commissioner for Retirement and Disability Policy at SSA. During her time as Deputy Commissioner, Dr. Kijakazi was responsible for planning and managing the development of program policy, policy research and evaluation, and statistical programs to inform programs administered by SSA. These programs include Retirement and Survivors Insurance, Disability Insurance, and Supplemental Security Income. From 2014 to 2021, Dr. Kijakazi served as an Institute Fellow at the Urban Institute where she developed collaborative partnerships to expand and strengthen Urban's rigorous research agenda, effectively communicate findings to diverse audiences, and recruit and retain a diverse research staff at all levels. Dr. Kijakazi also conducted research in the areas of economic security, structural racism, and the racial wealth gap. Prior to that, she was a program officer for the Ford Foundation and funded research on the racial wealth gap through her portfolio—Building Economic Security Over a Lifetime. Dr. Kijakazi holds a B.A. from SUNY Binghamton, an MSW from Howard University, and a Ph.D. in public policy from the George Washington University.

Dr. Hyun Ju Kim is a Project Director III at the University New Hampshire Institute on Disability (UNH-IOD). Her research interests include analysis of the role of Social Security disability programs on economic mobility, financial security, and health outcomes of people with disabilities, with a focus on vulnerable groups by race/ethnicity, gender, and immigrant status. At UNH-IOD, Hyun Ju is currently involved in the disability statistics and training project, which is funded by the National Institute on Disability, Independent Living, and Rehabilitation Research. When she joined UNH-IOD as a post-doctoral research associate in 2022, Dr. Kim was selected for the 2023 cohort of the Junior Scholar Intensive Training (JSIT) where she was a recipient of the JSIT Research Award. She intends to expand her research to investigate the food security among participants of SSI and Supplemental Nutrition Assistance Program (SNAP), barriers and facilitators of using Achieving Better Life Experience (ABLE) accounts among SSI recipients, and ethnic network effects among immigrant populations with disabilities in applying for DI/SSI. Prior to joining UNH-IOD, Hyun Ju worked at the World Bank as a consultant and conducted research on structural profiles of informality in the labor markets of the Middle East and North African region.

Sanders Korenman is Professor and Interim Associate Dean of the Marxe School of Public and International Affairs at Baruch College, CUNY, the CUNY Institute for Demographic Research. He researches issues in poverty and public policy, demography, and health. His recent research with Dahlia Remler and Rosemary Hyson developed a method to incorporate health insurance benefits and needs into US poverty measures. He was a member of the National Academies of Sciences' Committee on National Statistics Panel on Evaluation and Improvements to the Supplemental Poverty Measure that issued the 2023 *report, An Updated Measure of Poverty:*

(Re)Drawing the Line. That report's recommended revisions are embodied in the Principal Poverty Measure piloted in this study. He holds a B.A. in economics from the University of California, Berkeley and a Ph.D. in economics from Harvard University.

Siyan Liu is a research economist at the Center for Retirement Research at Boston College. Her research interests are in the financial well-being of older workers, retirement preparedness, and public pension plans. Before joining the center, Liu earned a Ph.D. from North Carolina State University in the field of labor economics. She holds an M.A. in economics from Vanderbilt University and a B.B.A. from the University of Hong Kong.

Gina Livermore is a senior fellow and director of the Center for Studying Disability Policy at Mathematica. For 30 years, she has evaluated interventions, programs, and policies affecting the employment of people with disabilities. She directs SSA's National Beneficiary Survey contract and directed the agency's original Ticket to Work and PROMISE demonstration evaluations. For the Rehabilitation Services Administration she is leading an evaluation of its Disability Innovation Fund Pathways to Partnerships Program. This national study is evaluating the model demonstration projects implemented in 20 states designed to improve the outcomes of children and transition-age youth with disabilities through better service coordination and innovative interventions. She has also directed and contributed to evaluations of employment interventions for people with disabilities implemented by state vocational rehabilitation agencies, community rehabilitation providers, and American Job Centers. In other work, Dr. Livermore has studied access to health care among people with disabilities in general and among Social Security Disability Insurance beneficiaries during the Medicare waiting period, the consequences of disability onset among older workers, and long-term poverty and material hardship among adults with disabilities. Livermore received an M.P.H. in epidemiology from Tulane University, and a Ph.D. in economics from the University of Wisconsin-Madison.

Natalie Lu is the Associate Commissioner (AC) for the Office of Research, Evaluation, and Statistics (ORES) in the Office of Retirement and Disability Policy (ORDP) at SSA and the agency's Statistical Official. Previously, Natalie served as the acting AC for the Office of Retirement Policy, the AC for the Office of Data Exchange, Enumeration & Medicare Policy in ORDP, the AC for the Office of Electronic Services and Strategic Information in the Office of Hearings Operations, the Deputy AC (DAC) in the Office of Quality Performance, the DAC in the Office of Chief Information Officer, and senior level positions in the Office of Central Operations and the Office of Disability Policy. Natalie began her federal career at the Department of Justice where she managed several Presidential initiatives including *the Advancing Justice Through DNA Technology program*. She served as the Special Assistant to the Deputy Secretary/Chief Financial Officer of the Department of Labor. Natalie next joined the Department of Health and Human Services successfully leading another Presidential Initiative – *Access to Recovery*. Natalie holds a bachelor's degree in chemistry and received a Ph.D. in biochemistry from the University of Maryland Baltimore County and completed post-doctoral research at the Johns Hopkins University.

Lisa M. Lynch, is the Maurice B. Hexter Professor of Social and Economic Policy at Brandeis University's Heller School for Social Policy and Management and Director of the Institute for Economic and Racial Equity. She is also co-director of the University of Maryland Baltimore County Retirement and Disability Research Consortium Center. Previously, she served as Brandeis University's Provost and Executive Vice President of Academic Affairs from 2014-2015 and 2016-2020, Interim President of Brandeis University from 2015-2016, and Dean of the Heller School for Social Policy and Management from 2008- 2014. Lynch is currently a member of the Economic Advisory Panel of the New York Federal Reserve Bank, and is an elected member of the executive committee of the American Economic Association. She has served as chief economist at the U.S. Department of Labor (1995-1997); director (2004-2009), chair (2007-2009) of the board of directors of the Federal Reserve Bank of Boston; chair of the Conference of Chairmen of the Federal Reserve System (2009); and president of the Labor and Employment Relations Association (2013-2014). In addition, she has served on the Governor's Council of Economic Advisors for the Commonwealth of Massachusetts (2008-2015) and the National Academies Committee on National Statistics (2009-2015). She is a research associate at the National Bureau of Economic Research and a research fellow at IZA (Institute for Labor Economics, Germany). She has been a faculty member at Tufts University, MIT, the Ohio State University, and the University of Bristol. Lynch earned her B.A. in economics and political science at Wellesley College, and her MSc. and Ph.D. in economics at the London School of Economics.

Nicole Maestas, Ph.D. is a Professor of Health Care Policy (Economics) at Harvard Medical School and a Research Associate of the National Bureau of Economic Research (NBER), where she directs the NBER's Retirement and Disability Research Center. She studies the economics of disability insurance, labor markets, healthcare systems, and population aging. Her research studies how the health and disability insurance systems affect individual economic behaviors, such as labor supply and the use of medical care. Dr. Maestas' research has shown how the federal disability insurance system discourages employment by people with disabilities. In other work, she examined how population aging affects economic growth and how working conditions affect individuals' ability and desire to sustain employment at older ages. In current work, Dr. Maestas is investigating the causes of the opioid epidemic and its impact on employment and participation in the federal disability programs, as well as the effects of state Medicaid policies on the health care and well-being of people receiving Supplemental Security Income (SSI) benefits. Dr. Maestas has published widely in the leading journals of economics, policy and medicine. She received her M.P.P. in public policy from the Goldman School of Public Policy at UC Berkeley, and her Ph.D. in economics also from UC Berkeley.

Isaac Marcelin is a professor of finance at the University of Maryland Eastern Shore. He earned his Ph.D. in finance from Southern Illinois University in Carbondale. He pursued post-graduate studies in public policy at the University of Maryland, College Park. Dr. Marcelin also served as a financial advisor and public policy analyst to two of Haiti's prime ministers for two years. Dr. Marcelin has over 10 years of experience conducting scientific research and has published articles in journals like the *Journal of Banking and Finance*, *International Review of Financial Analysis*, *Finance Research Letters*, *Research in International Business and Finance*, and *Emerging Markets Review*. He has served as a peer reviewer for various reputable journals in finance and economics. He has been leading several research projects funded by SSA through the NBER's Retirement and Disability Research Center, including (1) the economic impact of financial inclusion on SSA recipients and (2) improving recipiency in the U.S. social insurance: a scoping examination.

Jocelyn Marrow is a principal research associate at Westat. She is an anthropologist with clinical psychology training serving as an evaluator for Federal government programs and policies. Previous evaluation included the following: an evaluation of a RCT of supported employment with wrap-around services for people who were denied disability income; an evaluation of the quality of mental health services delivered to post-9/11 Veterans; and an evaluation of an NIH extramural grant program providing funds to institutions with modest levels of research. Marrow received her Ph.D. in anthropology and clinical psychology from the University of Chicago.

Nancy A. Miller is Professor and Director of the School of Public Policy and an Affiliate Professor in the Doctoral Program in Gerontology. She is also a Co-Director of the UMBC-led RDRC, in collaboration with the University of Baltimore, the Heller School for Social Policy and Management, Brandeis University, and Westat. She received both her M.A. and Ph.D. from the University of Chicago. Dr. Miller has conducted interdisciplinary health policy research, focusing on disability and aging issues, for over 30 years, first through her work at the Centers for Medicare and Medicaid Services and then as a faculty member in the School of Public Policy, which she joined in 1998. Her research interests are focused on chronic disease, disability, and long-term services and supports, with particular concerns toward access to care and healthcare disparities. Her research places a particular emphasis on examining factors that can be influenced by policy, particularly at the federal and state levels. In 2020, Dr. Miller received the UMBC Graduate Student Association Donald Creighton Outstanding Faculty Award, and in 2004, she received the University System of Maryland Regents Faculty Award for Excellence in Mentoring.

Alicia H. Munnell is the Peter F. Drucker Professor of Management Sciences at Boston College's Carroll School of Management. She also serves as director of the Center for Retirement Research at Boston College. Before joining Boston College in 1997, Professor Munnell was a member of the President's Council of Economic Advisers (1995-1997) and assistant secretary of the Treasury for economic policy (1993-1995). Previously, she spent 20 years at the Federal Reserve Bank of Boston (1973-1993), where she became senior vice president and director of research in 1984. Professor Munnell was co-founder and first president of the National Academy of Social Insurance and is currently a member of the American Academy of Arts and Sciences, the National Academy of Medicine, and the Pension Research Council at Wharton. She is a member of the boards of the National Bureau of Economic Research and the Pension Rights Center. In 2007, she was awarded the International INA Prize for Insurance Sciences by the Italian Accademia Nazionale dei Lincei in Rome. In 2009, she received the Robert M. Ball Award for Outstanding Achievements in Social Insurance from the

National Academy of Social Insurance. In 2015, she chaired the U.S. Social Security Advisory Board's Technical Panel on Assumptions and Methods. Alicia Munnell earned her B.A. from Wellesley College, an M.A. from Boston University, and her Ph.D. from Harvard University.

Jan Mutchler, Ph.D., is a professor of gerontology at the University of Massachusetts Boston and the founding director of its Center for Social and Demographic Research on Aging. In 2021, she was named director of the Gerontology Institute at the university's John W. McCormack Graduate School of Policy and Global Studies. Mutchler's scholarship focuses on diversity, inequality, and disparities in aging, seeking to strengthen scholarship and its impact for our growing and diverse older population. She produces the national Elder Index, a one-of-a-kind, county-by-county measure of the income needed by older adults to maintain independence and meet their daily living costs while staying in their own homes. Mutchler received a B.A. in sociology from the University of Mississippi, and an M.A. and Ph.D. in sociology from the University of Texas Austin. In 2016, she received the UMass Boston Chancellor's Award for Distinguished Service.

Dr. Dayo Oyeleye is an assistant professor in the Management, Marketing, and Public Administration Department in the College of Business at Bowie State University. Dr. Oyeleye utilizes analytical, technical, and strategic approaches to proactively inspire his students to go beyond just thinking about classroom assignments but to develop result-driven skills that will allow them to explore how they can contribute to the society in general. His teaching goal is to create a classroom environment that will effectively communicate and motivate his students to believe in themselves so they can achieve their potential and learn to think that everything is possible. Dr. Oyeleye is a people developer with 20 years of technical and organizational hands-on experience in leading people to be results-driven in the Information Technology (IT) industry, specifically focusing on technology adoption. Dr. Oyeleye is also dedicated to serving in the community. His passion continues to expand in coaching, and mentoring business owners, developing and facilitating leadership training for corporate organizations. Dr. Oyeleye received a Ph.D. from the University of Maryland Global College in IT management. He is a certified trainer for the I-Corps program and a member of the Entrepreneurship Innovation Center's Faculty Steering Committee.

Kristin L. Perkins is an assistant professor in the Department of Sociology at Georgetown University. She studies inequality and social stratification with a focus on families, households, and neighborhoods. Perkins's current research focuses on two areas: shared households and household instability among children and older adults; and neighborhood inequality, particularly gentrification and socioeconomic segregation in urban and suburban neighborhoods. Her research has appeared in journals including *Demography*, *Social Forces*, *Social Science Research*, *Sociological Science*, *Urban Affairs Review*, and *Cityscape*. Perkins teaches undergraduate courses in statistics, family sociology, and urban inequality. She holds a B.S. in urban and regional studies from Cornell University, an M.C.P. from the University of California, Berkeley, and a Ph.D. in sociology and social policy from Harvard University. Prior to joining the faculty at Georgetown, she was a postdoctoral fellow at the Joint Center for Housing Studies.

Matthew Pesavento will be a post-doctoral fellow at Ohio State University in Autumn 2024. His areas of interest include health and household finance. His current research focus is on the intergenerational effects of household cancer diagnosis, with particular focus on investment in higher education and labor supply. He holds a B.S. in economics from the University of Michigan, an M.A. in economics from Miami University, and a Ph.D. in public policy analysis from The Ohio State University.

Susan J. Popkin is an Institute fellow in the Metropolitan Housing and Communities Policy Center and codirector of the Disability Equity Policy Initiative at the Urban Institute. A nationally recognized expert on public and assisted housing programs and policy, Popkin also leads Urban's Future of Public Housing initiative. She has served as principal investigator on many mixed-methods studies on the impact of housing programs on resident outcomes, including Chicago's Plan for Transformation, HOPE VI, and Moving to Opportunity. This work also includes Urban's HOST Initiative, a research program that uses community engagement and community-based participatory approaches to explore new strategies for improving outcomes for families in public and assisted housing, and in conducting evaluations of complex community-based interventions, such as the local evaluation of Baltimore's Promise Heights Promise Neighborhood and the Annie E. Casey Foundation's Family Centered Community Change Initiative. Popkin is the author of *No Simple Solutions: Transforming Public Housing in Chicago;* coauthor of the award-winning *Moving To Opportunity: The Story of an American Experiment to Fight Ghetto Poverty;* lead author for the book *The Hidden War: Crime and the Tragedy of Public Housing in Chicago;* and coauthor of *Public Housing Transformation: The Legacy of Segregation.*

David Powell is a senior economist at RAND and a member of the Pardee RAND Graduate School faculty. His areas of expertise include public finance, health economics, labor economics, and econometrics. Powell's research examines shifts in the opioid crisis, the effects of tax policy on labor supply and health care decisions, and the role of health insurance benefit design. He has also developed methods to estimate quantile treatment effects and extended the use of synthetic control methods. Powell earned his Ph.D. in economics from the Massachusetts Institute of Technology.

Laura D. Quinby is a senior research economist at the Center for Retirement Research at Boston College. She conducts research on state and locally administered retirement programs – including pensions, disability and retiree health insurance, Medicaid, and state initiatives to expand private-sector coverage – as well as Social Security. Quinby earned a Ph.D. in public policy from Harvard University in the fields of labor economics and public finance. Her work appears in academic journals, such as the *Journal of Policy Analysis and Management* and the *Journal of Pension Economics and Finance,* as well as *issue briefs* that are widely cited by policymakers and the media.

Siavash Radpour is an assistant professor of economics at Stockton University's School of Social and Behavioral Sciences. Previously, he held the position of Associate Research Director of the Retirement Equity Lab at The New School for Social Research. Radpour's research focuses on the political economy of aging, especially how the aging of the U.S. population is changing the labor market, the retirement system, and the distribution of economic resources based on age, gender, race and ethnicity, and class. His current research focuses on the effects of the retirement system on wealth and income inequality, well-being, and economic growth and redistribution. Radpour earned his Ph.D. in economics from The New School for Social Research, his M.A. in international economics and business from the University of Groningen in the Netherlands and Corvinus University of Budapest, and his BS.c. in industrial engineering from the Iran University of Science and Technology.

Valerie Rawlston Wilson is a labor economist and Director of the Economic Policy Institute's Program on Race, Ethnicity, and the Economy (PREE), a nationally recognized source for expert reports and policy analyses on the economic condition of America's people of color. As PREE Director, Wilson has worked to elevate EPI's thought leadership on issues of racial and economic justice and expand PREE's capacity to prescribe policy solutions that center racial equity. Prior to joining EPI, Wilson served as Vice President of Research at the National Urban League Washington Bureau in Washington, DC. In 2022, she was President of the National Economics Association, and in 2023, she was elected to become a fellow of the National Academy of Public Administration. Throughout her career, she has written extensively on various issues impacting racial economic inequality in the United States—including employment, wage, income and wealth disparities. Her expertise in these areas has made her a highly sought-after speaker and consultant both nationally and internationally, and she has appeared in major print, television, and radio media.

Jarnee Riley is the senior study director at Westat and co-director of the University of Maryland, Baltimore County Retirement and Disability Research Consortium. Riley designs, implements, and manages complex health research studies, surveys, and program evaluations with vulnerable populations. She received her B.A. in mathematics from the University of Maryland, Baltimore County and her M.S. in epidemiology from The George Washington University.

Megan Rivera is a fellow for policy and advocacy at the Washington Center for Equitable Growth. Prior to joining Equitable Growth, she was a senior policy analyst at the Georgetown Center on Poverty and Inequality, where she led policy development and research projects on health and human services and postsecondary education. Rivera previously served as the policy and outreach advisor on the U.S. House of Representatives Select Committee on Economic Disparity and Fairness in Growth, where she analyzed and organized national field hearings on workforce development, access to financial services, small business, housing, infrastructure, taxes, macroeconomic stabilization, and human services delivery. She also co-authored the Committee's final findings and recommendation report, "Bridging the Divide: Building an Economy that Works for All" and served as an associate producer on the Committee's documentary, "Grit & Grace: The Fight for the American Dream." Previously, she served in research, policy, and advocacy roles for the University of Virginia's Department of Politics, Global Policy Center, and Equity Center, and the Texas House of Representatives. Rivera holds a B.S. in political science with honors from the University of Houston and a master's in public policy from the Frank Batten School of Leadership and Public Policy at the University of Virginia.

Bárbara J. Robles recently retired from the Federal Reserve Board, where she was a principal economist in the Division of Consumer and Community Affairs. Previously, Robles taught at Arizona State University, The University of Texas at Austin, and the University of Colorado-Boulder. She was also a tax examiner for the IRS, as well as a revenue estimator/economist for the Congressional Joint Committee on Taxation, scoring tax legislation for the House Ways and Means and Senate Finance committees. Robles earned her Ph.D. in economics from the University of Maryland College Park. She is the co-author of *Latino Farm Entrepreneurship in Rural America* and *Exploring Online and Offline Informal Work: Findings from the Enterprising and Informal Work Activities Survey*. Additionally, she is the author of *Economic Inclusion and Financial Education in Diverse Communities: Leveraging Cultural Capital and Whole Family Learning* and *US Latino Families, Heads of Households, and the Elderly: Emerging Trends in Financial Services and Asset-Building Behaviors*. She also co-authored the 2006 Gustavus-Meyers Human Rights award book, *The Color of Wealth: The Story Behind the US Racial Wealth Divide*. Robles is currently engaged in research exploring data collection methods and survey protocol addressing hard-to-reach populations and neglected communities, digital divide issues in community economic development, economic inclusion, tax and financial education, the gig economy, and entrepreneurship/self-employment.

Dr. Maya Rockeymoore Cummings is the president and CEO of Global Policy Solutions, a visiting scholar at Johns Hopkins University SNF Agora Institute, and a senior fellow at Brookings. With more than 25 years of experience in the government, nonprofit, academic, and business sectors, Maya has successfully directed research and advocacy strategies for various nonprofit, philanthropic, academic, and corporate clients. She is the former board chair of the National Committee to Preserve Social Security and Medicare and the National Association of Counties Financial Services Corporation and served on other boards including the National Council on Aging, National Academy of Social Insurance, and the Economic Policy Institute. Maya has been an Eastern region selection panelist for the White House Fellowship, a co-chair of the Commission to Modernize Social Security, a member of the National Conference of Black Political Scientists, and a founding member of the Experts of Color Network. The recipient of numerous honors and awards, she was named an Aspen Institute Henry Crown Fellow in 2004. Maya has appeared on *MSNBC, NPR, CNN, Fox News,* and *C-SPAN* and has been published in *The New York Times, Washington Post, Huffington Post, Houston Chronicle*, and *Essence Magazine,* among other news outlets.

Cortney Sanders currently serves as a Senior Advisor in the Office of the Commissioner at the U.S. Social Security Administration (SSA) leading the agency's equity efforts. Her current portfolio includes but is not limited to overseeing the agency's equity efforts and outreach to external stakeholders to help SSA operationalize equity as a fundamental element of its work and public service. Sanders is also the equity lead and senior representative of the agency on several Executive Orders such as Gender Equity and Customer Experience for the agency and spearheading an Interagency working group to support the Biden-Harris administration priorities for addressing barriers to approaching retirement. As Senior Advisor, Sanders oversees the agency priorities for research and policy, communications for equity, and intergovernmental affairs. Prior to her appointment as Senior Advisor with SSA, Sanders was a Senior Policy Analyst and Senior Manager at the Center on Budget and Policy Priorities where she led the organization research efforts on equity and inclusion for the State Fiscal Policy Division. She was also an independent consultant and advisor for several universities, government entities, and policy organizations. Sanders has over a decade of experience in diversity, equity, inclusion, and accessibility as a subject matter and began her career researching education, economic, fiscal, and social policy. Sanders is a graduate of the University of Texas, Austin (B.A.) and University of Michigan, Ann Arbor (M.P.P.).

Katie Savin, Ph.D., MSW is an assistant professor in the School of Social Work at California State University, Sacramento. They were an extramural fellow (2022-2023) at the University of Wisconsin-Madison Center for Financial Security, Retirement and Disability Research Consortium where they conduct mixed-methods, community-based, research assessing administrative burden among Supplement Security Income recipients. Their critical disability studies scholarship contributes to discussions of disability justice and bioethics that informed debate on care provision during COVID-19. Dr. Savin's experience as an SSDI recipient and as a medical social worker informed their path to their current research.

H. Luke Shaefer, Ph.D. is the Kohn Professor of Social Justice and Social Policy at the Ford School of Public Policy at the University of Michigan (U-M). At U-M, he also directs Poverty Solutions, a presidential initiative that partners with communities and policymakers to find new ways to prevent and alleviate poverty. His co-authored book, *$2.00 a Day: Living on Almost Nothing in America*, was named one of the 100 Notable Books of 2015 by the *New York Times*. His new co-authored book, *The Injustice of Place*, has been featured on *MSNBC*, *The Atlantic*, and *TIME*, among other outlets. He is the co-director of Rx Kids, the nation's first citywide maternal and infant health cash prescription program launched in Flint, Michigan in January 2024.

Emilia Simeonova joined Johns Hopkins Carey Business School in 2013 from Tufts University. Between 2011-2012 she was a research fellow at the Center for Health and Wellbeing at Princeton University. Emilia's research interests include the economics of healthcare delivery, patient adherence to therapy and the interaction between physicians and patients, racial disparities in health outcomes, the long-term effects of shocks to children's health, and the intergenerational transmission of health. Her research has been funded by the National Institutes of Health, the National Science Foundation, the Swedish Research Council, and the Danish Academy of Sciences. Emilia earned her Ph.D. in economics from Columbia University.

Michael Stepner is an assistant professor at the University of Toronto and a research principal at Opportunity Insights. His research examines the relationship between health and economic inequality, with a focus on how public policy can improve the health and financial security of low-income populations. He also serves as the network leader for Health Trends and Inequalities research at the NBER Center for Aging and Health Research, and as the executive director of the Opportunity Insights Economic Tracker. He received his Ph.D. from MIT in 2019, and his dissertation research was awarded the top dissertation award from the National Academy of Social Insurance.

Dmitriy Stolyarov is director of the Michigan Retirement and Disability Research Center. He is also a professor of economics at the University of Michigan. His primary research interest is macroeconomic theory, with a focus on microeconomic foundations. Stolyarov received a Ph.D. in economics from the University of Pennsylvania.

Dr. Carly Urban is a professor of economics at Montana State University Department of Agricultural Economics and Economics, a research fellow at the Institute for Labor Studies (IZA), a fellow at the TIAA Institute, and a co-director of the University of Wisconsin-Madison Retirement and Disability Research Consortium Center. Her research fields include public economics, political economy, and applied microeconomics and focuses broadly on how public policies influence individual behavior. Dr. Urban received a B.A. in economics from The George Washington University and a Ph.D. in economics from the University of Wisconsin-Madison.

Dr. Angelino Viceisza is Full Professor of Economics at Spelman College, Research Associate of the National Bureau of Economic Research (NBER), Co-Director of the NBER Retirement and Disability Research Center, Invited Researcher at J-PAL, Past-President of the National Economic Association (2024-2025), and Associate Editor *at Journal of Economic Behavior and Organization.* During the 2023-2024 academic year, he is Dr. Martin Luther King, Jr. and Phyllis Wallace Visiting Professor at MIT Sloan School of Management. Prior to joining Spelman, Dr. Viceisza was at the International Food Policy Research Institute (2007-2012). He has also held visiting positions at the Federal Reserve Bank of Boston (AEA CSWEP-CSMGEP Fellow, summer 2014), Duke University (2015-2016), and the Hoover Institution at Stanford University (National Fellow, 2020-2021). Dr. Viceisza's primary expertise is in behavioral and experimental economics, with applications in development, household finance, and entrepreneurship. A significant part of his research has studied determinants of financial remittances, i.e., money that migrants send to family and friends in countries of origin. Dr. Viceisza has extensive experience designing and conducting field experiments in a variety of countries including but not limited to El Salvador, Ethiopia, Peru, Senegal, the United States, and Vietnam. He obtained his Ph.D. in economics from GSU in 2008. He holds two master's degrees in economics (GSU, 2005, and Boston University, 2004), an MBA in international business (Temple University, 2001), and a bachelor's degree in accounting (formerly, University of the Netherlands Antilles, 2001).

Robert R. Weathers is the Chief Research Officer in the Office of Retirement and Disability Policy at the Social Security Administration (SSA). He is responsible for the implementation of the Foundations for Evidence-Based Policymaking Act of 2018 and coordinating the agency's evidence-building activities. His research focuses on the design and evaluation of SSA's random assignment demonstration projects, including work on the Accelerated Benefits Demonstration, the Benefit Offset Pilot Demonstration, and the Benefit Offset National Demonstration. He co-edited a book on disability statistics, and he has published journal articles and policy briefs that describe the effects of disability policy on the employment and program participation of individuals with disabilities. He has a Ph.D. in economics from Syracuse University.

Debra Whitman is an economist and expert on aging issues with experience in U.S. policymaking and international research. As Chief Public Policy Officer for AARP, Debra leads global policy and research to help communities, lawmakers, and the private sector improve our lives as we age. Previously, as staff director for the U.S. Senate Special Committee on Aging, Debra worked across the aisle to increase retirement security, lower healthcare costs, protect vulnerable seniors, make the pharmaceutical industry more transparent, and improve our long-term care system. She is a writer and public speaker, a mom, and an advocate for those whose voices need to be heard. Debra is the author of the forthcoming book, *The Second Fifty: Answers to the 7 Big Questions of Midlife and Beyond*. Follow her on X at @policydeb and on LinkedIn.

Malcolm V. Williams is the research department director for RAND's Behavioral and Policy Sciences department; director of Diversity, Equity, and Inclusion and professor of policy analysis at the Pardee RAND Graduate School; and a senior policy researcher at the RAND Corporation. His background is in health services research including access to care, disparities in health and health care, and community resilience to disasters. He has extensive experience developing and assessing community-based projects addressing population health and health equity. He currently leads an evaluation of the social networks developed to support the Million Hearts initiative which is a CDC/CMS funded initiative focusing on cardiovascular disease prevention. He is also leading an evaluation of the Healthiest Cities and Counties Challenge of the Aetna Foundation, which is seeding multi-sectoral partnerships to address health and health equity issues in 50 communities across the country. He recently co-led an NIH-funded study bringing together a partnership of over 60 churches in South Los Angeles, CA, with the Los Angeles Department of Public Health and various community-based health organizations. At Pardee RAND, Williams is the director of Diversity, Equity, and Inclusion and also leads the school's Social Justice and Racial Equity thread, one of four themes that are woven throughout the fabric of the academic program. Williams received his Ph.D. in health policy from Harvard University, and his M.P.P. from Georgetown University's McCourt School of Public Policy.

Susan Wilschke is the Associate Commissioner for Research, Demonstration, and Employment Support, within SSA's Office of Retirement and Disability Policy. She also serves as the agency's Evaluation Officer. She oversees a portfolio of research, analysis, and evaluations designed to improve administration of the disability programs and improve employment outcomes. This includes demonstration projects testing changes to program policies and services and collecting updated occupational data to inform disability decisions. She is also responsible for administering employment support programs and policies for beneficiaries with disabilities who want to work. Susan served as Deputy Associate Commissioner for Research, Demonstration, and Employment Support since 2012. She was previously Director of the Office of Program Evaluation within the Office of Program Development and Research, where she was responsible for research and policy analysis focused on improving SSA's disability and income support programs and for developing and implementing Social Security's work incentive policies. Susan started with the Social Security Administration in 1998 as a Presidential Management Intern. She spent 10 years in SSA's Office of Policy, working on SSI and disability policy issues. Susan received her master's degree in social service administration from the University of Chicago and a B.A. from Kenyon College.

Hongwei Xu is an associate professor of sociology at Queens College – CUNY. He is a sociologist and demographer by training. He received his B.A. from the Department of Sociology at Peking University in 2003. After college, he started his first job as a marketing manager at Hainan Airlines. Two years later, he realized that he was not cut out for the business world. So, he decided to go to the academic world and applied for graduate school in the U.S. He received his Ph.D. from the Department of Sociology at Brown University in 2012 and started his second job as a research fellow at the Institute for Social Research at the University of Michigan from 2011-2014.

Na Yin is the Co-Director of the New York Retirement and Disability Research Center, a recent addition to the SSA's Retirement and Disability Research Consortium. She is an associate professor at the Marx School of Public and International Affairs, Baruch College, City University of New York (CUNY). Beyond this, she is a faculty associate at the CUNY Institute for Demographic Research and holds positions at both the CUNY Graduate Center and the CUNY Graduate School of Public Health and Health Policy. As a labor and health economist, her research focuses on policies that enhance financial stability and promote better health for people with disabilities. Her work explores employment and healthcare policies, with a focus on those supporting federal disability beneficiaries. She also investigates the informal care needs of people with disabilities. Additionally, she has conducted significant research on the accuracy of self-reported disability measures and analyzed the actuarial aspects of Social Security retirement benefits. She teaches graduate courses in the economic analysis of public policy, economic demography, the demography of aging, and research methods. She holds a Ph.D. in economics from Stony Brook University.