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26th Annual Retirement and Disability Research Consortium Meeting August 7-9, 2024

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

Karolos Arapakis and **Laura D. Quinby**
Center for Retirement Research at Boston College

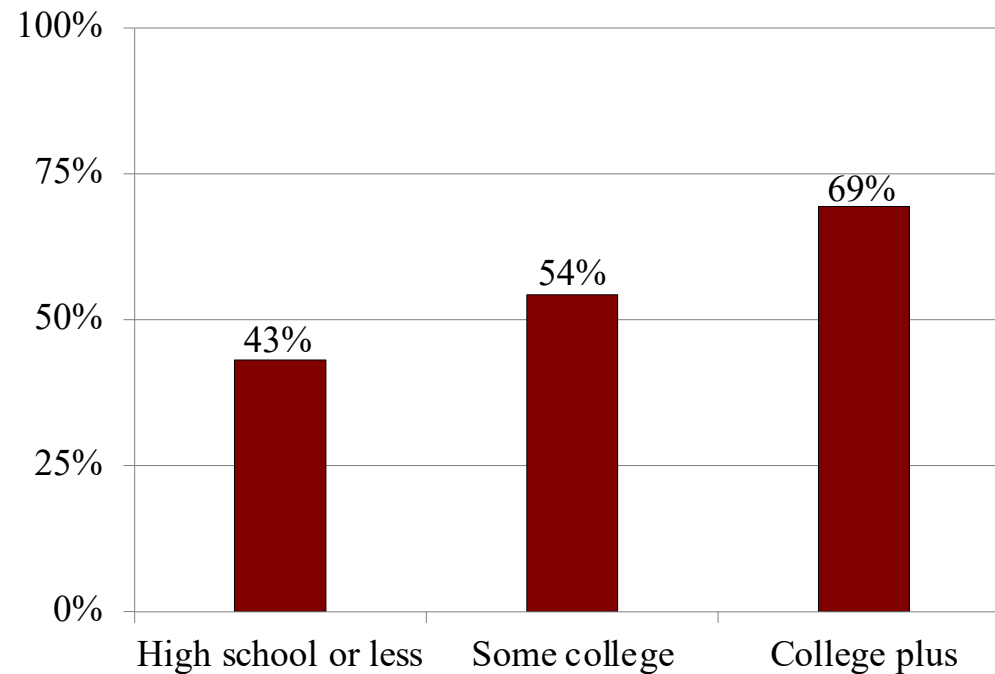
26th Annual Meeting of the Retirement and Disability Research Consortium
Washington, DC
August 9, 2024

Disclaimer

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, or Boston College. Neither the United States Government nor any agency thereof, nor any of their employees, makes any warranty, express or implied, or assumes any legal liability or responsibility for the accuracy, completeness, or usefulness of the contents of this report. Reference herein to any specific commercial product, process or service by trade name, trademark, manufacturer, or otherwise does not necessarily constitute or imply endorsement, recommendation or favoring by the United States Government or any agency thereof.

At any given point, a significant share of workers are not covered by an employer-sponsored retirement plan, and this gap affects all education levels.

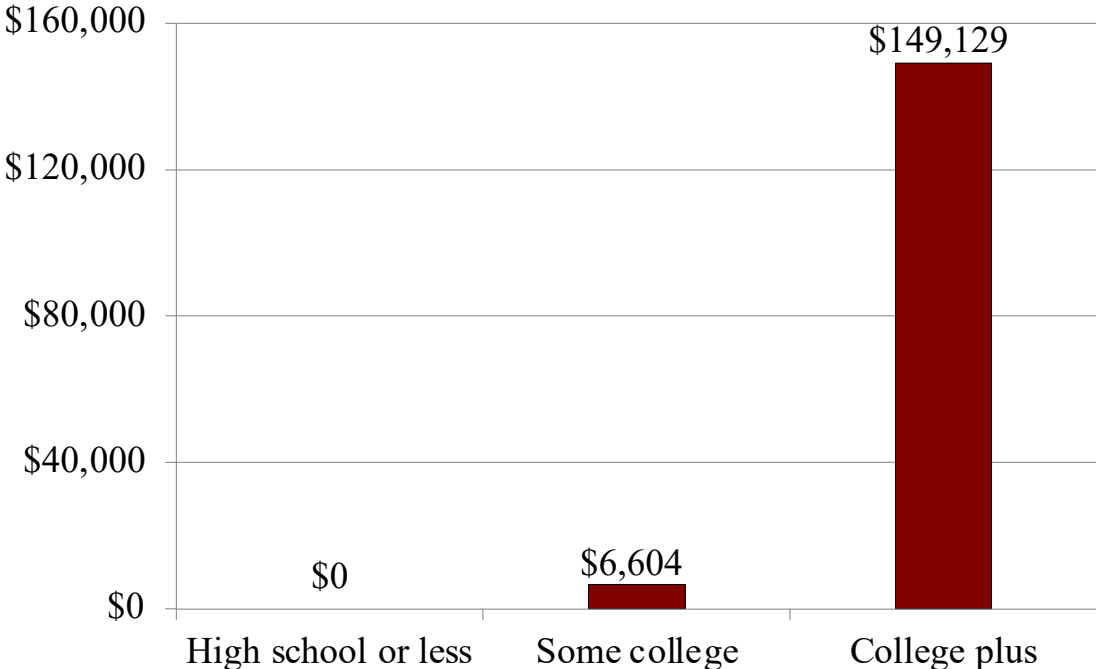
Share of Prime-Age Workers (25-54) Covered by an Employer-Sponsored Retirement Plan, by Education, 2018



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

Because of the lack of continuous coverage, households without a college degree often end up without meaningful resources.

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



Source: Authors' calculations from the *Health and Retirement Study* (1992-2022).

To expand coverage, some states automatically enroll workers without an employer plan in a payroll deduction Roth IRA.

- Workers have the option to opt out.
- Workers can withdraw their contributions at any point with no penalty.
- Most programs set the initial default contribution rate at 5 percent.
- The first \$1,000 of contributions are invested safely, with the rest invested in a target-date fund.

Will these auto-IRA savings prevent low and middle-income households from accessing Safety Net programs such as Medicaid?

- Of particular concern, Medicaid has a financial asset test for applicants over 65.
- The rules vary by state and the type of services (e.g., Medicaid for SSI recipients, the Medicare Savings Program, or LTSS).
- In most cases, household financial assets cannot exceed \$3,000.

To explore this question, we estimate auto-IRA savings for future households assuming a national program had launched in 2019.

1. The simulation starts with households in the 2019 SCF.
2. Lifecycle employment, earnings, and plan coverage are projected based on age, education, and race.
3. Auto-IRA balances are projected based on participation, contribution, and withdrawal behavior in the live programs.

The results are sensitive to a key assumption about 401(k) coverage: do workers cycle in and out of coverage, or do the uncovered always lack plans?

To show the range of possible outcomes, the analysis is run twice:

1. Assuming that all workers have some probability of 401(k) coverage each year (“intermittent coverage”); and
2. Assuming that some workers gain 401(k) coverage at the start of their work lives and stay in the plan until retirement (“continuous coverage”).

With intermittent coverage, many workers participate in the auto-IRA but ending balances are moderate.

Intermittent Coverage Simulation Results, at Ages 51-56, for Workers Ages 21-25 in 2019 (2019 Dollars)

Education	Share with a balance at ages 51-56	Among those with balances (median):	
		Balance after withdrawals	Balance assuming no withdrawals
High school or less	67%	\$25,371	\$43,654
Some college	70	27,595	50,110
College plus	72	22,304	41,150

Note: Auto-IRA balances are simulated for workers ages 21-25 in 2019.
 Source: Authors' simulations based on the *Survey of Consumer Finances* (2019) and data from live auto-IRA programs.

With continuous coverage, fewer workers participate but ending balances are significant.

Continuous Coverage Simulation Results, at Ages 51-56, for Workers Ages 21-25 in 2019 (2019 Dollars)

Education	Share with a balance at ages 51-56	Among those with balances (median):	
		Balance after withdrawals	Balance assuming no withdrawals
High school or less	44%	\$68,964	\$94,937
Some college	36	76,880	99,373
College plus	25	104,719	126,126

Note: Auto-IRA balances are simulated for workers ages 21-30 in 2019.
 Source: Authors' simulations based on the *Survey of Consumer Finances* (2019).

Conclusion

- Auto-IRAs are likely to produce meaningful new savings for less educated workers, who are most likely to rely on other safety net programs such as Medicaid.
- If households value Medicaid services more than their new savings, they may spend down their auto-IRAs to qualify.
- Alternatively, states could update Medicaid asset tests to disregard auto-IRA balances.

SSI and SSDI Utilization by American Indians and Alaska Natives – Medicaid Expansions and Long COVID

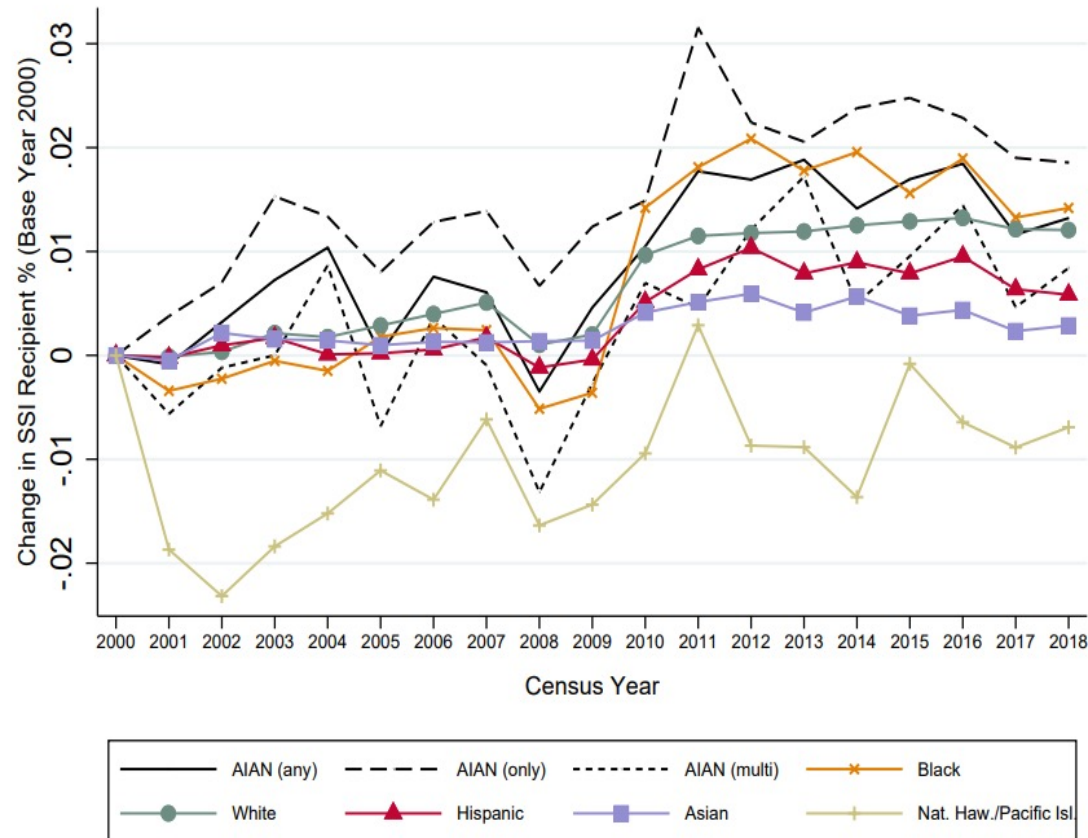
Randall Akee (UCLA) and Emilia Simeonova (Johns Hopkins)

Prepared for

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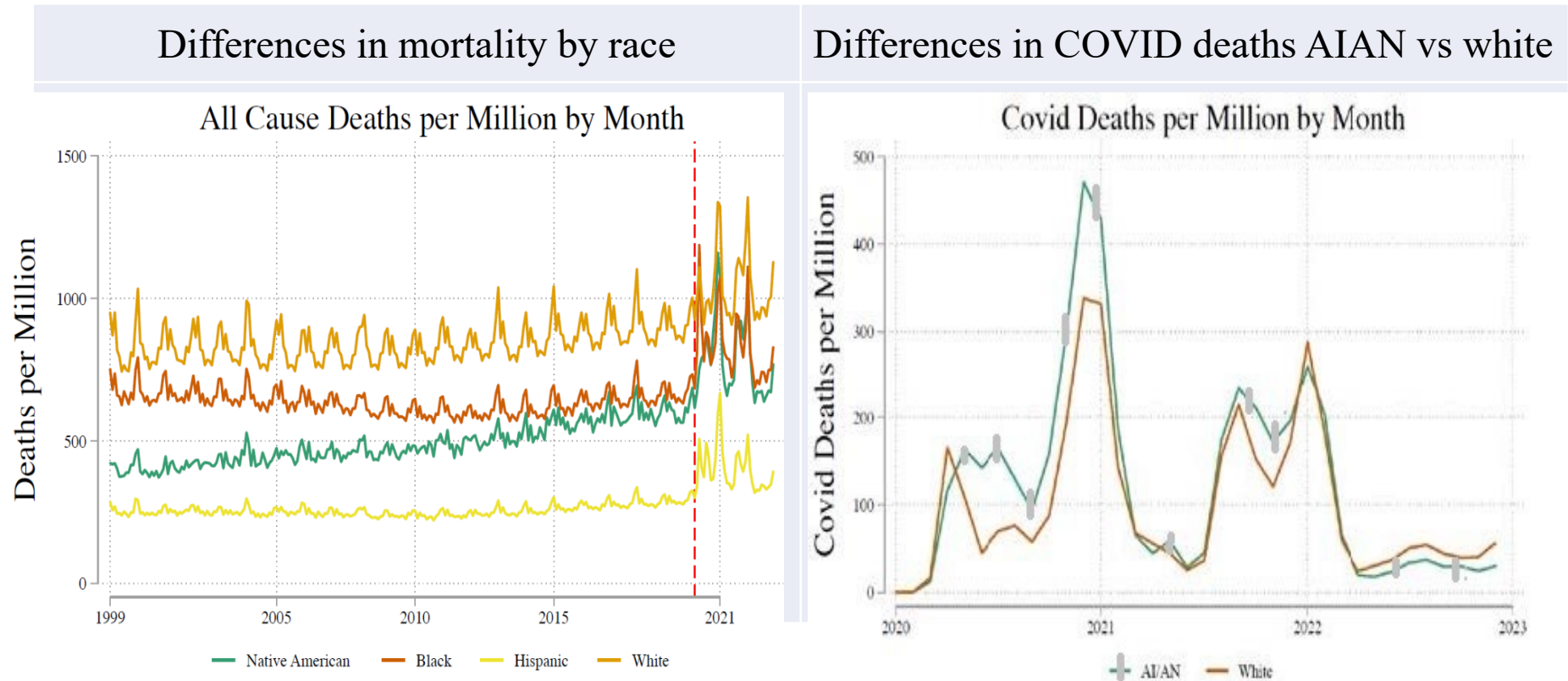
Motivation

- Participation of AIAN individuals in SSI is twice as high as that of other individuals



Motivation

- AIAN also had the highest COVID infection and mortality rates; Long COVID prevalence is correlated with socio-economic status

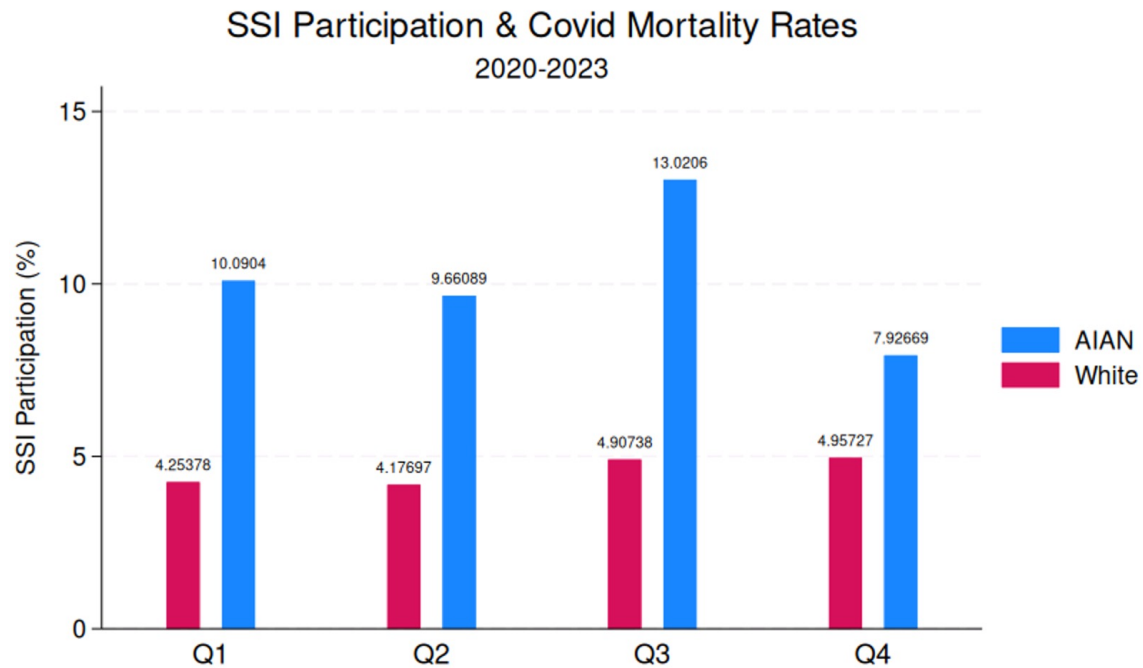


Main questions

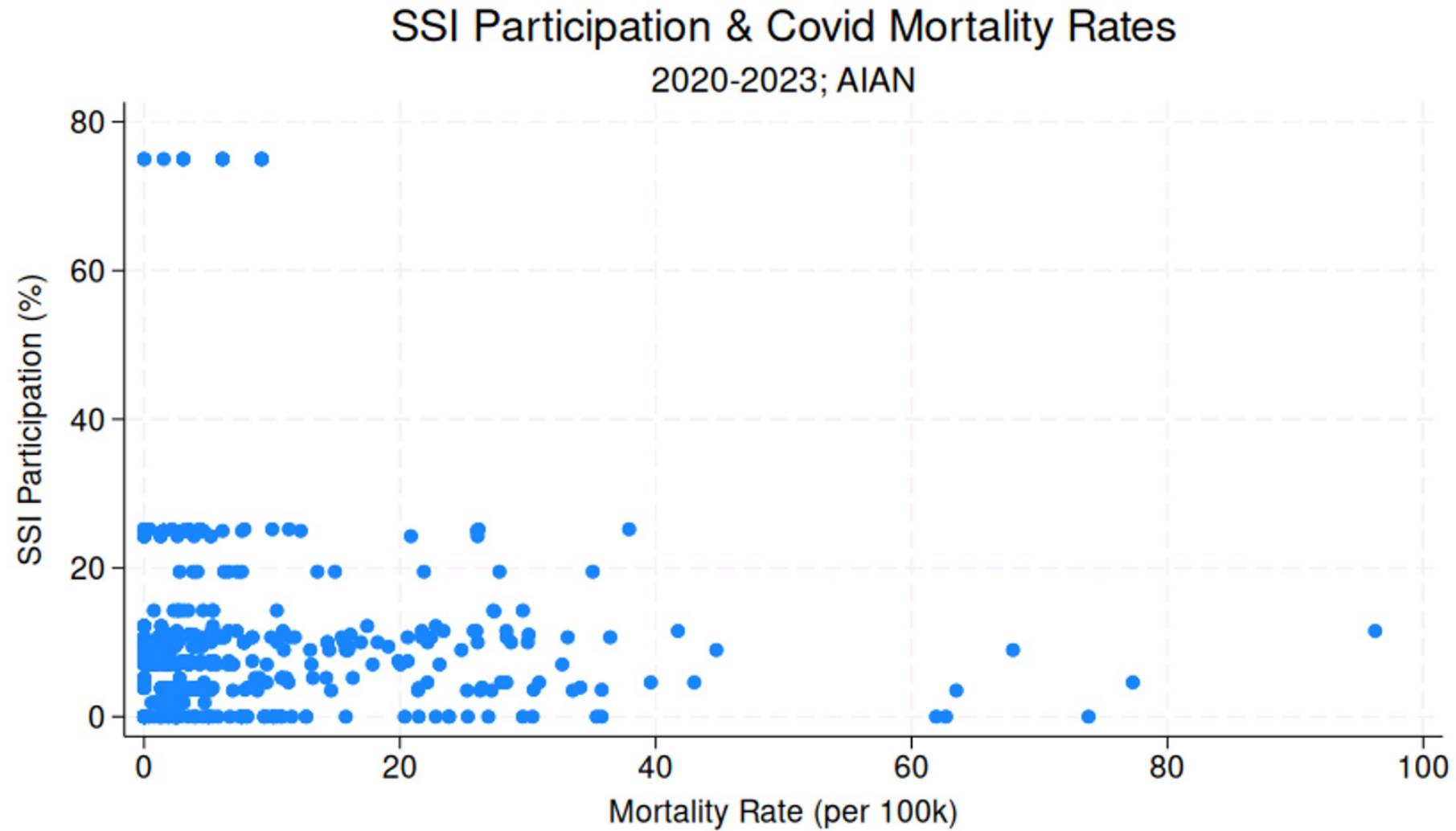
- Has the COVID epidemic affected SSI take up in AIAN?
- How has access to Medicaid coverage affected SSI take-up in this population?

Current findings

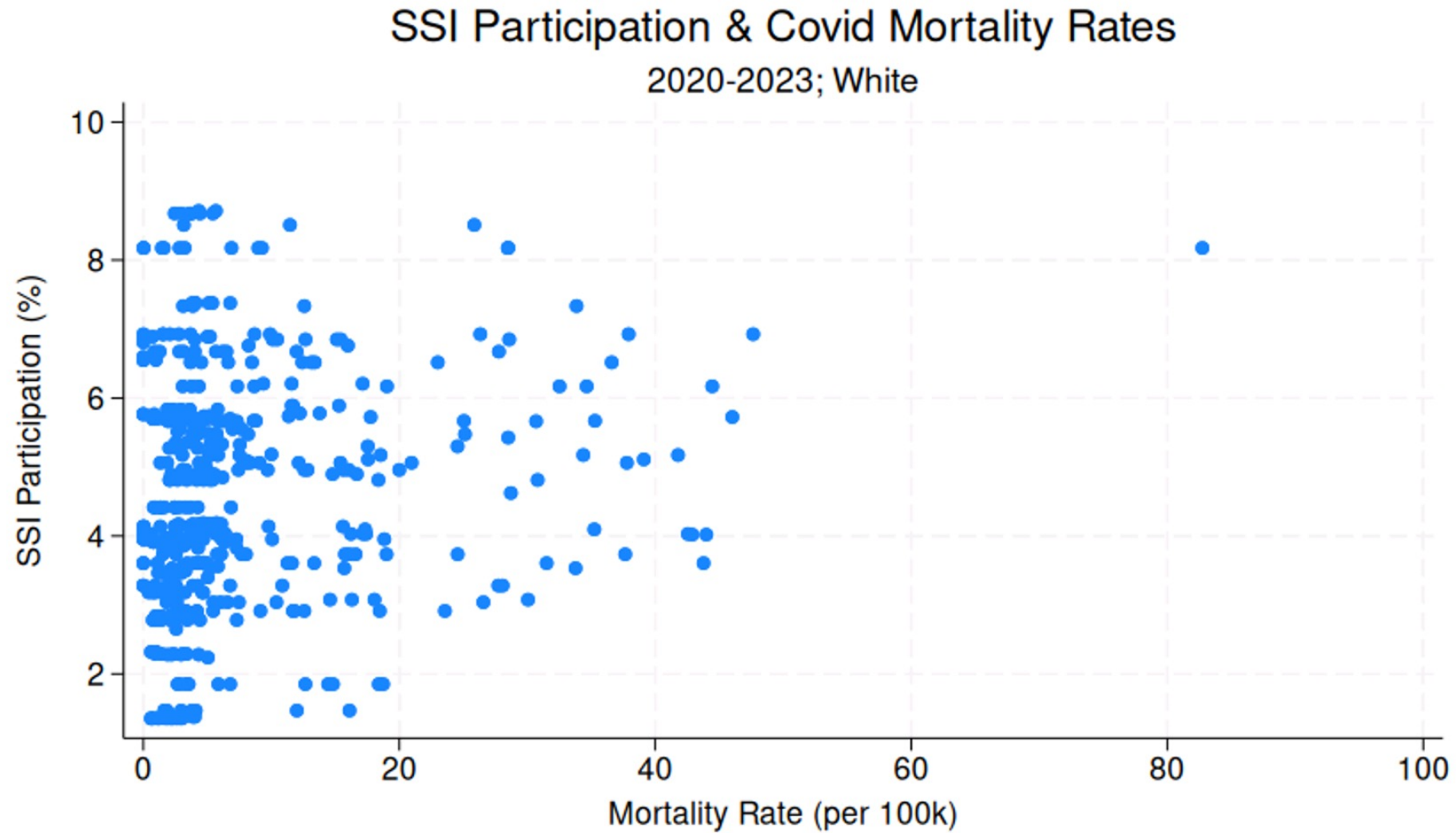
- Ideally, we would have rates of long-COVID by population type (race)
- But we do not, as the codes are not systematically used by health care professionals



Current findings



Current findings



Next steps

- Estimate the relationship between COVID diagnoses and SSI/SSDI receipt in individual data
- Investigate the prevalence of cardio- and neurological disorders post-COVID across AIAN/non-AIAN
- Consider the potentially mitigating effects of Medicaid availability and generosity

Unmet Needs of People Reporting Psychiatric Impairments on an Unsuccessful Application for Disability Benefits

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Supported Employment Demonstration (SED)

- Sponsored by the Social Security Administration
- Implemented and evaluated by Westat

- 36 months (2017-2020)
- Randomized controlled trial with 3 arms (2 treatment groups and a control)

- Services included:
 - Individual Placement and Support (IPS) Employment Services
 - Wrap-around care delivered at community mental health clinics or social service organizations

Participant Eligibility

- Primary, secondary, or alleged impairment listed on their application was a psychiatric condition
- Recently received a medical denial or denial of working above SGA
- 18-49 years old
- Lived in the catchment area of a clinical site
- Said they wanted to work

Westat, Inc. (2019). *Supported Employment Demonstration Early Assessment Report* for the Social Security Administration. Rockville, MD: Westat.

Participant Demographics at Baseline (n=2,960)

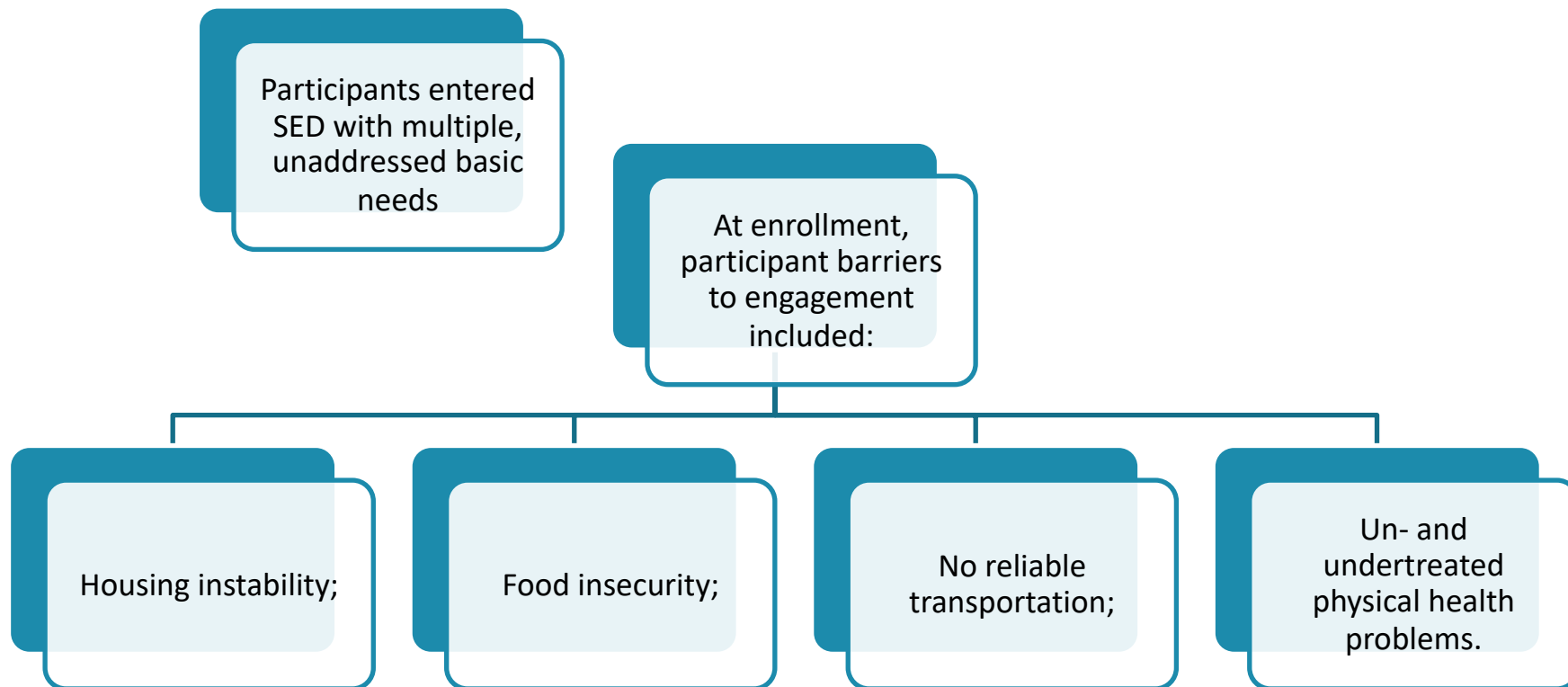
Variable	Number	Percent
Age Group		
• 18-34	1,247	42
• 35 and above	1,697	58
Gender		
• Male	1,280	43
• Female	1,664	57
Race/Ethnicity		
• White not Hispanic	1,421	48
• Black not Hispanic	834	28
• Hispanic	364	12
• Two or more races not Hispanic	246	8
• Other or missing	79	3

SED Process Evaluation

Purpose: Identify service needs of unsuccessful SSI/DI applicants with mental impairments



Finding: Unmet basic needs interfered with take-up of employment services



Data Collection

- Data collection from participants at baseline and 12 intervals over 36 months
 - Self-reported health conditions
 - Self-reported healthcare utilization
 - Composite International Diagnostic Interview (CIDI)* (n=1,842) at baseline
 - 12-item short-form health survey (SF-12)
- Site visits at 6 months after implementation and 3 intervals over 4 years
 - In-depth interviews with participants
 - In-depth interviews with service providers
 - Ethnographic observations

Positive scores on CIDI diagnostic modules at baseline

Condition	N	%
Anxiety disorder	1,311	71
Posttraumatic stress disorder	772	47
Generalized anxiety disorder	429	30
Personality disorder	1,191	65
Mood disorder	1,132	61
Major depressive episode	670	36
Dysthymia	372	20
Manic episode	201	11
Any indicator of psychosis	691	38

Borger, C., Marrow, J., Drake, R. E., & Taylor, J. A. (2021). Characteristics of enrollees in the Supported Employment Demonstration. *Psychiatric Services* 72(12), 1400-1406.

Depression, anxiety, and PTSD in participants' experiences

I have a problem dealing with authority. I was abused as a child. I don't wanna go there, but a lot of stuff reminds me. Like if a person yells at me, that will take me back to the ten-year-old or eight-year-old girl.

-female participant, Year 1

Large crowds, being around loud noises like in a restaurant, banging of pots and pans makes me jump and it makes me turn around.... A lot of my symptoms have to do with my childhood, the way I grew up, living in bad neighborhoods, hearing gunshots every night, living in and out of vehicles, national parks—growing up that way.

-male participant, Year 1

Service providers' descriptions of participants' depression, anxiety, and PTSD

Pretty much everybody [SED participants] is anxiety and depression.

-Nurse Care Coordinator, Southern site

Care Manager 1: *The majority of people with PTSD, it's a result of childhood trauma, not your war zone though.*

Care Manager 2: *Just kind of cumulative life trauma. The chronic poverty, housing issues, stuff like that.*

-Discussion with care managers at mid-Atlantic site

Participants' unfamiliarity with mental health services

[Participants] are still getting accustomed...to being involved in services.... They get confused about our role: "We're not your friend, but we're a professional, so we care."

-Employment Specialist at Midwestern site A, Year 2

We've gotten really good at describing the program, letting them know what they signed up for at the outset, because what we learned is that if you don't do that really well...their expectations are different and usually they'll end up being frustrated and drop out, or be really upset that things aren't moving the way they thought they would [and] just stop returning calls. Like, "This isn't what I thought it would be."

-Team Lead at Midwestern site B, Year 1

Self-reported health conditions at baseline

Condition or Illness	Number of SED Enrollees n	Percent of SED Enrollees ^a %
Back pain	1,872	63
Obesity (BMI ≥ 30)	1,383	47
Asthma, emphysema, chronic bronchitis or a lung disease	981	33
Hypertension	969	33 ^b
Osteoarthritis or degenerative arthritis	596	20
Ulcer or stomach disease	585	20
Diabetes	466	16
Thyroid problem	413	14
Liver disease	270	9
Rheumatoid arthritis	244	8
Kidney disease	188	6
Cancer	170	6
Stroke	152	5
Chronic Obstructive Pulmonary Disease	133	4
Congestive heart failure	87	3
Coronary heart disease	57	2
HIV	39	1
Sample size (N)	2,960	

^a Percentages exclude missing.

^b Respondents indicated that they told on two or more occasions that they had high blood pressure or hypertension.

Borger, C., Marrow, J., Drake, R. E., & Taylor, J. A. (2021). Characteristics of enrollees in the Supported Employment Demonstration. *Psychiatric Services* 72(12), 1400-1406.

Descriptions of participants' health problems

A flare-up can be so bad, it's like, 'forget it'...just walking down the street, my back tenses up so bad it's hard to breath, you know..... How am I going to try to do employment if I'm having a struggle just to make it to go to the bathroom? The family is like, "Why are you trying to do something when you need to focus on your health first?"

-female participant, Year 1

[Participants] won't pursue work—or some of them won't even talk about work—until something is done about their back, or their hip, or their knee.

-team lead for Midwestern site, Year 2

SED service providers addressed participants' physical health problems

- Coordinated medical care
- Found low-cost referrals for care
- Helped participants make medical appointments
- Provided transportation to medical appointments
- Tailored employment searches to participants' physical health problems
- Secured accommodations for physical limitations from employers; and
- Requested reimbursements from SED for special equipment to facilitate participants' work
- Requested and received training on medical illnesses

The SED population...there's a lot of just basic needs that are not being met right now. Although we do have folks that are very interested in working, they're also worried about, 'How do I eat today? Where am I going to sleep tonight?' and are really consumed with those challenges....

I think we only have one or two [SED participants] who are truly identifying themselves as homeless, but it seems like most of them are either on the verge of that, or really, like, couch-surfing. They really don't have a place to call home and don't have a reliable way of taking care of themselves.

-Administrator for West Coast site, Demonstration Year 1

[SED participants] are on the fringes of going...into the undertows of homelessness.... There's a level of acuity there that needs to be addressed, and if not, then we'll eventually see them [among homeless clientele].

-Administrator for South Central site, Demonstration Year 1

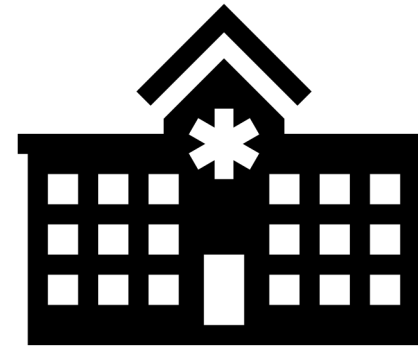


2024 RDRC Project

Barriers to Accessing Healthcare Services Among Denied SSI/DI Applicants

Purpose of RDRC Project

1. Assess how widespread a lack of access to healthcare was a barrier for SED participants
2. Identify what impairments improved over the course of 36 months of intervention and whether the intensity of treatment was correlated with improvement
3. Develop practical strategies for helping low-income, disadvantaged applicants with accessing healthcare



Sources and Methods

SED Participant Survey Data

- N=2,960
- Includes baseline and 12 observations over 36 months
- Data about healthcare usage:
 - Health insurance (y/n)
 - ER visits with complaints, quarter
 - ER visits with hospitalizations, conditions, length, quarter
 - Other hospitalizations, conditions, length, quarter
 - Outpatient visits, conditions, quarter
 - Walk-in clinic visits, conditions, quarter
 - Other MH service provider visits, quarter
- Data about impairments:
 - Self report
 - CIDI
 - CSI
 - WD-FAB
 - SF-12 (MCS, PCS)

New Data Collection

- In-depth interviews with professionals who work with SSI/DI applicants (e.g., claimant reps., benefits counselors, PCPs, CMHC case managers)
- In-depth interviews with Federal service providers/policymakers at SSA, SAMHSA, other orgs.
- Focus groups of former SED providers

Thank

You



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Colorado Symptom Index and SF-12 MCS differences from baseline to study exit

Variable	Weighted measures						Regression-adjusted estimates of difference-in-difference			
	Full-service (T1)		Basic-service (T2)		Usual Services (C)		T1 – C	T2 – C	T1 – T2	AT - C
	n	#	n	#	n	#				
Colorado Symptom Index										
Year 1 Difference	692	-3.12	724	-2.74	664	-3.32	0.26	0.37	-0.10	0.32
Year 2 Difference	675	-4.87	707	-4.48	659	-5.61	0.77	0.86	-0.09	0.82
Year 3 Difference	623	-6.62	641	-5.54	570	-6.43	-0.27	0.57	-0.84	0.16
SF-12 MCS scores										
Year 1 Difference	669	3.08	681	2.30	646	3.24	-0.33	-0.56	0.22	-0.45
Year 2 Difference	645	4.83	670	4.19	640	5.21	-0.68	-0.89	0.21	-0.79
Year 3 Difference	604	5.61	610	5.04	556	5.67	-0.38	-0.28	-0.09	-0.33

Notes: *** p<.01, ** p<.05, * p<.10. Impact estimates are regression-adjusted, with robust standard errors (SE) in parentheses. Regression-based estimates of impact may not be consistent with differences in weighted means. AT=All Treatment (T1 and T2 participants combined)

Taylor, J.A. et al., (2022). *Supported Employment Demonstration Final Impact and Cost-Benefit Analysis Report*. For the Social Security Administration. Rockville, MD: Westat.

SF-12 MCS differences from baseline to study exit

Variable	Weighted measures						Regression-adjusted estimates of difference-in-difference			
	Full-service (T1)		Basic-service (T2)		Usual Services (C)		T1 - C	T2 - C	T1 - T2	AT - C
	n	#	n	#	n	#				
Physical health (SF-12 PCS)										
Year 1 Difference	669	1.29	681	1.73	646	1.09	0.48	0.68	-0.20	0.58
Year 2 Difference	645	2.48	670	2.01	640	1.15	1.73***	1.13**	0.60	1.43***
Year 3 Difference	604	2.57	610	1.51	556	2.12	0.93	-0.58	1.51***	0.17

Notes: *** p<.01, ** p<.05, * p<.10. Impact estimates are regression-adjusted, with robust standard errors (SE) in parentheses. Regression-based estimates of impact may not be consistent with differences in weighted means. AT=All Treatment (T1 and T2 participants combined)

Taylor, J.A. et al., (2022). *Supported Employment Demonstration Final Impact and Cost-Benefit Analysis Report*. For the Social Security Administration. Rockville, MD: Westat.

Health Service Utilization During 36 Month Study Period

Variable	Weighted measures						Regression-adjusted estimates of impact			
	Full-service (T1)		Basic-service (T2)		Usual Services (C)		T1 – C	T2 – C	T1 – T2	AT - C
	n	#	n	#	n	#				
Emergency Room Visits	582	2.38	599	2.36	541	2.59	-0.28	-0.16	-0.12	-0.22
For mental health problem	582	0.26	599	0.31	541	0.25	-0.02	0.05	-0.07	0.02
For physical health problem	582	2.15	599	2.11	541	2.44	-0.32	-0.24	-0.07	-0.28
Number of nights spent in hospital	582	3.05	599	2.67	541	3.30	-0.32	-0.37	0.04	-0.34
Hospital Overnight Stays										
After ER visit for physical problem	582	0.47	599	0.45	541	0.55	-0.05	-0.06	0.01	-0.06
After ER visit for mental problem	582	0.14	599	0.19	541	0.12	0.01	0.07	-0.06*	0.04
Hospital stay for physical problem	582	0.19	599	0.17	541	0.17	0.01	0.01	0.01	0.01
Hospital stay for mental problem	582	0.04	599	0.07	541	0.06	-0.03*	0.00	-0.03**	-0.01
Outpatient Hospital Visit/Procedure	582	0.87	599	0.78	541	0.78	0.08	0.03	0.06	0.06
Preventive care	582	0.20	599	0.21	541	0.15	0.05	0.07*	-0.02	0.06**
Physical health	582	0.74	599	0.59	541	0.66	0.07	-0.06	0.13*	0.01
Other problem	582	0.17	599	0.14	541	0.16	0.01	-0.02	0.03	-0.01

Notes: *** p<.01, ** p<.05, * p<.10. Impact estimates are regression-adjusted, with robust standard errors (SE) in parentheses. Regression-based estimates of impact may not be consistent with differences in weighted means. AT=All Treatment (T1 and T2 participants combined)

Taylor, J.A. et al., (2022). *Supported Employment Demonstration Final Impact and Cost-Benefit Analysis Report*. For the Social Security Administration. Rockville, MD: Westat.

Participant Outpatient Visits

Variable	Weighted measures						Regression-adjusted estimates of impact			
	Full-service (T1)		Basic-service (T2)		Usual Services (C)		T1 - C	T2 - C	T1 - T2	AT-C
	n	#	n	#	n	#				
Routine Mental Health Visits										
Baseline	976	2.22	987	2.11	980	2.28	-0.08	-0.13	0.05	-0.10
Year 1	692	1.81	724	1.63	663	1.49	0.24	0.18	0.06	0.21
Year 2	676	1.32	707	1.46	658	1.26	0.00	0.19	-0.19	0.10
Year 3	622	1.32	641	1.16	569	1.31	-0.10	-0.19	0.09	-0.14
Routine General Health Visits										
Baseline	976	1.08	987	1.07	981	1.09	-0.04	-0.02	-0.03	-0.03
Year 1	692	0.84	723	0.80	664	0.77	0.03	0.04	-0.01	0.03
Year 2	676	0.66	706	0.67	658	0.62	0.00	0.05	-0.04	0.03
Year 3	622	0.73	640	0.63	570	0.65	0.07	0.01	0.06	0.04

Notes: *** p<.01, ** p<.05, * p<.10. Impact estimates are regression-adjusted, with robust standard errors (SE) in parentheses. Regression-based estimates of impact may not be consistent with differences in weighted means. AT=All Treatment (T1 and T2 participants combined)

Taylor, J.A. et al., (2022). *Supported Employment Demonstration Final Impact and Cost-Benefit Analysis Report*. For the Social Security Administration. Rockville, MD: Westat.

Participants' Expectations of SED services

- Previous encounters with social services were sometimes negative (humiliating, punitive)
- Experienced denial of disability income application as invalidating their health struggles
- Providers reported participants had difficulty establishing trust

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

David M. Cutler, Harvard University and NBER

Marema Gaye, Harvard University

Ellen Meara, Harvard University and NBER

Rand Obeidat, Bowie State University

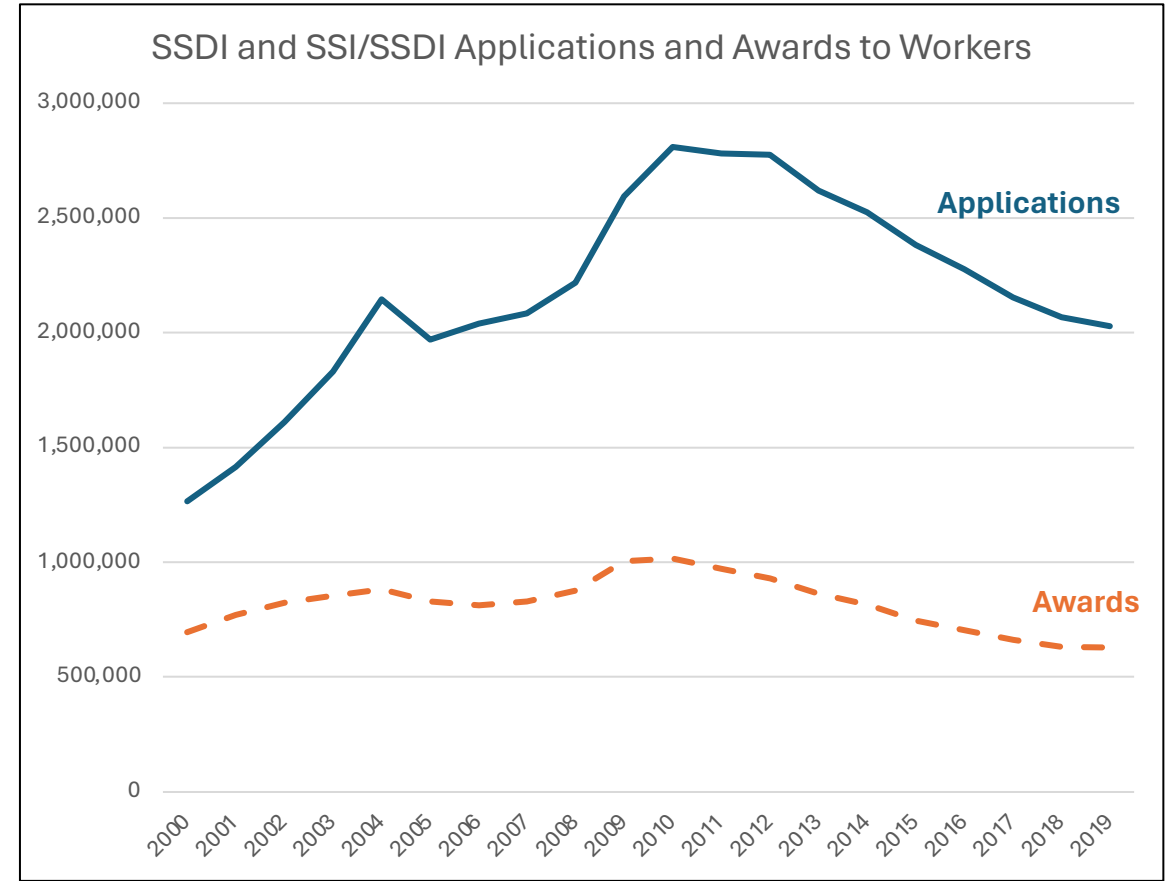
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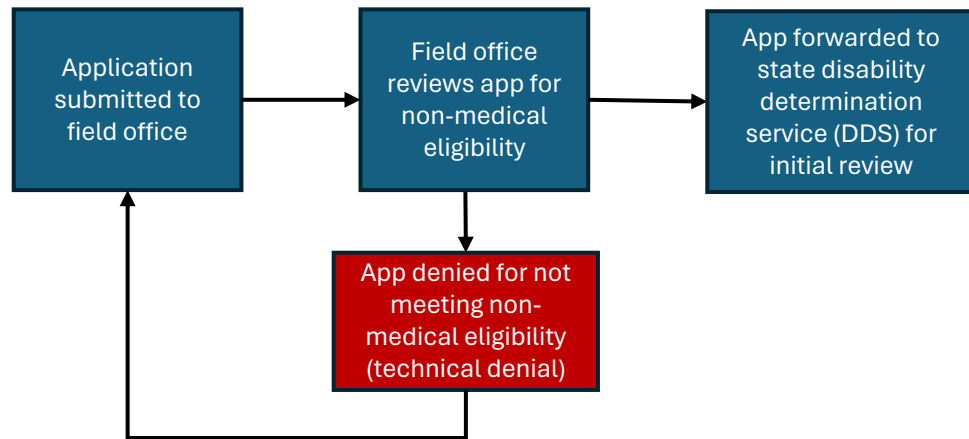
Background

- Motivation: SSDI applications & awards peaked in 2010
- Research questions
 1. How have outcomes of SSDI applications changed over time and across adjudicative levels?
 2. How has the composition of new SSDI awardees changed as allowance rates fall?



SSDI Application Process

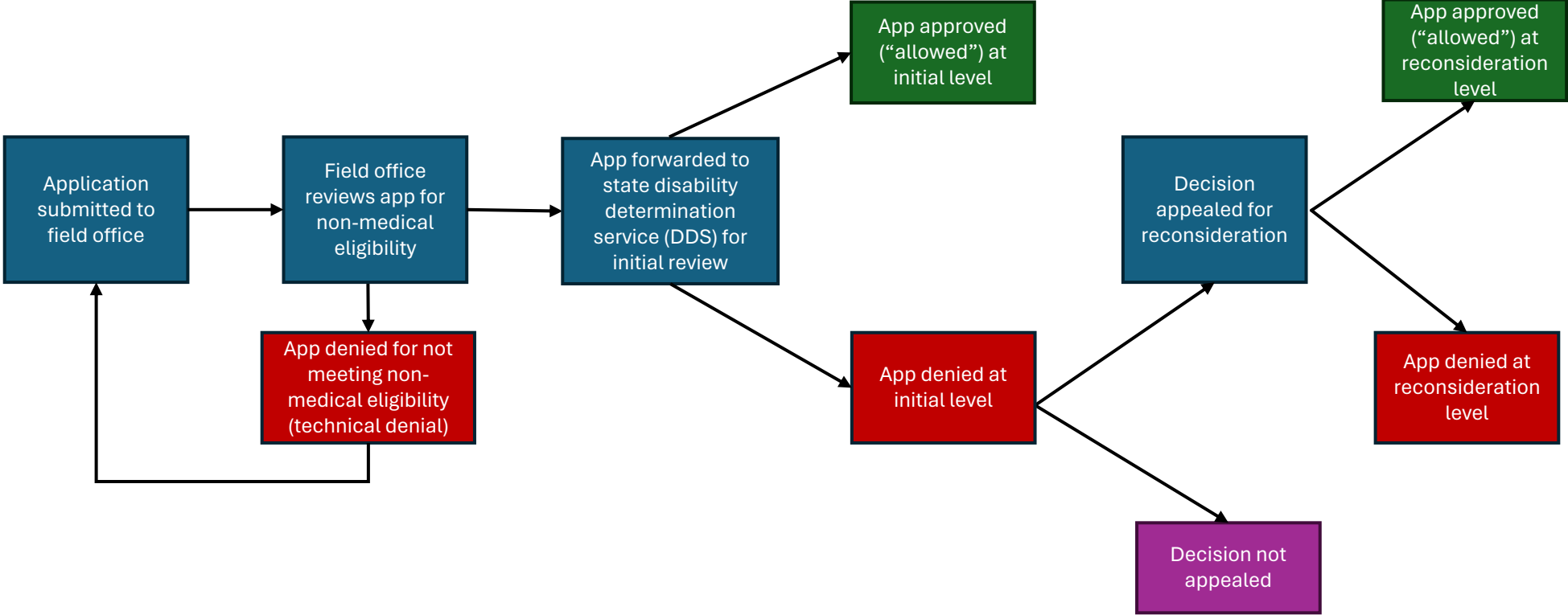
Technical review and forwarding to DDS



SSDI Application Process

Technical review and forwarding to DDS

Initial and reconsideration review



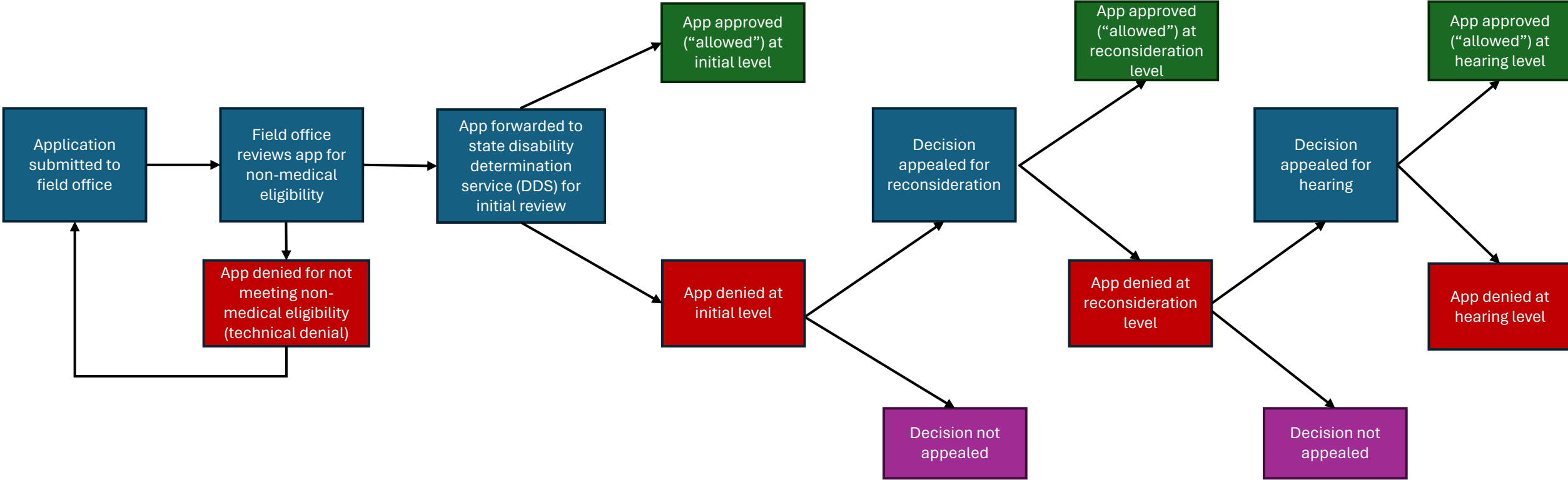
Note: In 10 states, the reconsideration step was eliminated for applications filed between October 1999 and March 2020.

SSDI Application Process

Technical review and forwarding to DDS

Initial and reconsideration review

Hearings & Above

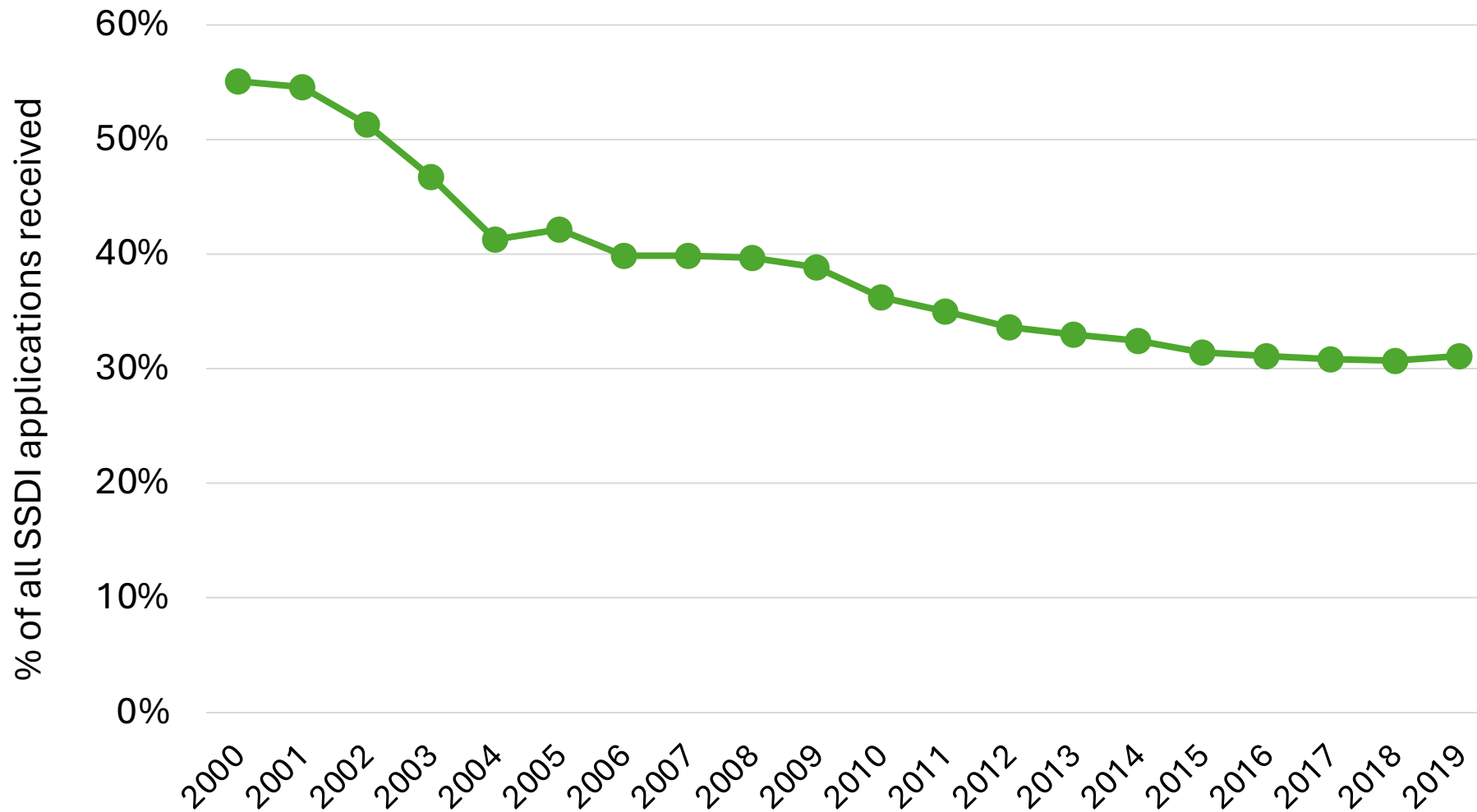


Note: In 10 states, the reconsideration step was eliminated for applications filed between October 1999 and March 2020.

1. How have SSDI application outcomes changed over time?

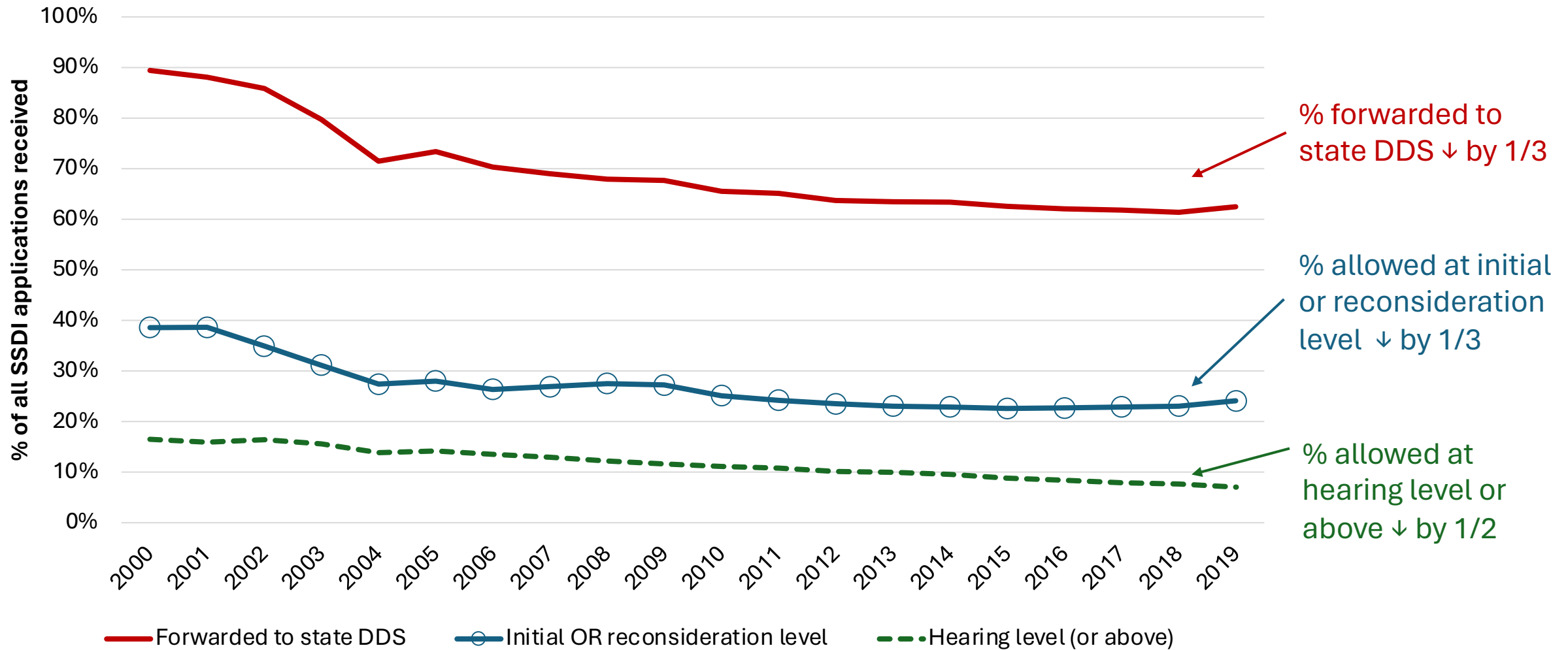
- Examined outcomes of SSDI applications 2000-2019
 - 2022 Annual Statistical Supplement
- Calculated
 - % applications approved (“allowed”) overall
 - % applications forwarded to state DDS for initial review
 - % applications allowed at initial or reconsideration level, and at hearing level (or above)

Allowance rate of SSDI applications



Allowance rate **declined** from 55% in 2000 to 31% in 2019

Adjudicative levels where allowances occurred



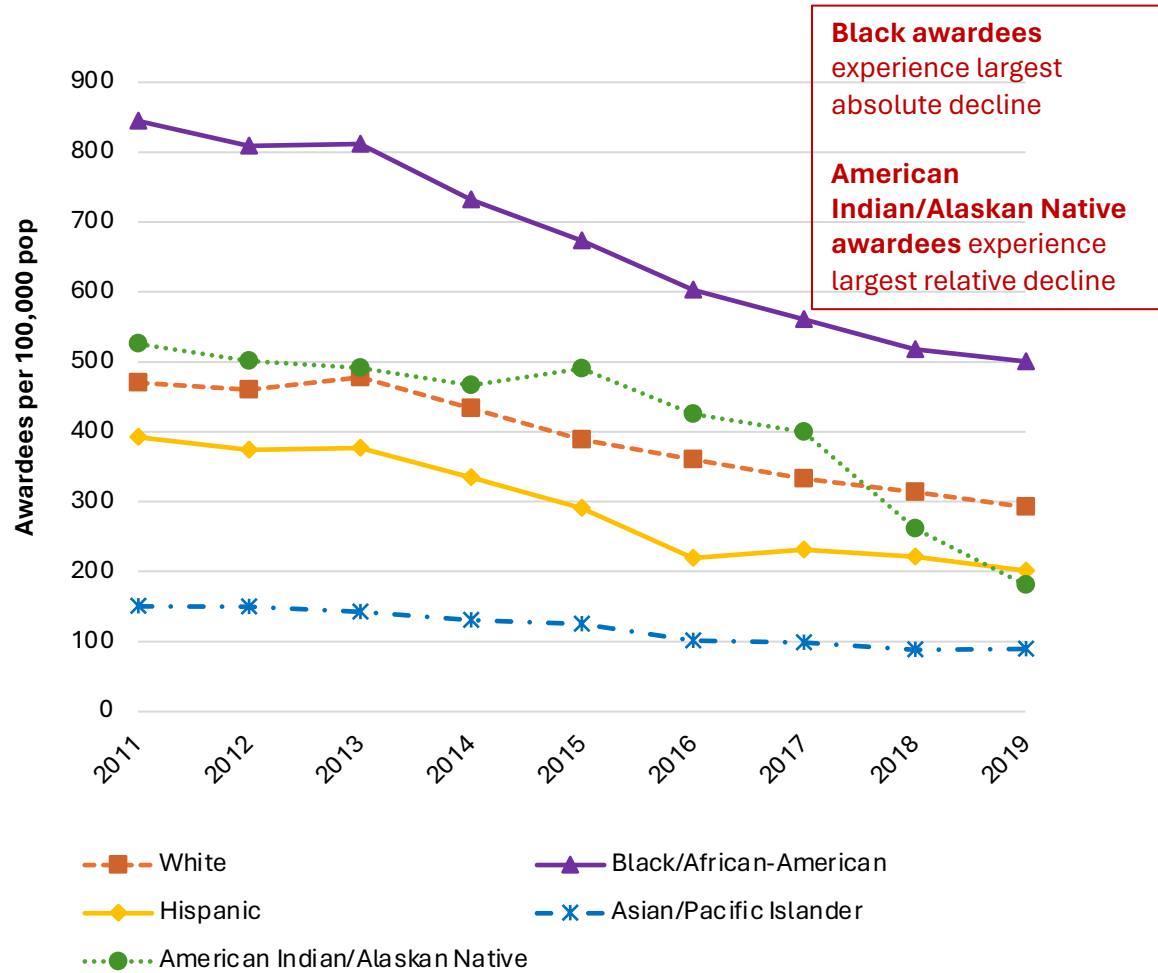
2. How has the composition of new SSDI awardees changed as approval rates fall?

- Identified new SSDI awardees in Medicare Master Beneficiary Summary File (MBSF)
 - Auto-enrolled in Medicare after 29 month waiting period (5 months after disability onset + 24 months of receiving disability benefits)
- Grouped new SSDI awardees along 5 dimensions:
 - Race and ethnicity (individual-level from MBSF)
 - Zip-code quartile of % population with college degree (American Community Survey, ACS)
 - Zip-code quartile of % population with income above federal poverty level, or FPL (ACS)
 - Zip-code quartile of % of foreign-born population who speak English well or very well (ACS)
 - Rural Urban Commuting Area (RUCA) category of zip code
- Report rate of new SSDI awardees per 100,000 population by group, by age

Today, I show 2011-2019 trends in 45-54 year olds (21% of new SSDI awardees in 2019)

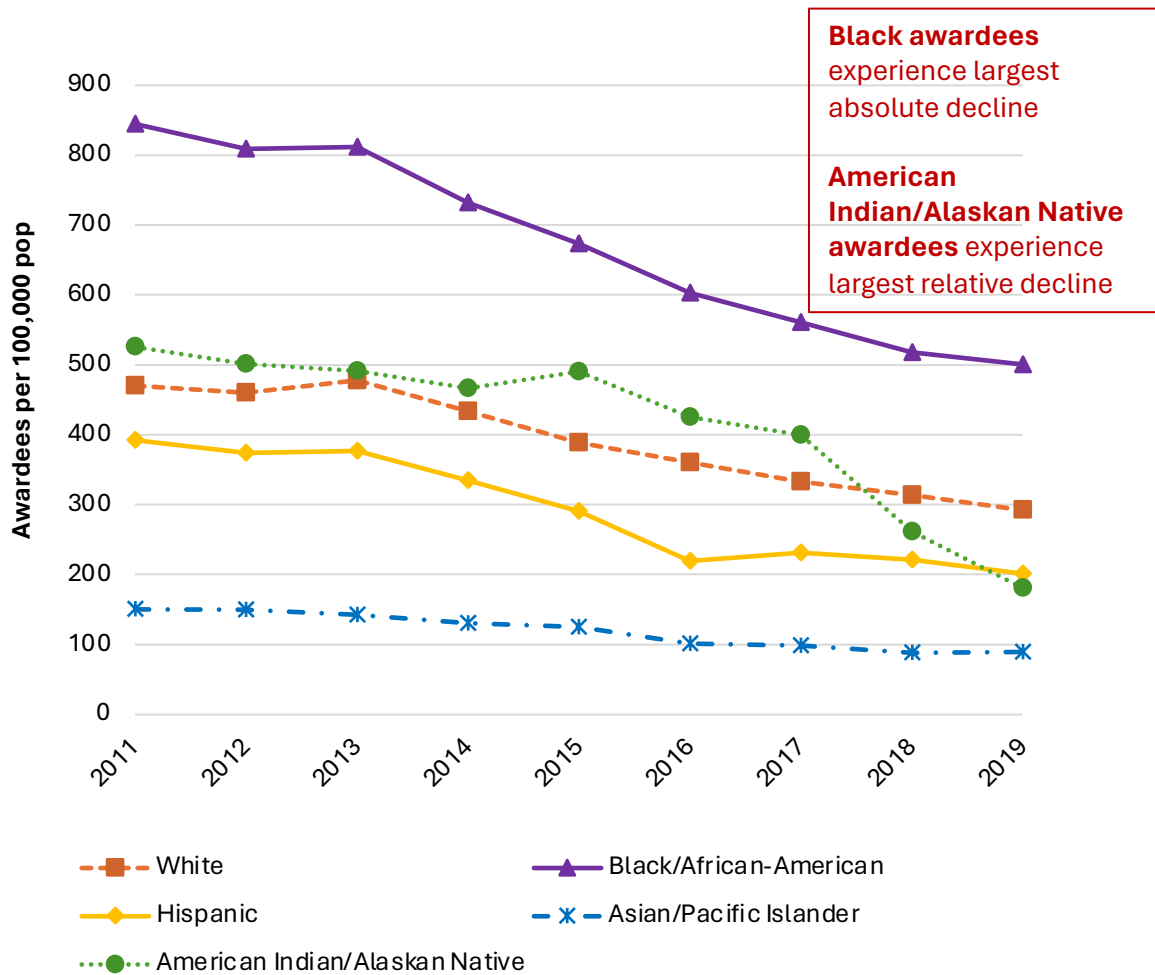
New SSDI awardees per 100,000 population (45-54 year olds)

By beneficiary race/ethnicity

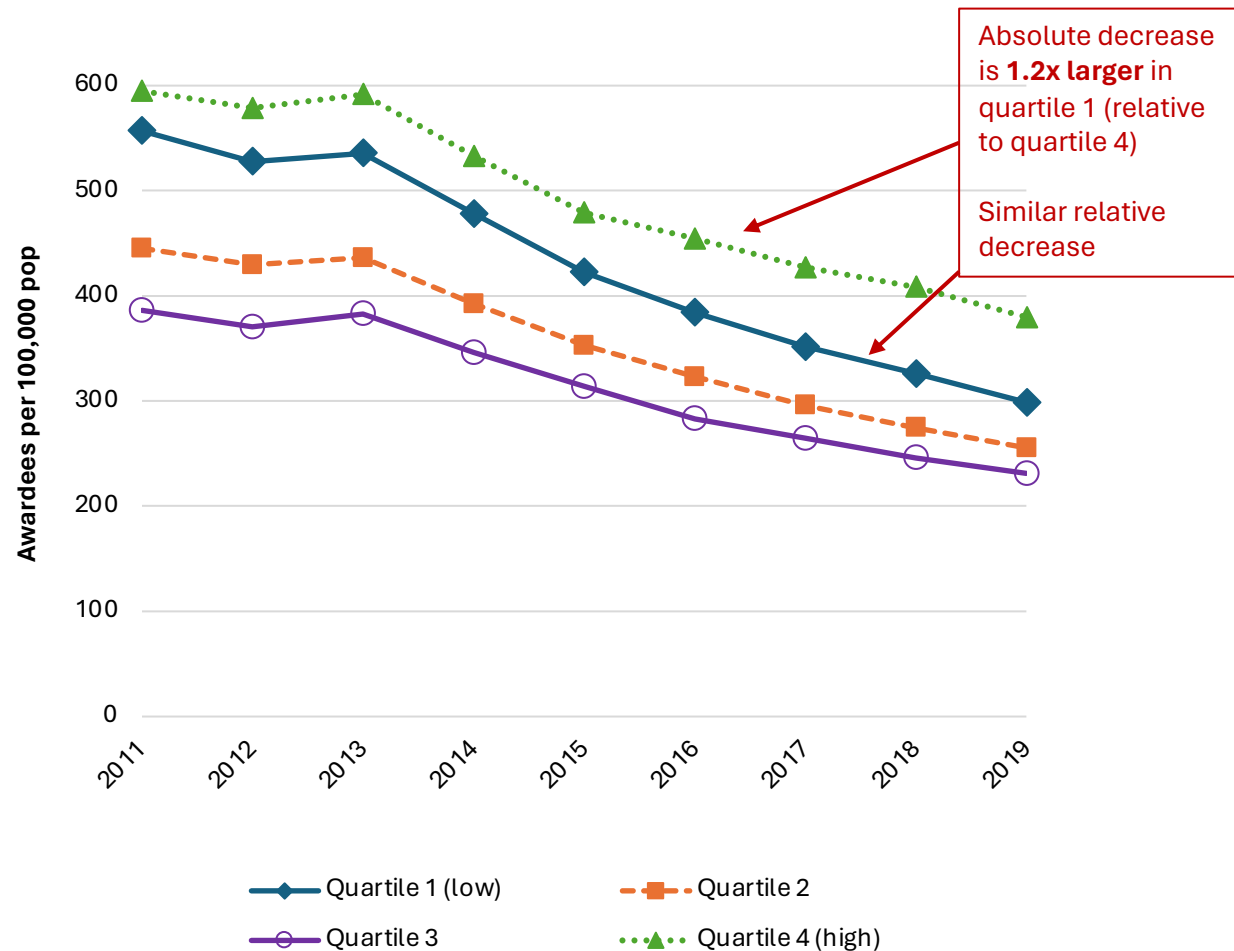


New SSDI awardees per 100,000 population (45-54 year olds)

By beneficiary race/ethnicity

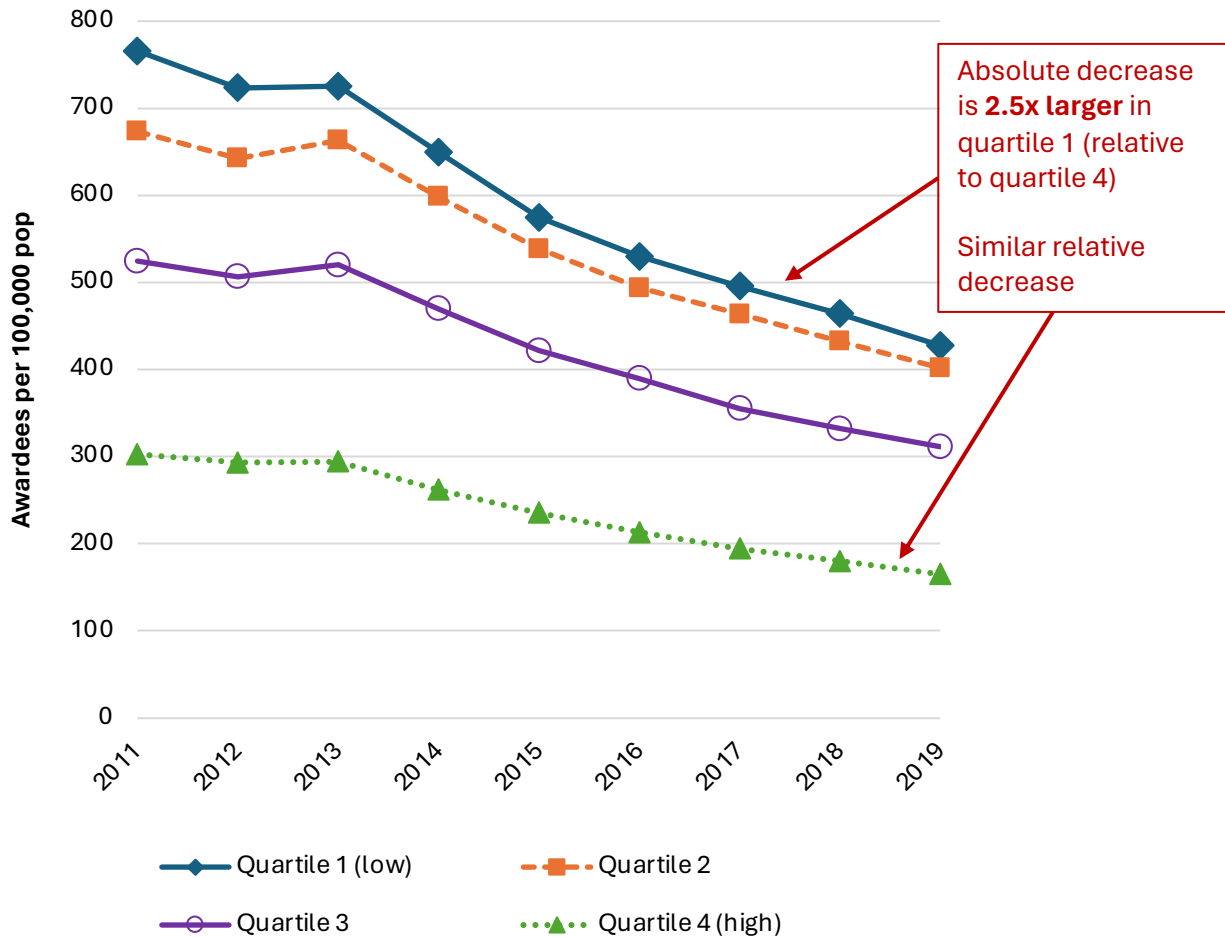


By zip code quartile: foreign-born pop. speaks English well



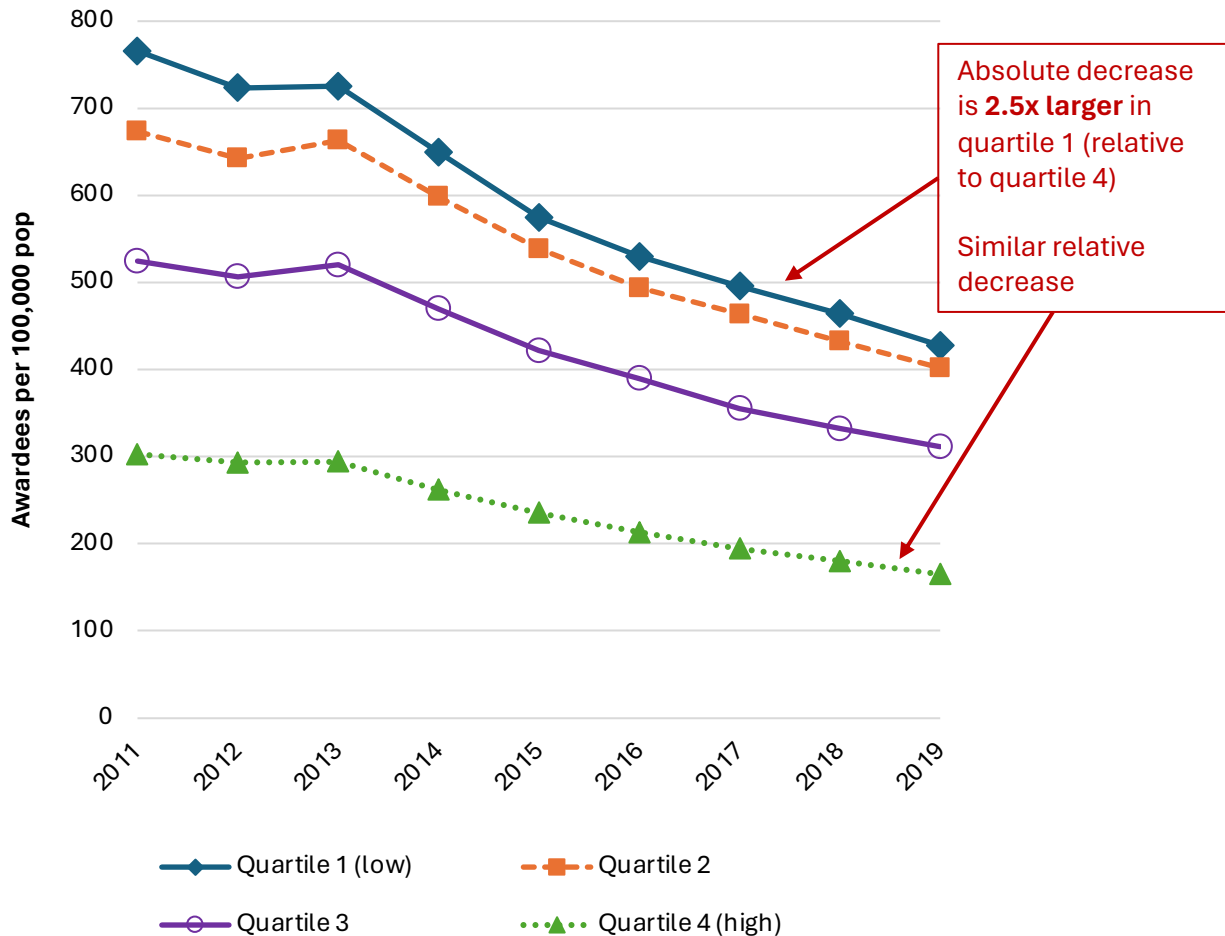
New SSDI awardees per 100,000 population (45-54 year olds)

By zip code quartile: **college education**

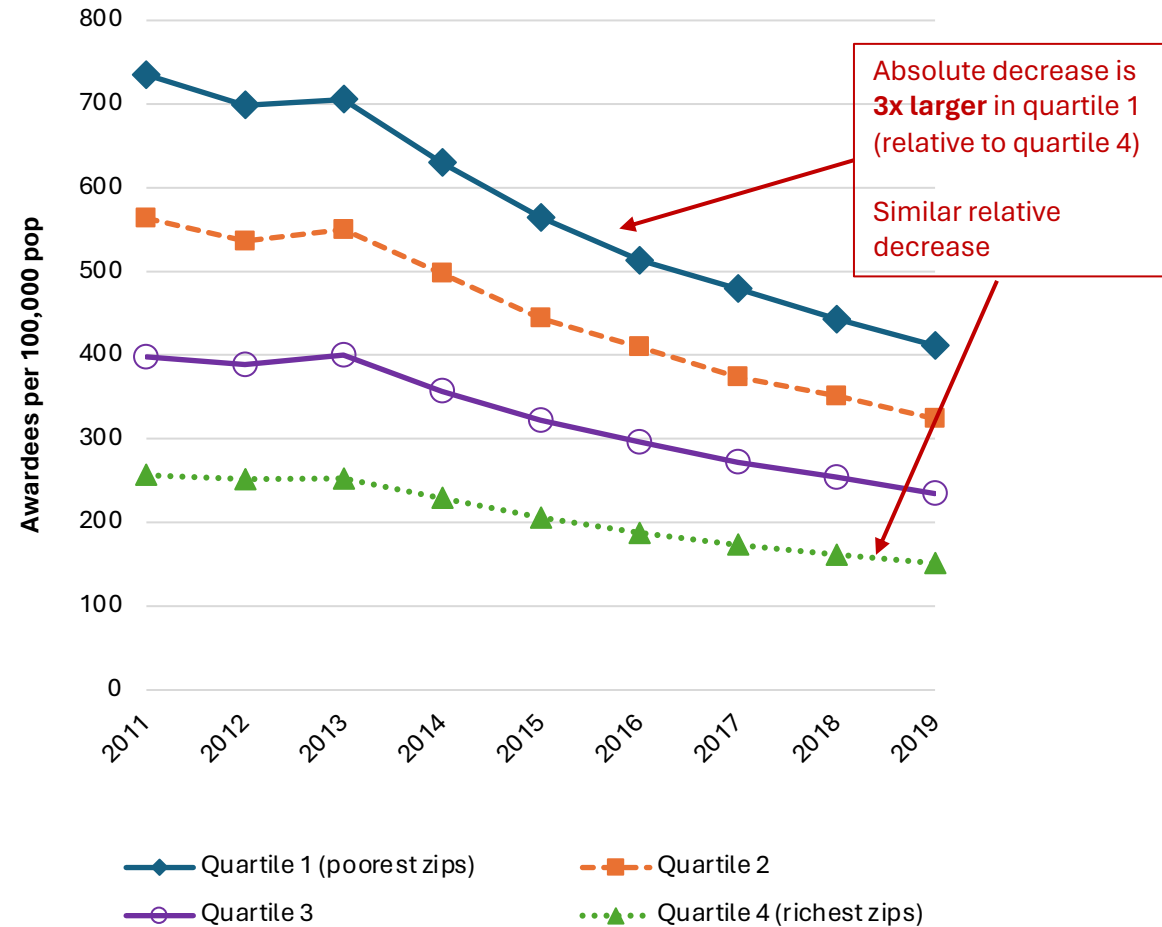


New SSDI awardees per 100,000 population (45-54 year olds)

By zip code quartile: **college education**

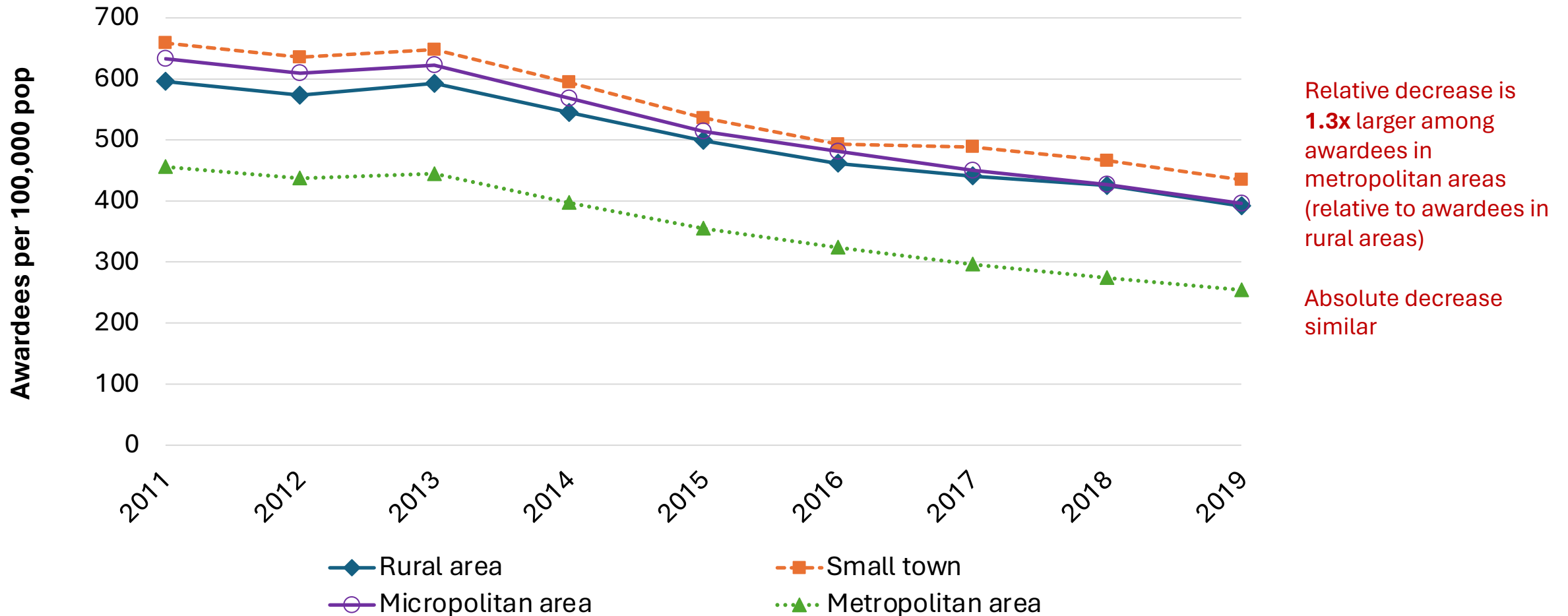


By zip code quartile: **income > FPL**



New SSDI awardees per 100,000 population (45-54 year olds)

By zip code RUCA category



Conclusions

- SSDI allowances have decreased between 2000-2019 due to
 - Higher rate of technical denials
 - Fewer allowances at initial/reconsideration level and hearing level
- As number of new SSDI awardees begin to decline after 2010,
 - Racial and ethnic minoritized groups experience a disproportionate decline in new awardees
 - Awardees in zip codes with the highest levels of poverty and lowest levels of college education experience largest *absolute* declines in rate of new SSDI awardees
 - May be expected given individuals with lower income and lower educational attainment are more likely to be on SSDI
 - Relative declines are similar to that of zip codes with lowest levels of poverty and highest levels of college education
 - Awardees in zip codes with higher proportions of non-English speaking populations and non-metropolitan zip codes do not appear to be disproportionately impacted

Next Steps

- Analyze application outcomes at each adjudicative level by state
- Stratify results based on body system of qualifying medical condition
- Working on obtaining aggregated data at the field office-level

Questions for Discussion

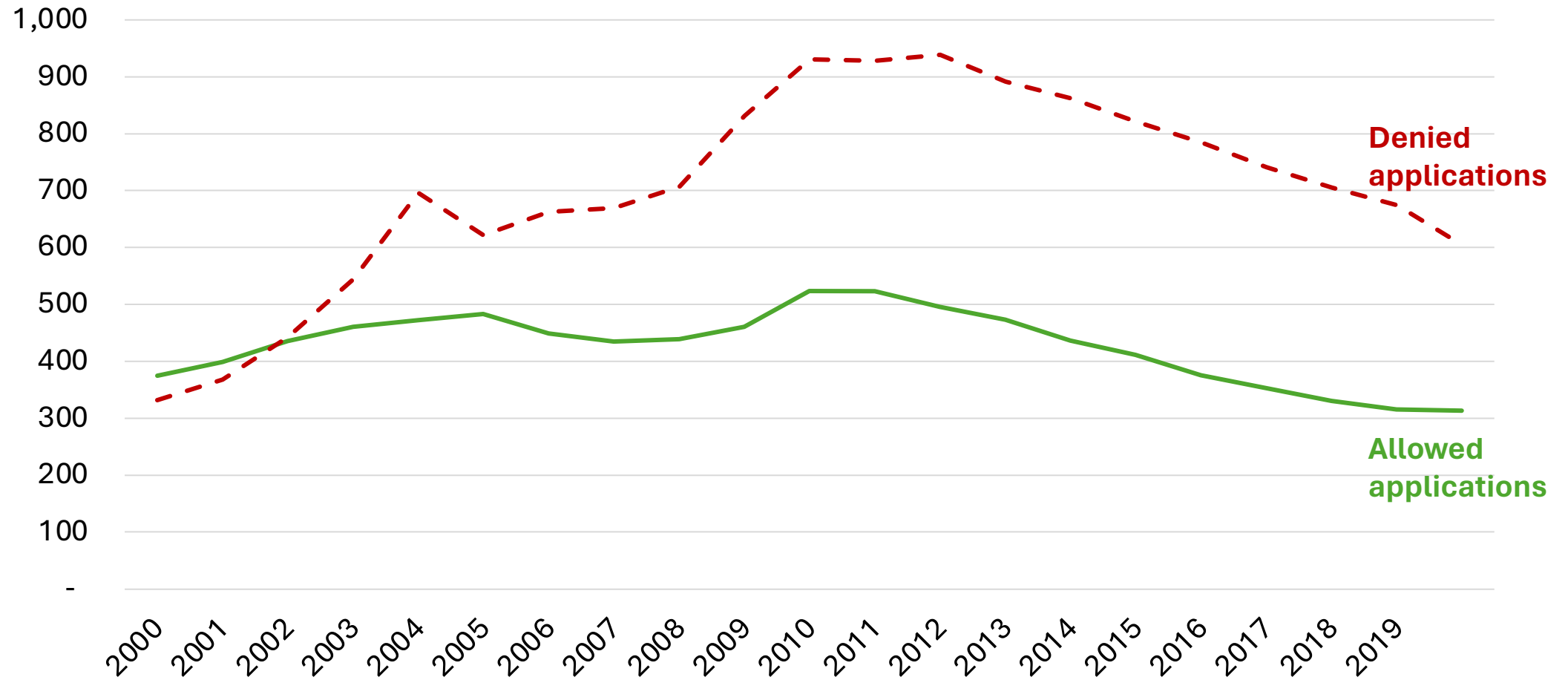
- Along what other dimensions should we analyze the changing composition of new SSDI awardees?
- How can we understand why applicants might reapply for SSDI after receiving a technical denial?
- What are some challenges or limitations in our approach in trying to answer these questions?

Thank you!

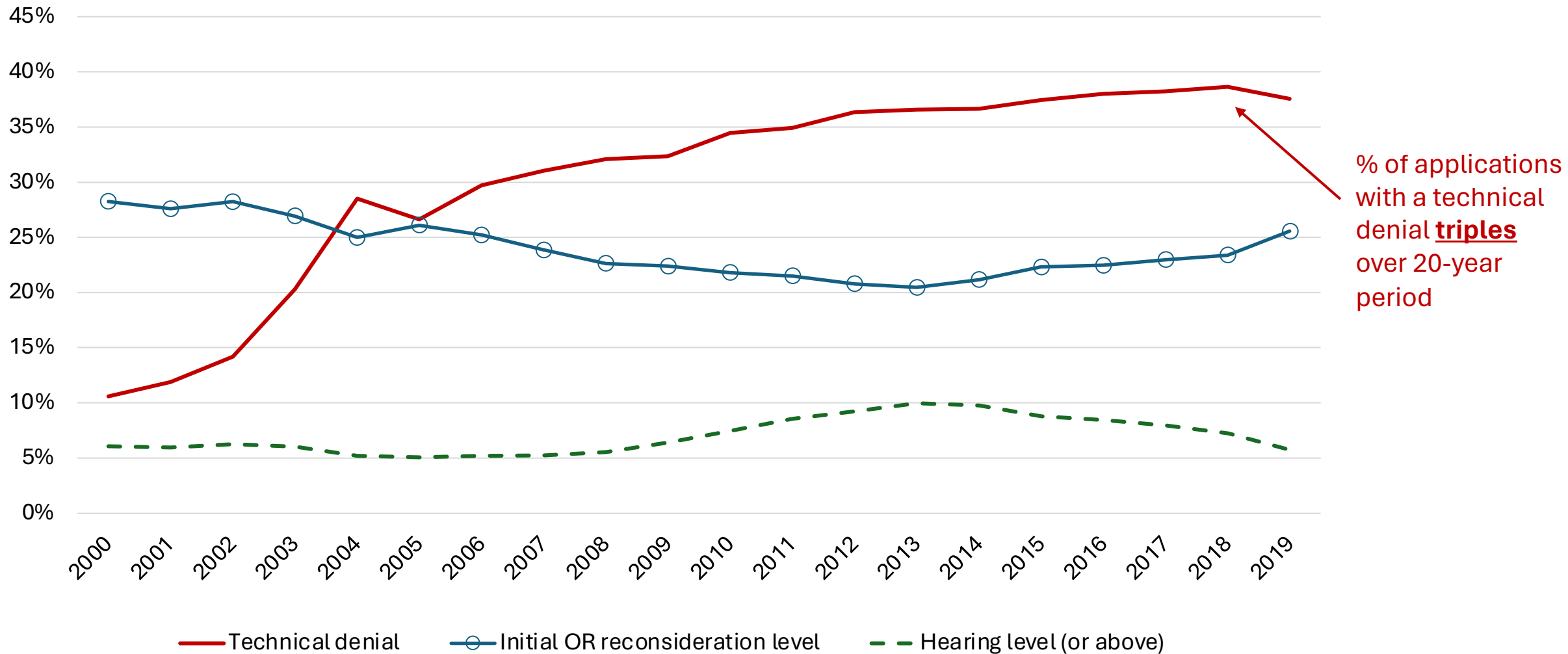
email: mgaye@hsph.harvard.edu

Appendix

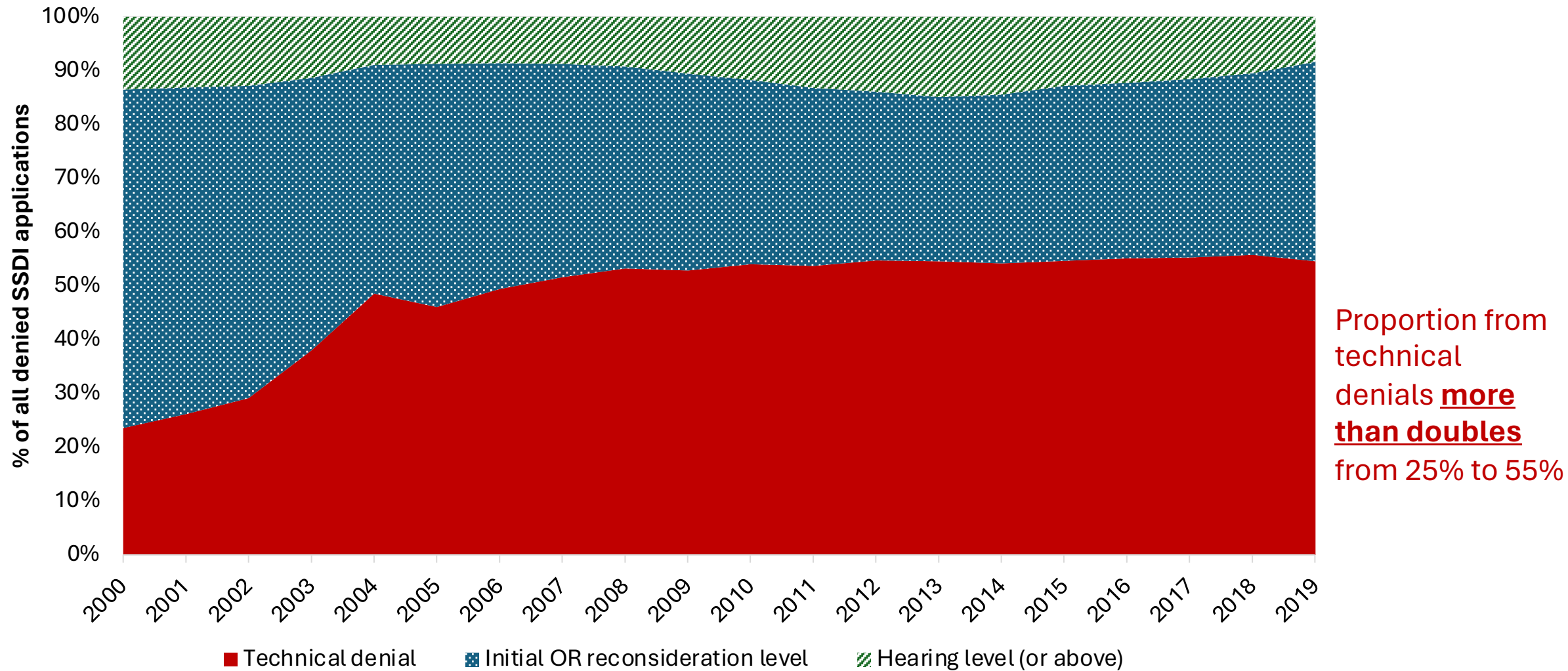
Status of SSDI applications, per 100,000 18-64 year old population



Adjudicative level where **denials** occurred



Proportion of **denied applications** from each adjudicative level



New SSDI awardees per 100,000 population by zip code quartile: **Pop. identifying as non-Hispanic White**

