Unequal Burdens of Delayed Diabetes Diagnosis: Older Adult Hispanics, Newly Diagnosed Diabetes, and Net Wealth

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Abstract

This study examines the longitudinal effects of newly diagnosed diabetes on household wealth among older Hispanic and non-Hispanic white adults using data from the RAND Health and Retirement Study from 2002 to 2018. Employing an event-study and before-and-after framework, the analysis evaluates changes in total net wealth and non-housing financial wealth following diagnosis. The results indicate that older Hispanics experience significant declines in net wealth and liquid assets after diagnosis, driven primarily by reductions in savings and

increased medical expenditures, while non-Hispanic Whites show no comparable decline. Although public health insurance, particularly Medicare, partially mitigates long-term losses, short- and medium-term financial vulnerability remains substantial among Hispanics. The findings suggest that delayed diagnosis and limited access to preventive care contribute to disproportionate economic hardship. These results underscore the importance of early detection, affordable access to healthcare, and targeted policies to reduce health-related wealth disparities.

Keywords: Diabetes, Aging Hispanics, Delayed Diagnosis, Medical Costs, Wealth.

JEL: I14, J14, J15, I18

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I. Introduction

Despite higher life expectancy and lower mortality rates, Hispanics face severe disparities in some chronic diseases' prevalence and mortality rates. Latinos are more likely to die due to liver disease and diabetes than non-Hispanic white individuals. Also, they are 1.6 times more likely to experience undiagnosed diabetes, leading to further complications; Hispanics are 34% more likely to develop a diabetes-related renal disease and 33% more likely to die from other diabetes-related diseases (CDC, 2021). Older Hispanics have a higher incidence of diabetes, arthritis, and high blood pressure than whites (Dunlop et al., 2001; Smith & Kington, 1997). Hispanic/Latino populations had the highest age-adjusted mortality rate for type 2 diabetes in 2023, exceeding non-Hispanic White rates (Ahmed et al., 2025).

Care for chronic conditions accounts for many healthcare expenses among elders (Machlin et al., 2008). Medicare diabetic beneficiaries pay $500 more than non-diabetics, and 60% spend more than 10% of their income (CDC, 2021). With low net health holdings, Hispanics are unready; the average Hispanic family has six times less wealth than a typical white family (SFC, 2019), while also holding low-wage jobs that lack benefits like healthcare insurance and retirement accounts. Healthcare costs rapidly increase among recently diagnosed patients and account for more than 62% of the bankruptcies in the country (Smith, 2005). These relational outcomes illustrate the need to further analyze how health shocks affect Latinos' wealth, especially later in life.

This paper analyzes the changes in net wealth and no-housing financial net wealth among Hispanics and non-Hispanic whites (NH Whites) after a new diabetes diagnosis. Using the Health and Retirement Study (HRS-RAND Longitudinal File) for 2002 to 2018, this study

addresses the following question: Does a diabetes diagnosis deplete wealth among older adult Hispanics more than among their comparable non-Hispanic white counterparts? How are these changes in the time after the diagnosis, and the dynamic of these changes? To answer these questions, I exploit the longitudinal nature of the data and follow a life milestone framework, using a methodology that combines an event study analysis and a before-and-after comparison, staggering the data around the milestone event: a new diabetes diagnosis. Using a pre–COVID-19 period dataset is good practice when studying the financial impact of a new diabetes diagnosis because it avoids confounding effects from pandemic-related disruptions, such as widespread job losses, income volatility, emergency policy interventions, and changes in healthcare utilization. Focusing on pre-pandemic data allows me to more accurately isolate the economic consequences of diabetes diagnosis itself, rather than capturing temporary shocks driven by public health restrictions, stimulus programs, and altered labor and insurance markets (Butler et al., 2023).

The event-study analysis shows that older Hispanics experience persistent declines in net wealth and non-housing financial wealth in the years following a diabetes diagnosis, with cumulative losses of approximately 6 to 12 percent over four years, largely driven by reductions in liquid assets such as savings and checking accounts. In contrast, non-Hispanic whites do not experience significant declines in wealth and, in some cases, show increases in net wealth due to growth in retirement assets. Before-and-after estimates indicate that Hispanics face an average post-diagnosis reduction of nearly 4 percent in non-housing financial wealth, whereas no significant change is observed among non-Hispanic whites. Wealth decomposition reveals that these declines are concentrated in liquid financial assets, with no evidence of increased debt accumulation, suggesting that households primarily finance health-related costs through asset depletion rather than borrowing.

This study examines the channels and mechanisms underlying the onset of diabetes among older adults. Mechanism analyses show that out-of-pocket medical expenses increase sharply after diagnosis for both groups, but the increase among Hispanics is nearly three times larger and remains elevated over time. Similarly, prescription drug use rises more steeply among Hispanics, reflecting delayed diagnosis and more intensive treatment needs. Although earnings losses are not statistically significant, Hispanics are more likely to exit employment and exhibit pre-existing work-limiting conditions, contributing to reduced financial resilience. Overall, the results indicate that newly diagnosed diabetes constitutes a significant financial shock for older Hispanics but not for non-Hispanic whites, primarily through increased medical costs and depletion of liquid wealth. These findings highlight the role of delayed diagnosis and unequal access to care in reinforcing health-related wealth disparities. It is assumed that health status (health capital) and changes in health (health shocks) could affect wealth differently. Here, I represent a health shock by the new diabetes diagnosis. The effect depends on the severity and differential prevalence of the health conditions. Changes in health conditions will differ between Hispanics and non-Hispanics due to the existing disparities in the US, expecting Hispanics to be more affected by diabetes diagnosis, given the barriers to access care, the community's higher prevalence of these conditions, and the delay in diagnosis. I hypothesize that the diagnosis of diabetes relates to changes in wealth in different ways. The vulnerability of older Hispanics is exacerbated by limited access to financial mechanisms to compensate for their lack of economic support, such as retirement benefits, generous health insurance, and family wealth transfers.

Understanding how health changes affect a population already vulnerable to economic shocks highlights the institutional barriers that prevent people from recovering financially from an unexpected health impact. The focus on older adults creates space to consider a population that,

on average, has financially settled, is closer to retiring from the labor market, and is expected to enter a cycle of wealth depletion, given that expenses are likely to exceed potential income.

Prior research shows that Hispanic and other minority populations experience higher diabetes prevalence and greater barriers to disease management, combined with socioeconomic disadvantages such as lower income, limited access to health care, and lower educational attainment, which together amplify the labor market and financial consequences of diabetes (Bastida & Pagán, 2002; Yedjou et al., 2024; Minority Health and Health Disparities, 2025).

Although these disparities and their links to financial hardship are well documented, existing studies rarely provide longitudinal, causal estimates of how a new diabetes diagnosis affects income, earnings, and wealth, particularly in comparisons between Hispanic and non-Hispanic populations, as most research focuses on prevalent cases rather than incident diagnoses (Patel et al., 2023; Pesavento et al., 2025). Recent administrative evidence indicates that individuals with diabetes face higher risks of adverse financial outcomes—including debt delinquency, bankruptcy, and foreclosure—with Hispanic patients experiencing especially elevated vulnerability, reflecting compounded effects of medical costs, employment instability, and cost-related care rationing (Pesavento et al., 2025). By directly estimating the differential economic impact of a newly diagnosed case of diabetes, this study addresses a critical gap in the literature and advances understanding of how health shocks contribute to persistent wealth disparities between Hispanics and non-Hispanic whites.

II. Literature Review

Limited work has been done on the combined health and wealth disparities issue (Wu, 2003; Lee & Kim, 2003, 2008). In an attempt to follow individual's life cycles and consumer dynamics, the life course literature has linked life milestones to changes in wealth, examining the

broader impact of health shocks, marital status changes, and retirement (Jones et al., 2020; Lee & Kim, 2008; Goda & Streeter, 2021). However, the exploration of differences in these life events across ethnicities is limited, with most analyses focusing on aggregated groups, such as non-whites, or on aggregated health conditions, such as having any extreme health condition or a stroke (Goda & Streeter, 2021).

Systematic analyses of racial disparities emphasize that minority populations, including Hispanics, experience greater prevalence and barriers in diabetes management coupled with socioeconomic challenges such as lower income and limited access to health care, two mechanisms that likely exacerbate the labor market and financial consequences of diabetes (Bastida & Pagán, 2002; Yedjou et al., 2024). Although prevalence and risk factors have been well documented, including the fact that Hispanic adults in the U.S. exhibit higher diabetes prevalence than non-Hispanic whites, disparities also extend into socioeconomic determinants that shape long-term financial trajectories (e.g., income, education, and access to care) (Minority Health and Health Disparities, 2025). Despite extensive evidence on the association between diabetes and financial hardship more broadly, the literature is sparse on longitudinal studies that estimate the causal impacts of newly diagnosed diabetes on income, earnings, and wealth trajectories—especially within ethnic subgroup analyses comparing Hispanic and non-Hispanic populations. Most high-quality longitudinal or administrative research integrates financial outcomes following a prevalent diagnosis rather than isolating incident-diagnosis effects, revealing a significant gap in the evidence base that this paper intends to address (Patel, M. R., et al., 2023; Yedjou et al., 2024; Pesavento et al., 2025).

Separately, the literature has extensively examined the rising racial and ethnic wealth disparities in the U.S. The average Hispanic family has six times less wealth than a typical white

family (Rodriguez, 2017; Asante-Muhammad et al., 2016). In 2013, the wealth of white households, based on median net worth, was $141,900 versus $13,700 for Hispanic families - a $128,200 gap, an increase from $122,600 in 2010 (Kochhar & Fry, 2014). Income is one of the components behind wealth disparities, but not the only one. Although Latinos are more likely to be in the labor force, they are concentrated in low-wage jobs (Stepler & Brown, 2016) and less likely to have access to job retirement accounts (Rhee, 2013). They also face barriers in the financial markets. About 50 percent of Latinos are outside the traditional banking system, with limited access to banking products (Burhouse et al., 2014; Blanco et al., 2018).

The relation between health and wealth is muddled by how both relate to tolerance to risk, discounted time, and self-management, making the direction of this relationship unclear (Adams et al., 2003; Smith, 2004, 2005; Adams et al., 2003; Lee & Kim, 2003; Thompson and Conley, 2016, 2019; and Mohanan, 2013). The theoretical hypothesis is that economic status is more likely to affect health in earlier stages of life (childhood and adulthood), but the relationship may likely reverse as individuals age (Smith & Kington, 1997; Smith, 1999). Healthcare costs increased rapidly among recently diagnosed patients and account for more than 62% of bankruptcies in the country (Himmelstein et al., 2009; Smith, 2004, 2005). Kijakazi et al. (2017) reveal the significant role of medical debt as an unsecured debt, not backed by other assets, among the Hispanic population.

Despite positive aggregate findings regarding life expectancy and mortality rates compared to non-Hispanic whites, Hispanics face severe disparities in the prevalence and mortality rates of specific diseases. Hence, the "*Latino advantage*" is not reflected in all health conditions. Latinos are more likely to die due to liver disease and diabetes than non-Hispanic White individuals in terms of differential health outcomes. The mortality rate of diabetic Hispanics is 65% more than

for whites (36% Hispanics versus 22% whites). These patterns also appear among elders. Hispanic elders have lower mortality rates than whites, but they also have a higher incidence of diabetes, arthritis, and high blood pressure than whites (Dunlop et al., 2001; Kington and Smith, 1997, NDSR, 2017).

A vast body of literature links income and health inequality (Deaton & Paxson, 1998), but little work has examined health and wealth disparities combined (Wu, 2003; Lee and Kim, 2003, 2008). Most of the studies connecting wealth and health have focused on all older adults (Smith, 1999, 2004, 2005; Kim & Lyon, 2005; Lee & Kim, 2008; Wu, 2003), while some have turned the focus to adults overall (Coile & Milligan, 2009; Grafova, 2015; Thompson and Conley, 2016, 2019). In these studies, the identification of health shocks relies on changes in health condition diagnoses from the prior period. Furthermore, health shocks aggregate health conditions into severe and mild categories (Smith, 1999, 2004, 2005; Kim & Lyon, 2005; Lee & Kim, 2008; Wu, 2003; Grafova, 2015). Severe conditions include diabetes, cancer, lung disease, heart conditions, and stroke, while mild conditions include high blood pressure, psychiatric problems, and arthritis.

More recent research indicates that type 2 diabetes is associated with adverse economic outcomes, including employment instability and diminished financial security. Large administrative data analyses show that adults diagnosed with diabetes experience significantly higher probabilities of adverse financial outcomes such as lower credit scores, medical and non-medical debt in collections, delinquent debt, bankruptcy filings, and foreclosure compared with those without diabetes. These associations persist after controlling for age, sex, race/ethnicity, insurance type, and employment earnings, and have been observed in U.S. populations through linked health and credit data spanning 2017–2021 (Pesavento et al., 2025). Importantly, this

study found that Hispanic ethnicity was associated with a greater relative risk of adverse financial outcomes compared with non-Hispanic individuals, suggesting disproportionate economic vulnerability among Hispanic patients with diabetes. Beyond labor outcomes, diabetes contributes to financial hardship through elevated costs of care, medication nonadherence due to cost constraints, and rationing behaviors that contribute to widening wealth disparities. Economic evaluations of diabetes patients report that financial toxicity may be significantly elevated among those with diabetes compared with those without, with deeper effects observed with intersecting vulnerabilities such as Hispanic ethnicity and lack of earned income (Pesavento et al., 2025).

This research expands the current literature on the effects of health disparities on wealth disparities between Hispanics and whites by directly estimating the differential effects of a health shock, such as a newly diagnosed case of diabetes.

III. Data and Methodology

I use the Health and Retirement Study (HRS-RAND Longitudinal File) from 2002 to 2018 of individuals in all six cohorts. Interviews are conducted every two years with individuals aged 50 and over and their spouses/partners. HRS-RAND contains detailed information about demographics, net wealth, assets, savings, retirement, health status, health insurance, and overall economic well-being.

Following a life-milestone framework for analyzing the impact of a new diabetes diagnosis, this study includes only individuals newly diagnosed with diabetes during the analysis period. That is, individuals who were diagnosed with diabetes at the time of joining the survey, or who were never diagnosed with diabetes during the analysis period, are not included. The estimation accounts for cohort-wave-specific changes to incorporate potential events that affect all groups

during a particular period or transition and group-specific components that would have affected those who were never diagnosed with the condition. Also, the study includes only individuals who respond to questions about ethnicity and race and who provide information about their household wealth. Furthermore, we use the time period with more consistency in the wealth and health conditions questionnaire. The final sample has 19,492 observations (person-survey year records) representing 3,315 unique individuals, 2,712 NH whites, and 603 Hispanics. The analysis in this study will look at the two groups separately and compare results based on their group-specific trajectories and distributions.

To identify the onset of diabetes, I use respondents' self-reported information on the newly diagnosed condition from one survey year to the next. Because a diabetes diagnosis can be preceded by or accompanied by other conditions, information about newly diagnosed conditions is included, along with any existing conditions. This means the study separately includes in the analysis the numbers of previously and newly diagnosed conditions.[1]

For net wealth, I focus the analysis on two aggregated measures: non-secondary-housing net wealth (NW) and non-housing financial net wealth (NHFW). The main difference between the two measures is that NHFW includes only stocks, savings, checking accounts, money market accounts, and other assets, minus debt. It doesn't include individual retirement accounts, Keogh plans, real estate assets, vehicles, or businesses, and debts associated with these assets, such as mortgages and amortization. Meanwhile, NW comprises the financial components of NHFW and all other components, except for real estate assets and debts associated with secondary houses. For the purposes of this study, the role of liquidity is relevant. The NHFW represents relatively more liquid wealth that can be affected by financial strains in a short period. Because changes in

[1] This is how Grossman's health capital concept is framed by using information on other previously diagnosed health conditions.

net wealth can be misleading, this analysis considers the actual real value base in 2015 dollars of household net wealth. The net wealth distribution among minority groups concentrates around zero; hence, using level values tends to bias the average net wealth changes.

Furthermore, because net wealth is typically skewed, with a higher concentration around zero and a tendency to lean towards negative values, especially for low-income groups, a log transformation is applied. The log transformation of variables with skewed distributions, as follows, log(wealth+|min net wealth|+1) (high concentration at zero and accumulation at extreme values), has been discussed in parallel among health and finance researchers. Although an inverse hyperbolic sine transformation (HIS) has also been found to effectively adjust the heteroskedasticity of the skew distribution among variables that do not take negative values (Bellemare & Wichman, 2020), the estimated marginal effects from these regressions are highly sensitive to the parameter values used in the transformation making it harder to use when comparing two different groups with different net wealth distributions (Norton & Mullahy, 2022). Moreover, for log transformation using the HIS transformation on variables with negative values like in the case of net wealth, the transformation's mean-preserving property can lead to improvements in wealth when changes occur at the extremes of the distribution (Ravallion, 2017). With health changes affecting individual finances from different sides of the equation, variations in wealth would be highly perceived among individuals at both ends of the wealth distribution.[2] All Estimates use individual weights, and because in some cases more than one person in a household may participate in the survey, a random individual is selected if two members of the same household are interviewed.

[2] To understand the robustness of the results, I explore different specifications. The results are consistently similar across different model and variable transformations.

Table 1 shows the total sample and ethnicity. Hispanics in the sample hold about a third of the net wealth of NH white older adults (average $154,399.72 Hispanics versus $433,625.22 NH whites), and almost a sixth of non-housing financial net wealth (average $21,351 Hispanics versus $124,385 NH whites). These gaps do not appear when comparing earnings between the two groups, indicating that older Hispanics have earnings similar to those of older NH white adults. These results are consistent with findings on racial/ethnic wealth gaps versus earning gaps among all adults. While earnings gaps are closing, wealth gaps between these groups in the US are rapidly widening. There are no large differences in the likelihood of working or in the degree of fine and gross motor skill limitation between the groups.

The Hispanic sample in this study is slightly younger (average age 66 versus 68) and more likely to be born abroad (57% versus 4%) than NH whites. There is a difference in the average age at first diabetes diagnosis, showing Hispanic people are more likely to be diagnosed later than NH whites. The difference between the two groups in health coverage rates is almost 20 percentage points. Part of this difference comes from Medicare coverage differences, with NH whites showing a rate of 62% compare to Hispanics of 52%. The advantage is reversed when looking at Medicaid, with Hispanics 19 percentage points more likely to have Medicaid coverage. Conversely, both groups have similar rates of having other health conditions and working-limiting health conditions. Hispanics are more likely to live in larger households and hire fewer people to help at home. Meanwhile, out-of-pocket (OOP) medical expenses among Hispanics are more than 60% higher than the average among NH Whites ($2,294 for Hispanics versus $3,459 for NH Whites), resulting in a larger share of these costs borne by their net wealth.

Inspired by Bayaz-Oztur et al. (2018), I adopt an event-study framework where the estimates are based on the individual's position relative to the moment of the diabetes diagnosis (Equation

1) and a before-and-after framework that follows a staggered approach and compares the differences in the aggregate values before and after the new diagnosis and aggregate values are collapsed into a single coefficient (Equation 2). This analysis circumvents the difficulties of establishing an adequate control group. Among older adults, the group of never-diagnosed diabetes patients has other severe health challenges that are correlated with the other conditions diabetic patients are also newly diagnosed with. The considered illustrative methodological approaches provide a clear view of the timing and dynamics of the components relative to the shock.

Regression analyses are done separately for each group: Hispanics and NH whites and estimates are presented in tables and graphs.

$$\boldsymbol{W_{it}} = \beta + \sum_{\boldsymbol{j=-10}}^{\boldsymbol{10}} \partial_t \boldsymbol{D_t^j} + \theta X_{it} + \varphi F_{it} + \vartheta S_t + \mu_i + \varepsilon_{it} \quad (1)$$

$$\boldsymbol{W_{it}} = \beta + \partial After_t + \theta X_{it} + \varphi F_{it} + \vartheta S_t + \mu_i + \varepsilon_{it} \quad (2)$$

where ***i*** stands for individual and ***t*** for time. ***W*** is the transformed measure of net wealth (NW and NFNW). ***D*** is the group of dummy variables indicating the timing position since the diabetes diagnosis. ***After*** is a single dummy indicator that is one after a diabetes diagnosis. ***Z*** represents access to health access indicators such as health coverage and changes in income. ***X*** represents a vector of individual-level characteristics, marital status, and the number of family members in the household, age-cohort. ***F*** stands for financial liquidity. ***S*** represents wave fixed effects, and ***μ*** the individual time-invariant fixed effects. ***ε*** are robust-clustered standard errors.

For identification, the onset of diabetes is treated as a life milestone that is not necessarily fully exogenous to an individual's behavior. However, even though individuals may perceive

themselves as more prone to developing the disease, the actual timing of the onset of diabetes is unanticipated by their perception.

III. Analysis

To show a clear transition of the effect of a new diabetes diagnosis on older Hispanics and NH whites, a series of figures is presented, supported by the estimated coefficients of the event study. Table 2 shows the results of equation (1) with all the full event study and coefficients for the main net wealth measures. Figure 1 (all panels) illustrates these estimates. Panels (A) and (B) show the results for all samples, while Panels (C) and (D) restrict the sample to those with health coverage or those aged 65 or older.

Hispanics with an onset of diabetes experience a decrease in the net wealth and the NHF net wealth during the four years right after being diagnosed with diabetes (between 0.3 and 0.6 percent decrease, accumulating an average reduction between 6 and 12 percent). The NHF net wealth of Hispanics does not recover after the onset of diabetes. There is some small recovery in net wealth, but it is not significant enough to return to pre-onset diabetes levels. The declines in both measures of net wealth are above the expected average wealth depletion among elders in the US (between 2-3 percent per year). Despite the decline in net wealth for Hispanics, it has stagnated, suggesting that Hispanics may be able to recover from the shock through other means that do not fully deplete their Wealth.[3] Conversely, NH whites do not experience declines in

[3] For robustness, other health-limiting conditions were used as a dependent variable for equations 1 and 2. Results in online appendix. No similar patterns were shown.

either measure of net wealth. On the contrary, their NW shows an upward trajectory, reflecting an increase in the net value of retirement assets.[4]

Table 4 top lines shows the estimated coefficients of Equation (2) for the variable *After*. The dip in the measures of NHFW after the onset of diabetes among Hispanics represents a change in the net wealth that averages a reduction of almost 4 percent, marking a before-and-after diabetes in the level of wealth holdings among Hispanics. NH whites show no significant reduction.

The analysis separated by gender, nativity, and coverage status shows that the decrease experienced by Hispanics is concentrated among groups more likely to hold some wealth (males, natives, and insured individuals).[5] For instance, male natives are more likely to use their financial holdings to respond to health changes than immigrant females. Females may rely on inter- and intra-household allocations beyond monetary distributions, such as elderly care or informal caretaker tasks. However, the data are insufficient to provide sufficient evidence on this point.

A. Wealth Components

Where are the net wealth variations coming from?— When looking at the source of wealth changes, we need to look at what components are a major part of the wealth for these groups. Table 3 shows the average values of net wealth components for each group. Among Hispanics with assets, those with net worth in their primary home and debt related to it are more likely to hold them, followed by savings and checking. Fewer Hispanics have a financial and investment component in their wealth portfolio. Interestingly, Hispanics have some hold on the net value of

[4] Older Hispanics with health insurance or those older than 65 still show a similar drop, but it is less significant, showing the role of health insurance either directly by reporting coverage or by likely being covered by public health coverage after the eligible age. Although not all Hispanics are likely to be eligible at 65 if they are nor citizen or permanent residents.

[5] Table A.6-A11 in the online appendix.

their businesses. Showing that Hispanics, when they hold assets, invest in housing or business creation, while little is kept in the financial market or long-term investment accounts. This is why the impact on the onset of diabetes is concentrated on liquid assets such as savings. Figure 2 (all panels) shows that older Hispanics show a reduction in the value of their checking/savings/MM accounts (Figure 2, Panel (A)), a reduction in the net value of their businesses, but the impact is not significant (Figure 2, Panel (C)), and there is no evidence on changes in debts, Figure 2 Panel (D).

B. Potential Mechanisms

The previous sections show a contemporaneous relationship between the onset of diabetes and net wealth depletion for older Hispanics, whereas NH whites show no change in net wealth or in any main net wealth components. Separating the analysis by group helps viewers understand the unequal trajectory of diagnosis for a chronic disease, which, by default, should not be a financial shock for an individual if diagnosed and adequately managed in a timely manner. Yet, the story and the evidence of the late diagnosis of diabetes in the Hispanic community map the road to a series of downfalls in terms of adverse conditions for those who are newly diagnosed. In a conventional setup, we would expect that the onset of a chronic disease affects individuals incrementally. It is not expected that other components of life will be affected contemporaneously. The diabetes diagnosis could be affecting net wealth because it is too severe and advanced once diagnosed, and that severity could have also been revealed by an early and gradual health deterioration. Moreover, the severity of the condition can have a direct financial impact, with medical costs rising, but the presence of helpers/family/ caretakers can mitigate the adverse effects of the disease, either through unpaid care or non-transactional help that still covers the rising expenses.

However, given evidence of changes in Hispanic net wealth, even among those with health insurance, and especially focused on the more liquid wealth components of this group, this section analyzes potential channels that may be driving those changes.[6] On the one hand, changes in earnings and the presence of a safety net are very important for mitigating the adverse effects of diabetes onset. We would expect that the shock of the diagnosis is cushioned by health insurance. In this particular older population, Medicare and Medicaid are especially relevant. Also, despite being closer to retirement age, a change in employment status can be another channel for wealth changes, given the role that income plays in maintaining liquidity. Figure 3 (all panels) shows the event study results for the analysis of equation (1) using individual earnings, Medicare, Medicaid, and working status as dependent variables separately. The results show that although earnings reductions are not statistically significant, older Hispanics are more likely than NH whites to drop out of employment after the onset of diabetes and no more likely to have Medicaid. Yet both groups show a pre-existing upward trend in the likelihood of having Medicare, consistent with the expected trend as the population ages and becomes eligible. Older NH whites show an increase in Medicare that coordinates with the onset of diabetes, hinting at the potential reverse connection between the onset of diabetes and access to medical care through Medicare for this group. For older Hispanics, the increase in Medicare coverage is significant several years after the diabetes diagnosis (Figure 3, Panel B).

Another potential channel to consider is the gradual impact that diabetes can have on an individual's overall well-being and skills when left untreated or underdiagnosed. We can consider that the onset of diabetes may also be accompanied by other conditions and a need for additional help with care. Figures 5 and 6 present different combinations of analyses intended to

[6] Regression results of equations (1) and 2 where the dependent variables are the ones discussed in this section, are shown in Table 5, and the event study coefficients are available in the online appendix.

gauge these potential factors. For changes in fine and gross motor skills, we see an increase in the lack of ability to manage the core activities included in each measure, right after the diagnosis of diabetes. After that increase, the change remains around zero, meaning that once individuals lose an ability, they don't regain it (Figure 5, Panels A and B). Furthermore, Figure 6 (Panel A and B) shows how the onset of diabetes comes together with the diagnosis of other conditions, although this is also experienced by older NH whites. What is very particular to older Hispanics is the higher likelihood of experiencing work-limiting health problems preceding the diagnosis of diabetes, which might hint at the case of pre-existing, underdiagnosed health conditions that can be tied to diabetes.[7] The complications associated with diabetes indicate that these groups also need care; however, Figure 6 panels (C) and (D) don't show significant changes in patterns for either group. Hispanics are already more likely to live with more people in the same household, so the need for care would not need to be reflected in a change in household size. Also, despite the increase in complications and loss of abilities for older Hispanics, we don't find evidence of any change in the number of paid helpers. Given the limitations of the survey's home care data, I cannot delve deeper into intrahousehold time and care allocations, which could shed light on the transfers of health costs amid the imminent increase in adverse health status.

Finally, and more precisely, direct financial mechanisms that can impact individuals are directly associated with medical costs. Figure 7 (all panels) highlights potential mechanisms that explain differences in wealth change associated with a new diabetes diagnosis. I evaluate the change in Out-of-pocket medical costs (in log terms) and the likelihood that the individual receives a prescription for a drug. The assumption is that delayed diabetes diagnosis and care

[7] The work-limiting conditions could reflect other health issues; however, they may indicate a pattern that leads to a health check-up and later diagnoses of diabetes and other comorbidities.

among older Hispanics, and potentially more acute symptoms, require more expensive care and treatment. As expected, OOP Medical costs increase among both groups right after a diabetes diagnosis. However, on average, the increase in proportion for Hispanics is three times the increase experienced by NH Whites after the onset of diabetes and stays higher for a prolonged period of time (Table 5 shows the before-and-after results with an increase of almost 40 percent for older Hispanics compared to 12 percent for NH whites). A similar but even stepper pattern is present in the prescription of new Rx drugs, where Hispanics are twice as likely to increase Rx drugs right after the onset of diabetes versus NH Whites (2 pp Hispanics versus 1 pp NH Whites), and that difference persists across time, making the difference between the two groups larger as shown in Table 5. This shows evidence of the delayed care and diagnosis that is prevalent among the Hispanic population, to the point that when a diagnosis is presented, the chronic condition is only manageable through more expensive treatments and medications, such as insulin.

IV. Concluding Remarks

Do health shocks affect Hispanics' wealth depletion and accumulation more than non-Hispanics? According to the evidence in this paper, yes, they do. Health shocks are not, per se, a source of disparities. In particular, diagnosing chronic conditions early, when they are manageable, is not expected to deplete individual resources. The underlying issue is the presence of institutional barriers and economic status that affect an individual's access to care, timely diagnosis, and ability to self-manage chronic conditions that result in turning a manageable situation into an unmanageable and costly one. This paper presents evidence of the potential severity of this population's financial burden after the new diagnosis of diabetes among the older Hispanic population. Throughout the analysis, the results are compared to those from older NH

whites to show that both groups have different trajectories, and the one from older Hispanics is more adverse and more lenient towards a story of lack of preventive care.

However, this analysis has its limitations. The onset of diabetes is determined by individuals' self-reporting of these diagnoses. This limitation is relevant if there is a difference in individual reporting by group, and what we see as a delay in diagnosis is merely a delay in individuals reporting the diagnosis in the survey. Clinical information could have helped us determine the exact timing of the diagnosis. Next, the HRS sample of Hispanics is too small to separate subgroups that are key to identifying access to health services, coverage, and other resources. Most Hispanics are immigrants, but the sample size was not large enough to allow the separation of this analysis into two groups.

This analysis could also be paired with one that further examines the role of intrahousehold allocations in the newly diagnosed individual’s households. Hispanics tend to live in multigenerational/multifamily households, in which caregivers are also more likely to live with their care recipients (Cadet et al., 2021). Health shocks can be a source of wealth inequality and economic disparities at the individual level and across generations. The family network may eventually reduce the cost of elderly care through intra-household resource reallocations, but it may also represent a negative intergenerational transfer if care costs are passed down through generations.

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FIGURES

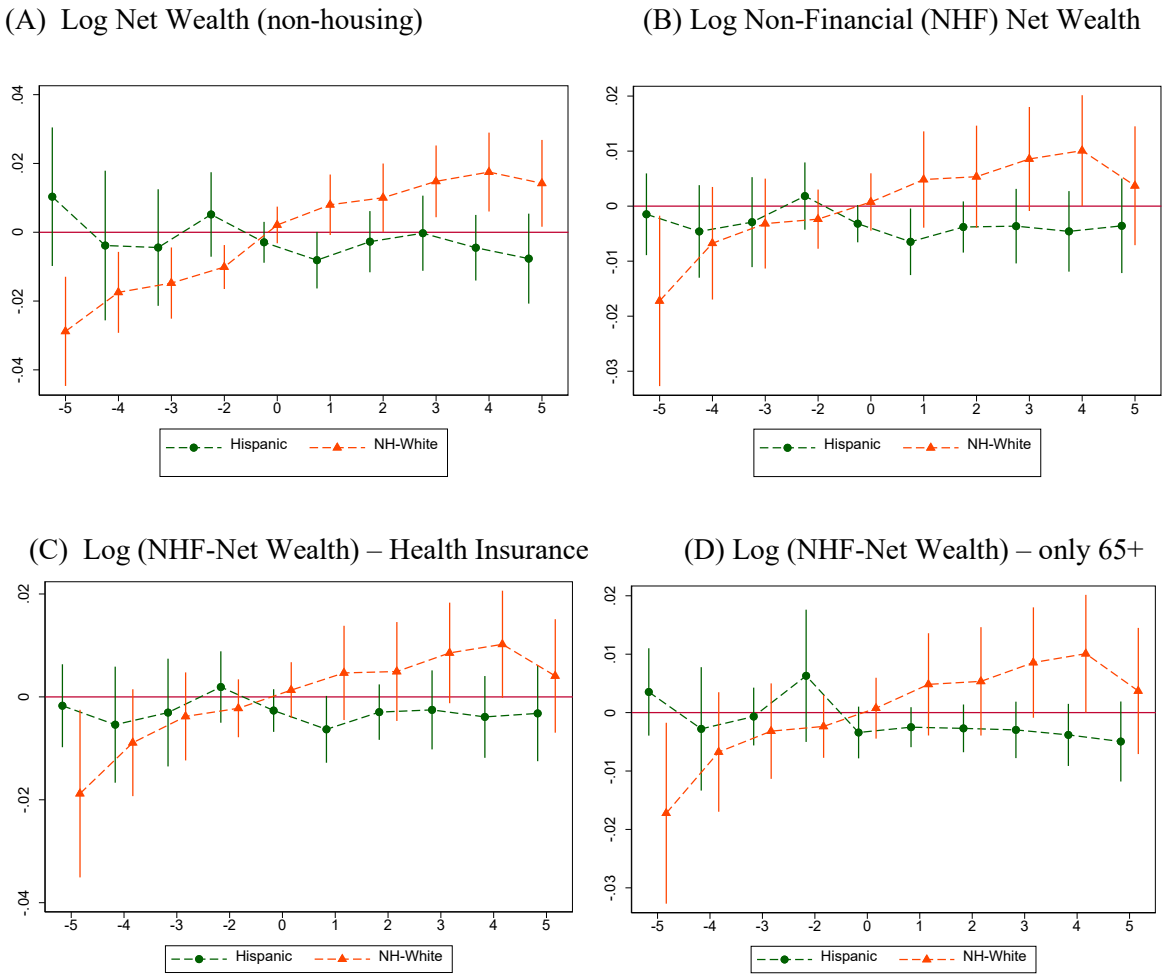


FIGURE 1. NET WEALTH EVENT STUDY

*Note: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. X-axis represents 2-year periods since event, where 2 means 4 years after the onset of diabetes. Other covariates in the model include marital status, place of birth, working status, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, HRS-cohorts fixed effects. Robust standard errors in brackets. Average of main variables in Table 1, and long-run effects in online appendix. *** p<0.01, ** p<0.05, * p<0.1.*

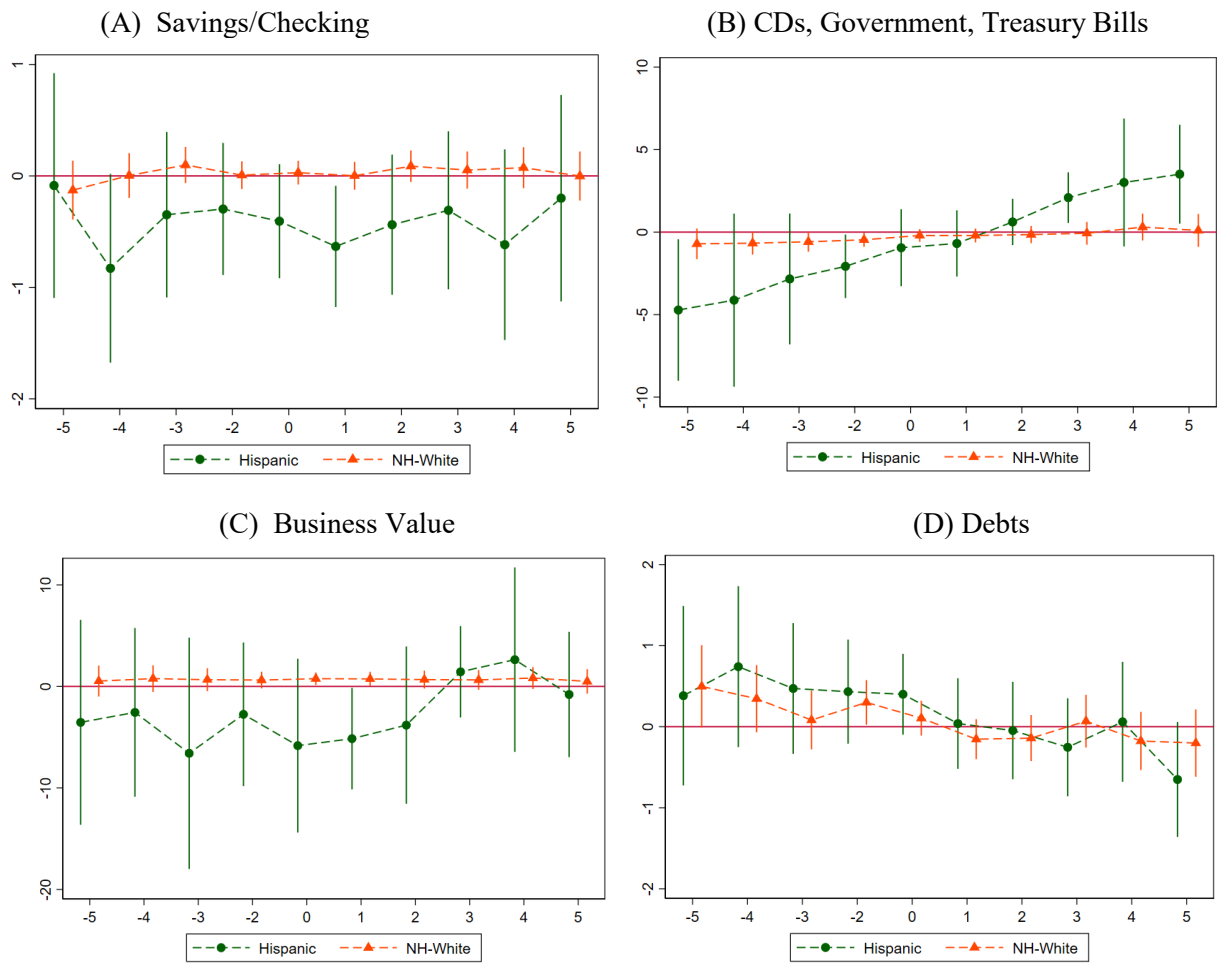


FIGURE 2. MAIN NET WEALTH COMPONENTS (ASSETS AND DEBTS)

*Note: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. X-axis represents 2-year periods since event, where 2 means 4 years after the onset of diabetes. Other covariates in the model include marital status, place of birth, working status, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, HRS-cohorts fixed effects. Robust standard errors in brackets. Average of main variables in Table 1, and long-run effects in online appendix. *** p<0.01, ** p<0.05, * p<0.1.*

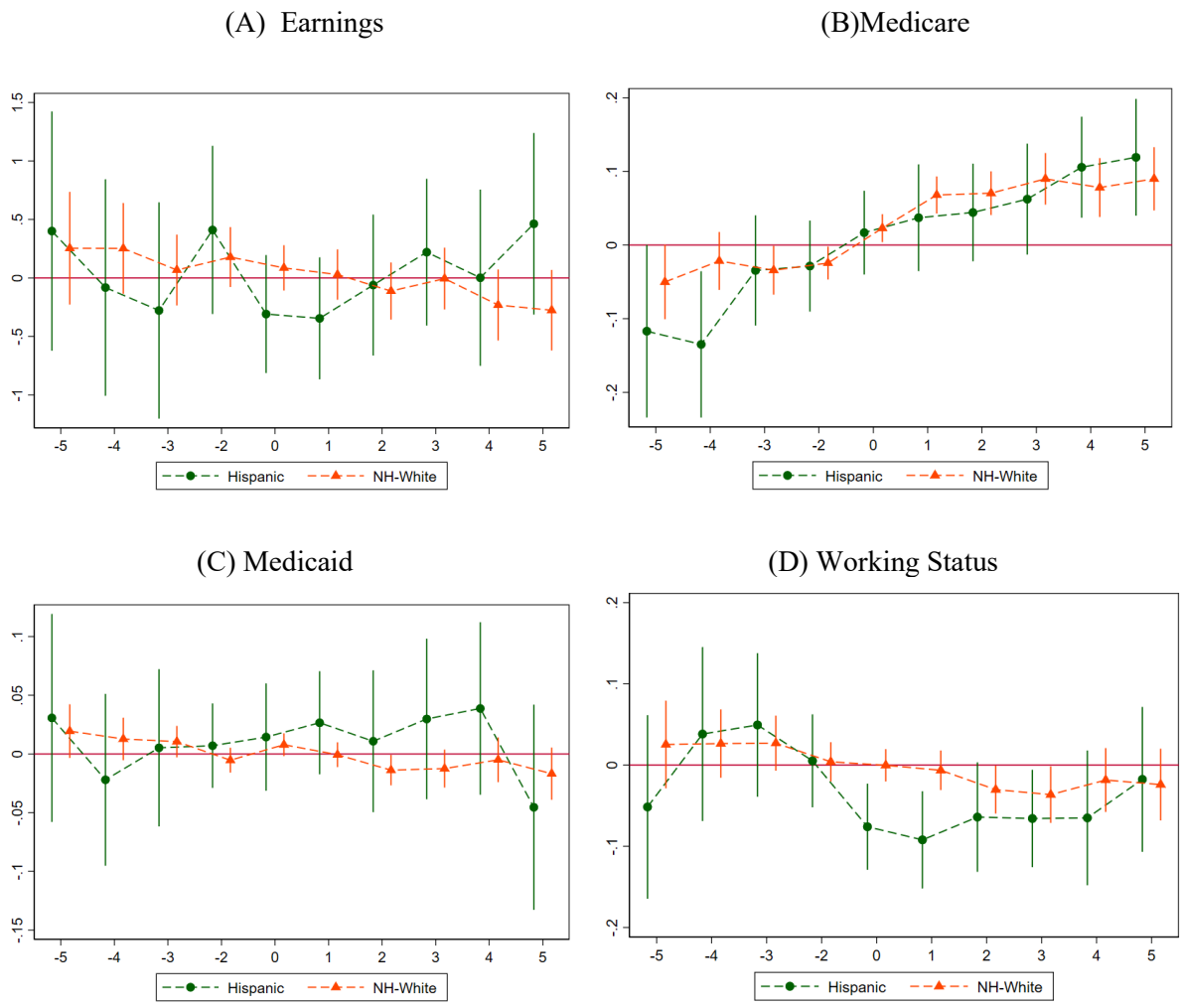


FIGURE 3. EARNINGS AND SAFETY NET

*Note: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. X-axis represents 2-year periods since event, where 2 means 4 years after the onset of diabetes. Other covariates in the model include marital status, place of birth, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, HRS-cohorts fixed effects. Robust standard errors in brackets. Average of main variables in Table 1, and long-run effects in online appendix. *** p<0.01, ** p<0.05, * p<0.1.*

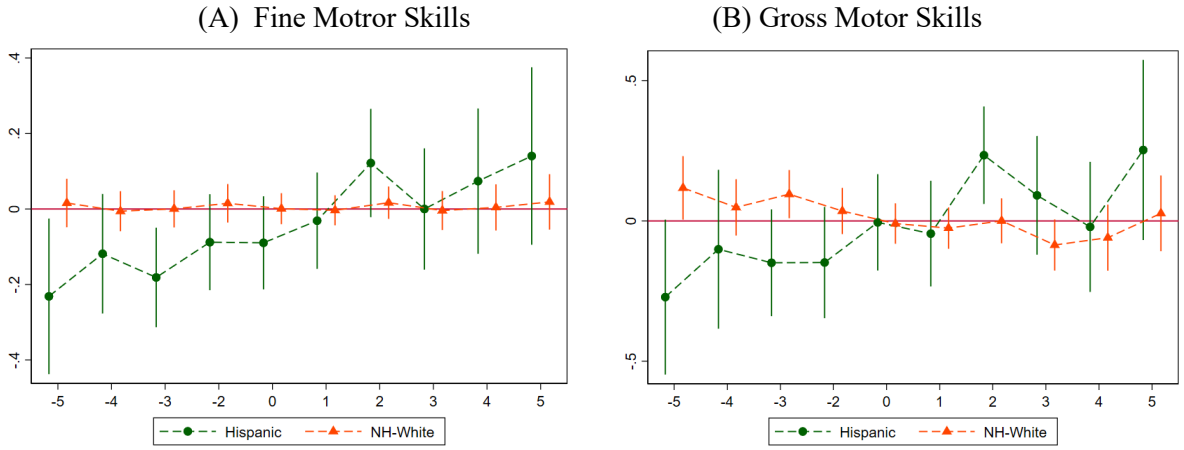
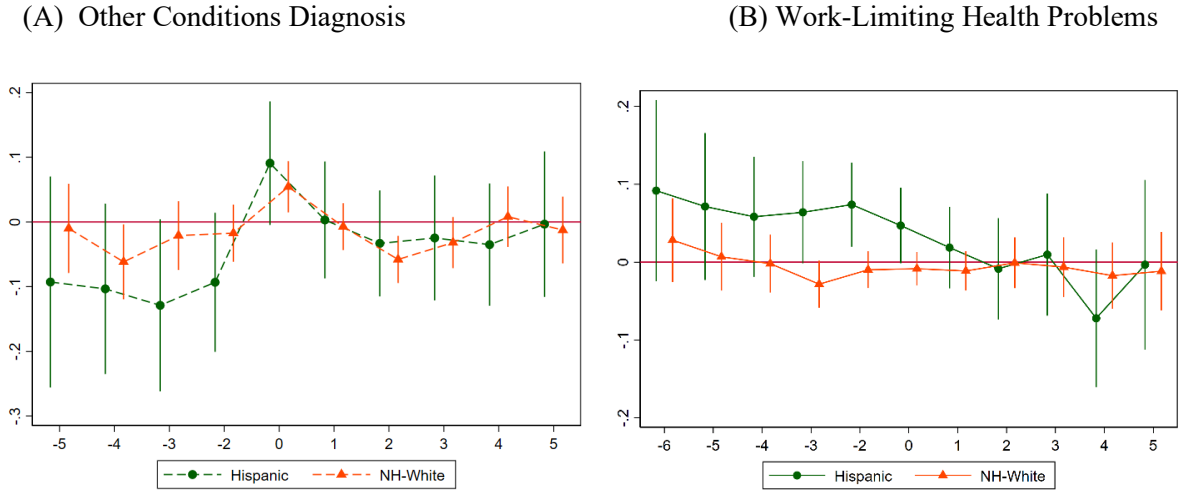
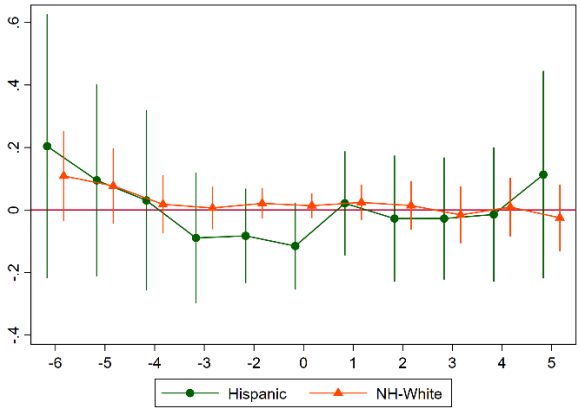


Figure 4. **FINE AND GROSS MOTOR SKILLS - MECHANISM**

*Note: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. X-axis represents 2-year periods since event, where 2 means 4 years after the onset of diabetes. Other covariates in the model include marital status, place of birth, working status, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, HRS-cohorts fixed effects. The variables fine motor (picking up a dime, eating, and dressing) and gross motor (walking one block, walking across the room, climbing one flight of stairs, and bathing) skills represent the change from the previous wave in the lack of corresponding abilities, and an increase represents deterioration of abilities. Robust standard errors in brackets. Average of main variables in Table 1, and long-run effects in online appendix. *** p<0.01, ** p<0.05, * p<0.1.*



(C) Number of People in the Household



(D) Number of Helpers Paid

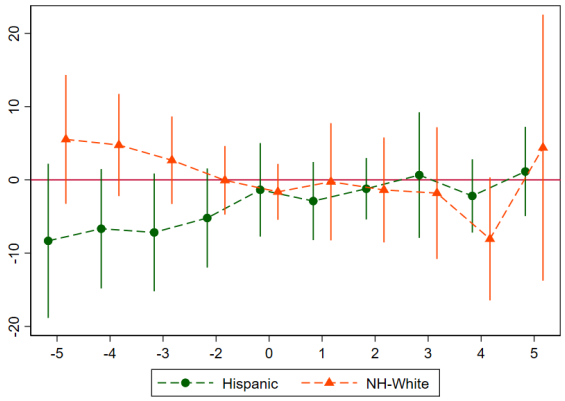
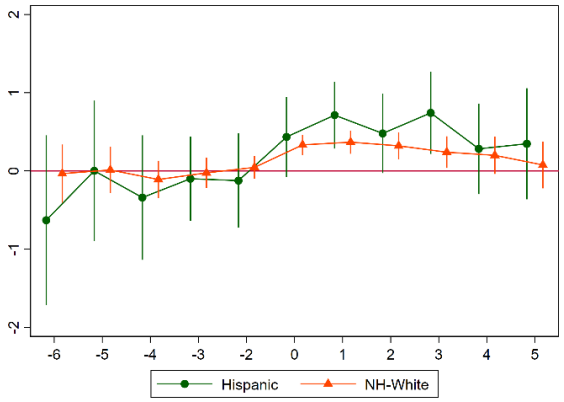


FIGURE 6. COMPLICATIONS AND CARE - POTENTIAL MECHANISMS

*Note: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. X-axis represents 2-year periods since event, where 2 means 4 years after the onset of diabetes. Other covariates in the model include marital status, place of birth, working status, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, HRS-cohorts fixed effects. Robust standard errors in brackets. Average of main variables in Table 1, and long-run effects in online appendix. *** p<0.01, ** p<0.05, * p<0.1.*

(A) Out of pocket Medical Expenses (Log terms)



(B) Rx Drugs usage

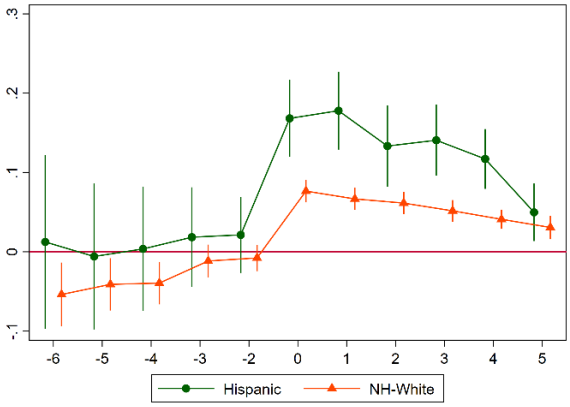


Figure 7. MEDICAL TREATMENT AND EXPENSES - POTENTIAL MECHANISMS

*Note: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. X-axis represents 2-year periods since event, where 2 means 4 years after the onset of diabetes. Other covariates in the model include marital status, place of birth, working status, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, HRS-cohorts fixed effects. Robust standard errors in brackets. Average of main variables in Table 1, and long-run effects in online appendix. *** p<0.01, ** p<0.05, * p<0.1.*

TABLES

TABLE 1— SUMMARY STATISTICS

	All		Hispanics		Non-Hispanics White	
	Mean	SD	Mean	SD	Mean	SD
Net Wealth (2015 dollars) - No second housing	400,052.09	851,078.09	154,399.72	542,358.64	433,625.22	879,642.84
Non-Housing Financial Wealth (2015 dollars) NHFW	111,996.84	404,842.34	21,351.97	198,979.74	124,385.21	423,807.79
Ratio NHFW/NW	0.18	0.43	0.12	0.41	0.18	0.43
Earnings	13,302.21	36,029.67	10,264.05	53,109.56	13,717.44	32,996.08
Working Status	0.38	0.48	0.35	0.48	0.38	0.49
Age at first diagnosis	69.77	9.44	70.36	9.34	67.11	9.43
Fine Motor Skills (c)	0.03	0.48	0.04	0.61	0.03	0.46
Gross Motor Skills (c)	0.09	0.85	0.08	0.96	0.09	0.84
Medicare	0.60	0.49	0.52	0.50	0.62	0.49
Medicaid	0.07	0.25	0.23	0.42	0.04	0.21
Female	0.51	0.5	0.59	0.49	0.5	0.5
Age	67.45	9.26	65.63	8.99	67.70	9.27
Immigrant	0.1	0.3	0.57	0.5	0.04	0.19
Any Health Coverage	0.94	0.3	0.8	0.39	0.96	0.19
Other Conditions	0.21	0.48	0.25	0.43	0.24	0.42
Number of people in HH	2.25	1.16	2.99	1.76	2.16	1.02
Number of Paid Help	5.42	109.46	2.03	38.78	5.88	115.80
Work-limiting health	0.08	0.87	0.07	0.96	0.08	0.86
Rx Drugs usage	0.89	0.28	0.8	0.39	0.91	0.28
OOP Medical Expenses	3,322.13	8,322.47	2,293.97	8,334.31	3,459.27	8,311.43
Number of observations	19,492		3,493		15,999	

Notes: Using HRS- RAND HRS Longitudinal File two-waves cohorts: Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. A random individual is considered if two members of the same household were interviewed. (c) stands for change. *Source:* Author calculations.

TABLE 2—CHANGE IN HOUSEHOLD WEALTH (EVENT STUDY)

	Hispanics		Non-Hispanic Whites	
	Log (Net	Log (NHF-Net	Log (Net	Log (NHF-Net
Years since event				
-10	-0.001	0.01	-0.017**	-0.029***
	[0.004]	[0.010]	[0.008]	[0.008]
-8	-0.005	-0.004	-0.007	-0.017***
	[0.004]	[0.011]	[0.005]	[0.006]
-6	-0.003	-0.004	-0.003	-0.015***
	[0.004]	[0.009]	[0.004]	[0.005]
-4	0.002	0.005	-0.002	-0.010***

	[0.003]	[0.006]	[0.003]	[0.003]
0	-0.003*	-0.003	0.001	0.002
	[0.002]	[0.003]	[0.003]	[0.003]
2	-0.006**	-0.008*	0.005	0.008*
	[0.003]	[0.004]	[0.004]	[0.004]
4	-0.004	-0.003	0.005	0.010**
	[0.002]	[0.005]	[0.005]	[0.005]
6	-0.004	0	0.009*	0.015***
	[0.003]	[0.006]	[0.005]	[0.005]
8	-0.005	-0.004	0.010**	0.018***
	[0.004]	[0.005]	[0.005]	[0.006]
10	-0.004	-0.008	0.004	0.014**
	[0.004]	[0.007]	[0.006]	[0.006]
Observations	3,493	3,493	15,999	15,999
R-squared	0.016	0.059	0.022	0.074
Number of *hhidpn*	603	603	2,712	2,712

Notes: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. Other covariates in the model include marital status, place of birth, working status, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, and HRS-cohorts fixed effects. Robust standard errors in brackets. The average of main variables for Hispanics 14.87 log net wealth and 14.55 for log NHF net wealth) and for NH Whites 14.95 for log net wealth and 14.59 for log NHF net wealth. *** Significant at the 1 percent level. ** Significant at the 5 percent level. * Significant at the 10 percent level.

TABLE 3—RATIO OF NET HOUSEHOLD WEALTH

	Average (2015 dollars)		Ratio	
	Hispanics	NH-Whites	Hispanics	NH-Whites
Net wealth (NW)	154,400	433,625	1	1
Earnings	10,264	13,717	0.07	0.03
Net Value Primary Home	166,976	200,264	1.08	0.46
Checking/Savings	12,657	33,831	0.08	0.08
Net Business value	199,357	315,833	1.29	0.73
CDs, Bills	13,848	52,092	0.09	0.12
Retirement (IRA)	15,859	72,256	0.10	0.17
Stocks	51,216	199,295	0.33	0.46
Bonds	27,849	113,854	0.18	0.26
Net value vehicles	10,544	16,643	0.07	0.04
Other Assets	6,408	58,231	0.04	0.13
Debts	3,638	4,557	0.02	0.01
Home Equity Loan	1,330	4,594	0.01	0.01
Amortization	25,297	37,314	0.16	0.09

Notes: Using HRS- RAND HRS Longitudinal File two-waves cohorts: Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. A random individual is considered if two members of the same household were interviewed. The ratio can exceed 1 because it is a net value, for the same reason, the sum of the component ratios can add to more than 1. Earnings are not directly part of net wealth; the ratio is included for illustrative purposes. All values are in 2015 dollars. *Source:* Author calculations.

TABLE 4— HOUSEHOLD NET WEALTH AND WEALTH COMPONENTS (BEFORE AND AFTER)

	Hispanics					NH- Whites				
VARIABLES in Log terms	After	sd	Obs.	R-squared	N. of hhidpn	After	sd	Obs.	R-squared	N. of hhidpn
Net Wealth	-0.002	[0.002]	3,493	0.008	603	0	[0.004]	15,999	0.02	2,712
NHF Wealth	-0.004*	[0.002]	3,493	0.051	603	0.001	[0.004]	15,999	0.069	2,712
Savings/Checking	-0.475*	[0.254]	3,493	0.014	603	-0.035	[0.057]	15,999	0.017	2,712
Net Value Business	-1.02	[1.472]	106	0.263	58	0.15	[0.396]	1,956	0.017	633
CDs, govt.	0.522	[1.358]	164	0.187	85	-0.133	[0.224]	3,985	0.028	1,410
Stock	-1.463*	[0.812]	169	0.166	79	-0.256	[0.165]	4,992	0.008	1,486
Debt	-0.118	[0.254]	3,493	0.007	603	-0.044	[0.121]	15,999	0.008	2,712

Notes: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. Other covariates in the model includes marital status, place of birth, working status, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, HRS-cohorts fixed effects. Robust standard errors in brackets. The average of main variables for Hispanics 14.87 log net wealth and 14.55 for log NHF net wealth) and for NH Whites 14.95 for log net wealth and 14.59 for log NHF net wealth (See online appendix). *** Significant at the 1 percent level. ** Significant at the 5 percent level. * Significant at the 10 percent level.

TABLE 5— EARNING, SAFETY NET, AND POTENTIAL MECHANISMS (BEFORE AND AFTER)

	Hispanic					NH-White				
VARIABLES	After	sd	Obs.	R-squared	N. of hhidpn	After	sd	Obs	R-squared	N. of hhidpn
Log OOP	0.393**	[0.198]	3493	0.021	603	0.120*	[0.070]	15999	0.016	2712
Rx Drugs	0.081***	[0.026]	3493	0.149	603	0.004	[0.008]	15999	0.076	2712
Work limiting	-0.017	[0.030]	3493	0.112	603	0.011	[0.012]	15999	0.149	2712
Other Conditions	0.083**	[0.040]	3493	0.011	603	0.062***	[0.016]	15999	0.005	2712
Fine Motor Skills	0.023	[0.052]	3016	0.007	595	0.003	[0.014]	14474	0.002	2705
Gross Motor Skills	0.029	[0.071]	3016	0.004	595	-0.009	[0.027]	14470	0.005	2705
Medicare	0.013	[0.030]	3493	0.417	603	0.052***	[0.013]	15999	0.412	2712
Medicaid	0.023	[0.023]	3493	0.061	603	-0.004	[0.005]	15999	0.011	2712
Work Status	-0.027	[0.029]	3493	0.204	603	-0.008	[0.127]	15999	0.204	2712
N. people in hhd	0.12	[0.090]	3493	0.036	603	0.01	[0.030]	15999	0.029	2712

Notes: Using HRS- RAND HRS Longitudinal File (2002-2018): Initial HRS, WB cohort, EBB cohort, and MBB, individuals older than 50 years with full information. Estimates use individual weights. Random individual is considered if two members of the same household were interviewed. Other covariates in the model includes marital status, place of birth, working status, liquidity ratio, number of family members in the household, percent-change income, other diagnosed conditions, any healthcare coverage, age-cohort, wave, HRS-cohorts fixed effects. Robust standard errors in brackets. The average of main variables for Hispanics 14.87 log net wealth and 14.55 for log NHF net wealth) and for NH Whites 14.95 for log net wealth and 14.59 for log NHF net wealth (See online appendix). *** Significant at the 1 percent level. ** Significant at the 5 percent level. * Significant at the 10 percent level.