Why the poor die 9 years earlier than the rich: An interview with Dr. Marc Cohen

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The United States is living through a crisis in longevity that can no longer hide behind statistical averages. After more than a century of steady progress, life expectancy has stagnated since 2010, with mortality now rising among the working class, while the most affluent enjoy the continued increases progress offers. Nowhere is this reversal more visible or damning than among the poor retired elderly.

A recent 2025 analysis by the National Council on Aging and the LeadingAge LTSS Center has provided the most precise measure yet of this divide between the rich and poor. Older adults in the lowest wealth decile (the poorest 10 percent) die, on average, nine years earlier than those at the top.

Drawing on Health and Retirement Study data from 2018 to 2022, the researchers found mortality rates of 17 to 21 percent among households who earned below $60,000, nearly twice those of the wealthiest quintile. Behind these numbers lies a simple truth—that poverty in old age maims and kills and at a much younger age.

The study's authors, including Dr. Marc A. Cohen of the University of Massachusetts Boston, describe a society where wealth has become a more powerful predictor of survival than genetics, geography or medical innovation. Among the roughly 34 million older-adult households the team analyzed, four in five live with little or no financial cushion. They are one illness, one spouse's death or one rent increase away from catastrophe. COVID-19 made that fragility unmistakable. As asset values soared for the top 20 percent, deaths mounted among older people of modest means, many confined to understaffed nursing homes or forced to delay medical care they could not afford.

The implications reach far beyond personal hardship. The United States spends nearly $4.9 trillion a year on healthcare (more than $14,000 per person) yet achieves the shortest lives and highest inequality among its peers. A quarter of that spending is lost to administrative waste and market complexity, while less than 3 percent goes to prevention or public health infrastructure. The result is a system optimized not for health but for the extraction of profits. Public health, once conceived as a collective good, has become the "poor relation of medicine," funded only when a crisis makes neglect impossible to ignore.

Dr. Cohen's research gives empirical weight to this structural indictment. A longtime analyst of long-term care financing and co-founder of the risk management firm LifePlans, he has spent decades studying how aging, health and economics interact. As co-director of the LeadingAge LTSS Center at UMass Boston, his work bridges academia and policy, quantifying what ideology obscures: that the premature deaths of millions of older Americans are not accidents of lifestyle but outcomes of design. His findings expose the moral arithmetic of a system in which physical survival itself is stratified by wealth.

In the following interview, Dr. Cohen reflected on what these data reveal about the nation's priorities, the consequences of decades of privatization and what must change if longevity is to be treated as a social right rather than a financial privilege.

Benjamin Mateus (BM): Dr. Cohen, your work has long examined how economic resources shape the experience of aging. To begin, could you introduce yourself and explain what motivated this latest study? What does it reveal about the relationship between wealth, longevity and the conditions of retirement in America?

And, perhaps as part of that, could you describe what measures of wealth you relied on and what those variables tell us about material security—not just income but the ability to weather crises or afford care?

Marc Cohen (MC): My background is in economics, finance and public policy, and I've devoted my career to studying issues related to long-term care—both financing and service delivery. About eight years ago, I was invited to join the University of Massachusetts Boston's Department of Gerontology to start a research center focused on aging: health, nursing homes, workforce, financing and consumer engagement. Together with my colleague Dr. Jane Tavares, we began working with the National Council on Aging (NCOA) on a series of studies they were interested in.

One of NCOA's core programs is the Benefits CheckUp, which helps older adults determine whether they qualify for public programs or benefits they aren't yet using. As part of that effort, they asked us to conduct broader research on what aging in America looks like. About six years ago, we decided to look at the data differently. The problem with averages is that they hide enormous variability. Averages can make inequality invisible.

So, we divided the population into wealth quintiles to understand how outcomes differ across the distribution. When I say "wealth," we looked not only at income but also at assets—financial holdings and housing equity, meaning the value of a home minus any debt or mortgage. We divided the population into five wealth groups and asked some basic questions: Who are these people? What do they look like economically? How do they live as they age? This most recent report is the fourth in a series we've produced for NCOA, and what becomes increasingly clear is that wealth stands in for a whole range of life-course conditions, not just income in later years.

Mortality rates were dramatically higher among those in the lower quintiles than among those at the top

In this latest study, we asked two straightforward questions. First, is there a difference in mortality across these wealth quintiles and, relatedly, what does that say about morbidity and overall well-being? Second, do people in different wealth brackets have the resources to live independently in their communities and meet basic needs?

We already knew from prior research that wealth and mortality are related. But what surprised us was how large that gap has become.

Mortality rates were dramatically higher among those in the lower quintiles than among those at the top. What's striking is that people in the lower wealth groups were, on average, younger, so you would expect their mortality to be lower—not higher—over a four-year period. You also would think they would be healthier. Yet we found the opposite.

Looking specifically at the bottom 20 percent versus the top 10 percent, we found about a *nine-year* difference in lifespan. That's staggering. It tells us that many of the so-called "social determinants of health" are at play here, not just access to healthcare or insurance, though those matter, but also health behaviors, nutrition, housing, transportation and whether people live in communities with enough services.

The second part of our analysis looked at people's ability to "age in place," meaning to remain independent and connected to their communities. My colleagues at UMass Boston developed a tool called the Elder Index, which is a much more accurate measure of what it costs to live independently. It accounts for geography, housing status and health, calculating local costs for food, transportation, healthcare and housing. When you compare those real costs with people's incomes, the picture is grim.

Our report shows that more than half of older households in the lower 60 percent of the wealth distribution are below the Elder Index. This means they must cut back on basic necessities just to remain in their communities. Among those in the bottom 20 percent, roughly 90 percent fall below the Elder Index. Many rely on programs like Medicaid or SNAP for nutrition assistance, but those safety nets are under threat.

Current legislative proposals, such as elements of the House Resolution 1 (HR 1) and the so-called OBBBA budget measures—the letters don't deserve to be spelt out—will make matters worse. These policies raise out-of-pocket costs for healthcare and food while imposing work requirement rules that push vulnerable people off programs they depend on. The idea that these are "able-bodied" individuals is simply false. Many are older adults with chronic conditions or disabilities. [*Note from Dr Cohen—"The demographics of these people are as follows: four in five are women, one in four are 50 or older, their average household size if 4.4 with no child dependents, 70 percent have a high school diploma or less, one in four live in rural areas, 79 percent have worked within the past five years and 30 percent are looking for work."*]

Also, we've studied the administrative burdens placed on recipients across states. What we found is when you make people constantly re-verify eligibility or provide extensive documentation, participation dramatically declines. People drop out not because they no longer qualify, but because they can't keep up with the paperwork. The result is that inequalities we already see, in both mortality and basic living standards, will only deepen. The burden of these policy choices falls most heavily on those least able to bear it.

BM: First, I think it's important to clarify that the Elder Index isn't the same as the poverty index. A person can be above the federal poverty line but still fall below the Elder Index.

MC: That's right. The whole reason we've moved away from using the federal poverty level is that it's based on a very narrow calculation—originally tied to the cost of a basic food basket. Although there have been some updates over time, it still doesn't account for the broader range of necessities older adults face today.

The Congressional Budget Office and others have recognized that the Elder Index provides a much more accurate picture of what it costs for an older person to live independently in their community. What you just described—people who are above the federal poverty level but below the Elder Index—we refer to as living in the gap.

Eligibility for most federal programs is based on the poverty line, so if you're "in the gap," you're technically not poor enough to qualify for assistance, yet you can't afford basic needs. You're living on the edge—one crisis away from falling into poverty. A serious illness, long-term care expense, job loss or even the death of a spouse can easily push you from that gap into true poverty.

BM: Let me move on to my next question, because it follows naturally from what you just said. Is this wealth-mortality gap mainly about access to care? You mentioned earlier that it's not. I would argue that a health system operating under the current socio-economic structure of society seems to encourage shorter lives among the poor because they're economically inconvenient to keep alive.

From your perspective, what does this longevity gap reveal about the structure of American society beyond individual behavior or lifestyle factors? And could you describe the people who make up that lower 60 percent you mentioned? What does their day-to-day reality look like? You've noted that many struggle with basic administrative demands, that they're often in poor health. In my experience many are wheelchair-bound or dependent on walkers, and they face enormous barriers just managing ordinary life with very little by way of basic support.

MC: What does it say about American society? I think it shows that, as a nation, we've come to accept an extraordinary level of income and resource inequality. Historically, we've tried to blunt its impact through the social safety net, but at some point we must ask, "When do we decide to close these gaps rather than just soften their consequences?"

When you know that your fellow citizens, people who have worked their entire lives, are likely to live almost a decade less simply because of their economic position, that should trouble all of us. And this isn't about people refusing to work. Many of those in the lower wealth brackets are working class Americans doing essential jobs: the person pumping gas, the grocery clerk, the home care aide. They keep society running, but their work doesn't produce the kind of wealth that insulates against hardship. In a society like ours, where value is measured in capital accumulation, that kind of labor is invisible, even though it's indispensable. And it is worth mentioning, that many of these jobs were deemed to be "essential" and these workers considered to be "essential workers" during the COVID-19 pandemic. Do we want people whom we deem as "essential" to have to give up on so many years of life?

What we wanted to do with this research was call attention to that contradiction. We talk about how much we value older Americans, how they built the country, yet we allow conditions that strip nearly 10 years from the lives of those without wealth. Regardless of political perspective, it's hard to argue that such an outcome is acceptable.

To be honest, when we began this study, we expected to find a two- or three-year difference in life expectancy between the highest and lowest groups. The nine-year gap was shocking. And if the current policy changes go through—reducing benefits and increasing out-of-pocket costs—we'll likely see that gap widening even further in our next analysis.

You also asked about whether this is mainly about access to healthcare. It's partly that, but it's also about lifelong environments and habits that are shaped by economic insecurity. As a physician, you understand how vital good nutrition, stable housing and primary care are to maintain health. Among vulnerable populations, we find that when people do engage with the healthcare system, their preferences and needs are often dismissed.

We've done studies showing that when patients feel unheard or disrespected, they disengage. They're less likely to seek preventive care, fill prescriptions or manage chronic conditions like diabetes. Over time, that leads to worse health and higher costs for the system as a whole.

And then there's geography. Many lower income older adults live in what we call "service deserts," areas with limited public transportation, little community supports and unaffordable housing. Housing itself is one of the most powerful social determinants of health. Simply put, if someone must choose between paying for heat or medication, their health will suffer.

The social determinants of health

So, access to care matters, but it's only one piece of a much larger puzzle. The social determinants of health—nutrition, housing, environment and the dignity with which people are treated—are all part of the same story. Together they reveal the real meaning of inequality; not just fewer years of life, but lives lived with far fewer options often accompanied by feelings of disrespect.

BM: Your dataset spans 2018 to 2022, which includes the early years of the COVID-19 pandemic. How did that crisis affect—or perhaps amplify—the wealth-mortality relationship you were studying? Did you observe any differences between the 2018-2019 period and the 2020-2022 group?

MC: With this particular dataset, we focused on the 2018 to 2022 period, but we have longitudinal data that goes back to 1998. That allows us to track changes in older adults' circumstances over time. For this study, our task was to analyze that specific window, but COVID-19 made the data incredibly complex.

The pandemic disproportionately affected older adults, especially those in institutional settings like nursing homes. At the same time, it hit the workforce that provides care for those elderly people, which further destabilized the system. So COVID introduced a whole layer of distortion and vulnerability that's hard to untangle.

We didn't separate the pre- and post-pandemic cohorts for this particular report, largely because of sample-size variation during that period, but we plan to in the next round of analysis as the dataset expands. Based on what we already know, though, the wealth-mortality gap has been growing over time. COVID certainly contributed to that widening, and [so will] the upcoming policy changes like those proposed by the recent bill passed by Trump.

BM: Given your extensive research on long-term care policy and facilities, what did the COVID-19 pandemic reveal about the state of long-term care in the United States and about how we care for older adults more broadly?

MC: I have a very clear answer to that. What we saw during the pandemic was the entirely predictable result of a chronically underfunded system. It's that simple. There just aren't enough resources going into long-term care, and what exists is organized in a deeply uneven way.

Medicaid is the primary public payer for long-term services and supports—nursing homes, home care, community-based care—but it's a means-tested program funded through general tax revenues and subject to the ups and downs of the budget process. If you're poor, Medicaid will often guarantee you institutional care, and while 47 states and the District of Columbia have programs that cover home- and community-based services, these programs are optional and are often underfunded, which results in long waiting lists for services. If you're wealthy, you can afford private insurance or pay directly. But if you're part of the broad, overlooked middle class, you're out of luck.

I've argued for years that we need a true social-insurance model for long-term services and supports, where everyone pays in and receives a basic level of coverage when care is needed. What we have now barely qualifies as a "system." In fact, I've been told that even calling it a system gives it too much credit.

During the pandemic, the cracks were impossible to ignore. We didn't have enough resources to attract and retain a stable workforce. We couldn't pay caregivers a living wage. States tried to patch the problem by passing emergency legislation to temporarily raise wages, and that helped for a time. But you also had a situation where labor-market competition for employees in nursing homes came from places like McDonald's or Burger King that sometimes paid more for work that was clearly less challenging.

Another issue on this topic frequently overlooked is immigration. Roughly one-third of the long-term care workforce in the United States is made up of immigrants. When immigration is restricted, it directly worsens the shortage of caregivers. That's an unintended consequence few policymakers consider.

So, we say we value our elders, the people who built this country, but we entrust their care to a workforce that's largely underpaid, undervalued and increasingly unstable. The people providing that care, many of them immigrants and women of color, are essential workers doing some of the hardest labor imaginable. They're the backbone of the system, and yet the system doesn't work for them either. That's what the pandemic revealed most clearly: a structure that depends on underpaid workers to care for our most vulnerable and purportedly valued citizens. Something is wrong with this picture.

BM: The way you describe the system and the workers who hold it together is very vivid, and I think the points you're making are critical. As a follow-up, in your experience working with policymakers, does this moral dimension resonate? I mean the recognition that health inequality, especially among the elderly, undermines democracy itself, do you find that awareness present in policy discussions, or is it largely absent?

MC: That's a great question. My sense is that policy change rarely happens unless there's local, constituent demand for it—from the bottom up. It's very unusual for a purely moral argument, on its own, to move policy across the finish line. The moral case is essential, but it's often not sufficient.

What makes it powerful is when it's paired with the voices of people who have lived these experiences. Their stories give life to the data. The kind of empirical work I do—statistics, mortality rates, percentages—can only go so far. Without the human dimension, it's too easy to forget that we're talking about real people, not just numbers.

In my experience, you also need an economic argument alongside the moral one. Policymakers need to see that inequality and underinvestment harm the economy. When workers must reduce their hours, turn down promotions, or leave the labor force to care for aging relatives, that affects employers, productivity and state revenues. There's a direct cost to doing nothing.

That said, I remain somewhat optimistic about long-term care because it's not strictly a partisan issue. Everyone has an elder in their life, parents, grandparents, someone they love. That personal connection can bridge divides and bring people together in ways that other issues can't.

Still, if you rely solely on the moral argument, it won't be enough. We have 200 years of social policy history showing that change only occurs when moral conviction combines with economic pressure and grassroots demand. The real obstacle isn't one ideology versus another but inertia. Doing nothing is the default.

A good example is Washington state, which created its own social-insurance program for long-term services and support. They start paying out benefits next year. That happened because policymakers there recognized that the cost of doing nothing was finally greater than the cost of acting.

BM: As our time is nearing an end, I'd like to ask one more follow-up question.

You mentioned feeling somewhat optimistic, but given the nature of a capitalist healthcare system, I wonder how far that optimism can really go. *The Lancet* and *STAT News* have both recently written about the financialization of medicine or how profit has become the organizing principle of care. We now spend trillions of dollars treating disease but comparatively nothing on prevention, and we see the results in fraud, waste and the privatization of programs like Medicare. This is but one facet of the broader picture.

Access to specialized care can take weeks. Meaning, someone can access orthopedic care in 12 days but must wait more than six to eight

weeks to see primary care. These delays fall hardest on working people and the working class elderly who have the highest medical demands, as your studies have indicated. So, given this level of corporate control and market distortion, how optimistic are you that policymakers will listen to such voices and empirical data instead of the corporate interests that profit from keeping the system just as it is?

MC: I can answer that question without necessarily accepting all the premises behind it. But I will say this. There's a line that gets attributed to Winston Churchill, that Americans will exhaust every other alternative before finally doing the right thing. That feels about right when it comes to healthcare.

What concerns me most right now are the ongoing attacks on the social safety net. That's what really keeps me up at night. These cuts target people who don't have access to private alternatives—the ones who can't simply buy long-term care insurance or pay out of pocket. For them, programs like Medicaid or Medicare aren't luxuries; they are their lifelines.

Still, the reason I remain somewhat optimistic is because this issue truly cuts across party lines. I'm a baby boomer—part of that "snake that swallowed the cow" coming through the demographic curve. My generation is very large and, frankly, very demanding. As more of us age and the need for care grows, the political pressure to act will only intensify. In my experience, policymakers often need proof points, examples that show reform can work. Take Massachusetts, where I live. What became known as "Romney Care" was our state's attempt to provide near-universal coverage. It wasn't perfect, but it demonstrated that you could insure everyone without bankrupting the system. The Affordable Care Act was modeled on that experiment.

So yes, I share many of your concerns about financialization and inequality, but I still believe progress happens when we can point to tangible successes. That's what brings skeptics along.

BM: Thank you so much for your time, Dr. Cohen. I enjoyed our conversation, and I hope we'll have the chance to talk again soon**.**