DEPARTMENT OF HEALTH AND HUMAN SERVICES
ASSISTANT SECRETARY FOR PLANNING AND EVALUATION
OFFICE OF HEALTH POLICY

PHONE: (202) 690-6870 FAX: (202) 401-7321

Date:

From: Ellie Dehoney **To:** Jennifer Klein

Phone: (202) 690- _____ **Phone:** _____
(202) 690-6870
FAX: (202) 401-7321 **Fax:** 456 - 2878

Number of Pages (Including Cover): 3

Comments:

Jen - I'll give you a call -
Ellie

Medicare and Medicaid Provide Critical Services for Older Women

- **Medicaid pays Medicare premiums for about 4 million elderly women in poverty. Most of these beneficiaries also recive Medicaid coverage for Medicare coinsurance and deductibles.[13]**

  (Jen - these figures were estimated by taking Lewin data on QMBs and SLMBs vs. Dual eligibles, and adjusting by the percentage of elderly women among Medicaid/Medicare enrollees (about 75%, according to 1993 Health Care financing Review article). I checked with HCFA and could not get a QMB/SLMB split, but since both dual eligibles (nearly 50% of all Medicare/Medicaid) and QMBs have their cost sharing covered, I think we're safe to say that most of them do.

MEDICARE
REDUCED BENEFITS AND INCREASED MEDICARE COSTS

Increases premiums

- **Over 19 million elderly women, more than a third of whom are at or near poverty, are currently enrolled in the Medicare Part B program. Under the Republican plan, elderly women will shoulder nearly 25 billion of the proposed $48.6 billion premium increase.[14]**

- **Over 20% ($10.4) billion of the increase would from elderly women with incomes below 200% of poverty.[15]**

---

[13] Estimates based on data from: HCFA, Office of Legislation and Inter-Governmental Affairs; The 1994 Greenbook, Tables B-11 and 5-1; and G. Chulis et al., "Health Insurance and the Elderly: Data from the MCBS," Health Care Financing Review, Spring 1993: Volume 14, Number 3, pp. 163-181

[14] Estimates based on data from: 1995 Greenbook, Tables 5-1 and B-11; CBO Savings estimates; and Statistical Abstract of the United States, 1995.

[15] Ibid.

Calculations for data on women in poverty's share of Medicare premium increases.

Based on 1995 Greenbook, Tables B-11 and 5-1, and 1995
Statistical Abstract of the United States

% of Medicare benies below 200% poverty	0.419674	8.203263	Greenbook B-11
% of aged Medicare beneficiaries enrolled in Part B	0.977337	19.54674	Greenbook 5-1
%/# of women in Medicare	0.59	20	stat abstract
(percentage elderly women/elderly men)			
% savings borne by women under 200%	24.786	10.40204	41.9% * 24.7 billion

Conservative estimates, given that a higher percentageof women are in poverty than men

to calculate QMBs and SLMBs vs. dual eligibles

0.749928	(from Health care Financing Review, % of women with Medicaid supplement = approximately 75%	
4.05	75% * 5.4 million	
	dual eligibles as a % of total	44.4%
	2.4/5.4	

Claculations: how much elderly women will shoulder form Greenbook

elderly as a % of all Part B	0.889091	Greenbook 5-1
women as a % of all Part B	0.506782	HCFA Review + 5-1

women will shoulder approximately 51% of reductions

0.51	48.6	24.786
amount borne		10.40204
by women below 200%		

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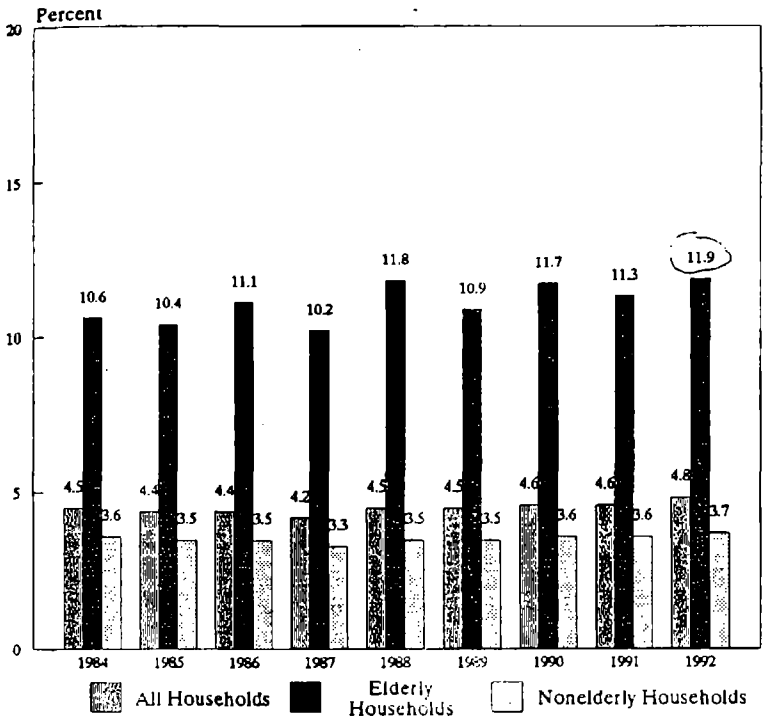
Comments:

Jen - I'll give you a call -
Ellie

1994 Greenbook

CHART B–2. DIRECT HOUSEHOLD SPENDING FOR HEALTH CARE AS A PERCENTAGE OF HOUSEHOLD INCOME BY TYPE OF HOUSEHOLD, 1984–92



Re-do

SOURCE: Congressional Budget Office calculations based on data from the Consumer Expenditure Surveys (CES) of the Bureau of Labor Statistics, 1984–1992.

NOTES: Direct household spending for health care consists of the amount directly paid for health insurance premiums by a household, as well as out-of-pocket spending for health care services, including deductibles and copayments.

Elderly households are those in which the primary home owner or renter in the household is 65 or older. Such households may include individuals younger than 65. Nonelderly households are those in which the primary home owner or renter in the household is younger than 65. Such households may include individuals age 65 or older.

Although expenditures for health care by the institutionalized population are not collected by the CES, if a member residing in the household contributes to health-related expenses of an institutionalized person, then those expenditures are counted as direct household spending for health care.

Household income refers to income before taxes.

ased the most r
n 1990 and 199
idly due equally
ost to the enrolle
since 1985—a d
program and th
e table B–8 for d
ts under Medicare
f their income fo
lees' per capita in
care costs unde
estimated 8.6 per
are of costs under

h care by elderly
on 65 or older, as
the early 1970's,
. Chart B–2 illus-
as a percentage of
nonelderly house-
direct household
sehold income for
. up slightly from
lderly households
ie for health care.

DICARE, SELECTED

	2000	Annual growth 1975–2000 (in percent)
0	$916	9.6
0	100	2.1
0	60.70	9.2
	673	4.7
	73	−2.5
	44.59	4.3

d halves of the year.

Statistical Handbook on Aging Americans

E3-5. Selected Characteristics, Annual Expenditures, Sources of Income, and Shares of Expenditures and Income, for Older Consumer Units, by Income Class, Consumer Expenditure Survey: 1988 to 1989

Item	All consumer units age 65 and over[1]	Age 65 to 74			Age 75 and over		
		Less than $15,000	$15,000 to $29,999	$30,000 and over	Less than $15,000	$15,000 to $29,999	$30,000 and over
Number of consumer units (in thousands)	17,621	4,961	3,288	2,052	5,322	1,336	661
Average number of persons	1.8	1.6	2.2	2.4	1.4	1.9	2.1
Age of reference person	73.8	69.4	69.2	68.4	80.8	79.3	79.1
Number of earners	.5	.4	.7	1.2	.1	.3	.5
Percent:							
Male	56	49	72	79	36	75	78
Homeowner	77	67	87	91	70	83	90
Black	10	14	9	3	12	2	2
College	25	15	29	57	15	29	52
Own at least one vehicle	78	76	96	99	58	89	92
Total expenditures	$18,372	$13,614	$20,862	$39,354	$10,424	$21,396	$37,656
Percent distribution:							
Food	15.3	16.4	16.8	14.1	17.7	13.7	11.3
Food at home	10.2	11.9	11.1	7.6	13.5	9.2	6.0
Food away from home	5.1	4.5	5.7	6.4	4.2	4.5	5.3
Housing	31.8	35.3	29.7	28.1	38.7	28.7	27.2
Apparel and services	4.5	4.7	5.3	5.3	3.3	3.5	4.2
Transportation	17.1	16.1	18.7	20.0	10.3	20.9	15.1
Health care	11.6	12.4	10.6	6.3	16.7	15.6	12.2
Entertainment	3.7	3.1	3.9	4.7	2.2	3.4	4.7
Other[2]	11.8	9.6	11.1	13.0	10.1	11.4	20.1
Personal insurance, pensions	4.3	2.4	4.0	8.5	1.0	2.8	5.2
Income before taxes[3]	$18,746	$8,654	$20,990	$52,875	$8,018	$21,049	$59,095
Percent distribution:							
Wages and salaries	19.7	6.4	21.8	37.2	1.9	8.1	10.1
Social security, retirement	58.3	85.9	68.3	33.3	88.5	72.4	39.8
Interest, dividends	15.2	4.2	8.2	16.6	6.2	16.5	44.5
Other income	6.8	3.5	3.7	12.9	3.5	2.9	5.6

[1]"Complete income reporters" only.

[2]Includes expenditures for alcoholic beverages, personal care, reading, education, tobacco, miscellaneous expenditures, and cash contributions.

[3]Income values are derived from "complete income reporters" only.

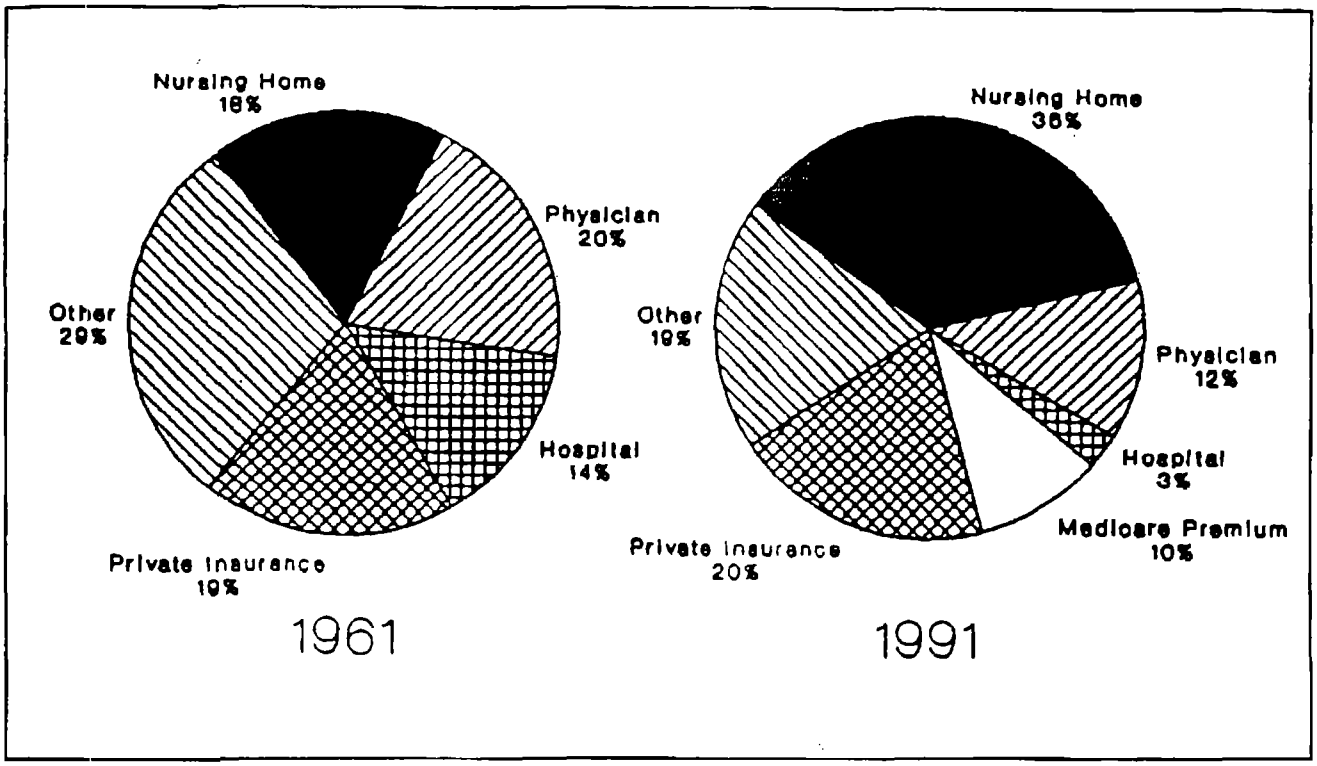
E3-6. Annual Expenditures, Expenditure Shares, and Characteristics of Single Consumer Units Classified by Sex and Selected Age Groups, Consumer Expenditure Survey: 1988 to 1989

	Single men			Single women		
	All ages	25-34	65 and over	All ages	25-34	65 and over
Income before taxes	$20,941	$22,931	$15,383	$13,803	$19,270	$9,989
Age of reference person	42	29	74	55	29	76
Percent homeowner	33	25	60	47	19	65
Number of earners	.8	1.0	.2	.5	.9	.1
Total expenditures	$18,668	$20,878	$13,977	$14,275	$17,416	$11,058
Percent distribution:						
Food	13	13	15	13	12	15
Food at home	5	5	8	8	5	11
Food away from home	8	9	7	5	7	4
Housing	31	32	34	37	34	41
Shelter	21	22	19	22	23	21
Utilities	6	5	8	8	6	11
Other housing[1]	5	5	6	7	5	9
Apparel and services	4	5	3	7	8	5
Transportation	20	22	20	14	18	9
Health care	4	2	12	7	4	13
Entertainment	5	5	3	4	6	3
Other[2]	22	21	14	17	18	14

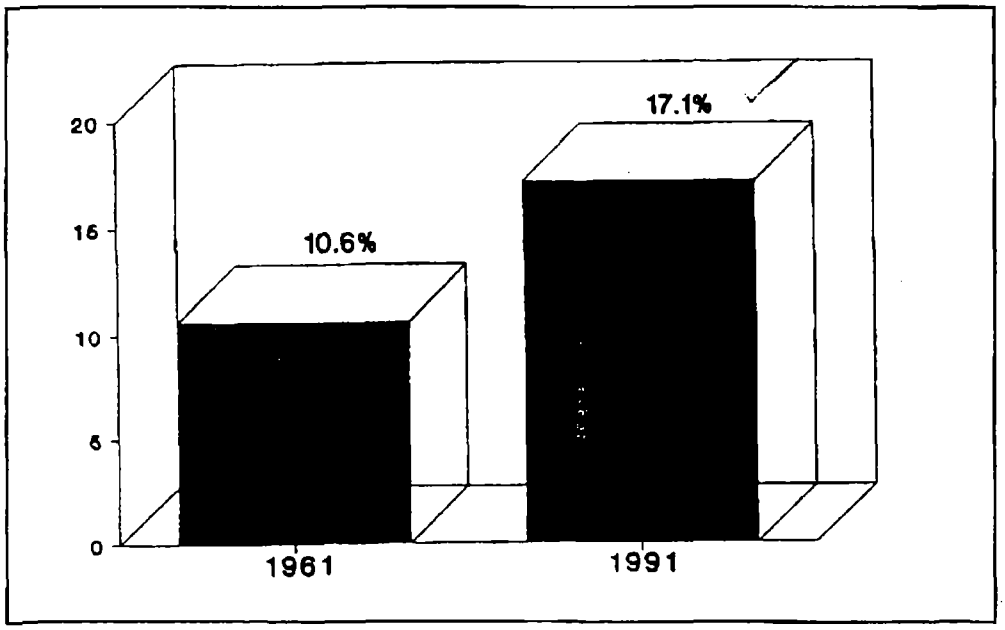
[1]Includes household operations, housekeeping supplies, and household furnishings and equipment.

[2]Includes alcoholic beverages, personal care, reading, education, tobacco, miscellaneous, cash contributions, and personal insurance and pensions.

E3-16. Distribution of Out-of-Pocket Health Care Costs Per Elderly Family



E3-17. Elderly Out-of-Pocket Health Care Expenses as a Portion of After-Tax Income



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Secretary

Washington, D.C. 20201

Date:

FACSIMILE

PLEASE NOTIFY OR HAND-CARRY THIS TRANSMISSION TO THE FOLLOWING PERSON AS SOON AS POSSIBLE:

Name(s): J. Klein

Department: _____

Phone#: _____

Fax#: 456-2878

FROM: Leslie Hardy

Assistant Secretary for Planning & Evaluation

Number of pages being transmitted (including fax sheet): 5

COMMENTS: _____

MEDICAL NEEDS AND EXPENSES

While all older Americans spend a significant portion of their incomes on health care, elderly women spend who live alone face the greatest financial burden.

Older Americans Spend A Significant Portion of Their Incomes On Health Care. Older Americans currently spend 21% of their incomes on health care.[17]

FILL IN RIGHT NUMBERS

Older Women Rely More Than Men On Long-Term Care. Twenty-two percent of women and 15% of men 65 or older either live in an institution or need help to live at home.[18] [COMPARABLE NUMBER OF MEN?]

- **Home Care.** Older women living alone are major users of paid home care services. ~~HOW MUCH HOME CARE DO THEY USE? HOW MUCH DOES IT COST?~~ About 62% of all women receiving paid home care live alone; another 28% live with adult children or others. Only 10% of women receiving home care are married.[19]

still checking

- **Nursing Home Care.** Over 75% of nursing home residents are women. Roughly 28% of all women over 85 live in nursing homes.[20] The average cost of nursing home care is $38,000 per year – more than four times the median income for older women. On average, women remain in nursing homes a year longer than men.[21]

(Compared with the 16% of men in this age group.)

WOMEN AS CAREGIVERS

Women are the primary caregivers for their spouses and parents.

---

[17]NEED CITE

[18]Guralnik and Simonsick, "Physical Disability in Older Americans, *J. Of Gerontology*, Vol. 48 (special issue): 3-10, 1993.

[19]Diane Rowland and Karen Davis. Caring for Women in Older Age. *An Unfinished Revolution: Women and Health Care in America*, DATE???.

[20]Bureau of the Census and National Institute on Aging, *Profiles of America's Elderly*, No. 4, November 1993.

[21]P. Kemper, et al A Lifetime Perspective on Proposals for Financing Nursing Home Care, *Inquiry* 28(4):333-344, Winter 1991.

- Today, more than 7 million Americans are unpaid caregivers who provide about 75% of all non-medical care to the frail elderly.[22] Seven out of ten of these caregivers are women.[23] The typical unpaid caregiver is a woman in her middle or older years (average age of 57) providing care to a parent, spouse or other relative. Women provide the care that has helped to alleviate the need for formal supportive services and health care and to forestall costly institutional care for loved ones.

- The role of "unpaid caregiver" has important consequences for women's health. Caregiving can be a significant financial drain, and it is likely to have an even greater emotional and physical impact, particularly as the woman gets older. The stresses and strains of care giving, including the inability to have a break from responsibilities, can lead to depression, reduced immunity levels, poor general health, and lower quality of life.[24]

- The majority of formal workers in the long-term care field are also women, as nurses or lower-skilled workers.[25] [BETTER DATA?] Still checking. See attached re paid home care aides

OLDER WOMEN'S DEPENDENCE ON MEDICARE AND MEDICAID

Number of Women Covered

- Medicare. Of the 37 million Medicare beneficiaries, over 20 million, or 57% are women. There are twice as many female beneficiaries over age 85 than men.[26]

- Medicaid. Over 4 million older Americans are covered by Medicaid. 60% of all Medicaid beneficiaries are women.[27]

Dependence on Medicare and Medicaid

---

[22]Paper presented by Fernando Torres-Gil, Assistant Secretary for Aging, at the Conference on Women and Aging: An Agenda for Action, October 30, 1995.

[23]U.S. Congress, 1987. House Select Committee on Aging, Exploding the Myths: Caregiving in America, January 1987.

[24]U.S. Public Health Service, Office on Women's Health, *Fact Sheet on Older Women's Health*, 1995.

[25]C. Costello and A.J. Stone eds. *The American Woman 1994-1995.*

[26]HCFA. *Medicare: A Profile* February 1995.

[27]Department of Health and Human Services, 1995.

Paid Home Care Aids (use to replace info. on "formal workers in LTC."

According to estimates based on the 1989 Current Population Survey, approximately 197,049 persons work as home care aides. The overwhelming majority (90%) of home care aides in the survey were female (see attached table for more info.).[1]

[1]S.J. Williams, series ed. *The Continuum of Long-Term Care: An Integrated Systems Approach.* Albany, NY: Delmar Publishers Inc., 1996.

TABLE 9.4. Characteristics of informal caregivers

Relationship	
Spouse	50%
Child	35%
Average Age	62 years
Own Health	
Excellent or Good	67%
Female	80%
Poor or Near Poor	29%
Caring for Severely Impaired Seniors (>=6 ADL Impairments)	43%
Also Caring for Children under 18 Years of Age	5%
Working	27%

Source: National Long-Term Care Survey, 1989.

NLTCS, about one-half of the primary caregivers (i.e., those who take primary responsibility for providing care) of the more severely ADL-impaired seniors are spouses; about one-third are children. The average age of primary caregivers in 1989 was 62. Two-thirds (67 percent) of primary caregivers of the ADL-impaired reported that their own health was excellent or good. Nearly four-fifths of primary caregivers of the ADL-impaired were women. Slightly over one-fourth (29 percent) were poor or near poor. Over two-fifths (43 percent) of primary caregivers of ADL-impaired seniors were caring for very severely disabled persons (i.e., those with five or six ADL impairments) (Jackson, 1992a, 1992b).

In view of the attention given in the gerontological literature to *women in the middle* (Brody, 1981; Boyd & Treas, 1989), it is interesting to note that only about 5 percent of primary caregivers of the severely disabled, i.e., those requiring help with personal care, had children under age 18 (Jackson, 1992a, 1992b). This is not surprising given the average age of those caring for disabled seniors. An examination of grandparenting responsibilities would probably reveal a higher percentage of informal caregivers with some type of child care responsibilities.

Compared to caregivers in 1982, caregivers in 1989 were slightly older, in slightly better health, more predominantly female, slightly better off financially, and more likely to be caring for more severely disabled seniors. Slightly more than one-fourth (27 percent) of the primary caregivers of the ADL-impaired seniors were working as of 1989, up from slightly less than one-fourth (23 percent) in 1982 (Liu, Manton, & Liu, 1985; Stone, Cafferata, & Sangl, 1987; Jackson, 1992a, 1992b).

Paid Home Care Aides

According to estimates based on the 1989 Current Population Survey (CPS) (Crown et al., 1992), approximately 197,049 persons work as home care aides (Table 9.5.). The overwhelming majority (over 90 percent) of home care aides in the survey were female. Their mean age was 45.5 years. Although most (72 percent) were white, home care aides were disproportionately (27 percent) black in comparison to the United States population generally. Over one-half (52 percent) reported having less than a high school education. Many home care aides reported no close family: a majority (62 percent) were single (widowed, divorced, separated, or never married), and a very high percentage (71 percent) were childless.

Home care does not appear to provide stable, full-time work for very many aides. Only 18 percent of home care aides reported being employed

TABLE 9.5. Characteristics of paid home care aides N=197,049

Female	90%
Mean Age	45.5 years
Race	
White	72%
Black	27%
Less than high school education	52%
Marital Status Single	62%
Childless	71%
No health insurance	34%
No pension coverage	36%
Median hourly wage (1988)	$4.00
Mean hourly wage	$5.17

Source: 1989 Current Population Survey (Crown, 1992)

THE HEALTH OF AMERICA'S OLDER WOMEN: A REPORT ON CURRENT STATUS AND THE IMPACT OF REPUBLICAN BUDGET CUTS

Jen —

Just some rough notes.

Call if you have questions.

Anne.

December 20, 1995

A PROFILE OF AMERICA'S OLDER WOMEN

DEMOGRAPHIC TRENDS

Add into/transition sentence; something like – The American population is aging; elderly women make up large & growing share; this is an important segment of our society.

The Population is Aging. Currently, 13% of the total population in the United States, or 33.2 million Americans, are 65 or older. In the next 35 years, by 2030, the number of Americans over the age of 65 will more than double, reaching 20% of the total population or 70 million.[1]

The Number of Older Women is Growing. --%, or about 20 million, of Americans age 65 or older are women. In the next 35 years, that number will grow to --% or -- million.[2]

Women Over 85 Are the Fastest Growing Segment of Society. [make sure this right]

- Life expectancy for women has increased steadily. In 1960, life expectancy at birth for females was about 73.[3] By 1992, life expectancy increased to about 79 years.[4] There is a gap between life expectancy for men and women. In 1989, for example, life expectancy at birth was 78.6 for a girl and 71.8 for a boy.[5] [MORE RECENT STATS FOR MEN V. WOMEN]

  can we get ♂ comparison

- The number of people over the age of 85 is growing quickly, and women account for --% of this group.[6] Today, --% of the population (2.5 million) are women over 85,[7] and --% (-- million) of the population will be women over 85 by the year 2030.[8]

---

[1] U.S. Bureau of the Census, Current Population Reports.

[2] NEED CITE

[3] C. Costello and A.J. Stone, eds. *The American Woman: 1994 - 1995* Women's Research and Education Institute, 1994

[4] NEED CITE

[5] Id.

[6] NEED CITE

[7] Current Population Survey, March 1995.

[8] NEED CITE

I'm not positive, but it might make more sense to put medical needs first, and then discuss finances. The argument seems to be: ① they need expensive medical care, but ② they don't have the $$ to pay...

Older Women Are Far More Likely Than Men to Live Alone. Almost four times as many women than men 65 or older live alone.[9] Because women have longer life expectancies and many women marry men who are older, the life expectancy for widowed women in the United States is about 17 years beyond the death of their spouses -- years in which increased frailty or disability are generally endured alone.[10]

what's the relevance? Is the point -- no one to care for them if disabled? Then put this after point on loss of functioning

Transition sentence: Elderly women are a vulnerable ...

FINANCIAL STATUS

older

Older Women Are Poorer Than Men.

- **The ~~average~~ median income for women 65 or older is about $8,500 a year**[11] [CHART IN BOOK P. 339 SAYS $11,323/P.233 -- MEDIAN = $9,740] The average income for men is [$20,381, about 80% more than the average for women. NOTE: THIS IS A 1991 NUMBER. CALL OLDER WOMEN'S LEAGUE]

- **Minority Women Are Poorer Still.** Minority women have substantially lower incomes. Black women age 75 and older had median incomes of $6,246 in 1991and women of Hispanic origin, $5,853.[12]

Save for minority section?

- In 1994, 40% of women aged 65 to 74 and 56% of women over 75 lived on incomes below twice the poverty line (income of less than $14,000) [CHECK -- I'VE LEFT OUT STRAIGHT POVERTY NUMBERS -- OKAY?]. [ALSO -- WHAT ABOUT MEN?][13]

Do these seem consistent?

Poverty Rates Among Women Living Alone Are Higher. Poverty rates are higher at every age for women who live alone than for men, and the disparity increases with age. In 1991, 27% of women 65 and over living alone were in poverty (income of $7,000), compared to 18.5% of men.[14] Another 14% of these women were near poor (income of $ -----). And the picture was even worse for minority women; nearly nine out of ten black women living alone had incomes below two times the poverty threshhold.[15]

Save for minority section?

---

[9]NEED CITE. "MEDICARE PROFILE"???

[10]C. Costello and A.J. Stone. *The American Woman 1994-1995*

[11]Older Women's League. 1995

[12]American Woman p. 233 - NEED BETTER CITE - - Bureau of the Census ????

[13]Bureau of the Census. Poverty Branch. 1994 data

[14]Bureau of the Cnsus. Poverty in the United States: 1991. 1992.

[15]Bureau of the Census. 1992

Half of All Women on Social Security Would be Poor Without It. As of 1990, 33% of unmarried women age 65 or older who received Social Security depended on it for at least 90% of their income; more than 18% had no other income.[16] Half of all women beneficiaries would be poor if they did not receive a Social Security benefit.[17]

HEALTH STATUS

Despite living, on average, seven years longer than men, women have poorer health outcomes and are more likely to have chronic diseases and disability than men.

- Women age 65 or older are more likely than men to suffer from chronic diseases like arthritis and diabetes. Any of these conditions may contribute to a loss of functioning, particularly as women age. [MORE INFO ON DIFFERENCES AT AGE 65 AND OLDER]

- More than half of all women over age 85 have problems managing basic daily activities like bathing and eating, as compared to only 34% of men in the same age group.[18] In addition, because women generally live longer than men, they are more likely to get diseases associated with very old age, including Alzheimer's and complications arising from osteoporosis.

PUT IN CHART HERE TITLED "DISEASES AFFECTING OLDER WOMEN"

DISEASE	NUMBER OF WOMEN AFFECTED	IMPACT ON WOMEN
Heart Disease and Stroke	In 1990, 3.6 million, or 1 in 3, women over 65 suffered from heart disease. In the same year, 1.1 million older women suffered a stroke.[19]	Leading cause of death. Dollars spent?

[16]American Association of Retired Persons (AARP) Fact Sheet, Facts About Older Women: Income and Poverty, 1995.

[17]R. O'Grady-LeShane, Economic Security for Midlife and Older Women. Background paper prepared for the Conference on Women and Aging: An Agenda for Action (sponsored by PHS Office on Women's Health and the National Policy and Resource Center of Women and Aging, Brandeis University), October 30, 1995.

[18]Health Care Financing Administration (HCFA), Medicare: A Profile, February 1995.

[19]National Heart, Lung and Blood Institute, 1990.

MEDICAL NEEDS AND EXPENSES

While all older Americans spend a significant portion of their incomes on health care, women spend more than men. [IS THIS TRUE?]

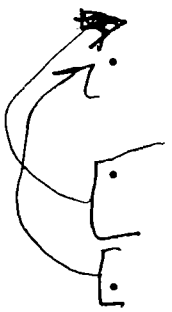
- Older Americans currently spend 21% of their incomes on health care.[20]

[JEN TO TALK TO JUDY FEDER, DIANE ROWLAND]

[DO WE HAVE DATA SHOWING THAT WOMEN SPEND MORE THAN MEN? THAT WOMEN ARE SPENDING AN INCREASING PERCENTAGE OF THEIR INCOMES ON MEDICAL EXPENSES?]

BREAKDOWN OF LEADING MEDICAL EXPENSES FOR ELDERLY WOMEN -- E.G., PRESCRIPTION DRUGS, NURSING HOME CARE.

Older Women Rely More on Costly Long-Term Care.



- 22% of women 65 or older either live in an institution or need help to live at home.[21] Twenty-six percent of all women over 85 live in nursing homes.[22]
- Over 75% of nursing home residents are women.[23] The average cost of nursing home care is $38,000 per year -- about three times the median income for older women.
- Women on average remain in nursing homes a year longer than men.[24]

---

[20]NEED CITE

[21]NEED UNDERLYING CITE NOT JUST AMERICAN WOMAN BOOK

[22]NEED CITE

[23]Bureau of the Census and National Institute on Aging, *Profiles of America's Elderly* No. 4, November 1993.

[24]P. Kemper, et al. "Lifetime Perspective on Proposals for Financing Nursing Home Care." *Inquiry* 28:333-344, Winter 1991. [CHECK CITE]

Need to make this section relevant. ① Highlight age (more than half of unpaid caregivers are over 57) ② Elderly women face special burdens. (A) Care for elderly spouse (data?) (B) care for grandchildren (data?) (C) Care for children (data?)

WOMEN AS CAREGIVERS

Women are the primary caregivers for their spouses and parents.

- Today, more than 7 million Americans are unpaid caregivers who provide about 75% of all non-medical care to the frail elderly.[25] Seven out of ten of these caregivers are women.[26] The typical unpaid caregiver is a woman in her middle or older years (average age of 57) providing care to a parent, spouse or other relative. Women provide the care that has helped to alleviate the need for formal supportive services and health care and to forestall costly institutional care for loved ones.

- The role of "unpaid caregiver" has important consequences for women's health. Caregiving can be a significant financial drain, and it is likely to have an even greater emotional and physical impact, particularly as the woman gets older. The stresses and strains of care giving, including the inability to have a break from responsibilities, can lead to depression, reduced immunity levels, poor general health, and lower quality of life.[27]

- The majority of formal workers in the long-term care field are also women, as nurses or lower-skilled workers.[28] [BETTER DATA?] relevant?

MINORITY WOMEN

[NEED INFORMATION]

Minority women face special health problems.

① Poorer ... Higher poverty rates

② Medical needs higher at older age b/c of neglect [NEED DATA]

③ More elderly women are primary caregivers in family (?)

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[25]Paper presented by Fernando Torres-Gil, Assistant Secretary for Aging, at the Conference on WOmen and Aging: An Agenda for Action, October 30, 1995

[26]U.S. Congress, 1987.

[27]U.S. Public Health Service, Office on Women's Health, *Fact Sheet on Older Women's Health* 1995

[28]C. Costello and A.J. Stone eds. *The American Woman 1194-1995*

THE IMPACT OF THE REPUBLICAN CUTS IN MEDICARE AND MEDICAID

OLDER WOMEN'S DEPENDENCE ON MEDICARE AND MEDICAID

Number of Women Covered

- **Medicare.** Of the 37 million Medicare beneficiaries, over 20 million, or 57% are women. There are twice as many female beneficiaries over age 85 than men.[29]

- **Medicaid.** Over 4 million older Americans are covered by Medicaid. 60% of all Medicaid beneficiaries are women.[30] How many of older women (breakdown older women/older men)

Dependence on Medicare and Medicaid

Older Women Are More Likely to Rely on Medicare and Medicaid. Because elderly women typically have lower socioeconomic status and more limited retirement benefits than elderly men, they are more likely than men to be either solely dependent on Medicare or to have coverage under Medicaid, which serves as supplemental insurance to Medicare for eligible low-income elderly people. -- million, or 23% of women age 65 or older, have only Medicare to cover their medical bills. An additional 2 million (11%) of older women rely on Medicaid in addition to Medicare.[31]

? → no other income?

Medicare and Medicaid Provide Critical Services for Older Women.

- Medicare covers a range of medical services, including hospital stays, physician visits and home health care.

Any details for older women?

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[29]HCFA. *Medicare: A Profile* February 1995

[30]Department of Health and Human Services. 1995

[31]C. Costello and A.J. Stone. *The American Woman 1994-1995*

- Medicaid also covers essential services for older women, including some -- like prescription drugs -- that are not covered by Medicare.

    - Medicaid will pay an average of over $800 for prescription drugs for an older woman on Medicaid in 1995.[32]

    - Approximately 68% of the nation's one million nursing home residents rely on Medicaid to pay for some or all their care. Over 75% of nursing home residents are women.[33]

    - In 1995, Medicaid paid Medicare premiums, coinsurance and deductibles for about 2 million poor, older women.[34] [WHAT ABOUT SLMB?]

[32]Department of Health and Human Services estimates from aged National Medical Expenditure Survey data, 1995.

[33]Department of Health and Human Services, 1995

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MEDICARE

REDUCED BENEFITS AND INCREASED MEDICARE COSTS

The Republican Medicare Plan Will Reduce Benefits and Increase Health Care Costs for Older Women. The Republican budget cuts Medicare by an unprecedented $[200] billion. These cuts will reduce the benefit provided by Medicare while increasing direct and indirect costs for beneficiaries.

- **Cuts Benefits.** Federal Medicare spending per beneficiary will be $[1,700] less than under current law in 2002.

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  - Over 15 million elderly women, more than a third of whom are at or near poverty, currently pay the Medicare Part B premium. Under the Republican plan, elderly women will shoulder more than [$24 billion of the proposed $48.6 billion premium increase.] [IS THIS CONVINCING?][35]

  - Over 20% or [$10.6] billion of the increase would come from elderly women with incomes below 200% of poverty.[36]

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- **Could Force the Poor to Leave Fee-For-Service Plans.** Without assistance with premiums, copayments and deductibles, poor Medicare beneficiaries may be forced to leave their fee-for-service plan and enroll in an managed care plan that does not require cost sharing -- if one exists in their area.

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would be nice to get incidence for rate for these elderly women (for injection) rate of incidence for rate for diseases covered)

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FILL THIS IN

LOSS OF MEDICAID COVERAGE

The reduction in Federal support of [$116 billion] in Medicaid spending could force states to deny coverage for [over 8 million] Americans in 2002 alone, according to estimates by the Department of Health and Human Services.

These people include:

- **[650,000] older women**
- **[330,000] nursing home residents -- about 75% of whom are women.**[37]

WOMEN PUSHED INTO POVERTY

[CHECK -- Over 185,000] women over age 65 would be thrown into poverty, largely as a result of the cuts in Medicare and Medicaid, according to the Department of Health and Human Services.[38]

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  Since OBRA '87, nursing home quality has improved dramatically. The use of physical restraints has declined 25%; dehydration has declined 50%; hospitalization rates have declined 31%.[40]

- **Federal Enforcement and Protections Would be Repealed.** The Republican bill takes away federal protections and enforcement and leaves responsiblity for ensuring nursing home quality with states. While states may want to maintain these guarantees, inadequate resources could lead them to fail to set and enforce quality standards that protect elderly and disabled people in nursing homes.

  - States could turn over their survey and enforcement responsibilities to private accreditation organizations with no federal review, therby reducing accountability and increasing variations in quality and enforcement.

  - Nursing homes would not longer be required to provide services to "attain or maintain the highest practicable physical, mental and psychosocial well being of each resident." Without this protection, residents could be denied skilled nursing and rehabilitative services necessary to improve their ability to function.

  - Residents would no longer be guaranteed the same comprehensive assessment of their health and functional status now required nationally.

  - Uniform data collection would not be required, making monitoring more difficult.

  - Federal training requirements for hands-on caregivers would be eliminated; each state could determine who would be trained and how.

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[39]Institute of Medicine NEED BETTER CITE

[40]Research Triangle Institute, HCFA, DATE?

WEAKENS PROTECTION AGAINST SPOUSAL IMPOVERISHMENT

The Republican budget undermines protections against spousal impoverishment that were signed into law by President Reagan in 1987. Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women.[41]

- Current federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to quality for Medicaid.

- Because the Republican budget repeals the guarantee of nursing home coverage, it also effectively eliminates any protection from spousal impoverishment. If an individual were denied coverage for nursing home care altogether, their spouse could be forced bear the burden of paying for that care.

- The Republican budget also repeals the right of individuals to enforce spousal impoverishment protections in court when they believe they have been wrongfully denied, making the protections unenforceable.

It would be great to get data that shows that spousal impoverishment basically protects older women. What we need is the following:

(1) How many ~~married~~ individuals are in nursing homes who have a living spouse

(2) What % of these individuals are men or women?

[41] Department of Health and Human Services, 1995.

Disease	Prevalence/Number of Women Affected	Additional Information
Heart Attack and Stroke	The rate of illness and death from heart disease rises rapidly for women over 55. One in three women over 65--3.6 million women--suffers from heart disease (1990 figure). Women are more likely than men to die after a heart attack, or to have a second attack. Cerebrovascular disease (including stroke) is the third leading cause of death among women. People over 65 account for nine out of ten deaths from the disease. In 1990, 1.1 million older women had a stroke.	The higher mortality among female heart attack victims may be attributable to the fact that the heart disease therapies used have been tested primarily on men, and may not be as effective for women.
Cancer	Lung cancer and breast cancer are the leading causes of cancer deaths among older women. Overall, the two diseases account for over half of all female cancer deaths. One out of every nine women will be diagnosed with breast cancer in her lifetime. About 70 percent of all deaths from cervical cancer occur among women over 50.	Although pap smears and mammograms can greatly reduce the risk of invasive cervical and breast cancer, many women do not receive these tests on a regular basis. Older women are less likely than younger women to have regular mammograms, despite the fact that the risk of breast cancer increases with age. Many older women without private insurance or supplemental Medigap insurance do not see physicians or receive preventive tests because they cannot afford the out-of-pocket costs (e.g., copayments, deductibles).

Disease	Prevalence/Number of Women Affected	Additional Information
Osteoporosis	Osteoporosis affects half of all women over 45 and 90 percent of women over 70. All told, 20 million women (and 5 million men) have osteoporosis. The disease causes 250,000 hip fractures a year. Women account for 75-80 percent of these hip fractures--about 200,000 a year. One out of every two women will have an osteoporosis-related fracture in her lifetime. About 40 percent of all falls by women over 75 result in a fracture. More deaths [of women in this age group?] are caused by falls than by pneumonia, diabetes or all other accidents combined.	Hip fractures are a leading cause of hospitalization and nursing home placements among older women. One out of every four older women who were living independently prior to the hip fracture required institutional care for at least a year after the injury.
Diabetes	Diabetes, a leading cause of death by disease and also a leading contributor to heart disease, stroke, blindness and amputation, is more prevalent among women than men. In 1993 there were over 3 million people over 65 with diabetes. Women accounted for 56 percent of diabetic patients between 65 and 74, and 64 percent of those 75 and over. Diabetes is also particularly dangerous for older women; women age 65 to 74 are four times as likely to die of the disease as women age 45 to 64.	
Arthritis	Arthritis is much more common in women than in men. While half of all persons over 65 report problems with arthritis, four out of every five women over 65 suffer from the disease.	
Alzheimer's Disease	About 4 million people suffer from Alzheimer's. Women are, again, more likely than men to be stricken by the disease, even taking into account the larger number of older women.	Care for Alzheimer's patients, which can be exceptionally demanding, is disproportionately provided by older women.

NATIONAL ECONOMIC COUNCIL
THE WHITE HOUSE
WASHINGTON, DC 20500
202/456-5374
202/456-2223 FAX

To: Jen Klein

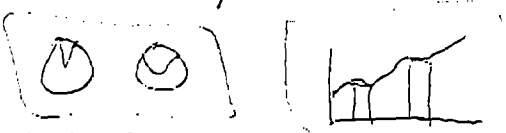
Organization: _____

From: **Pauline Abernathy**
Assistant Director to the National Economic Council

Pages to Follow: 11

Comments: _____

maybe I've been working on too many briefing books, but I think these stats would work well in graphs — it would tell the story more clearly. We could lighten with the graphics.



A PROFILE OF AMERICA'S OLDER WOMEN

DEMOGRAPHIC TRENDS

The Population is Aging. Currently, 13% of the total population in the United States, or 33.2 million Americans, are 65 or older. In the next 35 years, by 2030, the number of Americans over the age of 65 will more than double, reaching 20% of the total population or 70 million.[1]

The Number of Older Women is Growing. --%, or about 20 million, of Americans age 65 or older are women. In the next 35 years, that number will grow to --% or -- million.[2]

Women Over 85 Are the Fastest Growing Segment of Society.

- Life expectancy for women has increased steadily. In 1960, life expectancy at birth for females was about 73.[3] By 1992, life expectancy increased to about 79 years.[4] There is a gap between life expectancy for men and women. In 1989, for example, life expectancy at birth was 78.6 for a girl and 71.8 for a boy.[5] [MORE RECENT STATS FOR MEN V. WOMEN]

- The number of people over the age of 85 is growing quickly, and women account for --% of this group.[6] Today, --% of the population (2.5 million) are women over 85,[7] and --% (-- million) of the population will be women over 85 by the year 2030.[8]

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[1] U.S. Bureau of the Census, Current Population Reports.

[2] NEED CITE

[3] C. Costello and A.J. Stone, eds. *The American Woman: 1994-1995* Women's Research and Education Institute, 1994

[4] NEED CITE

[5] Id.

[6] NEED CITE

[7] Current Population Survey March 1995.

[8] NEED CITE

Older Women Are Far More Likely Than Men to Live Alone. Almost four times as many women than men 65 or older live alone.[9] Because women have longer life expectancies and many women marry men who are older, the life expectancy for widowed women in the United States is about 17 years beyond the death of their spouses -- years in which increased frailty or disability are generally endured alone.[10]

FINANCIAL STATUS

Older Women Are Poorer Than Men.

- **The ~~average~~ income for women 65 or older is about $8,500 a year.**[11] [CHART IN BOOK P. 339 SAYS $11,323/P.233 -- MEDIAN = $9,740] The average income for men is [$20,381, about 80% more than the average for women. NOTE: THIS IS A 1991 NUMBER. CALL OLDER WOMEN'S LEAGUE]

- **Minority Women Are Poorer Still.** Minority women have substantially lower incomes. Black women age 75 and older had median incomes of $6,246 in 1991and women of Hispanic origin, $5,853.[12]

- In 1994, 40% of women aged 65 to 74 and 56% of women over 75 lived on incomes below twice the poverty line (income of less than $14,000) [CHECK -- I'VE LEFT OUT STRAIGHT POVERTY NUMBERS -- OKAY?]. [ALSO -- WHAT ABOUT MEN?][13]

Poverty Rates Among Women Living Alone Are Higher. Poverty rates are higher at every age for women who live alone than for men, and the disparity increases with age. In 1991, 27% of women 65 and over living alone were in poverty (income of $7,000), compared to 18.5% of men.[14] Another 14% of these women were near poor (income of $ -----). And the picture was even worse for minority women; nearly nine out of ten black women living alone had incomes below two times the poverty threshhold.[15]

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[9]NEED CITE. "MEDICARE PROFILE"??

[10]C. Costello and A.J. Stone. *The American Woman 1994-1995.*

[11]Older Women's League. 1995.

[12]American Woman p. 233 - NEED BETTER CITE - Bureau of the Census ????

[13]Bureau of the Census. Poverty Branch. 1994 data.

[14]Bureau of the Census. Poverty in the United States: 1991. 1992.

[15]Bureau of the Census. 1992.

Half of All Women on Social Security Would be Poor Without It. As of 1990, 33% of unmarried women age 65 or older who received Social Security depended on it for at least 90% of their income; more than 18% had no other income.[16] Half of all women beneficiaries would be poor if they did not receive a Social Security benefit.[17]

HEALTH STATUS

Despite living, on average, seven years longer than men, women have poorer health outcomes and are more likely to have chronic diseases and disability than men.

- Women age 65 or older are more likely than men to suffer from chronic diseases like arthritis and diabetes. Any of these conditions may contribute to a loss of functioning, particularly as women age. [MORE INFO ON DIFFERENCES AT AGE 65 AND OLDER]

- More than half of all women over age 85 have problems managing basic daily activities like bathing and eating, as compared to only 34% of men in the same age group.[18] In addition, because women generally live longer than men, they are more likely to get diseases associated with very old age, including Alzheimer's and complications arising from osteoporosis.

PUT IN CHART HERE TITLED "DISEASES AFFECTING OLDER WOMEN"

DISEASE	NUMBER OF WOMEN AFFECTED	IMPACT ON WOMEN
Heart Disease and Stroke	In 1990, 3.6 million, or 1 in 3, women over 65 suffered from heart disease. In the same year, 1.1 million older women suffered a stroke.[19]	Leading cause of death. Dollars spent?

---

[16]American Association of Retired Persons (AARP) Fact Sheet, Facts About Older Women: Income and Poverty, 1995.

[17]R. O'Grady-LeShane, Economic Security for Midlife and Older Women. Background paper prepared for the Conference on Women and Aging: An Agenda for Action (sponsored by PHS Office on Women's Health and the National Policy and Resource Center of Women and Aging, Brandeis University), October 30, 1995.

[18]Health Care Financing Administration (HCFA), Medicare: A Profile, February 1995.

[19]National Heart, Lung and Blood Institute, 1990.

MEDICAL NEEDS AND EXPENSES

While all older Americans spend a significant portion of their incomes on health care, women spend more than men. [IS THIS TRUE?]

- Older Americans currently spend 21% of their incomes on health care.[20]

[JEN TO TALK TO JUDY FEDER. DIANE ROWLAND]

[DO WE HAVE DATA SHOWING THAT WOMEN SPEND MORE THAN MEN? THAT WOMEN ARE SPENDING AN INCREASING PERCENTAGE OF THEIR INCOMES ON MEDICAL EXPENSES?]

BREAKDOWN OF LEADING MEDICAL EXPENSES FOR ELDERLY WOMEN -- E.G., PRESCRIPTION DRUGS. NURSING HOME CARE.

Older Women Rely More on Costly Long-Term Care.

- 22% of women 65 or older either live in an institution or need help to live at home.[21] Twenty-six percent of all women over 85 live in nursing homes.[22]
- Over 75% of nursing home residents are women.[23] The average cost of nursing home care is $38,000 per year -- about three times the median income for older women.
- Women on average remain in nursing homes a year longer than men.[24]

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[20]NEED CITE

[21]NEED UNDERLYING CITE - NOT JUST AMERICAN WOMAN BOOK.

[22]NEED CITE

[23]Bureau of the Census and National Institute on Aging, *Profiles of America's Elderly*, No. 4, November 1993.

[24]P. Kemper, et al., "Lifetime Perspective on Proposals for Financing Nursing Home Care," *Inquiry* 28:333-344, Winter 1991. [CHECK CITE]

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  Since OBRA '87, nursing home quality has improved dramatically. The use of physical restraints has declined 25%; dehydration has declined 50%; hospitalization rates have declined 31%.[40]

- **Federal Enforcement and Protections Would be Repealed.** The Republican bill takes away federal protections and enforcement and leaves responsiblity for ensuring nursing home quality with states. While states may want to maintain these guarantees, inadequate resources could lead them to fail to set and enforce quality standards that protect elderly and disabled people in nursing homes.

  - States could turn over their survey and enforcement responsibilities to private accreditation organizations with no federal review, therby reducing accountability and increasing variations in quality and enforcement.

  - Nursing homes would not longer be required to provide services to "attain or maintain the highest practicable physical, mental and psychosocial well being of each resident." Without this protection, residents could be denied skilled nursing and rehabilitative services necessary to improve their ability to function.

  - Residents would no longer be guaranteed the same comprehensive assessment of their health and functional status now required nationally.

  - Uniform data collection would not be required, making monitoring more difficult.

  - Federal training requirements for hands-on caregivers would be eliminated; each state could determine who would be trained and how.

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[39]Institute of Medicine -- NEED BETTER CITE

[40]Research Triangle Institute, HCFA. DATE?

WEAKENS PROTECTION AGAINST SPOUSAL IMPOVERISHMENT

The Republican budget undermines protections against spousal impoverishment that were signed into law by President Reagan in ~~1987~~ 1988. Since this federal law went into effect in 1989, it has protected about 450,000 spouses of nursing home residents. Most of these spouses are women.[41]

- Current federal law ensures that spouses of people needing nursing home care do not have to lose everything they have in order for their spouse to quality for Medicaid.

- Because the Republican budget repeals the guarantee of nursing home coverage, it also effectively eliminates any protection from spousal impoverishment. If an individual were denied coverage for nursing home care altogether, their spouse could be forced bear the burden of paying for that care.

- The Republican budget also repeals the right of individuals to enforce spousal impoverishment protections in court when they believe they have been wrongfully denied, making the protections unenforceable.

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[41] Department of Health and Human Services, 1995.

[Suggest weaving some of these facts into other sections, as appropriate, rather than having separate section on minority population.]

Minority Populations

Demographic Trends

- Older Americans are becoming more racially and ethnically diverse. In 1994, 1 in 10 elderly Americans were non-Caucasian. In 2050, this proportion should rise to 2 in 10.[1]

Life Expectancy

- Gender is a more important factor than race or ethnicity in predicting a person's life expectancy. Although average life expectancy is shorter for black women (73.9 years) than white women (79.8 years), both groups of women have a longer life expectancy than their male counterparts—e.g., life expectancy at birth is 65 years for black men and 73.2 years for white men.[2]

These numbers are inconsistent w/ other life expectancy #s you gave me.

Living Arrangements:

- Although a majority of the elderly lived with their spouse in 1992, this generalization is not true for elderly African Americans. Only 37% of elderly African Americans lived with their spouse in 1992 as compared with 56% of elderly whites and 54% of Asians. Roughly half (51%) of elderly Hispanics lived with their spouse.[3]

- Differences in living arrangements among racial and ethnic groups are partially related to differences in marital status. For example, elderly black men and women are much less likely than other elderly to be married. Among elderly black women, 25% were married and 56% were widowed, whereas 41% of white women were married and 48% were widowed in 1992.[4]

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[1]U.S. Bureau of the Census, Economics and Statistics Administration, *Statistical Brief*, May 1995.

[2]National Center for Health Statistics (NCHS), "Annual Summary of Births, Marriages, Divorces, and Deaths: United States, 1994." *Monthly Vital Statistics Report*, 43 (13), October 23, 1995.

[3]Bureau of the Census and National Institute on Aging, "Living Arrangements of the Elderly," *Profiles of America's Elderly*, No. 4, November 1993.

[4]*Ibid.*

- Elderly living alone are more likely to be poor. In 1991, although less than 1 in 4 elderly white women who lived alone were poor, about 58% of such black women were poor. Half of elderly Hispanic women living alone had [redacted] incomes in 1991 below the poverty level.[5]

Health Status:

Breast Cancer/Cervical Cancer.

- Although the incidence of breast cancer is higher among white than among black women, the latter are more likely to die from this disease. Breast cancer is typically more advanced in black women when they are diagnosed: only 43% of black women,compared with 52% of white women, are diagnosed at a stage when the disease is still localized.[6]

- Mortality rates among white women for lung and ovarian cancer are higher than among black women, but lower for breast, endometrial, and cervical cancer.[7] These differences in mortality may be related to differential availability of preventive health care and access to treatment.

- The incidence of cervical cancer among black women is about one-third higher than the incidence among white women.[8] The mortaliy rate for cervical cancer among black women is nearly 3 times as high as the rate among white women.[9]

- Both the incidence of cervical cancer and mortality from this disease are higher among older African American, Native American, and Hispanic women than among white women.[10]

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[5]*Ibid.*

[6]C.C. Boring, T.S. Squires, and T. Tong. "Cancer Statistics." *CA-A Cancer Journal for Clinicians* 42(1):19-38, January-February 1992.

[7]NCHS. Unpublished cancer statistics, January 1993.

[8]NCHS, *Health United States, 1991 and Prevention Profile*, 1992.

[9]NCHS, January 1993.

[10]PHS, Office on Women's Health, *Fact Sheet on Older Women's Health*, 1995.

Diabetes

- Diabetes is more prevalent among women than men, almost entirely because its incidence is very high among black, Hispanic, and other minority women.[11] In the 45-74 age group, for example, 11% of black women and over 15% of Mexican American and Puerto Rican women have diabetes, compared to only 6% of white women.[12] The mortality rate for diabetes among black women is twice as high as that among white women.[13]

Hypertension, Obesity, Cardiovascular Disease

- Hypertension is a major risk factor for all forms of cardiovascular disease in both women and men.

- The prevalence of hypertension is highest among black women and rises steadily as women age.[14]

- Obesity (defined as 30% or more over ideal weight) has also been identified as increasing the risk for heart disease and stroke. Twenty-five percent of white and 44% of black women are 20% or more over their desirable weight. Also falling into this category are 39% of Mexican American, 34% of Cuban American, 37% of Puerto Rican, 40% of Native American, and 63% of Native Hawaiian women.[15]

- Mortality from heart disease increases with age and is highest among black women at all ages.[16]

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[11]Centers for Disease Control and Prevention (CDC), "Regional Variation in Diabetes Mellitus Prevalence—United States, 1988 and 1989," *Morbidity and Mortality Weekly Report* 39(45):805-812, November 16, 1990.

[12]K.M. Flegal et al. "Prevalence of Diabetes in Mexican Americans, Cubans, and Puerto Ricans from the Hispanic Health and Nutrition Examination Survey, 1982-1984," *Diabetes Care*14(7):628-638, July 1991.

[13]NCHS, "Advance Report of Final Mortality Statistics, 1990." *Monthly Vital Statistics Report* 41(7), 1993.

[14]National Center for Health Statistics, *Health, United States, 1992*, 1993.

[15]American Heart Association, *Heart and Stroke Facts: 1993 Statistical Supplement*, 1993.

[16]NCHS, *Health, United States, 1993*, 1994.

REVISED

Health Status

Note: **—new addition

- **Cardiovascular diseases are a leading cause of morbidity and disability among women. Approximately 36% of women 55-64 years of age and 55% of women 75 years or older with ischemic heart disease are disabled.[1]

- Symptoms of heart disease typically develop in women about 10 years later in life than is the case for men. That is, for women, heart disease is largely a postmenopausal disorder. Illness and death from heart disease rise dramatically in women after age 55.[2]

- Women are more likely than men to die after a heart attack or to have a second attack. ** In 1991, cardiovascular disease accounted for a greater proportion of deaths in women (46%) than in men (40%).[3]

- Women age 65 or older are more likely than men in this age group to suffer from chronic diseases like diabetes, arthritis, and osteoporosis. Any of these conditions may contribute to a loss of functioning, particularly as women age.

- **In 1993, there were 7.8 million diagnosed diabetic patients, 40% of whom where age 65 or older. Women accounted for 56% (and men 44%) of those patients between 65 and 74 years of age, but they accounted for 64% (and men 36%) of patients who were 75 or older.[4]

- In addition, because women generally live longer than men, they are more likely to acquire diseases associated with very old age, including Alzheimer's and complications arising from osteoporosis.

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[1]E.D. Eaker et al. "Cardiovascular disease in women." *Circulation* 88:1999 2009, 1993.

[2]D.J. Lerner and W.B. Kannel. "Patterns of Coronary Heart Disease Morbidity and Mortality in the Sexes: A 26 Year Follow-Up of the Framingham Population." *American Heart Journal* 111, No. 2 (1986):383-390.

[3]J.A. Horton, ed. *The Women's Health Data Book: A Profile of Women's Health in the United States*, Washington, DC: Jacobs Institute of Women's Health, 1995.

[4]DHHS, PHS, National Health Interview Survey data, 1993.

- **Women are at higher risk than men for osteoporosis due to their lower bone mass; additionally, bone loss is accelerated as estrogen levels decline during and after menopause.[5]**

- ****Osteoporosis affects 20 million women and 5 million men. One out of every two women and one in eight men will have an osteoporosis-related fracture in their lifetime.[6]**

- **Four out of every five women over 65 suffer from arthritis. Both arthritis and osteoporosis are diseases that limit mobility and thus contribute to diminished functional capacity and difficulties with activities of daily living. Arthritis, in particular, limits the ability of many older people to care for themselves.**

- ****Older women have greater limitations in functional status than men. In addition, the disparity between men and women becomes larger as they get older.**
- More than half of all women over age 85 have problems managing basic daily activities, like bathing and eating, as compared to only 34% of men in the same age group.[7]

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[5]*Ibid.*

[6]T. Wetle, *Overview of Women's Health*, paper presented at the Conference on Women and Aging: An Agenda for Action, October 31, 1995.

[7]Health Care Financing Administration (HCFA), *Medicare: A Profile*, February 1995.

Older women rely more on costly long-term care.

- 22% of women 65 or older either live in an institution or need help to live at home.[1] **Roughly 28 percent** of all women over 85 live in nursing homes.[2]

Additional notes:

Footnote 23 should be same citation as FN#2 on this page (i.e., Profiles of the elderly pub.)

Footnote 24 is correct, except make following addition *Inquiry 28(4)*

NOTE: Am trying to locate more info. LTC providers to augment bullet that follows paragraph about "unpaid caregiver."

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[1]Guralnik and Simonsick, "Physical Disability in Older Americans, *J. Of Gerontology*, Vol. 48 (special issue):3-10, 1993.

[2]Bureau of the Census and National Institute on Aging, "Living Arrangements of the Elderly, *Profiles of America's Elderly*, No. 4, November 1993.

Jen - re: "Older Women are More Likely to rely on Medicare and Medicaid". The figures in "The American Woman 1994-95" are significantly different than figures based on the Medicare Current Beneficiary survey (from a 1993 Health Care Financing Review; copy of relevant table attached). The CPS data in American Women comes from too small a sample to be reliable, and both sets of data are kind of old (1991 for the MCBS, 1990 for the CPS).

In case you decide to use "The American Women" stats, their figure for the number of women with Medicare-only is approximately 4 million (4.048).

Following is suggested language using the MCBS data:

Older Women are More Likely to Rely on Medicare and Medicaid. Because elderly women typically have lower socioeconomic status than elderly men, they are much more likely to be dependent upon both Medicare and Medicaid. Nearly 2.6 million, or 15% of elderly women are have coverage under Medicaid, which serves as supplemental insurance to Medicare for eligible low-income elderly people, compared to 870,000 (7%) of males.[10]

Alternate:

Older Women are More Likely to Rely on Medicare and Medicaid. Because elderly women typically have lower socioeconomic status and more limited retirement benefits than elderly men, they are more likely than men to be either solely dependent on Medicare or to have coverage under Medicaid, which serves as supplemental insurance to Medicare for eligible low-income elderly people. More than 1.7 million, or nearly 10% of females over age 65 have only Medicare to cover their medical bills. An additional 2.6 million, or 15% of older women rely on Medicaid in addition to Medicare.[11]

There are also significant racial disparities. The proportion of black persons with Medicare only is three times higher (28.6%) than the proportion of white persons (9.7%). The differences are even greater for those who rely on Medicaid to supplement Medicare coverage. About 10% of white persons over age 65 rely on Medicaid and Medicare, whereas thirty percent of black persons and over 40% of other racial or ethnic groups rely on both types of coverage.[12]

Jen - I didn't include #s because the size of the base populations are so different.

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[10] G. Chulis et al., "Health Insurance and the Elderly: Data from the MCBS," Health Care Financing Review, Spring 1993: Volume 14, Number 3, pp. 163-181

[11] Ibid.

[12] Ibid.

employer-sponsored plans, and there is an increase in the elderly's financial responsibility for insurance premiums.

As previously mentioned, there is a question whether employers will respond to FASB Rule 106 by reducing health insurance benefits for their retirees. Any recent corporate decisions to eliminate retirement health insurance would most likely show up in the data for the 65-69 age group, who became eligible for Medicare in the period 1986-90. In Table 2, 47.3 percent of persons age 65-69 had employer-sponsored insurance (including those with both private types). This was 5 percentage points higher than the share for persons age 70-74 (42.4 percent) who enrolled in Medicare in 1981-85. This data show no lessening of employer support for retiree health insurance, either in the aggregate for the whole population, or at the margin with persons age 65-69.

The share of persons with both Medicare and Medicaid benefits increases with age. About 8 percent of persons age 65-69 are entitled to Medicaid and this share increases to 16.1 percent of persons age 80-84. At age 85 or over, there is a sharp increase to 26.9 percent of persons with Medicaid. The large share of persons in the age 85 or over group with Medicaid probably reflects proportionately more persons of this age group in nursing homes. Nursing home benefits are often covered by Medicaid, either because the beneficiary was poor upon entering the facility or because the costs of the stay have depleted their financial assets and they qualify as medically needy. (Future MCBS reports will examine nursing home patterns of use and financing by the elderly.)

Sex

There are considerably more females (60 percent) than males (40 percent) in the Medicare population over age 65 (Table 3). This is because females live several years longer than males on average.

A larger share of males (13.8 percent) than females (9.8 percent) have Medicare as their only health insurance. This may be because a higher proportion of females have Medicaid coverage.

Males have a higher share of employer-sponsored supplemental insurance (37.8 percent) than females (29.8 percent). Proportionately more females (38.8 percent)

Table 3

Supplemental Medical Insurance of Medicare Elderly, by Sex: 1991

Sex	Sex Share	Total	Medicare Only	Private Individual Purchase	Private Employer-Sponsored	Private—Both	Medicaid	Medicare and Other
				Persons in Thousands				
Total	100.0	29,176	3,324	10,725	9,621	1,467	3,459	581
Male	40.0	11,666	1,610	3,934	4,408	636	866	211
Female	60.0	17,511	1,714	6,790	5,212	831	2,594	370
				Insurance Percent Share				
Total	—	100.0	11.4	36.8	33.0	5.0	11.9	2.0
Male	—	100.0	13.8	33.7	37.8	5.5	7.4	1.8
Female	—	100.0	9.8	38.8	29.8	4.7	14.8	2.1

NOTES: Includes Medicare persons age 65 or over who were alive during all of 1991. All numbers have relative standard errors of less than 30 percent.

SOURCE: Health Care Financing Administration, Office of the Actuary: Data from the Medicare Current Beneficiary Survey, round one

Gen weighted avg. Medicare only + Dual eligible

Males 21.2%

Females 24.6 %

males (33.7 percent) have individually purchased supplemental policies. The larger share of elderly males with employer-sponsored insurance probably reflects their greater participation in paid employment with retirement benefits. The larger share of females with individually purchased policies could reflect, at least in part, the need for many widows to purchase insurance to replace employer-sponsored coverage when the husband dies.

The share of females (14.8 percent) entitled to Medicaid benefits is double the share of males (7.4 percent). Since females live longer on average, more very elderly females may find themselves in financially reduced circumstances and/or with health needs that require long-term nursing care. In addition, more females than males did not work long enough in covered employment under Social Security to obtain pensions.

Race

The elderly Medicare population consists of 88.9 percent of the white race, 7.9 percent of the black or African-American race, and 3.2 percent of all other races (Table 4).

The proportion of black persons with Medicare only is three times higher (28.6 percent) than the proportion of white persons (9.7 percent). Persons of all other races also had a high proportion (16.4 percent) relative to white persons. If having only Medicare creates a financial barrier to receiving care, other races are more likely to face this barrier than the white race.

In both the individual and employer-sponsored insurance groups, white persons had shares that were about double that of black persons and all other races. Adding the separate private insurance shares together, 79.1 percent of white persons had some form of private supplemental insurance, nearly double the privately insured shares for black persons (40.1 percent) and persons of all other races (40.6 percent). Races other than white elderly probably did not work as extensively as white persons in employment that carried retirement health benefits. The lower shares of individually purchased private insurance for all other

Table 4

Supplemental Medical Insurance of Medicare Elderly, by Race: 1991

Race	Percent of Enrollees	Total	Medicare Only	Private Individual Purchase	Private Employer-Sponsored	Private—Both	Medicaid	Medicare and Other
				Persons In Thousands				
Total	100.0	29,176	3,324	10,725	9,621	1,467	3,459	581
White	88.9	25,949	2,514	10,119	8,987	1,407	2,397	525
Black or African American	7.9	2,294	657	420	463	[1]38	683	[1]33
All Other	3.2	933	153	186	171	[1]22	379	[1]23
				Insurance Percent Share				
Total	—	100.0	11.4	36.8	33.0	5.0	11.9	2.0
White	—	100.0	9.7	39.0	34.6	5.4	9.2	2.0
Black or African American	—	100.0	28.6	18.3	20.2	[1]1.7	29.8	[1]1.4
All Other	—	100.0	16.4	19.9	18.3	[1]2.4	40.6	[1]2.5

[1] Relative standard error of 30 percent or more.

NOTES: Includes Medicare persons age 65 or over who were alive during all of 1991.

SOURCE: Health Care Financing Administration, Office of the Actuary. Data from the Medicare Current Beneficiary Survey, round one.

ments and drugs. Without this additional coverage, Medicare beneficiaries are vulnerable to high out-of-pocket costs. As shown in Table 9, 68 percent of elderly women and 73 percent of elderly men supplement Medicare with private health insurance. Because of their typically lower socioeconomic status and more limited retirement benefit coverage, elderly women are slightly more likely than elderly men to be either solely dependent on

Table 9 - HEALTH INSURANCE COVERAGE STATUS OF THE ELDERLY POPULATION BY SEX AND INCOME, 1990

	Total Number (in millions)	Total Percent	Percent Distribution: Medicare and/or Private[1]	Medicare and Medicaid	Medicare Only	None
WOMEN					4,048	
Total, age 65 and over	17.6	100	68	(8)	23	1
Income[2]						
Poor	2.7	100	37	27	34	2
Low-income	5.2	100	61	9	30	1
Middle-income	5.8	100	77	3	19	1
High income	3.9	100	85	2	13	[3]
MEN						
Total, age 65 and over	12.6	100	73	(5)	21	1
Income						
Poor	1.0	100	28	30	38	4
Low-income	3.0	100	57	9	33	1
Middle-income	4.8	100	78	2	19	1
High-income	3.8	100	90	[3]	9	[3]

[1]Medicare and/or private includes those persons with either Medicare and private coverage or private coverage only.

[2]Income levels: Poor is less than 100 percent of federal poverty level; low-income is 100 to 199 percent of federal poverty level; middle-income is 200 to 399 percent of federal poverty level; high-income is 400 percent or more of federal poverty level.

[3]The sample size is too small to make national estimates.

Note: Details may not total to 100 percent due to rounding.

Source: Estimates are based on the Bureau of the Census March 1991 Current Population Survey.

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Medical Needs and Expenditures

The elderly spend much more of their income on health care than persons under age 65. In 1994, persons under age 65 spent 4.8% of their income on health care. The elderly spent more than twice that share (11.2%).

And/or?

Getting back to me

While all older Americans spend a significant portion of their incomes on health care, **elderly women who live alone face the greatest financial burden. On average, women over age 65 who live alone spend 16% of their income on health care vs. 11% for the elderly population as a whole. This disparity reflects both lower than average income and higher than average health care spending.**[9]

Health care absorbs a greater percentage for this subgroup both because their incomes are lower and their expenditures are hgiher.

[9] U.S. Bureau of Census, Current Population Reports, Series P-60-188, Income, Poverty and Valuation of Noncash Benefits: 1993, February 1995

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Number of Pages (Including Cover): 4

Comments:
Additional items - footnote corrections etc. Hope you can read my scribbles!

12/19

THE IMPACT OF THE REPUBLICAN CUTS IN MEDICARE AND MEDICAID

OLDER WOMEN'S DEPENDENCE ON MEDICARE AND MEDICAID

Number of Women Covered

- **Medicare.** Of the 37 million Medicare beneficiaries, over 20 million, or 57% are women. There are twice as many female beneficiaries over age 85 than men.[25]

- **Medicaid.** Over 4 million older Americans are covered by Medicaid. 60% of all Medicaid beneficiaries are women.[26]

Dependence on Medicare and Medicaid

Older Women Are More Likely to Rely on Medicare and Medicaid. Because elderly women typically have lower socioeconomic status and more limited retirement benefits than elderly men, they are more likely than men to be either solely dependent on Medicare or to have coverage under Medicaid, which serves as supplemental insurance to Medicare for eligible low-income elderly people.

- -- million, or 23% of women age 65 or older, have only Medicare to cover their medical bills.

- An additional 2 million (11%) of older women rely on Medicaid in addition to Medicare.[27]

Medicare and Medicaid Provide Critical Services for Older Women.

- Medicare covers a range of medical services, including hospital stays, physician visits and home health care.

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[25] HCFA. *Medicare: A Profile* February 1995.

[26] ~~Department of Health and Human Services, 1995.~~ HCFA, Medicaid: An Overview, September 1995.

[27] ~~C. Costello and A.J. Stone. *The American Woman 1994-1995:*~~ Current Population Survey, March 1995.

- Medicaid also covers essential services for older women, including some -- like prescription drugs -- that are not covered by Medicare.
  - Medicaid will pay an average of over $800 for prescription drugs for an older woman on Medicaid in 1995.[28]
  - Approximately 68% of the nation's one million nursing home residents rely on Medicaid to pay for some or all their care. Over 75% of nursing home residents are women.[29]
  - In 1995, Medicaid paid Medicare premiums, coinsurance and deductibles for about 2 million poor, older women.[30] [WHAT ABOUT SLMB?]

Note: FN #29 applies to 1st sentence of this bullet
2nd sentence found in "Profiles of America's Elderly Nov. 1993.

[28] Department of Health and Human Services estimates from aged National Medical Expenditure Survey data, 1995.

[29] ~~Department of Health and Human Services, 1995.~~ HCFA, Medicaid: An Overview, September 1995.

[30] Department of Health and Human Services, 1995.

WEAKENS NURSING HOME QUALITY STANDARDS

The Republican budget takes away key protections and enforcement of nursing home quality standards put in place by the Reagan Administration with bipartisan support.

- **Nursing Home Laws Have Resulted in Dramatic Progress.** The landmark nursing home reform law of OBRA '87, approved with bipartisan support during the Reagan Administration, sought to address at times deplorable treatment in nursing homes -- including unjustified physical restraints and gross negligence in caring for nursing home residents -- by establishing federal quality standards. Prior to the OBRA '87 reforms, the Institute of Medicine reported that all states had some facilities with serious deficiencies in nursing home quality of care.[35]

  Since OBRA '87, nursing home quality has improved dramatically. The use of physical restraints has declined 25%; dehydration has declined 50%; hospitalization rates have declined 31%.[36]

- **Federal Enforcement and Protections Would be Repealed.** The Republican bill takes away federal protections and enforcement and leaves responsiblity for ensuring nursing home quality with states. While states may want to maintain these guarantees, inadequate resources could lead them to fail to set and enforce quality standards that protect elderly and disabled people in nursing homes.

  - States could turn over their survey and enforcement responsibilities to private accreditation organizations with no federal review, therby reducing accountability and increasing variations in quality and enforcement.

  - Nursing homes would not longer be required to provide services to "attain or maintain the highest practicable physical, mental and psychosocial well being of each resident." Without this protection, residents could be denied skilled nursing and rehabilitative services necessary to improve their ability to

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This broader definition includes the effects of Federal tax policies (including the Earned Income Tax Credit), near-cash in-kind assistance programs such as food stamps and housing programs, and out-of-pocket health spending.

✓

[35] Institute of Medicine, ~~NEED BETTER CITE~~ Improving the Quality of Care in Nursing Homes, Washington, DC: National Academy Press, 1986.

[36] Research Triangle Institute, HCFA, and 1995 ~~DATE?~~

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Number of Pages (Including Cover): 4

Comments:

Jen - Here's the first wave of stuff. Call me with any questions

Ellie

Demographic Trends

The Population is Aging. Currently, 13% of the total population in the United States, or 33.2 million Americans, are 65 or older...

The number of Older Women is Growing. A total of **59%**, or about 20 million, of Americans age 65 or older are women. In the next 35 years, that number will grow to **38 million (55%)**.

(Jen: the percentage of women is actually projected to shrink from 59% to 55% between 1994 and 2030. Maybe we could say:

> **About 20 million, or 8% of Americans are women age 65 or over. In the next 35 years, that number will grow to 10% or 38 million - or - In the next 35 years, that number will nearly double, to 38 million or 10% of the population.[1])**

Women over age 85 are one of the fastest growing segments of Society.

- Life expectancy for women has increased steadily. In 1960, life expectancy at birth for females was about 73. By 1994, life expectancy increased to **(delete "about")** 79 years. There is a gap between life expectancy for men and women. **In 1994, life expectancy at birth was 79 for a female and 72.3 for a male.[2]**

- The number of people over the age of 85 is growing quickly, and women account for **72%** of this group. Today, **1%** of the population (2.5 million) are women over 85, a **figure that will more than double to 5.7 million (2% by 2030.)[3]**

Older Women are far More Likely than Men to Live Alone. Forty-two percent of women age 65 and over lived alone in 1992, compared with just 16% of elderly men.

The proportion of women living alone increases dramatically with age. About one-third (34 percent) of women aged 65 to 74 lived alone, compared to over half of women aged 85 and over.[4]

Because women have longer life expectancies...

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[1]U.S. Bureau of the Census. Statistical Abstract of the United States, 1995.

[2]U.S. Department of Health and Human Services, PHS, Monthly Vital Statistics Report, October 23, 1995

[3]Statistical Abstract of the United States, 1995.

[4]National Institute on Aging, Profiles of America's Elderly, November 1993

Financial Status

Older Women are Poorer than Men

- The median income for women 65 or older is about $8,500 a year. The median income for men is nearly $15,000, 76% higher than the median for women.[5]

- **Minority Women are Poorer Still.** Minority women have substantially lower incomes. In 1992, white women age 65 and older had a median income of $8,600, which was 38% higher than elderly black women's median income of $6,200, and 44% higher than the median income of older women of Hispanic origin ($6,000)[6]

  Alternate: In 1992, the median income of elderly white women ($8,600) was 38% higher than the median income of black women ($6,200), and 44% higher than the median income of Hispanic women ($6,000)[7]

Poverty Rates Among Women Living Alone are Higher. Poverty rates are higher at every age...In 1993, over 26% of women 65 and over living alone were in poverty (income of about $6,900), compared to 13.9% of men. Another 15.6% of these women were near poor (income of $8,700). And the picture was even worse for minority women; more than 85% of black women living alone had incomes below two times the poverty threshold.[8]

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[5]U.S. Bureau of the Census, Current Population Reports, Series P-60-188, Income, Poverty and Valuation of Noncash Benefits: 1993.

[6] U.S. Bureau of the Census, Current Population Reports, Series P-60-184, Money Income of Households, Families and Persons in the United States: 1992.

[7] Ibid.

[8]Bureau of the Census, 1993.

Bureau of Statistics Labor DOL

MEDICAL EXPENDITURE DATA

(This is all I could come up with for the elderly. The source is unpublished tables from the 1993 and 1994 Consumer Expenditure Survey. This is a survey of the civilian non-institutionalized population and the amount spent on various items.)

Single Women 65+

Amount spent on Health Care (1993-1994) = $2,055
---Health Insurance = 998*
---Medical Services = 543
---Drugs = 443
---Medical Supplies = 72
Average Annual Income (before taxes) = $12,499
Average Annual Income (after taxes) = $11,927

% of Average Annual (before tax) income spent on health care = 16.4%
" "Health insurance = 8.0%
" "Medical services = 4.3%
" "Drugs = 3.5%
" "Medical Supplies = 0.6%

*Not clear if copays and deductibles are included in health insurance or in medical services.

All Consumer Units (Households) CY 1994

% of Household Income (Before Taxes) Spent on Health Care
---All ages = $1,755/$36,838 = 4.8%
---ages 65+ (both sexes) = $2,678/$23,835 = 11.2%
---Ages 65-74 (both sexes) = $2,592/$26,266 = 9.9%
---Ages 75+ (both sexes) = $2,787/$20,736 = 13.4%

GUARANTEE OF MEDICAID COVERAGE FOR PEOPLE WITH DISABILITIES, ELDERLY, PREGNANT WOMEN, AND POOR CHILDREN

December 8, 1995

CURRENT LAW:

Medicaid guarantees coverage of certain basic health care services in every State for people with disabilities, the elderly, pregnant women, and children meeting certain financial criteria. States are allowed to cover some additional categories of people, either under State plan options or under waivers. Each State must provide comparable services in all parts of the State. Individuals may seek redress in Federal court for violations of these basic protections.

PRESIDENT'S PROPOSAL:

Coverage and Benefits. The President's proposal retains the guarantee of basic health benefits for those currently covered, who include people with disabilities, the elderly, pregnant women, and poor children. It also significantly increases State flexibility and streamlines procedures for expanding eligibility if States choose to do so.

Level and Form of Savings. The President's proposal achieves $54 billion in savings over 7 years by capping the annual per capita growth in federal matching payments, and by reducing and retargeting payments to Disproportionate Share Hospitals (DSH).

Geographic Comparability of Benefits. The President's proposal ensures equity by retaining requirements that States provide comparable services in all geographic areas of the State.

Due Process. Individual beneficiaries would retain the due process safeguard of being able seek redress in Federal court for violations of these minimum requirements.

REPUBLICAN PROPOSAL:

Coverage. The Republican proposal *repeals* the guarantee of coverage for those currently receiving benefits and provides States with virtually complete flexibility in establishing eligibility and benefit levels. While it requires States to cover poor children under the age of 13, pregnant women, and people with disabilities, *States would have complete discretion to determine the level of benefits provided and to define eligible disabilities.* In addition, they would have complete discretion in setting income and asset limits for eligibility for other categories of people.

Although the Republican proposal establishes "set asides" that require States to devote specified minimum percentages of total State spending to certain categories of people, the set-aside amounts cover only about 45% of State Medicaid spending for these groups. Specifically, their proposal establishes "set-asides" for low-income families, the elderly, individuals with disabilities, poor Medicare beneficiaries (known as qualified Medicare beneficiaries or QMBs), and services provided by Federally qualified health centers and rural health centers. In general, the set-aside percentage is 85 percent of the State's spending for mandatory services for that group in 1992-1994. For QMBs, the set-aside percentage is 90 percent of the 1993-1995 spending on premiums. Exceptions would be allowed for States to provide lower set-aside amounts.

Benefits. The Republican proposal eliminates the guarantee of a minimum set of benefits for those who receive coverage. States could eliminate almost any benefit currently covered by Medicaid. The only required services would be immunization and restricted family planning.

Level and Form of Savings. The Republican proposal creates a Medicaid block grant that would provide states with $163 billion less federal assistance than under current law. Each State's block grant is fixed and will not vary with changes in costs or need.

Geographic Comparability of Benefits. The Republican proposal eliminates all requirements that comparable services be provided across the different geographic areas of a State.

Due Process. Individuals would lose the right to seek redress in Federal court to enforce the remaining Federal safeguards.

ANALYSIS:

Inadequacy of Resources Will Force States To Reduce Coverage and Benefits.
While both plans contain savings, the President's proposal protects coverage by capping spending growth *per capita*, creating incentives to increase efficiencies but not to eliminate coverage.

The Republican block grant would reduce average per capita spending growth from 7.0% to 1.6% per year over the seven years -- substantially lower than either the private sector growth rate or even the general inflation rate. Per capita spending growth in the private sector is projected to grow at 7.1% per year, based on CBO data. By comparison, under the President's proposal, per capita spending growth would be constrained to 5.6% per year.

With spending rising only 1.6% per beneficiary -- 77% below the private sector rate -- it will be *impossible* for States to maintain current eligibility and benefit levels. States will not be able to achieve this level of savings through increased efficiencies from managed care and reductions in payments to providers alone:

- **Managed Care Will Not Produce Enough Savings.** Benefits for the elderly and disabled people account for more than two-thirds of Medicaid spending. Since there is little evidence that managed care is appropriate for this population, managed care may not produce significant savings in two-thirds of Medicaid spending. Managed care can be appropriate for poor children and their families, but current Medicaid projections already assume that 20%-50% of this Medicaid population will be in managed care.

- **Medicaid Payments to Providers Are Already Low.** Medicaid already reimburses provides at a significantly lower rate than Medicare. Much deeper reductions will likely lead more doctors and hospitals to turn away Medicaid patients.

- **States Will Therefore Be Forced to Reduce Coverage and Benefits.** The Urban Institute concluded that even if States could absorb half of the cuts by reducing services and provider payments, they would still have to deny coverage to millions of Americans by 2002. Based on the Urban Institute analysis, HHS estimates that nearly 8 million people could be denied coverage in 2002 including:

    - 3.8 children
    - 1.3 million people with disabilities
    - 850,000 older Americans

- **Total Federal and State Medicaid cuts could exceed $400 billion.** Although the reconciliation bill reduces federal Medicaid spending by $163 billion, the total Medicaid cuts could ultimately be much greater. A new analysis by the Center on Budget and Policy Priorities shows that if states provide only the funding required to receive their full block grant allocation and provide no additional funding, the total reduction in federal and state Medicaid funds would *total $420 billion over seven years*, compared with current law.

No Guarantee of Coverage or Meaningful Benefits. Although the Republican proposal requires States to cover pregnant women, children under 13, and people with disabilities, the sharp reduction in federal assistance may force States to provide *minimal* health benefits. The block grant set-asides cover only about 45% of State Medicaid spending for these groups, allowing States to more than cut their spending in half in each of the specified areas. Financially strapped States could be forced to eliminate coverage of valuable services such as well-child care, prenatal care and long-term care for chronically-ill seniors and disabled individuals.

Elimination of Comparability Requirements May Lead to Serious Inequities. The lack of requirements that benefits be comparable across a State could lead a State to short-change certain needy but politically weak populations or geographic areas and to shift benefits to others.

Republican Proposal Abolishes Due Process Protections. Eliminating the right of an individual to sue a State in Federal court, removes any meaningful ability of beneficiaries to seek legal protection from possible State abuses of their broad new discretion. Moreover, the minimal required services and procedural "guarantees" in the Republican proposal are meaningless for those who are ineligible under new State rules.

PRESIDENT'S MEDICARE PROPOSAL

The Medicare savings and structural reforms included in the President's balanced budget proposal have been carefully designed to strengthen the Medicare Trust Fund, expand health plan options for beneficiaries and assure that Medicare benefits continue to be affordable for the 37 million elderly and people with disabilities the program serves.

The Medicare Trust Fund is Strengthened through 2011. The savings and structural changes assure the financial health of the Medicare Trust Fund through 2011 -- placing the Fund in a better position than it has been in 18 out of the last 20 years.

Savings Achieved Without Any New Beneficiary Cost Increases or Arbitrarily Imposed Budget Caps. The Administration's proposal has specific and scorable policy changes that assure program efficiency and produce $124 billion in savings. This is achieved without undermining the structural integrity of the program, imposing new costs on beneficiaries, or arbitrarily capping the program's growth to an index that has nothing to do with health costs.

The Cuts are Significantly Smaller than the Republican Conference Agreement. The Administration proposes smaller cuts for all major categories of the Medicare program (i.e., beneficiaries, hospitals, physicians, home health care providers and nursing homes). The differences in beneficiary and hospital cuts are particularly significant. The Administration has $42 billion less in beneficiary cuts and $44 billion less in hospital cuts than the Republican conference agreement. (See attached charts.)

The Reforms Hold the Medicare Per Beneficiary Program Growth Rate to Approximately that of the Private Sector. On a per person level, the President's proposal holds the Medicare program to a growth rate that is slightly lower than the 7.1 percent per person private sector growth rate as estimated by the Congressional Budget Office. In contrast, the Republican Conference Medicare cuts would constrain Medicare growth per beneficiary to over 20 percent below the private sector per person growth rate. (See attached chart.)

Republican Cuts Will Lead to Cost Shifting or Access and Quality Problems. The Administration believes that cuts of the magnitude advocated by the Republicans would result in significant cost-shifting ($84.7 billion according to the bipartisan National Leadership Coalition on Health Care) or reduced quality and access to needed health care providers. This is why the American Hospital Association has stated: "the reductions in the conference report will jeopardize the ability of hospitals and health systems to delivery quality care, not just to those who rely on Medicare and Medicaid, but to all Americans."

Choices of Plans are Expanded Under Medicare in a Pragmatic, Responsible Way. The President's plan retains a strong Medicare fee-for-service program and significantly increases choices of alternative health plans, including new managed care options (PPOs and HMOs with point of service options) as well as provider networks. In contrast, the Republican approach -- which includes Medical Savings Accounts and other options that tend to manage risk rather than manage costs -- will fragment the Medicare risk pool.

Medicare is Improved by Expanding Preventive Programs, including better mammography coverage, colorectal screening, and a new respite benefit for families of Alzheimer's patients.

Disease	Prevalence/Number of Women Affected	Additional Information
Osteoporosis	Osteoporosis affects half of all women over 45 and 90 percent of women over 70. All told, 20 million women (and 5 million men) have osteoporosis. The disease causes 250,000 hip fractures a year. Women account for 75-80 percent of these hip fractures--about 200,000 a year. One out of every two women will have an osteoporosis-related fracture in her lifetime.	Hip fractures are a leading cause of hospitalization and nursing home placements among older women. One out of every four older women who were living independently prior to the hip fracture required institutional care for at least a year after the injury.
Falls	About 40 percent of all falls by women over 75 result in a fracture. More deaths of women in this age group are caused by falls than by pneumonia, diabetes or all other accidents combined.	
Diabetes	Diabetes, a leading cause of death by disease and also a leading contributor to heart disease, stroke, blindness and amputation, is more prevalent among women than men. This is largely due to the high incidence of the disease among black, Hispanic and other minority women. Black women are twice as likely as their white counterparts to die of diabetes. In 1993 there were over 3 million people age 65 or older with diabetes, of whom 60 percent--almost 2 million--were women. Diabetes is particularly dangerous for older women; women age 65 to 74 are four times as likely to die of the disease as women age 45 to 64.	
Arthritis	Arthritis is much more common in women than in men. While half of all persons over 65 report problems with arthritis, four out of every five women over 65 suffer from the disease.	

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Heart Attack and Stroke	The rate of illness and death from heart disease rises rapidly for women over 55. One in three women over 65--3.6 million women--suffers from heart disease (1990 figure). Women are more likely than men to die after a heart attack, or to have a second attack. Mortality from heart disease, at all ages, is highest among black women. Cerebrovascular disease (including stroke) is the third leading cause of death among women. People over 65 account for nine out of ten deaths from the disease. In 1990, 1.1 million older women had a stroke.	The higher mortality among female heart attack victims may be attributable to the fact that the heart disease therapies used have been tested primarily on men, and may not be as effective for women.
Cancer	Lung cancer and breast cancer are the leading causes of cancer deaths among older women. Overall, these two diseases account for over half of all female cancer deaths. One out of every nine women will be diagnosed with breast cancer in her lifetime. Although the incidence of breast cancer is higher among white women, black women are more likely to die of the disease. Part of the problem is that breast cancer is usually more advanced in black women by the time it is diagnosed. About 70 percent of all deaths from cervical cancer occur among women over 50. Mortality from the disease is especially high among low-income elderly women. While the incidence of cervical cancer is about one-third higher for black than for white women, the mortality rate for black women is almost three times as high. Older Hispanic and Native American women are also more likely than older white women to be diagnosed with and die of cervical cancer.	Although pap smears and mammograms can greatly reduce the risk of invasive cervical and breast cancer, many women do not receive these tests on a regular basis. Older women are less likely than younger women to have regular mammograms, despite the fact that the risk of breast cancer increases with age. Many older women without private insurance or supplemental Medigap coverage do not see physicians or receive preventive tests because they cannot afford the out-of-pocket costs (e.g., copayments, deductibles).

Disease	Prevalence/Number of Women Affected	Additional Information
Alzheimer's Disease	About 4 million people suffer from Alzheimer's. Women are, again, more likely than men to be stricken by the disease, even taking into account the larger number of older women.	Care for Alzheimer's patients, which can be exceptionally demanding, is disproportionately provided by older women.
Depression	Older women are twice as likely to experience depression as their male counterparts. Symptoms of "pseudo dementia," depression that often follows major life losses (e.g., death of a spouse) can include withdrawal, confusion and memory loss.	Although treatment can assist most people who suffer from depression, many do not seek treatment.