DRAFT

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

December 20, 1995

A PROFILE OF AMERICA'S OLDER WOMEN

DEMOGRAPHIC TRENDS

The aging of the American population has significant implications for women. Women represent a majority of older Americans and an even larger proportion of the very old, those aged 85 and over.

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, 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. About 20 million, or 8% of Americans aged 65 or older, are women. In the next 35 years, that number will nearly double, to 38 million or 10% of the population.[2]

- Life expectancy for women has increased steadily. In 1960, life expectancy at birth for females was about 73. By 1994, life expectancy increased to 79 years. Average life expectancy is shorter for men than for women. In 1994, when life expectancy at birth was 79 for a female, it was 72.3 for a male.[3]

Women Over 85 Are One of the Fastest Growing Segments of Society. The number of people over the age of 85 is growing quickly, and women represent an even larger proportion (72%) of this group. Today, 2.5 million are women over 85, a figure that will more than double to 5.7 million by 2030.[4]

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

[2]Id.

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

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Older Women Are Far More Likely Than Men to Live Alone. Forty-two percent of women aged 65 and over lived alone in 1992, compared with just 16% of older men. The proportion of women living alone increases dramatically with age. About one-third (34%) of women aged 65 to 74 lived alone, compared to over half of women aged 85 and over.[5] 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.[6]

FINANCIAL STATUS

Older women are typically poorer than older men, and women over 85 and minority women are even more likely to be poor. The most vulnerable group is elderly women living alone.

Older Women Are Poorer Than Older Men. The median income for women 65 or older is $8,600 a year. The median income for men is about $15,000, 76% higher than the median for women.[7]

[HHS CHECK] Fifteen percent of older women live in poverty, compared with 8% of older men. Twenty-one percent of women over age 85 have incomes below the federal poverty level.[8] Forty percent of women aged 65 to 74 and 56% of women over 75 live on incomes below twice the poverty line ($14,000).[9]

Minority Women Are Poorer Still. Minority women have substantially lower incomes. 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).[10]

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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 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; [HHS CHECK -- NEED 1993 DATA] in 1991, more than 58% of black women and half of Hispanic women 65 and older living alone were poor.[11]

Widowhood often drives women into poverty. A study by the National Bureau of Economic Research found that half of poor widows were not poor when their husbands were alive.[12]

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.[13] Half of all women beneficiaries would be poor if they did not receive a Social Security benefit.[14]

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 Suffer from Chronic Health Conditions. Women age 65 or older are more likely than men to suffer from serious chronic conditions. [HHS -- NEED LIST OF CONDITIONS THAT DISPROPORTIONATELY AFFECT WOMEN e.g. Chronic health problems that disproportionately affect poor elderly women include hypertension (62%0, heart disease (25%), and diabetes (21%).] Older women are also more likely to experience non-life-threatening chronic health conditions. For example, four out of five women 65 and over

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suffer from arthritis, compared with [HHS -- NEED NUMBER] men.[15] [OR 61% of older women, and 70% of poor elderly women, have arthritis, compared with 46% of older men -- 1987 data]. These conditions may contribute to a loss of functioning, particularly as women age.

Women 85 And Older Are Even More Vulnerable. These problems become more serious with increasing age. Women over the age of 85 are extremely vulnerable. 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.[16] 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.

The following table illustrates the prevalence and risks of particular diseases faced by older women.

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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 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]

- **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]

WOMEN AS CAREGIVERS

Women are the primary caregivers for their spouses and parents.

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- 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?]

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.

[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

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.[28]

Medicare and Medicaid Provide Critical Services for Older Women.

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

- Medicaid also covers essential services for older women, including some that are not covered by Medicare -- like prescription drugs, dental care, eyeglasses, hearing aids, and more extensive long-term care.

    - Medicaid will pay an average of over $800 for prescription drugs for an older woman on Medicaid in 1995.[29]

    - 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.[30]

    - In 1995, Medicaid paid Medicare premiums, coinsurance and deductibles for about 2 million poor, older women.[31] [WHAT ABOUT SLMB?]

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

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

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

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

THE IMPACT OF THE REPUBLICAN CUTS IN MEDICARE AND MEDICAID

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.

- **Increases Premiums.** The Republican budget increases premiums from 25% of Part B program costs to 31.5%. **In 1996 alone, this change will increase costs for elderly couples by $[264] and elderly individuals by $[132].** The President's balanced budget plan maintains current policy and permanently sets premiums at 25% of program costs.

    - 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?][32]

    - Over 20% or [$10.6] billion of the increase would come from elderly women with incomes below 200% of poverty.[33]

- **Allows Doctors to Overcharge.** Under current law, Medicare limits the amount doctors can charge beneficiaries above Medicare payment rates. The Republican Medicare plan creates new, private fee-for-service plans that are similar to Medicare but that allow doctors to overcharge -- so-called "balance billing."

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

[33]Id.

- **Ends Financial Protection for Poor Medicare Beneficiaries.** As many as [----] poor elderly women will lose funding for their Medicare premiums -- just when these premiums are being increased. [NEED TO MAKE CONSISTENT WITH INFO ABOVE.]

    - Medicaid currently pays all Medicare premiums, coinsurance and deductibles for people below 100% of poverty (known as QMBs) -- two million of whom are elderly women -- and premiums for people with incomes between 100% and 120% of poverty. The Republican proposal completely eliminates coverage of coinsurance and deductibles for these poor elderly and disabled people. And while Republicans claim to cover premiums, they set aside *less than half* of the money needed to cover their premiums in 2002, denying premium coverage to as many as [------] poor elderly and disabled women.

    - **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.

INCREASES COSTS FOR BENEFICIARIES WITHOUT EXPANDING BENEFITS OR PREVENTION

- The Republican budget increases beneficiary costs while adding only one new benefit -- coverage of oral nonsteroidal antiestrogen for the treatment of breast cancer.

- Currently, Medicare does not cover the array of preventive benefits now offered by many private plans, particularly managed care plans. These preventive benefits can both increase beneficiary's helath and reduce costs.

- President Clinton's balanced budget proposal updates the Medicare benefit package to make it more comparable to private sector benefit packages, including:

    - **Mammography.** The President's proposal eliminates cost sharing for mammography services and provides annual screening mammograms.

    - **Certain Colorectal Screening.** Early detection of cancers and other serious conditions can result in less costly treatment, enhanced quality of life and, in some cases, a greater likelihood of cure. The President's proposal provides coverage for some colorectal screening.

    - **Preventive Injections.** The President's proposal would increase payments for certain preventive injections provided in physician offices which will encourage providers to immunize beneficiaries.

- **Respite Benefit for Families of Beneficiaries with Alzheimer's Disease.** The President's plan creates a Medicare respite benefit for families of beneficiaries with Alzheimer's disease or other irreversible dementia, covering up to 32 hours of care per beneficiary per year, administered through home health agencies or other entities. Services could be provided in the home or in a day care setting.

MEDICAID

ENDS GUARANTEE OF COVERAGE UNDER MEDICAID

The Republican plan cuts [$116] billion from Medicaid and repeals the program, replacing it with a "block grant." The plan completely eliminates Medicaid's guarantee of defined, meaningful coverage for Americans who are sick, elderly, poor or disabled.

- Because the block grant constrains spending growth per beneficiary to [1.6%] per year, providing [28%] less funding than under current law by 2002, states will be forced to significantly reduce Medicaid eligibility and benefits.

- Under current law, all states are required to cover a minimum set of services, including hospital, physician, and nursing home services. states have the option of covering an additional 31 services, including prescription drugs, hospice care and personal care services. Under the block grant, states could eliminate almost any benefit covered by Medicaid. The only required services would be immunizations and family

LOSS OF MEDICAID COVERAGE

The reduction in Federal support of [$116 billion] in Medicaid spending could force states to deny meaningful 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.**[34]

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

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

Services.[35]

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.[36]

  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%.[37]

- **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

[35]Department of Health and Human Services, December 1995. Note: In this analysis, poverty is defined more broadly than in official poverty statistics from the Census Bureau. This broader definition includes the effects of Federal tax policies (including the Earned [illegible]

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.

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.[38]

- 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.

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

Health Status (see attached chart for additional details)

- **Symptoms of heart disease typically develop in women about 10 years later in life than in 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.[1] Women are more likely than men to die after a heart attack ro to have a second attack.**

- 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 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.

- **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.[2]**

- **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.**

- 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.[3]

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[1]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.

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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.

[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.

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.[28]

Medicare and Medicaid Provide Critical Services for Older Women.

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

- Medicaid also covers essential services for older women, including some that are not covered by Medicare -- like prescription drugs, dental care, eyeglasses, hearing aids, and more extensive long-term care.

    - Medicaid will pay an average of over $800 for prescription drugs for an older woman on Medicaid in 1995.[29]

    - 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.[30]

    - In 1995, Medicaid paid Medicare premiums, coinsurance and deductibles for about 2 million poor, older women.[31] [WHAT ABOUT SLMB?]

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

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

[30]Department of Health and Human Services, 1995

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

THE IMPACT OF THE REPUBLICAN CUTS IN MEDICARE AND MEDICAID

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.

- **Increases Premiums.** The Republican budget increases premiums from 25% of Part B program costs to 31.5%. **In 1996 alone, this change will increase costs for elderly couples by $[264] and elderly individuals by $[132].** The President's balanced budget plan maintains current policy and permanently sets premiums at 25% of program costs.

    - 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?][32]

    - Over 20% or [$10.6] billion of the increase would come from elderly women with incomes below 200% of poverty.[33]

- **Allows Doctors to Overcharge.** Under current law, Medicare limits the amount doctors can charge beneficiaries above Medicare payment rates. The Republican Medicare plan creates new, private fee-for-service plans that are similar to Medicare but that allow doctors to overcharge -- so-called "balance billing."

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

[33] Id.

- **Ends Financial Protection for Poor Medicare Beneficiaries.** As many as [----] poor elderly women will lose funding for their Medicare premiums -- just when these premiums are being increased. [NEED TO MAKE CONSISTENT WITH INFO ABOVE.]

    - Medicaid currently pays all Medicare premiums, coinsurance and deductibles for people below 100% of poverty (known as QMBs) -- two million of whom are elderly women -- and premiums for people with incomes between 100% and 120% of poverty. The Republican proposal completely eliminates coverage of coinsurance and deductibles for these poor elderly and disabled people. And while Republicans claim to cover premiums, they set aside *less than half* of the money needed to cover their premiums in 2002, denying premium coverage to as many as [------] poor elderly and disabled women.

    - **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.

INCREASES COSTS FOR BENEFICIARIES WITHOUT EXPANDING BENEFITS OR PREVENTION

- The Republican budget increases beneficiary costs while adding only one new benefit -- coverage of oral nonsteroidal antiestrogen for the treatment of breast cancer.

- Currently, Medicare does not cover the array of preventive benefits now offered by many private plans, particularly managed care plans. These preventive benefits can both increase beneficiary's helath and reduce costs.

- President Clinton's balanced budget proposal updates the Medicare benefit package to make it more comparable to private sector benefit packages, including:

    - **Mammography.** The President's proposal eliminates cost sharing for mammography services and provides annual screening mammograms.

    - **Certain Colorectal Screening.** Early detection of cancers and other serious conditions can result in less costly treatment, enhanced quality of life and, in some cases, a greater likelihood of cure. The President's proposal provides coverage for some colorectal screening.

    - **Preventive Injections.** The President's proposal would increase payments for certain preventive injections provided in physician offices which will encourage providers to immunize beneficiaries.

- **Respite Benefit for Families of Beneficiaries with Alzheimer's Disease.** The President's plan creates a Medicare respite benefit for families of beneficiaries with Alzheimer's disease or other irreversible dementia, covering up to 32 hours of care per beneficiary per year, administered through home health agencies or other entities. Services could be provided in the home or in a day care setting.

MEDICAID

ENDS GUARANTEE OF COVERAGE UNDER MEDICAID

The Republican plan cuts [$116] billion from Medicaid and repeals the program, replacing it with a "block grant." The plan completely eliminates Medicaid's guarantee of defined, meaningful coverage for Americans who are sick, elderly, poor or disabled.

- Because the block grant constrains spending growth per beneficiary to [1.6%] per year, providing [28%] less funding than under current law by 2002, states will be forced to significantly reduce Medicaid eligibility and benefits.

- Under current law, all states are required to cover a minimum set of services, including hospital, physician, and nursing home services. states have the option of covering an additional 31 services, including prescription drugs, hospice care and personal care services. Under the block grant, states could eliminate almost any benefit covered by Medicaid. The only required services would be immunizations and family

LOSS OF MEDICAID COVERAGE

The reduction in Federal support of [$116 billion] in Medicaid spending could force states to deny meaningful 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.**[34]

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

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

Services.[35]

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.[36]

  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%.[37]

- **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

[35]Department of Health and Human Services, December 1995. Note. In this analysis, poverty is defined more broadly than in official poverty statistics from the Census Bureau. This broader definition includes the effects of Federal tax policies (including the Earned

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.

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.[38]

- 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.

[38]Department of Health and Human Services, 1995

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LOSS OF MEDICAID COVERAGE

The reduction in Federal support of [~~$116~~ billion] in Medicaid spending could force states to deny meaningful 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 likely to be women.~~[35]

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~~[36] Department of Health and Human Services, 1995.~~

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- 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.

[How many individuals in nursing homes have a living spouse? Percentage of men v. women? Add family financial protections?

* See attached table from 1987 NMES re: marital status of "current" (on 1/1/87) 65+ nursing home residents — no significant gender difference in % married. However, there is a major gender difference in % not married (i.e. 68% of women vs. 18% of men).

U.S.

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

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TABLE OF SPSEX BY MARSTATB

SPSEX(SEX)

	MARSTATB(BMDP IMPUTED MARITAL STATUS)		
Frequency Percent Row Pct Col Pct	0: NOT MARRIED	1: MARRIED	Total
1: MALE	480 18.24 71.96 21.16	187 7.11 28.04 51.52	667 25.35
2: FEMALE	1788 67.96 91.04 78.84	176 6.69 8.96 48.48	1964 74.65
Total	2268 86.20	363 13.80	2631 100.00

TABLE OF SPSEX BY MARSTATB

SPSEX(SEX)

	MARSTATB(BMDP IMPUTED MARITAL STATUS)		
Frequency Percent Row Pct Col Pct	0: NOT MARRIED	1: MARRIED	Total
1: MALE	221895 17.82 72.03 20.65	86180 6.92 27.97 50.36	308075 24.74
2: FEMALE	852418 68.44 90.94 79.35	84951 6.82 9.06 49.64	937370 75.26
Total	1074313 86.26	171131 13.74	1245445 100.00

65+ Nursing Home population 1987 NMES

29

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Caring for Women in Older Age

Diane Rowland and Karen Davis

THE AGING OF THE AMERICAN population has especially significant implications for women. Women outlive men by an average of seven years.[1] A wife often cares for her husband through a long illness, and then spends a number of years living alone, without immediate assistance when her own health fails. The death of a spouse also typically brings a reduced standard of living, as savings are exhausted to pay medical and funeral expenses and income from pensions and Social Security is reduced.[2]

As the population ages, these problems will become more acute. By the year 2030, one in five Americans will be 65 years of age or older, up from one in nine today.[3] The absolute growth in the number of older people and the increasing proportion of older people over the age of 75 will lead to a substantial increase in the number of people needing long-term care. Most of these people will be women;[4] three-fourths of all nursing home residents are women.

For these reasons, a clear picture is needed of the health and long-term care needs of older women, and the steps this nation could take to assure them a better quality of life.

Profile of Older Women

In 1987 there were 16.6 million women 65 years of age and older in the United States, representing 59 percent of all older Americans. Women represent an even larger proportion (68 percent) of the very old, those aged 85 and over.

The authors wish to thank The Commonwealth Fund and The Brookdale Foundation for financial support, Barbara Lyons and Paula Grant for research assistance, and John Hanfelt for programming assistance.

Approximately one-third of all people aged 65 and older live alone (Exhibit 1). Older women are much more likely than older men to live alone; many are widows. Forty-four percent of older women live alone, compared with 19 percent of older men. This discrepancy reflects both the longer life expectancy of women, which makes it more likely that they will outlive their husbands, and the fact that women tend to marry men who are older than they are.

People living alone are particularly at risk as their health fails. Without someone immediately available to provide assistance, older people who have severe physical or mental limitations must rely on informal support from family members, obtain formal home care from a home care aide or agency, move in with family, or enter a nursing home or other type of sheltered living arrangement.

Older women are typically poorer than older men. The feminization of poverty holds true not only for younger families but for elderly people as well. Fifteen percent of older women are poor, compared with 8 percent of older men (Exhibit 1). Twenty-one percent of women over age 85 have incomes below the federal poverty level.

Women whose husbands are still alive fare much better than widows. The most vulnerable group is elderly women living alone, 27 percent of whom live in poverty—a poverty rate that is higher than that among children and almost five times as high as among women in other living arrangements (6 percent). While 44 percent of all elderly women live alone, 79 percent of poor elderly women live alone (Exhibit 1). Widowhood often drives women into poverty. A study by the National Bureau of Economic Research found that half of poor widows were not poor when their husbands were alive.[5]

According to future projections by ICF, Inc., by the year 2020 poverty among older people will be almost exclusively poverty among older women.[6] Although women have been entering the labor force in greater numbers and have increasingly become eligible for their own private pension and Social Security income, the poverty rate among older women is not expected to decline significantly between now and 2020. For example, the percentage of poor and near-poor men living alone will decline from 38 percent in 1987 to about 6 percent by 2020. The percent of poor and near-poor women living alone will decline only from 45 percent to 38 percent 25 years from now.[7] Increased participation in the labor market and improvements in pension coverage are projected to only modestly improve poverty rates among elderly women living alone.

Exhibit 1
Sociodemographic Characteristics of Persons Aged 65 and Over
United States
1987

	Total	Men	Women	Poor Men	Poor Women
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Years of Age					
65-74	60.7	64.8	57.8	52.9	47.7
75-84	31.0	28.7	32.6	35.6	38.7
85 and Older	8.3	6.5	9.6	11.5	13.6
Race					
White	88.8	88.9	88.7	68.1	71.3
Black	8.3	8.1	8.5	23.5	22.9
Hispanic	2.9	3.0	2.8	8.4	5.8
Income (Percent of Poverty Income)					
Less than 100%	12.2	8.4	14.9	100.0	100.0
100 - 199%	28.4	25.0	30.7	-	-
200% and Over	59.4	66.6	54.4	-	-
Living Arrangement					
Alone	33.4	18.7	43.8	47.0	78.8
With Others	66.6	81.3	56.2	53.0	21.2

Source: Estimates based on analysis of the 1987 National Medical Expenditures Survey.

The Supplemental Security Income (SSI) program, the federal program that provides cash assistance to low-income elderly and disabled persons, fails to lift all elderly people out of poverty for three reasons. First, half of those eligible for SSI fail to participate—largely because they do not know about the program or believe they are ineligible.[8] Second, the income eligibility level for SSI is set at 75 percent of the federal poverty level for a single person, and at 90 percent of the federal poverty level for an elderly couple.[9] Consequently, many poor single elderly people are not covered. Finally, SSI places severe restrictions on assets ($2,000 in liquid assets plus a home and car). As a result, low-income elderly people with modest assets may not qualify.

Health and Older Women

Health Insurance

The greatest concern of elderly people is the fear that they will experience a serious illness.[10] In the United States this fear is heightened by a health care financing system that provides inadequate protection against health care bills. As a result, older Americans also fear that medical expenses will exhaust their savings and they will not be able to afford needed care.

Nearly all elderly people are covered by Medicare. However, Medicare benefits are limited largely to hospital and physician services, and even these services are covered only after a substantial deductible is incurred. In 1994, Medicare beneficiaries are required to pay the first $696 of a hospital bill per spell of illness, and the first $100 annually of physician bills. In addition, Medicare beneficiaries must pay 20 percent of all physician charges in excess of the $100 annual deductible, as well as any charge the physician makes in excess of what Medicare deems a reasonable fee. Medicare beneficiaries must pay a monthly premium of $41.10 for Part B physician coverage.

Medicare does not cover prescription drugs or other services or equipment such as dental care, eyeglasses, or hearing aids. For patients with serious chronic conditions, these expenses can amount to several thousand dollars annually.

Medicare covers very little long-term care. It pays for home health services only for those elderly who are recovering from a condition such as a broken hip, who require the specialized services of a registered nurse or physical therapist, who are homebound, and who require intermittent care. Ongoing services, such as personal care for a person with Alzheimer's disease, are not covered. Payment for nursing home care is similarly limited to short-term convalescent care for patients requiring skilled nursing care following a hospitalization.

Because of these limitations in Medicare coverage, most Medicare beneficiaries obtain supplementary coverage from private health insurance or Medicaid. However, 12 percent of all Medicare beneficiaries rely solely on Medicare for assistance in paying their health care bills (Exhibit 2).

Since older women are more likely to be poor, a higher proportion of older women than men qualify for Medicaid. In 1987 12 percent of elderly women and 6 percent of elderly men had Medicaid to supple-

ment Medicare (Exhibit 2). Medicaid pays the Medicare Part B premium and the deductible and coinsurance for Medicare-covered services. Medicaid is especially important in assisting elderly people in paying for long-term care services. About half of all nursing home expenditures are paid by Medicaid. Since older women are more likely to become impoverished and to live in a nursing home, this coverage is critical. Despite the fact that most Medicaid enrollees are low-income women and their children, 71 percent of all Medicaid outlays go to assist the elderly and disabled poor.[11]

Older men are somewhat more likely than their female counterparts to have private health insurance to supplement Medicare (80 percent vs. 78 percent). About half of this coverage is provided through employer health benefit plans for retirees. Married men, with their longer work history in better paying jobs, and their spouses are more likely to have retiree health benefits than single women. For elderly women living alone, 76 percent have private health insurance compared with 79 percent of women living with their spouse or others (Exhibit 2).

Private health insurance plans vary in the benefits they cover. Typically, however, such plans pick up the Medicare deductibles and coin-

Exhibit 2
Health Insurance Coverage, Persons Aged 65 and Older
United States
1987

	Total	Medicare Only	Medicare and Medicaid	Medicare and Private Insurance
Total	**100.0**	**12.1**	**9.2**	**78.7**
Men	100.0	14.4	5.6	80.0
Women	100.0	10.5	11.7	77.8
Women by Living Arrangements				
Alone	100.0	8.6	15.2	76.2
With Others	100.0	11.9	9.0	79.1
Women by Poverty Income				
Less than 100%	100.0	17.8	40.6	41.6
100 - 199%	100.0	12.3	12.1	75.6
200% and Over	100.0	7.4	3.6	89.0

Source: Estimates based on analysis of the 1987 National Medical Expenditures Survey.

surance, and some cover such services as prescription drugs. However, few private health insurance plans have comprehensive long-term care benefits. As a result, even those with private coverage to supplement Medicare must worry about the possibility of financial hardship if they become seriously impaired.

Health Status of Older Women

Although women live longer than men, this longevity can be a mixed blessing. Since the prevalence of chronic conditions and the risk of serious impairment increase with age, older women are especially vulnerable to illness in later life. The relatively greater rate of poverty among older women, especially among those living alone, also puts them at risk for serious illness.

Elderly men and women are about equally likely to rate their health as fair or poor (47 percent versus 48 percent) (Exhibit 3). Among poor elderly people, the numbers increase; 60 percent of poor elderly men and 64 percent of poor elderly women rate their health as fair or poor.

Elderly women are more likely to suffer from a serious chronic health condition than are elderly men. Seventy-seven percent of elderly men have chronic conditions, compared with 84 percent of elderly women (Exhibit 3). Chronic health problems are much more prevalent among the poor elderly than among higher income elderly. For example, 88 percent of poor elderly women report chronic health conditions, compared with 82 percent of elderly women with incomes of more than twice the poverty rate.

Older women are more likely to experience non–life-threatening chronic health conditions than are men. For example, 61 percent of older women, and 70 percent of poor elderly women, have arthritis, compared with 46 percent of older men (Exhibit 3). This condition, although not life-threatening, cripples and can make it extremely difficult for an older woman living alone to take care of herself and maintain her independence. Other chronic health problems that disproportionately affect poor elderly women include hypertension (62 percent), heart disease (28 percent), diabetes (21 percent), and cerebrovascular disease (8 percent).

Older men are more likely to have chronic heart disease than are older women (24 percent versus 21 percent) (Exhibit 3). However, the differences between men and women decline with age, so that in later life both men and women must be concerned about becoming victims

Exhibit 3
Health Status of Persons Aged 65 and Over, Percentage Distribution
United States
1987

	Total	Men	Women	Poor Men	Poor Women
Self-Assessed Health Status					
Excellent/Good	52.5	53.2	52.0	39.7	35.7
Fair/Poor	47.5	46.8	48.0	60.3	64.3
Percent with Chronic Conditions					
None	18.9	22.8	16.1	25.2	12.4
One	31.2	31.0	31.3	20.6	23.7
Two or More	49.9	46.2	52.6	54.2	63.9
Percent with Selected Chronic Conditions					
Arthritis	54.9	46.0	61.2	48.7	70.0
Hypertension	49.8	44.8	53.3	53.2	61.8
Heart Disease	22.1	24.0	20.8	26.4	28.2
Diabetes	14.7	15.6	14.0	24.1	20.6
Cerebrovascular Disease	7.5	9.2	6.1	15.0	8.4
Cancer	13.3	13.0	13.5	12.2	10.4

Source: Estimates based on analysis of the 1987 National Medical Expenditures Survey.

of heart attacks. Elderly women are more likely to report hypertension and be at risk for serious strokes than elderly men.

Older men are more likely than older women to have hearing impairment, perhaps as the result of occupational exposure to noise during their younger years (Exhibit 4). Hearing impairment is more common among poor elderly women. Vision problems are more common among older women. One-third of older women and one-fourth of older men have vision problems. Among poor elderly women, over two-fifths have a problem with vision. Poor vision can be an important contributing factor to falls or other injuries, and can hamper the ability of older people to take care of themselves.

Health Care of Older Women

Access to health care services is especially important for the health and well-being of older women. Living longer, more prone to chronic conditions, and most at risk for serious impairment, older women are heavy users of the health care system.

Exhibit 4
Disability among Persons Aged 65 and Over, Percentage Distribution
United States
1984

	Total	Men	Women	Poor Men	Poor Women
ADL Limitation					
Moderate	7.2	5.7	8.3	9.3	10.9
Severe	6.9	5.3	8.1	7.3	12.1
IADL Limitation					
Moderate	2.9	2.0	3.5	2.9	5.8
Severe	11.2	8.9	12.7	16.9	18.3
Percent with Selected Disabilities					
Falls	20.4	16.6	23.0	18.9	27.2
Mobility	10.1	8.0	11.6	13.6	18.8
Hearing	37.5	44.4	32.7	51.3	38.4
Vision	29.4	25.4	32.2	33.8	41.0

Source: Estimates based on analysis of the 1984 Supplement on Aging, National Health Interview Survey.

In 1987, 29 per 100 older women were hospitalized during the year (Exhibit 5). This rate increases to 37 per 100 for poor older women. For those who rate their health as fair or poor, about 42 per 100 older women were hospitalized, including 40 per 100 poor elderly women. This compares with 42 hospitalizations per 100 among elderly men who rate their health as fair or poor.

Older people also make extensive use of physician services. Ambulatory visits to physicians in 1987 averaged 8.6 per person for older women and 8.5 visits per person for poor older women (Exhibit 5). Older women in fair or poor health saw physicians 10.8 times, compared with 10.3 times for older men in fair or poor health.

Poor older women see physicians somewhat less frequently than higher income older women. Among those in fair or poor health, poor women averaged 10.5 physician visits annually, compared with 10.8 physician visits for older women with family incomes more than twice the poverty level.

Differences in use of health care services by income reflect the fact that higher income older women are more likely to have private health insurance compared to lower income women (89 percent versus 42 percent), while poor elderly women are more likely to have only Medi-

Exhibit 5
Utilization of Health Care Services, Persons Aged 65 and Over
United States
1987

	Total	Men	Women	Poor Men	Poor Women
Annual Physician Visits per Capita					
Total	8.3	7.8	8.6	6.7	8.5
People in Fair or Poor Health	10.6	10.3	10.8	10.2	10.5
Annual Hospital Admissions per 100 Population					
Total	30.1	31.9	28.9	33.1	36.7
People in Fair or Poor Health	42.0	42.0	42.0	42.7	39.9

Source: Estimates based on analysis of the 1987 National Medical Expenditures Survey.

care coverage (18 percent versus 7 percent). Studies have shown that those elderly with both Medicaid and Medicare make the same use of health care services as those with Medicare and private health insurance. However, those who rely solely on Medicare tend to use health care services at a lower rate.[12]

Older Women and Long-Term Care

Older Women and Disability

When older women need caregiving, the resources available to them are often limited. Older women are especially at risk for serious disability that limits their capacity to care for themselves. The most common measure of physical disability is whether assistance is required in performing five basic activities of daily living (ADL): eating, using the toilet, dressing, bathing, and moving from a bed or chair independently. The level of physical disability can be characterized by the number of ADL limitations and the type of assistance required. Severe physical disability is defined as the need for direct human assistance with two or more ADL. Those with more moderate physical disability require human assistance with only one ADL or can rely on special equipment or the help of another person on a stand-by basis to compensate for their ADL deficits.

Eight percent of older women living at home have severe ADL limitations, compared with 5 percent of elderly men (Exhibit 4). In addi-

tion, another 8 percent of older women and 6 percent of older men have moderate ADL limitations.

Poor elderly women are at substantially greater risk of ADL limitation than higher income older women. Twelve percent of poor older women experience severe ADL limitation, and 11 percent experience moderate ADL limitation. Together, almost one-fourth of poor elderly women living at home need some type of assistance in carrying out basic ADL, compared with 14 percent of elderly women with incomes more than twice the federal poverty level. Since poor women are much more likely to be living alone, this need for assistance represents a substantial threat to their continued independence and well-being.

Older women are also more likely than older men to be seriously limited in their ability to carry out such instrumental activities of daily living (IADL) as managing their money or keeping house (13 percent versus 9 percent) (Exhibit 4). Eighteen percent of poor elderly women report severe IADL limitation, and 6 percent report moderate IADL limitation.

Older women must also worry about a serious fall. Twenty-three percent of older women have a problem with falling, compared with 17 percent of older men (Exhibit 4). Among poor elderly women, 27 percent report problems with falls. Osteoporosis, a condition characterized by thinning of the bones, is more common among women than men, putting women at higher risk for fractures or other bone conditions. The fear that an elderly woman living alone will fall when no one is around to provide immediate assistance is a major concern of families, and often leads to institutionalization.

Frequent falling and fractures not only can cause injuries leading to hospitalization, but can lead to permanent disability. Older women are 50 percent more likely than older men to suffer from limitations in mobility. Twelve percent of older women living at home and 8 percent of older men experience mobility difficulties (Exhibit 4). Among poor elderly women, 19 percent report difficulty with mobility—more than twice the rate among older women with incomes more than twice the poverty level.

All these problems become more serious with increasing age. Women over the age of 85 are extremely vulnerable. Almost two-fifths of all women aged 85 and over living at home have moderate to severe ADL limitations, and almost half have moderate to severe IADL limitations. These rates are substantially higher than for men over age 85

(27 percent and 34 percent, respectively). Since women over age 85 are most likely to be poor and living alone, this loss of functioning can seriously undermine their well-being and places them at substantial risk of institutionalization.

Older Women and Long-Term Care

Almost 1.7 million older Americans who are limited in their ability to carry out important daily tasks live alone.[13] The great majority of these are women. Elderly people who are married or live with others usually have family members to provide assistance. Those who live alone may have family or friends nearby or pay someone to help them. Surprisingly, 73 percent of disabled elderly people living alone manage without help even though they experience difficulty with feeding, bathing, or clothing themselves.

As the disability becomes increasingly severe, however, assistance must be sought from formal paid sources or from family and friends. A quarter of a million elderly people living alone are severely disabled and receive formal or informal assistance. About 34 percent of disabled elderly people living alone who receive assistance rely solely on paid help from a personal care aide or a home care agency. Approximately 53 percent use a combination of unpaid and paid help, while 13 percent rely on unpaid help from family and friends only. (For an account of the impact of these arrangements on caregivers, see Chapter 5, "Women as Unpaid Caregivers: The Price They Pay.")

Older women living alone are major users of paid home care services. About 62 percent of all women receiving paid home care live alone; another 28 percent live with adult children or others. Only 10 percent of women receiving home care are married.

Elderly people living alone have more difficulty remaining at home when their ability to function independently is impaired, and are especially at risk of institutionalization. Fourteen percent of such people enter a nursing home within two years, compared with 8 percent of impaired people living with a spouse.[14]

Three-quarters of all nursing home residents are women. Three-fourths of these women were widowed at the time of admission; only 11 percent of women in nursing homes are married.[15]

Medicaid is a major source of financing for nursing home care. However, it is available only after a person has become impoverished. As a result, institutionalization not only robs older people of their in-

dependence, but also takes any savings that they may have accumulated over a lifetime of work. Recent legislation provides protection of some income and assets for spouses of nursing home residents living in the community. Spouses are not, however, eligible for Medicaid.

It is a tragic irony that women who have shouldered the burden of caring for others over their lifetimes all too often have no one to turn to when they need care. Twenty-five percent of elderly people living alone have no living children.[16] Another 20 percent do not have children within an hour's travel time. Although families provide an enormous amount of support to elderly parents, this care may simply not be feasible in the case of many older women.

Policy Directions

In a nation as wealthy as the United States, the plight of older women is not inevitable and should not be tolerated. Modest improvements in current programs could provide a minimum floor of economic and health security that would permit all older people to live out their lives with dignity.

Three major actions would go a long way to improving the economic, health, and social well-being of older Americans:

1. Increase the floor of income support under the SSI program to the poverty level;
2. Cover all poor and near-poor persons under Medicaid;
3. Expand Medicare to cover home care services.

SSI

The most effective approach to eliminating poverty among older people is to increase the income eligibility threshold for SSI. Raising it to 100 percent of the poverty level for everyone would reduce the poverty rate among elderly people living alone by about 29 percent, from 19 percent to 12 percent.[17] The estimated cost of this expansion is $2.3 billion for elderly people and $1.7 billion for disabled, non-elderly people (in 1987). It would raise about 600,000 persons above the poverty line, about 400,000 of them widows.

The impact of this policy change would be greater if extensive outreach efforts were made to enroll all eligible people in the SSI program. Outreach efforts to enroll eligible persons work. A demonstration of outreach for SSI conducted in three sites by the American Association of Retired Persons found that over a three-month period,

applications for SSI were increased by 90 percent and awards were increased by 60 percent.[18]

Expanded Medicaid Coverage

The Medicare Catastrophic Act of 1988 contained important provisions expanding Medicaid coverage to all poor elderly and disabled Medicare beneficiaries. Although most of the act was repealed, these provisions were retained. As a result, states are now required to provide all Medicare beneficiaries whose incomes are below the federal poverty level with Medicaid "Medicare wrap around" coverage; that is, Medicaid pays for the Medicare Part B premium, deductibles, and other cost-sharing. States have the option of making all Medicaid services including prescription drugs available to poor Medicare beneficiaries. In the Omnibus Reconciliation Act of 1990 (OBRA 90) states were required to phase in the Medicare Part B premium for Medicare beneficiaries with incomes up to 120 percent of the federal poverty level.

These expansions provide important assistance to poor and near-poor elderly who would otherwise find the high cost of uncovered Medicare expenses a major financial burden. However, since the cost of prescription drugs and other uncovered expenses can easily amount to thousands of dollars, near-poor elderly with incomes between the poverty level ($6,931 in 1993) and 200 percent of the poverty level also need assistance. Medicaid should be expanded to provide coverage to the near-poor elderly, with a sliding scale premium contribution. All Medicaid services should be covered for low-income Medicare beneficiaries, not just the cost-sharing for Medicare benefits. Prescription drug coverage is especially vital for many chronically ill elderly. It is estimated that the cost of this expansion would be $4.4 billion to federal and state governments (in 1990).[19]

Medicare and Home Care

Finally, home care should be added as a covered service under Medicare for those who are seriously impaired, for example, those with two or more ADL limitations or serious cognitive impairment. Covered benefits should include in-home and adult day care services, with the number of hours of care tied to degree of impairment (for example, 15 to 25 hours of personal in-home care per week or substitution of two hours of adult day care for each hour of in-home care).

If Medicare beneficiaries contributed 20 percent of the cost, with Medicaid picking up the costs for those below the poverty level and providing sliding scale assistance to those with incomes of up to 200 percent of the poverty level, the cost in 1989 dollars would be $6.8 billion.[20]

This benefit would enable more elderly people to maintain their independence and provide relief and support to families caring for a frail elderly person. Most important, it honors the desire of the overwhelming majority of elderly people to continue to live in their own homes.

These steps are quite modest and represent an achievable public policy agenda. By the year 2000 no elderly person should continue to live in poverty. No elderly person should live in fear of the financial devastation that uncovered medical bills can inflict. And no elderly person should be robbed of her dignity in old age through avoidable institutionalization and impoverishment. These steps will in turn help provide care for the caregivers—older women who have devoted most of their lives to caring for their children and caring for their elderly parents and husbands.

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PUBLIC POLICY ISSUES FOR THE 1990s

Old and Poor: Policy Challenges in the 1990s

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ABSTRACT. Despite an overall decline in the rate of poverty among elderly people in recent decades, certain subgroups of the elderly still suffer from high poverty rates. These include elders living alone, minorities, the very old, and widows. The gap between these vulnerable subgroups and more affluent elders is expected to grow in the decades to come. The most important tool available to

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policymakers seeking to reduce elderly poverty is the SSI program. An increase in benefit levels is recommended as well as a vigorous outreach program, because about half of elders apparently eligible are not participants. A second important tool is Medicaid. As of 1984, only 29% of poor elders, and 8% of near-poor elders, received Medicaid coverage to fill gaps in Medicare. Remedial measures are outlined. Altogether, at an estimated annual cost of only $5 billion, the United States could eliminated elderly poverty and assure that no elderly person is driven into poverty by burdensome medical expenses.

Significant strides have been made in the last two decades in reducing poverty among elderly people. In 1970 poverty rates for persons aged 65 and older were 25%—twice the rate for all persons (Committee on Ways and Means, 1989). By 1987 poverty rates for the elderly had been cut in half, falling to 12.2%— slightly below the general poverty rate of 13.5% for all persons.

This tremendous improvement in the economic security of older people is attributable in large part to improvements in Social Security benefits. Poverty rates for elderly people would be 55% without Social Security and other government transfer programs (Committee on Ways and Means, 1989). The Supplemental Security Income (SSI) program has also contributed to the reduction in poverty. Established in 1972, this federal cash assistance program provides a uniform national floor of cash benefits to poor elderly and disabled people, which are indexed to increase with inflation. Most SSI beneficiaries are also eligible to receive Medicaid assistance to help with medical bills.

Despite the accurate perception that the incomes of the elderly as a group are improving both absolutely and relative to other population groups, a significant minority of the elderly population does not share in this increasing prosperity. More than 3 million elderly people continue to live in poverty and an additional 4.3 million elderly people are "near-poor," with incomes hovering just above the poverty level (Commonwealth Fund Commission, 1987b).

A major policy challenge facing the nation in the 1990s is how to assure a minimal level of economic security for all older Americans—including both an adequate income to meet the basic daily necessities of life and reasonable financial protection to prevent impoverishment from medical and long-term care expenses. One of

the most efficient methods of guaranteeing a decent income in old age for all is to improve the basic income support afforded by SSI to permit a dignified old age without serious deprivation. Since medical and long-term care expenses can cause severe financial burdens on low-income elderly people, Medicaid eligibility should also be expanded to cover all poor and near-poor elderly people. Extending Medicaid eligibility helps to fill the gaps in Medicare for the low-income elderly population. Improvements in these two vital programs should be addressed by policy officials over the next decade.

This paper reviews the extent of poverty among population subgroups of elderly people, especially those who live alone, and gives estimates of trends in poverty over the next 35 years. It presents results of a micro-simulation model that estimates the impact of improving SSI eligibility levels over this time period. It also presents information on the financial burdens posed by chronic illness and out-of-pocket medical expenses, and analyzes the impact of policy proposals to improve Medicaid's protection of poor and near-poor elderly people.

ASSURING ECONOMIC SECURITY FOR ELDERLY PEOPLE

Although major advances have been made over the past several decades in raising the income of the elderly population overall, these gains have not been shared equally by all elderly people. Certain groups of elderly people, such as those who live alone, minorities, the very old, and widows, continue to face high rates of poverty. Even more distressing, the gap in income between these vulnerable groups of elderly people and their more affluent counterparts is expected to widen, not narrow, in the future (Commonwealth Fund Commission, 1987b).

Poverty Among Elderly People

In 1987, approximately 12.2% of elderly people struggled to live on incomes below the poverty line, less than $131 per week for an elderly couple and $104 for a single elderly individual. The risk of living in poverty is dramatically higher for specific subgroups of the elderly population. Elderly people who live alone are particularly

vulnerable to financial difficulties compared to those who live with a spouse; the poverty rate for them is five times higher than the poverty rate for elderly couples (19% versus 4%) (see Figure 1) (Commonwealth Fund Commission, 1987b).

About 1.7 million elderly people living alone are poor. Of these, 1.4 million are women, almost 80% of whom are widows. The incidence of poverty is substantially higher among minorities—43% for blacks and other nonwhites and 35% for Hispanics—compared with a poverty rate of 16% for white elderly people living alone.

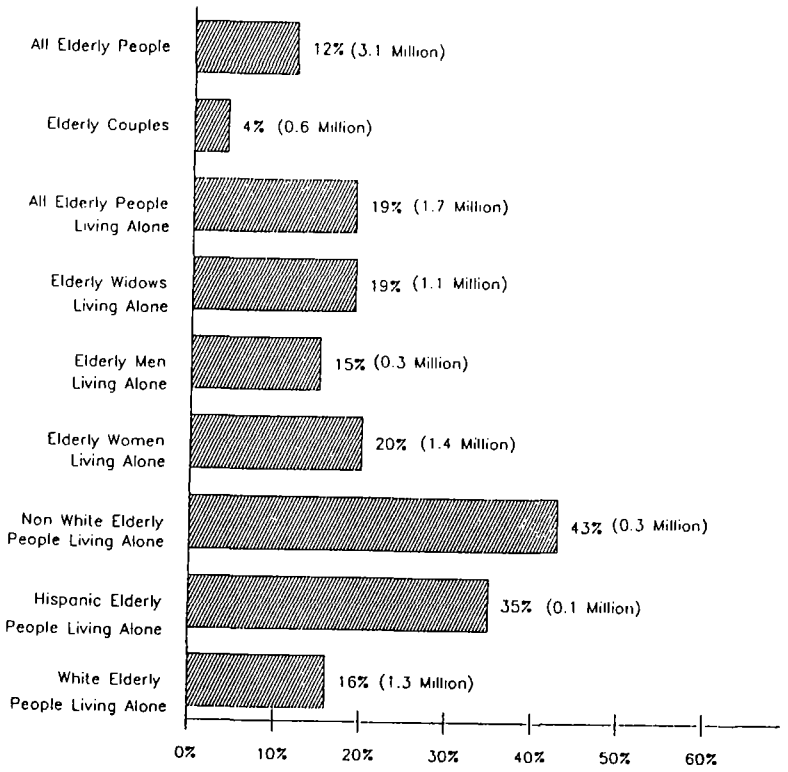
Many elderly people who live alone have incomes just slightly above the poverty level. About one-fourth of elderly people living alone are near-poor, with incomes between 100% and 150% of the federal poverty level. Together, 43% of elderly people living alone are poor or near-poor. For elderly minorities who live alone the situation is even bleaker; 70% have incomes below 150% of poverty.

The poverty gap of elderly people—that is, the amount of money that would in principle eliminate their poverty—was estimated at $2.9 billion in 1987 (Commonwealth Fund Commission, 1987b). Elderly people living alone accounted for 60% ($1.8 billion) of this total even though they made up only one third of the elderly population. Elderly widows living alone had a poverty gap of $1.2 billion. But the cost of eliminating poverty among elderly people is well within our societal resources, representing only .062% of the $4.5 trillion GNP in 1987.

Causes of Poverty Among Elderly People Living Alone. Insight into the causes of poverty among elderly people can be gained by examining their sources of income. Poor elderly people are much more likely to rely heavily on publicly sponsored benefits than those who are more affluent. Social Security benefits, for instance, comprise 79% of the incomes of poor elderly people living alone and Supplemental Security Income (SSI) contributes another 14%. Employment, pension, and asset income taken together contribute only 7%. On the other hand, moderate- to high-income elderly persons with incomes of 300% of poverty or greater who live alone depend upon Social Security benefits for only 22% of their total incomes. For them, income from assets contributes 52%, employer

FIGURE 1

Poverty Rates Among Various Subgroups of Elderly People 1987



Source: Commonwealth Fund Commission, 1987b.

pensions 13%, and employment earnings 12% of total income (Commonwealth Fund Commission, 1987b).

The obvious dependence of poor and near-poor elderly people on Social Security benefits illustrates the importance of ensuring adequate benefit levels for beneficiaries. However, in many cases the treatment of widows under the Social Security program can actually contribute to the risk of poverty for these women. If a spouse retires before age 65, the couple's Social Security benefit level is permanently reduced throughout the lifetime of either person. In addition, with the death of the spouse, the widow faces a substantial reduction in income. Her Social Security benefits as a widow are reduced to 50% to 70% of the couple's previous benefit level. At lower levels of income, the remaining Social Security survivor's benefit may be inadequate to meet the remaining spouse's needs.

For many elderly persons who were not poor earlier in life, high inflation in the 1970s eroded the value of many sources of retirement income; savings accounts lost purchasing power as did some pension and annuity incomes. For others, rapidly escalating medical costs and unexpectedly longer life spans stretched savings thin. A study conducted by David Wise of the National Bureau of Economic Research provides important insights on why widows are poor (Wise, 1987):

- About half of poor widows were not poor before the death of their husband. A husband's death can cause his widow's poverty in several ways:
  - —Medical and funeral expenses consume resources.
  - —Pension income is frequently lost.
- Husbands of poor widows had worse health and retired earlier than those who were not poor. They also earned less when they worked. These factors suggest that lower income relative to needs during the family's working years results in less savings and the very low asset incomes of elderly people who live alone.

In all, the causes of poverty among elderly people are complex. Their economic status is the culmination of a lifetime of economic decisions and events. Many factors including employment history,

the ability to save, health status, and the timing of retirement affect the amount of retirement income received throughout the remainder of a person's life.

Future Projections of Poverty. While poverty among certain groups of elderly people remains a serious problem, several factors suggest that poverty among elderly people may decline in the future. To examine the future incomes of elderly people, ICF, Inc. conducted a micro-simulation using the PRISM model of trends in incomes of elderly people from 1987 to 2020 (Commonwealth Fund Commission, 1987c). These estimates take into account growth in real benefits under Social Security, greater labor force participation of women, and recent changes in pension laws that will provide better protection for future retirees and their spouses than was the case in the past.

Between 1987 and 2020 the elderly population is expected to increase to 51.5 million. The number of elderly people living alone will increase by more than 50%, from 8.8 million to 13.3 million. ICF estimates of the future income of the elderly population show that not all elderly people will share in continuing prosperity. While most of the population will fare well economically over the next 30 years, poverty rates among older people living alone will show only marginal improvement.

Poverty among elderly people living alone will continue to average about 19% through the end of this century. By the year 2020, poverty among this group will drop only slightly to 15% and will continue to plague women primarily. In absolute numbers, the number of poor elderly people living alone will increase from 1.7 million in 1987 to 1.9 million in 2020. For women who live alone, poverty rates will actually worsen, climbing from 20% today to 22% at the turn of the century and then declining only marginally to 18% by 2020. On the other hand, poverty rates among elderly couples and elderly men living alone are expected to virtually disappear over the next 30 years—further widening the disparities in economic security among subgroups of the elderly population.

A key question is why the poverty rate among elderly people living alone will remain largely unchanged through the turn of the century and not be reduced. The most important reason is a demographic one. Due to declining mortality rates and a shift in the age

structure of the population, the average age of elderly people living alone will increase over the period 1987 to 2005. Because persons age 85 and over are the poorest elderly people, it is not surprising that the poverty rate for elderly people living alone does not decline during the next 15 years. As elderly individuals deplete their assets and as the buying power of pensions is eroded, the proportion of elderly people living alone who are poor will remain high.

The economic status of men will improve substantially more than that of women over time, despite the fact that women are now in the workforce in greater numbers than in the past (Commonwealth Fund Commission, 1987b). Men are more likely to receive larger Social Security and pension benefits because they earn higher wages and are likely to have more years of coverage than women. Because women's careers are likely to be interrupted, their Social Security and pension benefits will be lower. In addition, to the extent that working women hold low-wage and/or part-time jobs that offer inadequate pension coverage, or none at all, benefits at retirement will be little better than they are for elderly women today.

Without further interventions, the gap between elderly women living alone and all other persons will substantially widen over the next 30 years. To explore whether specific policy options could be used to alleviate poverty among elderly people, ICF simulated the expected impact of various public and private alternatives on future poverty rates.

Their results indicate that in the short-term, government initiatives such as changes in the SSI program are the most effective means of improving the situation (Commonwealth Fund Commission, 1987c). Over the long term, efforts to expand pension coverage and enhance employment opportunities may have some effect. However, further work by ICF (1988a) has shown that even dramatic improvements in pension benefits and coverage will have a limited impact on low-income elderly persons even through the year 2040.

Poor Elderly People and the SSI Program

The SSI program provides monthly cash payments to the low-income aged, the blind, and the disabled. Payments under this pro-

gram consist of a basic federal payment intended to provide an eligible individual with a minimal level of income and in 27 states an additional supplemental amount. For many elderly people, however, SSI is not fulfilling its potential as an income security program. There are several reasons why it has not eliminated poverty among the elderly population. First, the federal SSI eligibility criteria for income and assets is extremely stringent. Second, for those poor elderly people who are eligible and do receive SSI benefits, that amount does not supplement income adequately to raise them to the poverty threshold. Third, many individuals who appear to be eligible, do not participate in the program. As a result, only about one third of poor elderly living alone receive SSI (Commonwealth Fund Commission, 1987c).

Improving the Benefit Level Under SSI. The current federal SSI benefit level does not raise the incomes of poor elderly people who are eligible to the poverty line. The maximum federal benefit for elderly individuals is 76% of the poverty threshold and for elderly couples, 90% (Commonwealth Fund Commission, 1987b).

The federal SSI benefit level in 1987 was supplemented by states to varying degrees; however, only five states supplement federal payments to a level near or exceeding (98% to 136%) the poverty level for a single individual. Another 15 states provide supplementary payments that yield total benefits in the range of 80% to 92% of the poverty level. In 31 states, a small state supplement or no supplement leaves an individual's total income between 76% and 79% of poverty, about $78 a week in 1987. For many, this level of income is inadequate to meet daily needs; in some cases, the beneficiary may still suffer serious deprivation.

Clearly, income needs of poor elderly persons could be met to a greater degree if SSI benefits were higher. Because the SSI program is directed to those elderly most in need, it is possible to assist the poorest elderly almost immediately. A first step could be to address the inequity that exists between benefits paid to individuals as opposed to couples. By increasing federal SSI benefits for individuals to the same fraction of the poverty line (90%) as received by a two-person eligible family, the poverty rate for elderly people living alone would drop immediately from 19% to 14% (see Figure 2) and 26% of the poverty gap of the elderly living alone would be eliminated (Commonwealth Fund Commission, 1987c).

FIGURE 2

Percent of Elderly People in Poverty under Alternative SSI Benefit Levels

		SSI-90 Alternative a/		SSI-100 Alternative b/	
	Current Law	Percent in Poverty	Percent Change	Percent in Poverty	Percent Change
1987					
Elderly Living Alone	18.9%	13.7%	-27.5%	12.3%	-34.9%
Elderly Living with Others	5.7%	4.5%	-21.1%	4.1%	-28.1%
ALL ELDERLY	11.6%	8.5%	-26.7%	7.8%	-32.8%
2001-2005					
Elderly Living Alone	18.9%	14.1%	-25.4%	12.8%	-32.3%
Elderly Living with Others	4.3%	3.2%	-25.6%	3.0%	-20.2%
ALL ELDERLY	10.9%	8.2%	-24.8%	7.4%	-32.1%
2016-2020					
Elderly Living Alone	14.9%	11.0%	-26.2%	10.2%	-31.5%
Elderly Living with Others	3.0%	2.4%	-20.0%	2.1%	-30.0%
ALL ELDERLY	8.2%	6.1%	-25.6%	5.6%	-31.7%

a/ This alternative would raise the SSI federal maximum benefit to 90 percent of the poverty threshold for single individuals. The maximum benefit for married couples is currently about 90 percent of the married couple poverty threshold.

b/ This alternative would raise the SSI federal maximum benefit to 100 percent of the poverty threshold for both married couples and single individuals.

Source: Commonwealth Fund Commission, 1987c.

Setting the SSI benefit at the poverty line would eliminate about 29% of the poverty gap of elderly people living alone, and would markedly reduce the poverty rate among this group from 19% to 12% (Commonwealth Fund Commission, 1987c). About 600,000 elderly persons living alone who would otherwise be poor, would be raised above the poverty line. Of these, about 400,000 are widows. The estimated cost for this in 1987 was $4 billion, of which $2.3 billion or 58% would go to the elderly with the remainder assisting the disabled. Nearly all (97%) of the funds for the elderly would assist poor or near-poor elderly people. Raising the SSI benefit level would also markedly reduce poverty in future years. By 2020 the poverty rate among elderly people living alone would be 10%—half of what it is today—if the SSI benefit level were raised to 100% of the poverty level. Poverty among elderly people would not be completely eliminated because the low-asset test restricts eligibility and because not all eligible participate in the program.

Improving Participation in SSI. Another troubling concern is that it appears that only about half of persons who appear to meet the income and asset criteria for SSI eligibility actually participate in the program (Louis Harris and Associates, 1987). By state, participation rates vary from under 30% to over 80% (ICF, 1988b). Unfamiliarity with the program or its eligibility guidelines appear to be major stumbling blocks to participation among those potentially eligible. The Harris survey asked elderly people who appeared to be eligible for SSI, but were not participating in the program, why they had not enrolled. Twenty-four percent indicated that they had never heard of SSI, and another 21% believed they were not eligible (Louis Harris and Associates, 1987).

To address this information gap, a major SSI outreach effort was conducted by The Commonwealth Fund Commission and the American Association of Retired Persons (AARP) in 1988 in three cities—Pittsburgh, El Paso, and Oklahoma City. The project combined a media approach with grassroots efforts to increase awareness and to enroll more eligible people.

In each of the three sites, dramatic increases in the numbers of elderly people filing SSI applications and awarded benefits was achieved (AARP, 1988). The greatest impact was in Pittsburgh where applications increased by about 160% and awards by 70%. Outreach efforts for SSI and other public assistance programs are

now being undertaken by AARP in an additional 30 sites. Efforts of this type must be a part of future SSI program improvements to ensure that this important benefit reaches the vulnerable individuals it is intended to assist.

Elderly people who are poor today will not benefit from long-range efforts to raise income levels. But the SSI program, already in place, can be used effectively to mitigate some of the financial hardship that the poorest elderly people experience. Improving the benefit and participation levels of the program should be a policy priority for the next decade.

ASSURING MEDICAID COVERAGE FOR LOW-INCOME ELDERLY PEOPLE

In addition to their struggle to meet routine living expenses, the 7.4 million elderly people who are poor or near-poor have little available income to meet additional or unexpected medical or long-term care expenses. When illness strikes, these low-income elderly people depend on Medicare for assistance with their bills, yet Medicare coverage can easily fall short. The impression that Medicaid supplements Medicare for all poor elderly people is false. Only a third of poor elderly people have Medicaid coverage to fill in Medicare's gaps. As a result, many old, poor and underinsured elderly people face hard choices between basic necessities and needed health care, such as physician services, prescription drugs, and chronic care.

Health and Poverty Among Elderly People

The burden of illness is a serious problem for low-income elderly people. Poor and near-poor elderly people are more likely to experience health and functional problems that require medical and long-term care services than elderly people who are economically better off. Yet, they are less able to afford needed care and their insurance protection is often inadequate. Those who incur large out-of-pocket expenses are at high risk of impoverishment.

Low-income elderly people are also more likely to be in fair or poor health than higher income elderly people. In the Common-

wealth Fund Commission Study (1987a), 44% of poor and 41% of near-poor elderly people in 1984 reported their health as "fair" or "poor" compared to 22% of elderly people with moderate or high incomes, and 60% of poor black elderly people rated their health as fair or poor.

Chronic illness is much more common among poor elderly people. One half of poor elderly people reported having hypertension; more than 60% suffered from arthritis; over 40% had vision or hearing problems; and 12%, diabetes (Commonwealth Fund Commission, 1987a). Proper treatment of these conditions requires access to often expensive medications and supplies. Many of these services, most notably prescription drugs, are not covered Medicare benefits.

Functional impairment can further compound the medical problems of poor elderly people. Over one third of poor elderly people reported being restricted in one or more activities of daily living, such as eating or bathing, compared to 17% of those with moderate or high incomes (Commonwealth Fund Commission, 1987a). Among elderly people with severe physical or cognitive impairments, 40% are poor and an additional 29% are near-poor (Commonwealth Fund Commission, 1989). Such restrictions often increase the need for assistance in the home and special transportation arrangements to obtain medical care and further add to the financial burdens these individuals face for care.

Health Insurance Coverage for Elderly People. Medicare provides basic health insurance protection for hospital and physician services for nearly all elderly people. However, for many elderly Medicare coverage provides essential but inadequate protection (Davis & Rowland, 1986). Medicare requires extensive cost-sharing for acute-care services and does not cover extended long-term care. As a result, it provides financing for less than half of all personal health care expenditures for the elderly population (Waldo, Sonnefeld, McKusick, & Arnett, 1989).

Beneficiaries in 1989 were required to pay a premium of $382 (including the Catastrophic coverage) for coverage under the physician services component of Medicare (Part B). Substantial cost-sharing is required for covered services including a hospital deductible ($560 in 1989), a Part B deductible ($75), 20% coinsurance on all physician charges allowed by Medicare, plus any excess charges

for those physicians who do not accept Medicare assignment. In addition, many acute-care services such as prescription drugs, dental care, eyeglasses, hearing aids, are not covered under Medicare.

Gaps in Medicare benefits have led 72% of elderly people to obtain supplementary private health insurance, or Medigap policies; however, low-income elderly people are less likely to have them—42% of poor elderly and 65% of near-poor elderly in 1984 had supplemental coverage (Commonwealth Fund Commission, 1987a). Poor and near-poor elderly people can incur substantial financial burdens in meeting Medigap premium payments. They are more likely than those with higher incomes to have to purchase these policies themselves, rather than to receive them as a retirement benefit.

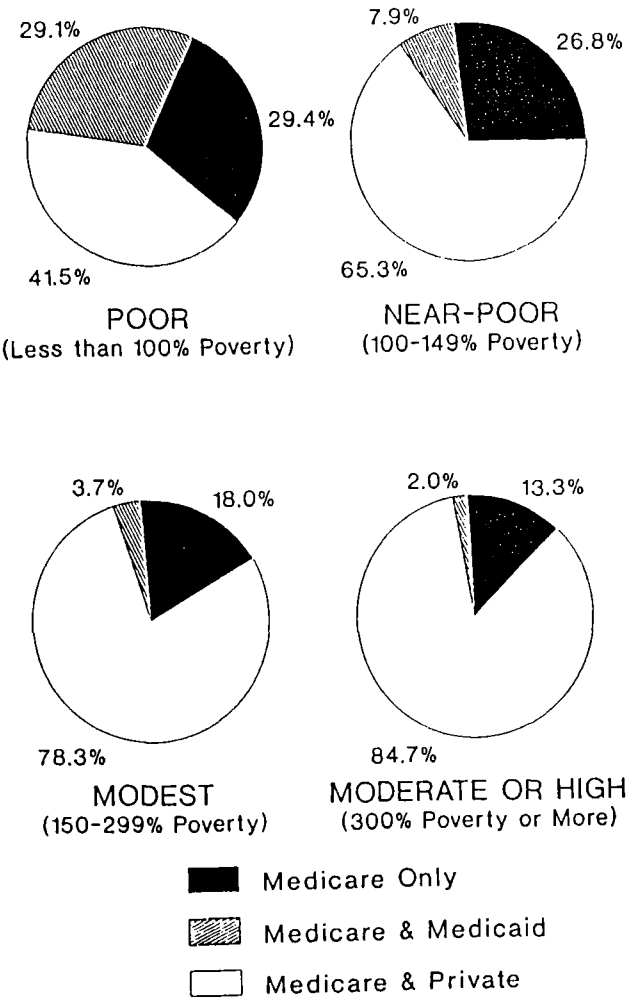
For low-income elderly people, Medicaid coverage can provide an important supplement to Medicare. For these individuals, Medicaid pays the Medicare premiums and cost-sharing requirements. In many states, beneficiaries also receive coverage for prescription drugs, dental care, and community-based and institutional long-term care services. However, less than one third (29%) of poor elderly people and only 8% of near-poor elderly people received Medicaid coverage in 1984 (see Figure 3) (Commonwealth Fund Commission, 1987a). Twenty-nine percent of poor and 27% of near-poor elderly people relied solely on Medicare for assistance with medical bills. Among Medicare beneficiaries without Medicaid or Medigap coverage, 44% were poor or near-poor with incomes below 150% of poverty. For these people, the out-of-pocket expenses not covered by Medicare can be devastating.

Financial Burden for Medical Expenses. In 1986, the average elderly person spent nearly $1,000 on his or her own medical expenses (Rowland & Lyons, 1988). Forty-four percent of out-of-pocket spending was for cost-sharing and medical services and 56% for premiums for Part B Medicare coverage and private MediGap insurance. Thus, over half of out-of-pocket spending by elderly people goes for premiums that help to protect against out-of-pocket spending for direct medical services.

For poor and near-poor elderly people, out-of-pocket health care costs consume much of their available income. Again in 1986, estimated out-of-pocket medical care spending was $608 per capita for

FIGURE 3

Health Insurance Coverage of Elderly People by Income, 1984



Source: Commonwealth Fund Commission, 1987a.

poor elderly individuals and $808 for the near-poor elderly—representing more than 10% of total income in both groups (Commonwealth Fund Commission, 1987a). For both poor and near-poor elderly people, out-of-pocket spending was almost equally split between services and premiums.

Medically Impoverished Near-poor Elderly People. For many near-poor elderly people, medical expenses can reduce meager incomes to levels that, in effect, shift them into poverty. In 1987, the poverty level for a single individual was $5,393. An elderly person living alone with an income just above this level at $5,500 was considered near-poor. However, if that individual had out-of-pocket medical expenses of over $117, those expenses would reduce the income available for daily living to below the poverty level. In this way, many near-poor elderly people actually become impoverished by their medical expenses—and constitute a large pool of "hidden-poor" elderly people.

Adjusting for medical expenses increased the proportion of elderly people who were poor in 1987 by one third from 12% to 17% (Commonwealth Fund Commission, 1987a). Medical expenses take an especially heavy toll on elderly people who live alone. When medical expenses were considered for the same year, the poverty rate among this group climbed from 19% to 27%. Almost half (47%) of all elderly people living alone had incomes below 150% of the poverty level when accounting for medical expenses.

In all, one third of near-poor elderly people were reduced to poverty by their out-of-pocket payments for medical care. To a large extent, these payments were for insurance premiums to assure protection against unexpected or large medical expenses. Medicare premiums and payments to purchase private Medigap coverage accounted for 40% of out-of-pocket spending by the near-poor who were medically impoverished.

Financial Burden for the Long-Term Care Population. In addition to the gaps in acute care coverage, financing for long-term care remains largely unaddressed by Medicare and private insurance programs (Rivlin & Wiener, 1988). As a result, the burden of procuring and paying for long-term care services falls heavily on the impaired elderly themselves and their families. The Medicare program, which covers almost all elderly people, focuses on short-term

post-acute benefits. The private supplemental policies purchased by most elderly people also do not cover long-term care services, and private long-term care policies are largely unavailable or unaffordable. Although Medicaid does provide some long-term care services, benefits are oriented towards nursing home care and are available only after personal resources have been nearly exhausted.

Nursing homes dominate spending for long-term care services, consuming 80% of total expenditures (Scanlon, 1985). In 1987, $33 billion was spent on nursing home care for the elderly population (Waldo et al., 1987). Over half (58%) of this amount was paid directly by elderly people and their families. For the 1.3 million elderly people who reside in nursing homes, the cost, often in excess of $22,000 per client per year, can be a crushing financial burden (Rivlin & Wiener, 1988). Although the Medicaid program pays for 36% of nursing home costs for the elderly, most elderly people must impoverish themselves and their families to be eligible for Medicaid assistance. Although important provisions were included, and not later repealed, in the Medicare Catastrophic Coverage Act of 1988 to protect spouses from becoming impoverished, the means-tested Medicaid program remains the primary formal source of public and private financing for nursing home care.

In addition, many severely impaired elderly people live in the community where financing for personal care services is extremely limited. It is estimated that almost all (97%) of these 1.6 million people rely on the support of family and friends and, in fact, 70% rely solely on this source of informal care (Commonwealth Fund Commission, 1989).

Caregiving, however, exacts a heavy financial, physical, and emotional toll, especially on the wives and daughters who compose over half of all informal caregivers (Stone, Cafferata, & Sangl, 1987). A third of caregivers have incomes of less than 125% of the poverty level and most (89%) have modest means, with incomes below 400% of poverty. For many caregivers, balancing work and caregiving becomes too difficult, and they must give up their jobs in the formal workplace. Thus, the demands of caregiving can compound economic difficulties a family faces in trying to care for an impaired elder.

For those people without sources of informal support or whose

needs exceed available resources, substantial financial strain can be incurred in obtaining services. Based on monthly expenditures, Liu and his colleagues estimated the cost of home care expenses for frail elderly people (Liu, Manton, & Liu, 1985). Updating these costs to 1989, those with severe functional limitations who purchase formal care would spend an average of $7,800 per year; those with milder limitations would also spend substantially—between $1,500 and $2,000 (Commonwealth Fund Commission, 1989).

Medicaid and Elderly People

The Medicaid program is of vital importance in providing many elderly people with assistance for medical bills. Medicaid is also extremely important for those in need of long-term care because no other public or private program provides significant coverage (Neuschler, 1988). Medicaid eligibility, however, is linked to the SSI cash assistance program, and therefore, has stringent income and asset eligibility criteria. As a result, less than one-third of poor elderly people have Medicaid coverage to assist with Medicare premiums and cost-sharing and to provide supplemental coverage to Medicare (Commonwealth Fund Commission, 1987a).

Medicaid coverage of the low-income elderly population varies widely among states. Currently, 11 states cover virtually all of the aged poor and some near-poor while 39 states do not cover all of the aged poor (Davis, 1986). Varying eligibility requirements result, in part, because states determine their own eligibility groups and income and asset criteria under broad federal guidelines.

Most Medicaid beneficiaries receive coverage automatically when they qualify for cash assistance under SSI. However, states can determine whether to require a separate application, or to limit coverage to those who would have qualified under pre-SSI eligibility rules. Non-SSI beneficiaries may also qualify under optional medically needy coverage offered by the state, or under special provisions allowing coverage of individuals in nursing homes. Fourteen states do not automatically cover all SSI beneficiaries (Congressional Research Service, 1988). These are the so-called 209b states, which chose to use the more restrictive eligibility standards in effect for the aged, blind, and disabled in 1972 when the federal

SSI program was enacted. Fifteen states do not provide coverage for the medically needy.

Medicaid coverage substantially alters the financial burden of medical expenses for poor and near-poor elderly people. In 1986, poor elderly people without Medicaid coverage spent more than twice as much out-of-pocket as those with Medicaid, $815 compared to $388 (see Figure 4) (Commonwealth Fund Commission, 1987a). Poor elderly people without Medicaid coverage paid twice as much for prescription drugs and 50% more for physician services than poor elderly people with Medicaid and spent almost a quarter of their incomes on out-of-pocket health expenses.

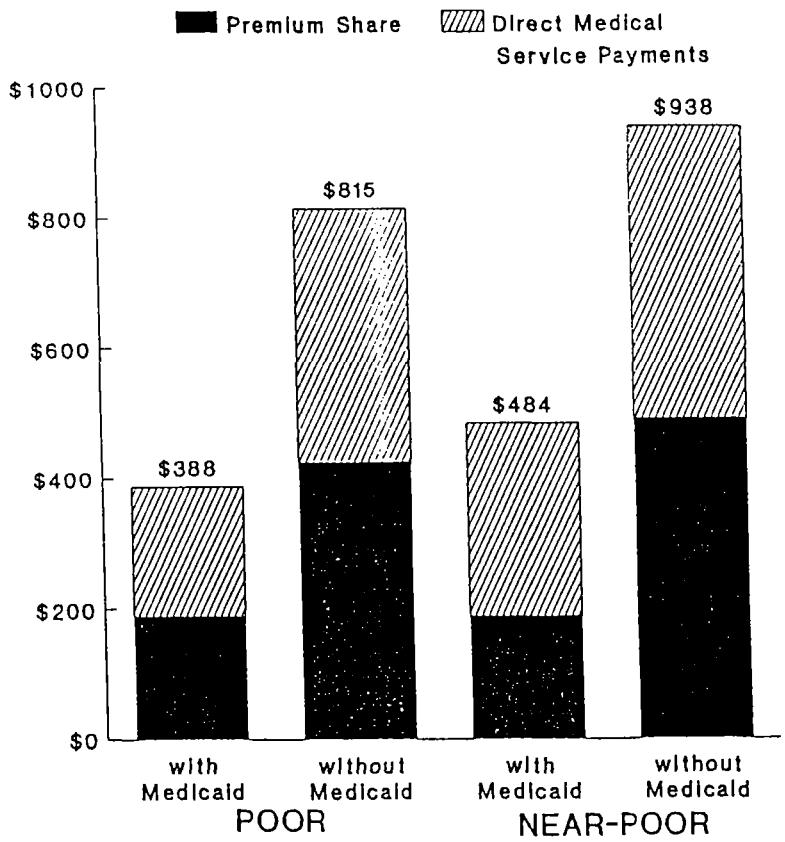
In 1986, Congress gave the states the option of extending Medicaid coverage to elderly and disabled people with incomes up to the poverty level. However, very few states took advantage of this option (Rowland, Salganicoff & Lyons, 1989). As part of the Medicare Catastrophic Coverage Act of 1988—and a part not repealed by Congress in 1989—states were required to provide Medicare buy-in assistance to poor elderly and disabled people through their Medicaid programs. Specifically, states must pay Medicare premiums, deductibles, and coinsurance for elderly and disabled people with incomes below the poverty level and whose assets are below twice the resources standard used in the SSI program. By January 1989 states were required to cover persons with incomes below 85% of poverty and to increase those covered as a percent of poverty until, by January 1, 1992, all persons with incomes below 100% of poverty are covered. This provision was an important expansion of Medicaid to poor elderly and has helped remove some of the wide disparities in coverage among states.

However, this provision fails to provide complete Medicaid benefits to poor elderly people because states were only required to pick up Medicare premiums and cost-sharing. They were not required to provide full Medicaid benefits including supplemental services such as prescription drugs, dental care, eyeglasses, and hearing aids. Moreover, this provision did not address the impoverishment that medical expenses can inflict on the near-poor, nor the financial burden related to long-term care.

Insurance protection could be made more widely available to needy elderly people by allowing those with incomes between 100% and 200% of poverty to purchase Medicaid coverage to assist

FIGURE 4

Out-Of-Pocket Spending for Medical Care by Poor and Near-Poor Elderly People, 1986



Source: Commonwealth Fund Commission, 1987a.

with Medicare premiums and cost-sharing; it could also provide additional benefits not covered by Medicare. Near-poor elderly people could contribute toward the cost of this expanded benefit package on a sliding scale. The estimated cost of this expansion was $1 billion in 1987, of which $550 million would be borne by the federal government and $450 million by state governments (Commonwealth Fund Commission, 1987a).

SUMMARY

The elderly population as a whole has made substantial progress in the past several decades in terms of economic security and access to health care services. However, specific subgroups of elderly people, those who live alone, the very old, minorities, and widows continue to face severe economic hardships. Under current projections, the situation for these vulnerable people is not expected to improve substantially in the future. Yet, for a relatively small investment—less than $5 billion total—this nation could eliminate poverty among its elderly and assure that no elderly person is driven into poverty by burdensome medical expenses.

This objective could be achieved by making modest improvements in current SSI and Medicaid programs. The SSI benefit level could be increased to the federal poverty threshold and indexed with increases in that threshold over time. Medicaid coverage could be extended to all poor Medicare beneficiaries, and the near-poor elderly could be permitted to purchase Medicaid coverage on a sliding-scale contributory basis.

Budgetary pressures should not lead to the infliction of unbearable burdens on low-income elderly people or deter access to needed health care services. A humane and decent level of support is feasible even within the constraints of the current budget and should be a high priority for action.

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ONE

Assessing and Improving Women's Health

Karen Scott Collins, Diane Rowland, Alina Salganicoff, and Elizabeth Chait

HIGHLIGHTS

THE SUBJECT OF WOMEN'S HEALTH has broadened in recent years, reflecting women's determination to understand and improve their health and reflecting the recognition that health and disease often affect women and men in different ways—biologically, psychologically, and socially. In addition, a woman's health care needs vary significantly over the course of her lifetime, with the focus typically changing from reproductive health to the care of chronic conditions. Many of these concerns are just beginning to receive the attention necessary to achieve real progress in the delivery of quality health care services to women.

The following points highlight some of the important issues relating to the health status of women today:

- Heart disease, which accounts for about 31 percent of female deaths, is the leading cause of death among American women overall, as it is among American men. However, cancer and diabetes have been gaining on heart disease. The proportion of female deaths from these two causes increased in the past two years.
- Lung cancer has replaced breast cancer as the leading cause of women's deaths from cancer.
- Smoking rates are declining faster for women than for men; however, the women most likely to smoke are those in their childbearing years. More than 28 percent of women age 25 to 34 smoke.
- The risks of developing invasive cervical and breast cancers can be greatly reduced by Pap smears and mammography. Yet many women, especially

those with low incomes and low educational levels, still do not receive these tests on a routine basis.

- An estimated four million women are victims of domestic violence every year. One hundred seventy thousand women are assaulted in their fifth to ninth month of pregnancy.
- The spread of AIDS (Acquired Immune Deficiency Syndrome) is growing more rapidly among women than men. From 1989 to 1990, there was a 34 percent increase in the number of women diagnosed with AIDS. In New York City, AIDS is now the leading cause of death among black women age 24 to 44.
- Because females have a longer life expectancy than males, they are more likely to acquire the diseases associated with very old age, including Alzheimer's and complications arising from osteoporosis (a loss of normal bone density).
- It has become increasingly clear that menopause plays a role in altering risks of certain conditions such as heart disease; however, much more research is needed to understand this association and what it means.
- Women are more likely than men to use health care services; as a result, women's relationship to the health care system tends to have more importance in their lives.
- Largely because women are far more likely than men to be eligible for Medicaid, men are more likely than women to lack any kind of health insurance coverage.
- Many poor and low-income women are not, however, eligible for Medicaid. Unless she is pregnant, disabled, or elderly, a poor childless woman is not eligible for Medicaid regardless of her income. One-third of poor women have no health insurance of any kind.
- The current health care system emphasizes highly specialized care, rather than comprehensive primary and preventive health care. The result is that many women do not receive treatment for problems such as depression or counseling that would help them change behaviors that are risky to their health.
- Health care reform must ensure that the specific health needs of American women are met through greater availability of health care providers who are able to meet those needs, through insurance coverage for all Americans, and through the expansion of medical research and education to include issues of concern to women.

INTRODUCTION

It is often assumed that, because women live longer than men, they must be healthier. However, living longer does not necessarily imply good health. Though females may have more biological protection than males in some respects, they are still at risk for many of the same conditions. There are also important differences in the health concerns of men and women relating to conditions that are unique to women as well as those that affect both women and men but have been studied primarily in men. In addition, women and men tend to use the health care system in significantly different ways.

Another important issue is that this country's current health care system still presents barriers to care for women, particularly with respect to health insurance coverage. While there has been much overall progress in the effectiveness of health care, there are still significant gaps both in knowledge about female health specifically and in women's access to care.

This chapter presents an overview of women's health issues, including an explanation of conditions that concern women at different times in their lives and a discussion of measures that can be undertaken to prevent disease and disability. The chapter also examines how women interact with the health care system, as measured by their health insurance coverage and by the extent to which they seek or receive care.

A HEALTH PROFILE OF AMERICAN WOMEN

In developing strategies to improve women's health, it is important to take stock of their current status and to identify those areas or conditions where intervention could lead to better health. The following profile discusses major causes of mortality in American women and specific diseases and conditions that can affect them over the course of their lives.

Life Expectancy

Progress in improving life expectancy has been one of the notable achievements of the twentieth century. As Table 1 shows, the expected life span of Americans born in 1900 was 47.3 years; in 1989, average life expectancy at birth was 75.3 years. Both males and females have benefitted from the improvements in living conditions and treatment of infectious disease, once

Table 1 • LIFE EXPECTANCY AT BIRTH AND AT AGE 65 BY RACE AND SEX, 1900–1989 (in years)

ALL RACES

	Life Expectancy					
	At Birth			At Age 65		
	Both Sexes	Female	Male	Both Sexes	Female	Male
1900	47.3	48.3	46.3	11.9	12.2	11.5
1960	69.7	73.1	66.6	14.3	15.8	12.8
1970	70.9	74.8	67.1	15.2	17.0	13.1
1980	73.7	77.4	70.0	16.4	18.3	14.1
1989	75.3	78.6	71.8	17.2	18.8	15.2

WHITES

	Life Expectancy					
	At Birth			At Age 65		
	Both Sexes	Female	Male	Both Sexes	Female	Male
1900	47.6	48.7	46.6	—	12.2	11.5
1960	70.6	74.1	67.4	14.4	15.9	12.9
1970	71.7	75.6	68.0	15.2	17.1	13.1
1980	74.4	78.1	70.7	16.5	18.4	14.2
1989	76.0	79.2	72.7	17.3	19.0	15.2

BLACKS

	Life Expectancy					
	At Birth			At Age 65		
	Both Sexes	Female	Male	Both Sexes	Female	Male
1900	33.0[1]	33.5[1]	32.5[1]	—	11.4	10.4
1960	63.2	65.9	60.7	13.9	15.1	12.7
1970	64.1	68.3	60.0	14.2	15.7	12.5
1980	68.1	72.5	63.8	15.1	16.8	13.0
1989	69.2	73.5	64.8	15.5	17.0	13.6

[1]Number is for "all other" population.

Source: National Center for Health Statistics 1992.

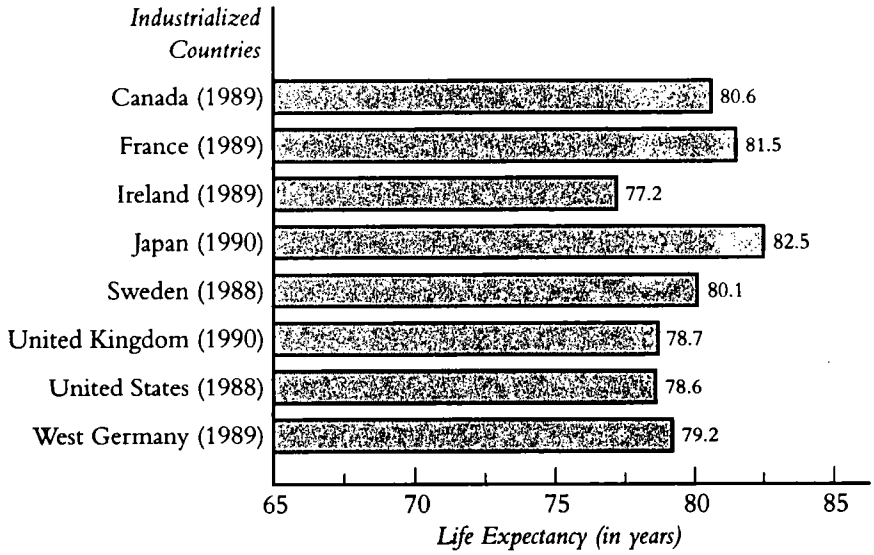
a major cause of early death. Women have also been the beneficiaries of advancements that have resulted in a 90 percent decline in maternal mortality—from 73.7 deaths for every 100,000 births in 1950 to 7.3 deaths for every 100,000 births in 1989 (National Center for Health Statistics [NCHS] 1992).

These improvements have contributed to the widening of the life expectancy gap between females and males. In 1989, life expectancy at birth was 78.6 years for a girl and 71.8 years for a boy. Although narrowing, the gap remains in later years. On average, in 1989 a woman who reached age 65 could expect to live 18.8 more years and a man at age 65 could expect to live 15.2 more years.

Gender is a more important factor than race in predicting a person's life expectancy. Although average life expectancy is shorter for black women than for white women, both groups of women have a longer life expectancy than men. A female child born in America in 1989 could be expected to live an average of 79.2 years if she were white and 73.5 years if she were black. However, as can be seen in Table 1, the life expectancy gap between black and white women narrows after age 65.

Despite the significant increase in life expectancy for Americans during the twentieth century, the United States is behind other highly industrialized countries in this regard. Life expectancy at birth is highest for females in Japan (82.5 years for those born in 1990) (Figure 1). In Sweden, Canada,

Figure 1 • FEMALE LIFE EXPECTANCY AT BIRTH IN SELECTED INDUSTRIALIZED COUNTRIES



Source: World Health Organization 1992.