Journal of Women, Politics & Policy, 30:222–247, 2009

ISSN: 1554-477X print / 1554-4788 online
DOI: 10.1080/15544770902901874

Routledge
Taylor & Francis Group

Health Coverage and Expenses: Impact on Older Women's Economic Well-Being

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The health issues women face over the course of their lives, as well as policies that shape Medicare, Medicaid, and other supplemental coverage can affect retired women's economic well-being. This study uses a nationally representative sample of Medicare beneficiaries aged 65 and older in 2002 to explore gender-based differences in health and long-term care use, spending patterns, and the financial burden of health and long-term care out-of-pocket health expenses. Women's health care expenses were higher than men's; older women paid for a greater share of their total spending out of pocket and they faced a greater financial burden by shouldering these out-of-pocket costs with less income at their disposal. Low-income women, those with Medigap or no supplemental coverage, and white women, who are less likely to qualify for Medicaid which covers long term care, faced the greatest financial burdens associated with health and long-term care costs. The implications of these findings for women in the context of the current health policy landscape are discussed. Controlling health spending and developing options to finance long-term care are key elements of the policy solutions that will need to be developed to preserve and support economic security for millions of retired women in the United States.

KEYWORDS women, Medicare, Medicaid, long-term care, financial burden, health care costs, retirement, health expenses, retirement, low-income

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INTRODUCTION

Health care is a critical issue for older Americans. The two major publicly-financed programs in the United States, Medicare and Medicaid, provide millions of seniors with vital health care coverage and help to maintain their economic well-being. Yet, with rising health care costs in the United States, paying for health care imposes a financial hardship on many older Americans. Moreover, health care costs have increased at a faster rate than per-capita income in recent years, which places a disproportionate burden on seniors, many of whom live on fixed and modest incomes and tend to use more acute medical and long-term care services than younger adults. For older women, the burden of health care costs can be particularly troublesome. Compared to older men, women are in a more tenuous economic situation. They have, on average, lower incomes, fewer assets, and less generous retirement benefits than older men (see Lee in this issue; Holden and Fontes in this issue). Women also tend to live longer and experience more chronic, disabling conditions in their older years. Furthermore, because a greater share of older women than men are widowed and live alone, older women have fewer economic and social resources to obtain long-term care services when needed. With Medicare spending continuing to climb and growing anxiety about the fate of entitlement programs, decisions made by policymakers in the near future could have major implications for the health and retirement security of older women today and for generations to come.

This article examines health care coverage, costs, and utilization among women and men on Medicare who are aged 65 and older. Specifically, we explore how women's use of health care services differs from that of men, and the extent to which out-of-pocket health expenses for both acute and long-term care place a disproportionately high burden on women, particularly those who are older, lack supplemental Medicare coverage, or need long-term care services. We also discuss the implications of these findings for women in the context of the current health policy landscape.

BACKGROUND AND CONTEXT

Health coverage is a critical element of economic security for older women. Virtually all women aged 65 and older have health insurance. Medicare, enacted in 1965 as a partner program to Social Security, now provides health insurance coverage to 43 million elderly and disabled Americans under age 65. Medicaid, the federal-state health insurance program for low-income Americans, also plays an important role in providing coverage to over 3 million older women, mainly those with very low incomes by supplementing Medicare and financing long-term care. In addition, as will be discussed, many seniors have additional coverage, either employer-sponsored retiree insurance or individually-purchased Medigap policies to supplement

Medicare. While seniors appear to be more insulated from the financial burden of health care than younger adults because of the universal nature of Medicare and their access to other coverage sources, many may still be hard-pressed to pay their health care bills and sometimes forego needed medical care.

Health coverage is especially critical because health care is expensive and costs are rising fast. In fact, health costs continue to climb at a pace that far exceeds the growth in income, threatening individuals' abilities to finance their own medical care. Spending on health care in the United States reached $1.9 trillion in 2004, and accounted for 16 percent of the nation's Gross Domestic Product (Smith et al. 2006a). Growth in spending for health insurance premiums, an indicator of what workers and employers are paying for health care is significantly outpacing inflation and the growth in personal income (Claxton et al. 2005). The unrelenting rise in health care spending concerns public and private payers alike, and has generated great interest in finding effective strategies to curb the growth in medical spending now borne by individuals, employers, states, and the federal government.

Both Medicare and Medicaid are likely to remain under the fiscal spotlight due to an aging baby boom generation and pressures to control entitlement spending. Policymakers at the federal level have expressed some alarm about the long-term solvency of Medicare, an issue which has taken on greater urgency with the new prescription drug benefit and burgeoning federal deficits. Medicaid, as the nation's primary government program that pays for nursing home care, faces similar strains. These challenges are only compounded by cyclical downturns in the economy that produce spikes in Medicaid costs when enrollment grows, as this critical health care safety net absorbs many of those who become impoverished, unemployed, or uninsured. Private payers are also under pressure to cut costs, and these efforts have already taken a toll on retirees and their families, as well as aging workers approaching their retirement. Over the past several years, there has been considerable erosion in employer-sponsored retiree plans with the share of large employers offering retiree health benefits declining from 66 percent in 1988 to 33 percent in 2005 (Claxton et al. 2005; Gabel et al. 2005). In addition, employers are adopting other strategies to lower costs by limiting their liability for retiree medical expenses, including reducing or eliminating health benefits and raising premium contributions and cost-sharing requirements (Fronstin 2005). It is not yet clear whether the new Medicare drug benefit will hasten the erosion of these highly-valued employer-sponsored benefits as some have predicted (Congressional Budget Office 2003). There is concern that the new drug coverage may reduce the responsibility that some employers feel to provide this benefit for their retired workers. Employers might cut benefits to save costs, knowing their retirees can now get access to drug coverage through Medicare.

Amidst the growing uncertainty about the fate of public and private health coverage for older Americans, there is already some concern that retirees will face serious difficulty financing their own health and long-term care expenses in the future. An analysis by the Employee Benefits Research Institute (EBRI) estimates that a 65-year-old who retires in 2006 and lives to age 80 will need a total of $115,000 to pay for insurance premiums and other out-of-pocket health care costs over that 15-year period. The amount of savings needed nearly doubles to $214,000 if she lives to age 90 (Helman et al. 2005). Savings may need to be significantly larger, however, since this estimate excludes the cost of long-term care, such as services provided in a nursing home which are often a central element of health care for many frail older women. Long-term care services can be extremely expensive. A year in a nursing home cost approximately $70,000 in 2004, while the average annual cost for personal care is $9,000, and the average rate for a home health aide is $18 per hour (Congressional Budget Office 2004).

As policymakers search for strategies to rein in the cost of Medicare and Medicaid, and as employers also look to limit their own liability, it is at least plausible that individuals will be asked to pick up a greater share of their medical tab over time. These policies could come in the form of higher premiums, higher cost-sharing requirements, or narrower benefit packages. Policies such as these have been justified by some as a strategy to make individuals more aware of their health care spending practices and to guard against frivolous use of health care services and unnecessary expenditures (Goodman, Musgrave, and Herrick 2004). In this context, this article takes a careful look at coverage, utilization, and spending patterns among older women today, and sets a framework for understanding the potential implications of policies that would shift additional costs on aging Americans.

DATA AND METHODS

The analysis in this article is based on data from the 2002 Medicare Current Beneficiary Survey (MCBS) Cost and Use file. Unless otherwise noted, all estimates presented in this article are derived from the analysis of this data file. The analysis provides estimates of Medicare beneficiaries aged 65 and older who are both living in the community and in institutions such as nursing homes. The MCBS is a survey of a representative sample of the Medicare population, including both aged and disabled enrollees who are living in the community as well as in facilities. The Cost and Use file integrates survey information reported directly by beneficiaries with Medicare administrative data. The sample size for this analysis includes 6,195 women and 4,396 men aged 65 and older. The survey includes data on the demographics of respondents—such as sex, age, race, living arrangements,

income, health status, and physical functioning—the use and costs of health care services, and supplementary health insurance arrangements. The survey collects information on inpatient and outpatient hospital care, physician services, home health services, durable medical equipment, long-term and skilled nursing facility services, hospice services, and prescription drugs.

We analyzed MCBS data from 2002 to compare the demographics of older women to those of older men and assess key differences in age, income, marital status, health status, and living arrangements. (The variables that were created are explained in more detail in Appendix A.) We also explored differences in health and long-term care service utilization and total out-of-pocket spending for those services. We aggregated spending on both premiums (Medicare Parts A and B and supplemental insurance coverage) and all medical and long-term care services reported in the MCBS. Finally, we examined the burden of out-of-pocket health care spending among older women on Medicare as measured by the ratio of annual out-of-pocket spending on medical care and insurance premiums to annual income. For this analysis, we arrayed all women 65 and older on Medicare, computed the ratio of each woman's out-of-pocket spending to annual income, and then looked at the median value (the midpoint). Survey-reported income includes all sources, such as pension, Social Security, and retirement benefits, reported on a pre-tax basis. Because survey-reported income for married individuals is for both the individual and spouse, we divided income for married respondents in half to analyze the ratio of spending to income at the individual level.[1] It is worth noting that this approach may artificially inflate ratios of spending to income for married women because it does not take into consideration the fact that married women usually have access to both halves of the couple's income. Unfortunately, the MCBS collects only respondents' individual-level medical information and does not allow for aggregation of spending for husbands and wives.

Estimates derived from this analysis of MCBS data are presented as both mean (arithmetic average of values) and median (that which lies exactly at the midpoint of values arrayed in order from lowest to highest values). For example, mean out-of-pocket spending is calculated by summing out-of-pocket spending for each individual in the MCBS and dividing the total by the number of individuals. The mean value is a commonly reported summary measure of out-of-pocket spending as reported in the MCBS. The median is often thought to be a more representative summary measure, however, because the mean can be heavily influenced by extreme outliers at both high and low ends. Summary measures of income are particularly sensitive to outlying values at the high end. Therefore, we describe out-of-pocket spending as a share of income in terms of median values, rather than mean values.

THE DEMOGRAPHICS OF OLDER WOMEN ON MEDICARE

When we examined demographics and economic status between older women and men on Medicare, some important differences emerged that highlight older women's economic and social vulnerability.

Age, Marital Status, Living Situation, and Income

The median age for women was slightly higher than for men (76.1 versus 74.7), and a larger share of women lived to older ages than men (see Table 1). Among women on Medicare aged 65 and older, 16 percent were over 85 years of age compared with 10 percent of men. Nearly half (48 percent) of older women on Medicare were widowed, compared with only 15 percent of older men. Widowed women were disproportionately low-income and a greater share lived alone (data not shown). In fact, 41 percent of women aged 65 and older lived alone, compared with only 19 percent of men. A larger proportion of older women than men also lived with their children or in a long-term care facility such as a nursing home. Nearly three-quarters of men older than age 65 lived with their spouse compared to 40 percent of women. These differences in living arrangements have major implications for women's ability to live in the community should they become sick or impaired.

Older women are at a considerable economic disadvantage compared to older men. Older women had an average annual income that was 72 percent of that of older men—a rate that is similar to income patterns of younger men and women (US Department of Labor 2005). More than one in five women (22 percent) had an annual income that was less than $10,000, and over half (56 percent) had incomes less than $20,000. Women who were more likely to have incomes below $10,000 included the oldest-old (aged 85 and older) and women of color. One-third of women aged 85 and older had annual incomes below $10,000. Nearly half (48 percent) of all Black women and 43 percent of Hispanic women aged 65 and older receiving Medicare had annual incomes below $10,000 (see Figure 1).

Health Status and Functional Limitations

An important determinant of both health care use and spending is health status (see Table 2). Overall, about one in four women (26 percent) and men (23 percent) on Medicare reported their health as fair or poor, with the share of each increasing with age. About one in five (21 percent) women aged 65 to 74 reported being in fair/poor health, a share which increased to one-third (35 percent) among women aged 85 and older. A higher proportion of older women than men reported the presence of two or more chronic conditions

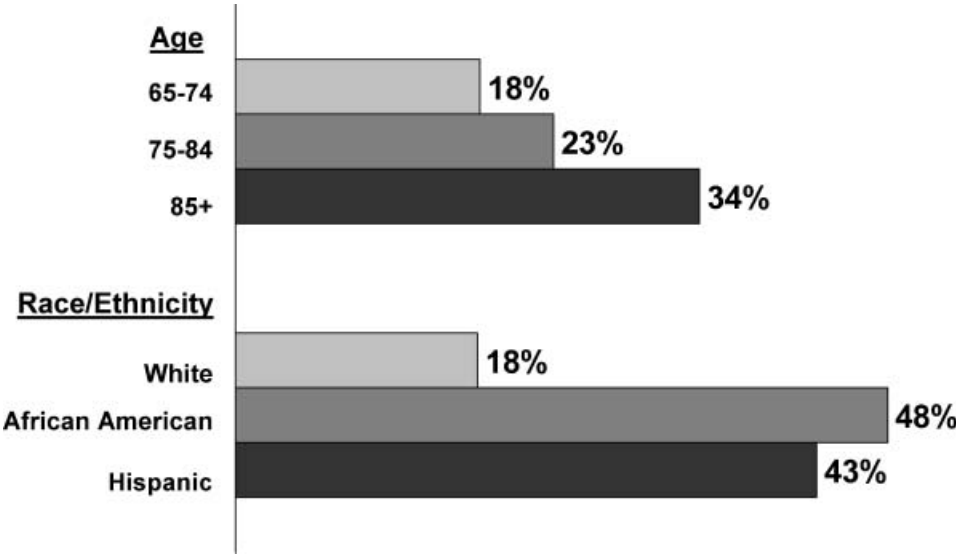
TABLE 1 Selected Characteristics of Medicare Beneficiaries (Aged 65 and older) by Sex, 2002

	Women	Men
Demographics		
Number of beneficiaries	20.8 million	15.1 million
Age		
Average age	76.1 years	74.7 years
65 to 74 years	47%	54%
75 to 84 years	37%	36%
85 years and over	16%	10%
Race/Ethnicity		
Black (Non-Hispanic)	8%	8%
White (Non-Hispanic)	81%	82%
Hispanic	7%	7%
Asian/other	4%	3%
Marital Status		
Married	40%	73%
Widowed	48%	15%
Never Married	3%	4%
Divorced/Separated	9%	8%
Living Arrangement		
Among those age 65 and over		
Lives alone	41%	19%
Lives with spouse	40%	72%
Lives with children	13%	4%
Lives in long-term care facility	6%	3%
Among those age 85 and over		
Lives alone	59%	32%
Lives with spouse	10%	52%
Lives with children	23%	11%
Lives in long-term care facility	21%	11%
Economic Indicators		
Median annual income	$18,000	$25,000
Average annual income	$25,921	$36,161
Share with income: less than $10,000	22%	12%
$10,000 to $20,000	34%	25%
$20,000 to $30,000	21%	25%
$30,000 to $40,000	10%	13%
$40,000 and greater	14%	26%

Source: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use file.

(65 percent versus 53 percent, respectively). While certain conditions were more common among older men than women, such as emphysema, heart disease and skin cancer, a larger share of women reported having hypertension, arthritis, and osteoporosis. The largest gender difference is seen in osteoporosis: 30 percent of women reported this condition compared with only 4 percent of men.

A larger share of older women than men experienced health conditions associated with long-term care needs, and the proportion of women with such impairments increased with age. One in five (21 percent) older women



Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

FIGURE 1 Percent of Women on Medicare Aged 65+ with Income Below $10,000, by Age and Race/Ethnicity, 2002

had a cognitive or mental impairment[2] compared to 17 percent of older men. Among women aged 85 and older, 25 percent had cognitive impairments. A larger proportion of older women than men also had functional limitations that impaired their ability to perform activities of daily living (ADLs), such as bathing, eating, dressing, using the toilet, and getting in and out of chairs. Overall, 16 percent of women aged 65 and older and 12 percent of men had limitations with two or more ADLS; among women aged 85 and older, more than one-quarter of women (27 percent) had two or more ADLs. A larger fraction of older women than men also had limitations with instrumental activities of daily living (IADLs) associated with independent living, including doing light or heavy housework, preparing meals, managing money, shopping for food and personal items, and using the telephone (14 percent of older women versus 8 percent of older men).

HEALTH INSURANCE COVERAGE OF OLDER WOMEN

The Role of Medicare and Medicaid

MEDICARE

Unlike the population under age 65, older Americans have nearly universal health insurance coverage. Almost all people aged 65 and over are entitled to Medicare, the federal health insurance program for the elderly and people

TABLE 2 Chronic Conditions Among Non-Institutionalized Medicare Beneficiaries Aged 65 and Older, By Sex, 2002

	Men	Women			
	65+	65+	65–74	75–84	85+
Chronic health conditions					
Fair/Poor health	23%	26%	21%	28%	35%
2 or more chronic conditions	53%	65%	63%	71%	59%
Hypertension/High blood pressure	56%	63%	59%	67%	70%
Emphysema/Asthma	16%	13%	14%	14%	10%
Diabetes	20%	19%	20%	19%	14%
Arthritis	51%	65%	61%	69%	69%
Parkinson's disease	2%	1%	1%	1%	1%
Osteoporosis	4%	30%	26%	34%	31%
Stroke	12%	12%	9%	14%	17%
Heart condition	47%	40%	34%	44%	51%
Skin cancer	24%	16%	12%	20%	21%
Other cancer	18%	19%	17%	23%	18%
Urinary incontinence - more than once/week	5%	12%	9%	13%	20%
Functional status/Disability					
Broken hip	2%	5%	2%	5%	12%
Alzheimer's disease	3%	4%	1%	4%	10%
Percent with cognitive/mental impairment	17%	21%	19%	21%	25%
2 or more limitations in activities of daily living (ADLs)	12%	16%	11%	18%	27%
2 or more limitations in instrumental activities of daily living (IADLs)	8%	14%	10%	16%	19%

Source: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use file.
Note: Cognitive/mental impairment is defined as diagnosis with of mental retardation, mental disorder, Alzhiemer's disease, or memory loss that interferes with activities for beneficiaries in the community.

with disabilities that provides coverage for a broad range of health services. Medicare covers 44 million people—37 million people aged 65 and older and 7 million people under age 65 with a permanent disability. The program helps pay for most major medical services, including hospital stays, physician visits, preventive care (including annual screenings), medical supplies, and other ancillary services. A prescription drug benefit was also recently added to Medicare, effective January 1, 2006.

Medicare is organized into four parts (Henry J. Kaiser Family Foundation 2006):

- *Part A* pays for inpatient hospital, skilled nursing facility, home health, and hospice care. Accounting for 41 percent of benefit spending in 2006, Part A is funded mainly by a dedicated tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each).
- *Part B* pays for physician, outpatient, and home health visits, and preventive services. Part B is funded by taxpayers through general revenues and beneficiary premiums and accounted for 35 percent of benefit

spending in 2006. Medicare beneficiaries paid a monthly Part B premium of $93.50 in 2007 (estimated to increase to $96.40 in 2008). In 2007, those with annual incomes over $80,000 ($160,000 per couple) began paying a higher, income-related monthly Part B premium.

- *Part C* refers to the Medicare Advantage (MA) program, through which beneficiaries can receive integrated coverage for hospital, physician, and, in most cases, prescription drug benefits by enrolling in a private managed care plan, such as a health maintenance organization (HMO), preferred provider organization (PPO), or private fee-for-service (PFFS) plan. Medicare Advantage accounted for 14 percent of Medicare benefit spending in 2006. Approximately 20 percent of Medicare beneficiaries are enrolled in a MA plan.
- *Part D* is the new prescription drug benefit, delivered through private plans that contract with Medicare. Part D, which is funded by general revenues, beneficiary premiums, and state payments, accounted for 8 percent of benefit spending in 2006. Enrollees in Medicare drug plans pay a monthly premium that averaged $25 across plans in 2006, along with deductibles and cost sharing for prescription drugs that vary by plan. Additional subsidies to pay for plan premiums and cost-sharing amounts are available for low-income beneficiaries.

Despite Medicare's importance, it has relatively high cost-sharing requirements and notable gaps in the benefit package. Medicare primarily covers acute medical needs; Medicare's long-term care coverage is restricted to post-acute care (following a hospital discharge) and there is no coverage for hearing aids, eyeglasses, or dental care, which are all important services for older adults. The program also has significant cost-sharing requirements including a deductible for hospitalizations ($992 in 2006), a monthly premium for Part B and 20 percent coinsurance for most Part B services, and premiums, deductibles, and co-payments for MA managed care plans and Part D drug plans. There is no cap in Medicare on beneficiaries' out-of-pocket spending, which could expose the small share of beneficiaries without supplemental coverage to catastrophic expenses.

Although Medicare does not cover long-term stays in nursing home facilities, it does cover shorter-term post-acute care services such as skilled nursing care and home health visits. However, Medicare will only cover skilled nursing facility care for up to 100 days following a hospital discharge, and is generally available only for beneficiaries with a need for skilled care. Beneficiaries with needs that are more custodial in nature typically pay for these services directly, unless they qualify for Medicaid.

Medicaid

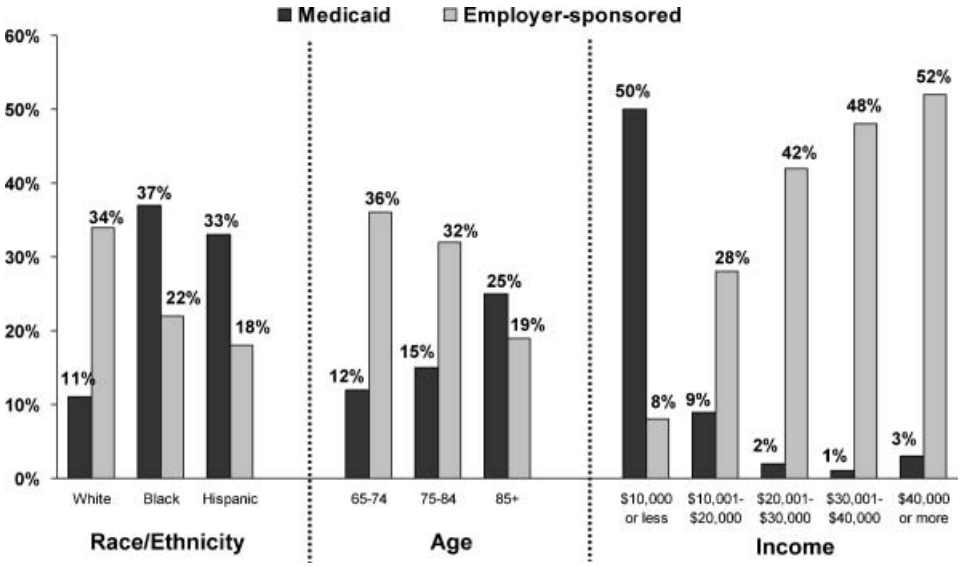
Medicaid is the health insurance program for low-income populations in the United States. The program plays a critical role in protecting many of the

poorest seniors from Medicare's cost-sharing obligations and fills many of Medicare's benefit gaps, particularly the lack of coverage for long-term care and, until 2006, prescription drug coverage (Kaiser Commission on Medicaid and the Uninsured 2006). Medicaid is financed by the states and the federal government but administered at the state level, meaning that states can design their own benefit packages and exercise control over who is entitled to benefits, guided by broad federal rules.

Medicaid is the nation's single largest payer for long-term care and covers approximately half (46 percent) of nursing home care expenditures in the United States (O'Brien 2005). Several state Medicaid programs also extend coverage to include home and community-based services, and other services such as dental care and transportation. These benefits are especially critical for older women as they have health needs that predispose them not only to need more health care services than older men, but also because they often require very costly long-term care provided in both institutions and community settings.

Together with Medicare, Medicaid is vital in protecting older women's financial security. While most of those covered by Medicaid are under age 65, approximately 6 million seniors who are on Medicare also qualify for Medicaid, due to their very low incomes and limited financial assets (Kaiser Commission on Medicaid and the Uninsured 2006). In fact, 70 percent of Medicaid beneficiaries who are aged 65 and older are women (Henry J. Kaiser Family Foundation 2007) and the vast majority of them also have Medicare. These beneficiaries are referred to as "dual eligibles" because they qualify for both programs. The level of assistance from Medicaid for seniors is commensurate with their income. Most dual eligibles also qualify for federal Supplemental Security Income (SSI) cash assistance because their incomes are very low and they have depleted any assets they may have had. Many seniors become eligible for Medicaid after they have exhausted their financial resources paying for health and long-term care (sometimes known as "medically needy" or "spend down"). These beneficiaries receive assistance with Medicare premiums and cost sharing and full coverage of Medicaid benefits, including nursing home care.

For Medicare beneficiaries with income or resources just above the Federal Poverty Level (FPL), Medicaid's assistance is more limited, primarily covering Medicare premiums. Qualified Medicare Beneficiaries (QMBs), with incomes up to the poverty line (assets up to $4,000 for an individual), receive help with Medicare premiums and cost-sharing obligations, but do not receive benefits like nursing home care. Specified Low-Income Medicare Beneficiaries (SLMBs), with slightly higher incomes (100 percent to 120 percent of FPL), receive help with Medicare premiums only. It is worth noting that not all low-income seniors on Medicare have Medicaid coverage. For many beneficiaries with savings or other property that exceeds $2,000 in value, the asset test disqualifies them from Medicaid eligibility (Rice and Desmond 2005). For others, the eligibility process, with its complex



Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

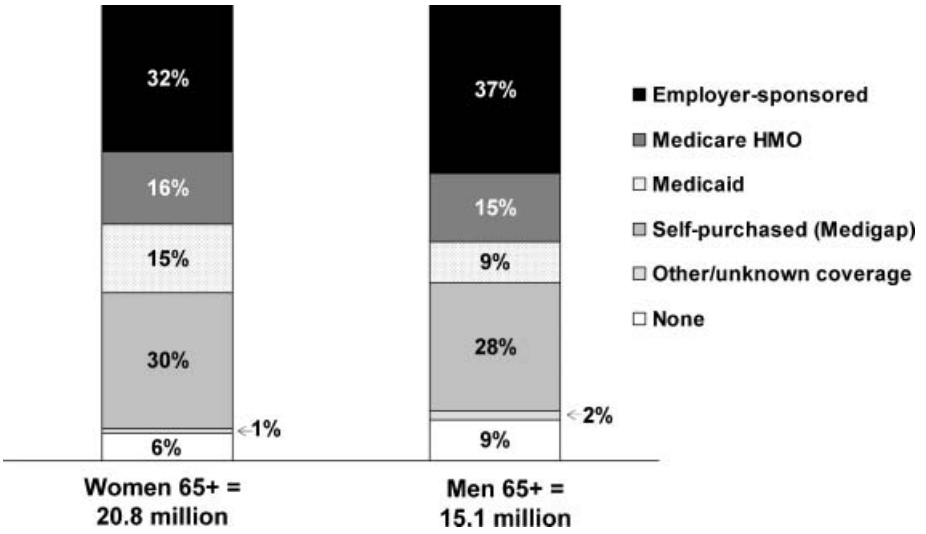
FIGURE 2 Medicaid and Employer-Sponsored Retiree Coverage Among Women on Medicare Aged 65+, 2002

documentation requirements and other administrative burdens, makes enrollment difficult to complete (Smith et al. 2006b).

Among the Medicare population aged 65 and older, women are more likely to have Medicaid coverage (15 percent) than men (9 percent), which is related to their need for and use of long-term care as well as higher poverty rates. Among older women, supplemental coverage by Medicaid also varies by age, income, and race/ethnicity (see Figure 2). Medicaid coverage is more prominent among the oldest and frailest women: among women on Medicare aged 85 and older, one-quarter also have Medicaid coverage. This is a function of both greater use of long-term care services and reduced income and assets among older women, conditions which make them eligible for Medicaid. Half of very low-income older women (with annual incomes below $10,000) are covered by Medicaid. Medicaid also plays a critical role for women of color. Because they are disproportionately poor and therefore more likely to qualify for Medicaid, a larger share of Black and Hispanic elderly women had Medicaid than white women. More than one-third of Black (37 percent) and Hispanic (33 percent) elderly women have Medicaid coverage compared to just one in 10 white elderly women (11 percent).

Private Insurance Coverage

A majority of older women on Medicare reported having some source of private supplemental coverage, including employer-sponsored retiree



Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

FIGURE 3 Sources of Supplemental Coverage Among Medicare Beneficiaries Aged 65+, 2002

health coverage or a self-purchased Medigap policy. There are some important differences in the distribution of types of private supplemental coverage between older men and women that can have significant implications for access to care, out-of-pocket spending, and the overall financial burden attributable to health care. A relatively small share of older men (9 percent) and women (6 percent) on Medicare reported that they had no supplemental coverage (see Figure 3); these individuals, as will be discussed, were extremely vulnerable to experiencing sizable financial burdens due to health expenses.

EMPLOYER-SPONSORED COVERAGE

Employer-sponsored plans for retirees are the primary source of supplemental coverage for people on Medicare, including older women. Typically, employer-sponsored retiree coverage includes prescription drug coverage and a cap on out-of-pocket expenses; these plans often help fill in Medicare's cost-sharing requirements (McArdle et al. 2005). Long-term care, however, is typically not a covered benefit. A smaller share of older women (32 percent) than older men (37 percent) received this retiree benefit because of their lower workforce participation, breaks in employment history, and greater demands for childcare and eldercare. Among older women, a smaller share of those who were low-income, Black or Hispanic, or those aged 85 and older had employer-sponsored retiree coverage than other groups (see Figure 2).

MEDIGAP

Many seniors purchase private insurance policies to supplement Medicare, known as Medigap. Medigap policies help with Medicare's cost-sharing requirements, but typically are not as comprehensive as employer plans. Medigap policies are no longer allowed to cover prescription drugs now that Medicare offers a prescription drug benefit, and most do not have an out-of-pocket spending limit for policyholders. In 2002, roughly one-third of men and women aged 65 and older purchased a supplemental Medigap policy. A larger share of white older women (33 percent) had self-purchased supplemental coverage (Medigap) than Black (15 percent) and Hispanic (16 percent) women (data not shown), which is likely related to the greater affordability of Medigap policies among white women due to their higher incomes. White women might also be more inclined to purchase a Medigap policy because they are less likely than women of color to qualify for Medicaid coverage.

HEALTH AND LONG-TERM CARE UTILIZATION AND SPENDING

Women's health and functional status affect the type, duration, and intensity of health care services they use, which in turn affects how much women spend for their health and long-term care and the extent of the burden of health expenses.

Utilization of Medical, Post-Acute, and Long-Term Care Services

Acute care is considered to be care that is typically needed for a short period of time or for an immediate medical need, such as a hospitalization or a physician office visit to receive treatment for an illness or injury. There were many similarities in acute care utilization between older men and women: for example, roughly the same percentages of both older men (18 percent) and women (19 percent) were hospitalized annually (see Table 3). A higher percentage of older women, however, had at least one outpatient visit in 2002 (62 percent versus 53 percent) and a claim for Part B services, which include physician, outpatient, or preventive services (82 percent versus 77 percent). A vast majority of both women and men used prescription drugs (88 percent versus 86 percent), but on average older women filled more prescriptions per year than men (31 prescriptions versus 25 prescriptions).

Although there was moderate variation between older women and men in terms of acute care utilization, there were more significant differences in long-term care utilization, such as nursing home or home health care. Given longer life spans, higher levels of chronic conditions, and higher rates of functional impairment and solitary living arrangements, it is not surprising that a larger share of older women than men needed and used long-term

TABLE 3 Selected Acute and Long-term Care Service Utilization for Medicare Beneficiaries (Aged 65 and Older) by Sex, 2002

	Women	Men
Acute care		
Percent with a hospitalization	19%	18%
Percent with an outpatient visit	62%	53%
Percent with a Part B claim	82%	77%
Percent with a prescription drug fill	88%	86%
Average number of prescription drug fills*	31 prescriptions	25 prescriptions
Long-term care		
Percent with a home health visit*	8%	6%
Number of home health agency visits	122 visits	91 visits
Percent living in long-term care facility for full year	8%	5%
Among 65+, percent living in long-term care facility for full year	6%	3%
Among 85+, percent living in long-term care facility for full year	21%	11%
Number of days in a skilled nursing facility*	34 days	30 days
Number of days in a hospice*	66 days	47 days

*Reflects utilization among beneficiaries with reported use of service.
Source: Kaiser Family Foundation analysis of Medicare Current Beneficiary Survey 2002 Cost and Use file.

care services. Long-term care is often provided informally by family and friends at home; through home- and community-based services, such as home health care, personal care, and adult day care; or in formal institutional settings, such as nursing homes or residential care facilities (US Department of Health and Human Services 2002). These services and supports are critical when women's ability to live independently and care for themselves is compromised by a chronic illness or disability.

Similar percentages of older women and men had a home health visit in 2002 (8 percent versus 6 percent), but older women had on average many more visits than men (122 visits versus 91 visits). As was discussed earlier, a much smaller share of older women than men have a spouse at home to provide caregiving as they grow older and have greater health needs. The percentage of women who used home health care rose with age, with just 4 percent of women 65 to 75 years having at least one home health visit in 2002 but reaching 15 percent among those aged 85 and older (data not shown). Only a small percentage of older women (5 percent) and older men (4 percent) had at least one Medicare-covered skilled nursing facility admission in 2002 (data not shown). However, women had slightly longer average lengths of stay than men (34 versus 30 days). The percentage of women with a skilled nursing facility admission was higher for those aged 85 and older than for women aged 65 to 84 (data not shown).

Because women live longer than men and many are widowed or living alone in their later years, a larger share of older women than men have a long-term nursing home stay. Of the 2 million older Medicare

beneficiaries living in nursing home facilities for the entire year in 2002, 72 percent were older women (data not shown). The percentage of older women on Medicare that lived in a long-term care facility for the entire year (6 percent) was double that of men (3 percent). Not surprisingly, as women age, a larger share end up permanently residing in a long-term care facility, with 21 percent of women aged 85 and older living in a long-term care facility for the full year, compared with 11 percent of men aged 85 and older (see Table 3).

Total and Out-of-pocket Health and Long-Term Care Spending

Differences in health care utilization rates translate into differences in health care spending. While Medicare, Medicaid, and supplemental coverage provide financial protection against the costs associated with medical care, some beneficiaries, particularly older women, are not fully insulated from these expenses and end up bearing a large share of the costs out-of-pocket. As will be discussed in more detail, women's health care expenses were higher than men's; older women paid for a greater share of their total spending out of pocket; and they faced a greater financial burden by shouldering these out-of-pocket costs with less income at their disposal.

Total spending

Overall, older women on Medicare incurred higher total health costs than men. Total costs include spending by Medicare, Medicaid, private third-party payers, and beneficiaries themselves for premiums, cost sharing, deductibles, and uncovered services. On average, older women's total annual health expenses for acute and long-term care were nearly $700 higher than older men's, averaging $11,647 for women and $10,971 for men (see Table 4).

Among older women, total health care spending varied considerably by socio-economic status and other factors. Not surprisingly, as women aged, their average health expenses rose, with spending levels more than doubling for women aged 85 and older compared with women aged 65 to 74. The amount of total health spending was inversely related to income, with lower-income women spending far more than higher-income women. Surprisingly, Black and white women had considerably higher total spending levels than Hispanic women.

Spending levels also varied considerably for women with different types of supplemental coverage. In 2002, total spending was highest among women on Medicaid, in part because of expenses for nursing home and other long-term care services paid for by Medicaid. Total health care spending was lowest among older women enrolled in Medicare HMOs who have been found to be typically healthier than other Medicare beneficiaries

TABLE 4 Total Spending on Medical and Long-term Care and Percent Spent Out-of-Pocket by Medicare Beneficiaries Aged 65 and Older, by Sex and Selected Characteristics, 2002

	Mean total spending	Percent of total spent out-of-pocket
By sex		
Women	$11,647	34%
Men	$10,971	30%
Among older women		
By age		
65–74 years	$8,282	36%
75–84 years	$12,397	33%
85 years and older	$19,775	34%
By race/Ethnicity		
White Non-Hispanic	$11,878	37%
Black	$13,076	18%
Hispanic	$8,860	24%
By annual income		
$10,000 or less	$14,893	21%
$10,001–$20,000	$11,635	35%
$20,001–$30,000	$10,367	43%
$30,001–$40,000	$9,758	43%
$40,001 or more	$9,618	47%
By supplemental insurance coverage		
None	$10,117	52%
Medicare HMO	$7,062	44%
Medicaid/QMB	$21,842	14%
Employer-sponsored	$9,887	33%
Self-purchased (Medigap)	$9,056	48%
By out-of-pocket spending quintile		
Bottom 20%	$7,094	8%
Top 20%	$26,574	43%

Source: Kaiser Family Foundation Analysis of Medicare Current Beneficiary Survey 2002 Cost and Use file.

and thus use fewer services and incur lower spending on medical care (Medicare Payment Advisory Commission 2004). Total spending levels were similar for women with employer-sponsored retiree coverage and self-purchased Medigap, though there were notable differences in the share of costs that out-of-pocket spending represented. Older women on Medicare who lacked supplemental coverage incurred an average of $10,117 in health costs in 2002.

Share of spending borne by beneficiaries

There were also differences in the amount of spending shouldered directly by male and female Medicare beneficiaries aged 65 and older. In addition to having higher overall spending levels on average, older women paid a larger share in out-of-pocket expenses than older men (34 percent and 30 percent, respectively; see Table 4). Interestingly, there were few differences in the share of spending paid for by women in different age groups, with women

in all the age groups bearing about one-third of overall costs, despite higher costs as women age.

In higher-income groups, older women shouldered a larger share of costs (see Table 4). Provider visits and hospital care accounted for a relatively small share of out-of-pocket spending for older women because Medicare and supplemental coverage cover a large share of these costs. This variation by income, along with that by race/ethnicity, is likely attributable to the fact that a larger share of low-income women and women of color qualify for Medicaid, which shields them from many of Medicare's cost-sharing obligations in a way that other types of supplemental coverage do not. The importance of the type of supplemental coverage is also quite evident with women with Medicaid at the low end of the spectrum (paying 14 percent of costs) and women without any supplemental coverage at the high end paying for more than half (52 percent). It is worth noting that, on average, women with Medigap also paid for about half of total costs (48 percent). Women in Medicare HMOs also paid a large share of costs directly (44 percent). Women with employer-sponsored coverage paid for one-third of costs, on average.

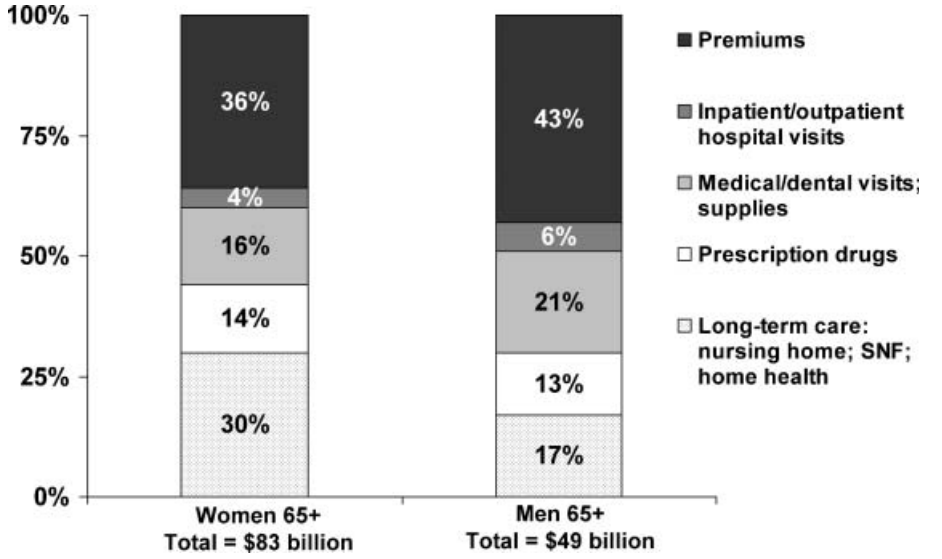
The components of out-of-pocket spending

Of the various components of out-of-pocket spending, including both premiums and health care services, our analysis shows that premium costs represented the largest source of out-of-pocket spending for both older men and older women on Medicare (see Figure 4). Spending on premiums accounted for more than one-third of older women's out-of-pocket costs (36 percent), and its share was even higher for older men (43 percent). Out-of-pocket spending on health care services, post-acute and long-term care spending—such as home health, nursing homes, and other institutions—accounted for 30 percent of older women's out-of-pocket spending, compared to 17 percent for men's. In dollar amounts, older women overall spent over twice as much as men on long-term care in 2002 ($1,209 and $557 respectively).[3]

Prescription drug spending was another significant component of out-of-pocket costs for both older men ($428) and older women ($546) in 2002. Out-of-pocket spending on prescription drugs is expected to change now that Medicare offers a prescription drug benefit, but the magnitude of the effect is as yet unknown. Provider visits and hospital care accounted for a smaller share of out-of-pocket spending for older women because Medicare and supplemental coverage cover a large share of these costs.

The burden of out-of-pocket spending

As expected, median annual out-of-pocket spending among women was higher than men's ($2,595 versus $2,315; see Table 5), and women's out-of



Source: Kaiser Family Foundation analysis of the Medicare Current Beneficiary Survey 2002 Cost and Use File.

FIGURE 4 Components of Out-of-Pocket Spending by Medicare Beneficiaries Age 65+, by Sex, 2002

pocket spending varied by demographic characteristics, socioeconomic status, and type of supplemental insurance. Among older women on Medicare, those in the oldest group (aged 85 and older) spent the most out-of-pocket on their health care in 2002, mainly due to their greater health care needs and functional impairments, as well as the higher prevalence of chronic illness among this population (see Table 5). Median out-of-pocket spending for women aged 85 and older was 50 percent higher than for women aged 65 to 74. Women who were younger, Hispanic or Black, and had supplemental coverage through Medicaid, HMOs or their employers had among the lowest median out-of-pocket spending levels.

While our analysis of out-of-pocket spending shows important differences between older men and women, as well as among subgroups of older women, a more revealing indicator of the burden of health spending on individuals is to examine median out-of-pocket spending as a percent of income. Our analysis shows that, at the median, older women spend 17 percent of income on health care expenses, compared with 14 percent for older men. As women age, however, they spend a larger share of income on health; among those aged 85 and older, median spending on health care as a share of income was 23 percent. And more women than men reach these older ages.

In terms of the amount of out-of-pocket spending paid by older women at different income levels, our analysis shows that the absolute dollar amount

TABLE 5 Median Out-of-pocket Spending and Out-of-Pocket Spending as Percent of Income, by Medicare Beneficiaries Age 65 and Older, by Sex and Selected Characteristics, 2002

	Number of beneficiaries	Out-of-pocket spending	
		Median ($)	Median spending as percent of income
By sex			
Women	20,791,785	$2,595	17%
Men	15,073,700	$2,315	14%
Among older women			
By age			
65–74 years	9,750,086	$2,312	14%
75–84 years	7,717,794	$2,803	19%
85+ years	3,323,905	$3,133	23%
By race/Ethnicity			
White Non-Hispanic	16,765,415	$2,825	18%
Black	1,736,192	$1,533	13%
Hispanic	1,403,635	$1,437	15%
By annual income			
$10,000 or less	4,668,434	$1,614	26%
$10,001–$20,000	6,975,819	$2,615	22%
$20,001–$30,000	4,271,527	$2,821	16%
$30,001–$40,000	2,019,202	$3,002	13%
$40,001 or more	2,856,803	$2,927	8%
By supplemental insurance coverage			
None	1,282,013	$2,499	25%
Medicare HMO	3,283,023	$1,968	14%
Medicaid/QMB	3,159,327	$846	11%
Employer-sponsored	6,615,708	$2,502	14%
Self-purchased	6,156,503	$3,502	24%
By out-of-pocket spending quintile			
Bottom 20%	4,157,498	$665	5%
Top 20%	4,162,244	$6,757	47%

Source: Kaiser Family Foundation Analysis of Medicare Current Beneficiary Survey 2002 Cost and Use file.

of spending is less at lower incomes (see Table 5). This could be in part a result of the economically protective effect of Medicaid, which covered half of all women with incomes below $10,000, as well as the fact that those with lower incomes spend less on health care because they have a smaller amount of disposable income. Yet, despite the prominence of Medicaid for the low-income group, the burden of out-of-pocket spending, measured as a share of income, was highest for the poorest groups. Women in the lowest income category (annual income $10,000 or less) had the highest burden, spending over one-quarter (26 percent) of their income on health care in 2002. The out-of-pocket spending burden was the lowest for the most affluent group, with annual income more than $40,000, at only 8 percent.

The burden of out-of-pocket spending for older women varied by the type of supplemental coverage they had. Health expenses among those

without any supplemental insurance consumed one-quarter of their income, the same as for women who purchased Medigap supplemental insurance. Dual eligibles (those with Medicare and Medicaid) had the lowest out-of-pocket spending burden (11 percent) in 2002, again likely due to the protective effect of Medicaid. Older women enrolled in Medicare HMOs and those with employer-sponsored insurance had the same median ratio of out-of-pocket spending to income (14 percent each).

The out-of-pocket burden was also greater for white women than women of color. Older white women spent a median 18 percent of their income on health care expenses, compared with 13 percent for older Black women and 15 percent for older Hispanic women. This could be a result of higher rates of Medicaid coverage among Black women and Hispanics, which provides sizable protection from out-of-pocket costs. Because a smaller percentage of older white women had Medicaid coverage, they incurred higher costs for premiums for supplemental coverage and other out-of-pocket costs.

Finally, we examined the burden of out-of-pocket spending among those older women who incurred very low out-of-pocket health care costs and those who experienced catastrophic levels of out-of-pocket spending in 2002. This helps to shed light on the impact of out-of-pocket health care costs on those who are the sickest and frailest and who consume the most services. Not surprisingly, the 20 percent of older women in the bottom out-of-pocket spending quintile, who spent $665 at the median for out-of-pocket costs in 2002, spent only about 5 percent of their income on health and long-term care. In contrast, the 20 percent of older women in the top quintile of out-of-pocket health care spending had median spending of $6,757 in 2002, which consumed nearly half (47 percent) of their income. Clearly, for those with high health expenses, the financial burden is very great.

DISCUSSION

Medicare was established in 1965 because private health insurance in the United States failed to cover roughly half of the senior population (Davis and Collins 2005). At the time, the predominant system of private employer-sponsored coverage was generally not available to older, non-working people. Today, Medicare provides considerable protection to women aged 65 and older, and is a key element of financial security for older women in their retirement years. Without Medicare, women would be hard-pressed to find comparable health insurance coverage in the private marketplace. Yet, Medicare falls short in protecting older people from potentially high out-of-pocket costs associated with their medical and long-term care needs. Medicare lacked a prescription drug benefit until 2006 and has high cost-sharing requirements, no limit on out-of-pocket spending, and little

coverage for institutional long-term care beyond post-acute medical services. These gaps are particularly problematic for many older women who, as this analysis shows, have lower incomes than men and spend more out-of-pocket on health care in absolute dollars and as a share of their income.

Although supplemental insurance provides help filling Medicare's benefit gaps, even those with supplemental insurance are at risk for large out-of-pocket expenses in the face of rising health care costs. The steady erosion of employer-sponsored coverage—due to both the termination of coverage for retirees and increases in premiums and cost-sharing requirements—threatens to undermine financial protections for current and future retirees. The 25 percent of older women in 2002 with Medigap are also in a financially precarious situation. The relatively high out-of-pocket expenditures among those with Medigap suggest that these policies still have large gaps in the way of true insurance protection from catastrophic costs. Seniors without any form of supplemental insurance are especially vulnerable; they pay more out-of-pocket for their medical care than those with supplemental coverage. Although seniors without any supplemental insurance are a roughly similar proportion of both senior women and men (8 percent of women and 9 percent of men) these approximately 1.3 million women (2.7 million people in total including men over 65) are exposed to potentially financially devastating expenses.

Medicaid has been a lifeline for low-income Medicare beneficiaries, a group that is disproportionately female. Medicaid offers considerable protection for those who qualify in terms of greater benefits, reduced out-of-pocket costs, and long-term care coverage. Until the Medicare Part D drug benefit took effect in 2006, Medicaid was a key source of prescription drug coverage for low-income seniors. However, Medicaid's reach is limited because it requires individuals to meet strict income and asset tests or become impoverished by spending down their income and assets to qualify for coverage. The asset test has proven to be a barrier to coverage for many seniors because it requires considerable administrative and documentation requirements. Also, though Medicaid is the nation's primary public funder of nursing home care, it has historically had an institutional bias, providing more avenues of assistance to those who need institutional rather than home or community-based care (O'Brien 2005). While this is changing, the historically limited coverage of home- and community-based care has a disproportionate effect on older women, a greater share of whom live alone and are widowed compared with older men. Older women may be prematurely forced to reside in an institutional setting because they lack the resources and supports to remain in their own home.

Until 2006, the lack of a prescription drug benefit under Medicare contributed significantly to the burden of out-of-pocket spending for older women. Some—especially those who lacked prescription drug coverage before the benefit went into effect—stand to gain from having access to

insurance that was previously unavailable. Those with low incomes and with catastrophic drug expenses may get the most help, given the design of the new drug benefit and the extra subsidies available to low-income beneficiaries. Given the high out-of-pocket spending that women have incurred on prescription drugs, the new Medicare drug benefit is expected to alleviate burdens for some, while others may continue to absorb high out-of-pocket costs for their prescriptions—particularly if they have expenses in the so-called "doughnut hole."[4]

Despite coverage for prescription drugs under Medicare, older women are still at risk for high long-term care expenses. There are few viable national policy options on the horizon that would provide comprehensive assistance to those who need long-term care—particularly those who are not poor enough to qualify for Medicaid, but still lack the means to purchase a long-term care insurance policy. For millions of older women who may one day need long-term care, this gap in Medicare's coverage could have devastating financial consequences, wiping away their life savings and jeopardizing their ability to pay for other costs unrelated to their health needs. Given the high costs of long-term care, and competing demands on limited income, it may be unrealistic to expect working families to put away sufficient savings to cover these costs if and when the need arises decades later.

Looking to the future, there is some concern that the health security of older women may be threatened by fiscal pressures affecting Medicare and Medicaid. With the aging of the population, and fewer current workers per beneficiary to pay taxes that support Medicare and Social Security, policymakers face increasing pressure to adopt policies that will slow the growth in Medicare spending and curtail the growth in entitlement spending. These policies could have a direct and negative effect on older women. For example, efforts to raise the age of eligibility for Medicare could result in more women being uninsured when they turn 65, at an age when they are not likely to find affordable and comprehensive coverage in the non-group private insurance market. Proposals to raise premiums or cost-sharing requirements would also disproportionately affect older women, who have less disposable income to pay for their health care costs and who already bear a greater burden of out-of-pocket costs than older men.

Medicaid, like Medicare, is also likely to be at the forefront of future policy discussions, due to financial pressures facing the program. Recent activity at the state level provides some insight into the nature of changes that may be on the horizon. State waiver programs give states the ability to make sweeping changes in their Medicaid programs, and the 2005 Deficit Reduction Act gave states additional flexibility to make programmatic changes without prior federal approval. These changes could allow states to adopt block grants and entitlement caps, which limit the public sector's liability for health costs. Again, these changes could have significant repercussions for older women who comprise the vast majority of the dual

eligible population and who have very little in terms of economic resources to offset the additional financial burdens that these changes may impose.

Relieving the financial burdens experienced by older women will entail the development of policies that deal with the fundamental cost drivers in the health care system. Premiums are rising rapidly, and co-payments and cost-sharing requirements are also increasing at the same time that benefits are being scaled back. Many seniors, particularly women, living on modest and fixed incomes may not be financially equipped to meet these costs. Rising health care burdens will mean that increasing numbers of women may be faced with hard choices to go without health care or other supportive services that they need to maintain their health and well-being. As this analysis shows, spending on long-term care is a major component of health care spending for women and a significant contributor to their out-of-pocket burdens. The development of long-term care financing options that go beyond shoring up the Medicaid program for the poorest and frailest also will be even more critical with the impending wave of retirement of the baby-boom generation. Controlling health spending and developing options to finance long-term care are among the most intractable health policy problems facing our nation. They are also key elements of the policy solutions that will need to be designed and implemented in order to preserve and support economic security for millions of retired women in the United States.

ENDNOTES

1. Other researchers have used a similar approach, including Marilyn Moon (2006), Caplan and Brangan (2003), and Crystal et al. (2000).

2. For our analysis, cognitive impairment is defined as a diagnosis of mental retardation, a mental disorder, Alzheimer's disease, or memory loss that interferes with activities. For those who reside in facilities, the definition also includes the presence of schizophrenia or dementia.

3. The spending levels discussed here are averages for all women and include women who did not use long-term care services. Actual spending levels for women who used long-term care services are considerably higher.

4. Under the Medicare standard drug benefit in 2006, after an enrollee's total drug costs exceed the initial benefit limit ($2,250), she must pay 100 percent of drug costs until expenditures reach $3,600 out-of-pocket when she would qualify for catastrophic coverage for remaining drug costs. This gap in coverage is sometimes referred to as "doughnut hole."

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APPENDIX A

Overview of the 2002 Medicare Current Beneficiary Survey

Sample population: The 2002 MCBS Cost and Use file includes a total of 12,697 survey respondents—7,104 women and 5,593 men. Survey weights applied to each individual result in an aggregate total of 41.8 million beneficiaries—23.4 million women and 18.4 men. For this analysis, the sample was restricted to survey respondents aged 65 and older. In 2002, a total of 10,591 (weighted value = 35.9 million) MCBS survey respondents fit this criteria, including 6,195 women (weighted = 20.8 million) and 4,396 men (weighted = 15.1 million.)

Demographic variables: These include age, sex, race/ethnicity, marital status, education level, Census region, and metro status. Health status information includes a self-reported question about general health, and a series of questions about chronic conditions.

Insurance coverage variables: Health insurance coverage information includes Part A and B enrollment, Medicare HMO enrollment, Medicaid eligibility, private health insurance (employer and individual), and other public plans. Coverage of various types is reported for each month of the calendar year.

Spending variables: The MCBS provides data on insurance premiums, Part A and B spending, and spending for health care services, both out-of-pocket and third-party payments.

Income: The variable for income represents the best source or estimate of income of the sample person and spouse (if applicable), including all sources, such as pension, Social Security, and retirement benefits.