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**Older Women's Access to Health Care:  
Potential Impact of Medicare Reform**

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# **Older Women's Access to Health Care: Potential Impact of Medicare Reform**

## **EXECUTIVE SUMMARY**

### **Introduction**

This Issue Paper identifies and discusses key issues related to women age 65 and older and proposed changes in the Medicare program. There are various reasons why it is useful to view public policy proposals through a lens that clarifies their potential or likely impact on defined population groups, such as women and men, minorities and ethnic groups, age cohorts, or income classes. In general, this type of analysis can inform the development of options that have the greatest prospect of fulfilling policy intentions, while avoiding disproportionately negative impacts on the most vulnerable beneficiaries.

### **Purpose**

The purpose of this Issue Paper is to analyze the potential impact of various Medicare reform proposals on older women's access to health care.

### **Methods**

Part I of this Issue Paper is based on a review of the literature on older women's access to health care, and a comparison of relevant demographic and socioeconomic data and data on out-of-pocket health expenditures by gender. Part II selects four broad policy options that have been suggested for Medicare reform (premium support, change in the age of eligibility, a prescription drug benefit, and assuring access to post-acute care), and considers the potential impact of these proposals on older women. Concluding comments point out areas of concern for older women outside of the insurance coverage framework, such as assuring effective delivery of preventive services, that are rarely addressed in the current Medicare policy debate.

### **Findings**

Older women outnumber older men in Medicare and are disproportionately represented among poor and low-income beneficiaries age 65 and older.

Older women are more subject than men to chronic illness and health conditions that severely limit their activities of daily living (ADLs) and that may require treatment with prescription medications.

Older women are more likely than men to use care in post-acute or non-acute-care settings such as nursing facilities or to receive care from home health agencies.

Women tend to outnumber men in the ranks of the uninsured in the 10 years preceding Medicare eligibility.

Medicaid figures more prominently as a source of health care coverage for older women than older men, while older men are more likely to lack any supplemental insurance coverage.

However, among beneficiaries with private sources of supplemental coverage (i.e., Medigap or employer-sponsored), Medigap figures more prominently for older women than for older men.

Analysis of out-of-pocket spending for health care reveals certain disparities between older women and older men:

- Women, on average, spend a higher percentage of their incomes on health care than do men. The disparity widens with age.
- Women, on average, spend substantially more than men on short-term nursing home care, but substantially less on inpatient hospital care.
- Women tend to be more burdened by prescription drug costs than men.

Older women, even if they have adequate insurance coverage, may encounter barriers to health care due to factors such as caregiving responsibilities, living arrangements, or provider attitudes.

## **Implications of Medicare Reform Proposals**

**Privatizing Medicare: The “Premium Support” Approach.** One sweeping proposal is to restructure Medicare by creating a “premium support” system, exemplified by the Federal Employee Health Benefits Program (FEHBP). Under a premium support approach, Medicare would contribute defined amounts toward health plan premiums. Each beneficiary would annually select an approved private health plan to provide his or her Medicare coverage. The government would contribute a share of the plan’s premium and the beneficiary would contribute an additional portion, if necessary, to purchase the plan of his or her choice. Proponents assert that premium support would give beneficiaries more options for health benefits and cost-sharing arrangements, and that competition among private plans for Medicare enrollees would help contain health care costs in the long run. Others are concerned about how a premium support system would distribute the burden of health care cost increases over time, and whether the value of the core benefits now guaranteed under original Medicare could be maintained.

Older women are generally in a more precarious financial position than older men because they tend to have lower incomes. If competition in the marketplace under premium support failed to control health plan costs, women overall would feel the effects more severely as their premiums and cost-sharing burdens increased. Further, adverse selection in the insurance market could result in fewer plan options and more access barriers for women, who tend to have more chronic, long-term health problems.

**Raising the Age of Eligibility.** Some policy experts support increasing the age of Medicare eligibility from age 65 to age 67. Concurrently, concern about the decline in private insurance

coverage in the pre-retirement population has led to proposals to lower the age of Medicare eligibility. These proposals typically provide for a voluntary “buy-in” program for certain groups of pre-retired persons, such as those age 62-64. Individuals in these groups who are not otherwise eligible to enroll in Medicare could elect to purchase coverage.

Because women nearing retirement age (age 55 to 64) are less likely than men in the same age group to have private insurance, a delay in the age of Medicare eligibility could leave more women than men without coverage from any source. As for expanding insurance options prior to Medicare eligibility, women in particular could benefit from an opportunity to buy into Medicare before age 65, again because they are particularly at risk for lack of coverage from age 55 to 64. However, the relevance of a “buy-in” option depends on a program design that is widely affordable by both women and men.

**Introducing a Prescription Drug Benefit.** The current lack of a Medicare prescription drug benefit is a significant gap in health insurance coverage for beneficiaries. Without a drug benefit, many beneficiaries who are vulnerable to high out-of-pocket costs may forgo needed treatments. There is little question that prescription drug coverage could benefit older women, given that they are more likely than men to suffer from certain chronic illnesses that require prescription drug treatment and tend to have lower incomes with which to purchase drugs or lack adequate drug coverage. Specific proposals to provide prescription drug coverage must be evaluated carefully in terms of their potential impact on women’s overall out-of-pocket health costs.

**Assuring Access to Care in Post-Acute Settings.** Options for Medicare reform that relate to care provided in post-acute (and sub-acute) settings have particular relevance for older women. Reforms in reimbursement policy in this area are under way, through implementation of certain provisions of the Balanced Budget Act (BBA) of 1997 and refinements to that law in subsequent years. Research is continuing into the impact of the BBA on beneficiary access to home health care and care in skilled nursing facilities (SNFs). As the predominant users of the home health and SNF benefits, older women have much at stake in the debate about appropriate future measures to protect or improve access. In addition, policy proposals that would change Medicare coinsurance requirements in post-acute care have implications for older women. A new requirement for coinsurance for home health care would disproportionately burden older women, who tend to be heavier users of these services and to have lower incomes. Proposals to create a single annual deductible and coinsurance rate should be evaluated to determine if access to SNFs would be improved and how out-of-pocket costs for older women would be affected.

## **Conclusions**

Given the financial vulnerabilities facing older women, the most important Medicare reforms are the ones that address the availability, adequacy, and affordability of health insurance coverage. A prescription drug benefit and cost-sharing reform that assures access to post-acute care are notable in this respect. There are serious questions as to whether a Medicare premium support system would be affordable for many beneficiaries in the long run. Similarly, concerns about affordability arise in the context of proposals to raise the age of Medicare eligibility. Some form

of a Medicare buy-in option would help to offset this potential problem. However, policymakers will be challenged to design a buy-in program that would be affordable to those who need it most.

The role of Medicaid should not be overlooked in the Medicare reform debate. For the most complete assessment of how Medicare reform might affect older women, further analysis and careful consideration must be given to the role of Medicaid in the lives of older persons. Further, a focus on Medicaid as part of the Medicare reform debate could provide a needed opportunity to confront the challenge of developing policies for long-term care of older persons. For older women who are living with chronic conditions and often without the support of a life partner, access to long-term care is a critical concern, especially as health and functional status decline.

Finally, it is reasonable to question whether or how Medicare policy affects access to health care in ways not strictly limited to coverage. Recent Medicare proposals, with some exceptions, fail to address health care access outside the insurance coverage framework. Current knowledge, however, clearly points in certain directions for many older women. For example, less educated and poorer women need targeted health promotion and disease prevention messages, so that they are aware of the importance of seeking timely health care services. Since Medicare covers certain preventive and screening services such as mammograms and Pap smears, there is a clear rationale for developing policies to increase the effective delivery of these services. Other barriers to access may be more difficult to address in the context of Medicare reform.

The enduring policy challenge is to maximize Medicare's value to its more vulnerable beneficiaries. These include many women who are poor, who live in ethnic or minority communities, or who live alone and lack informal support. Insurance coverage may increase, but does not necessarily guarantee, their access to health care services.

# Older Women's Access to Health Care: Potential Impact of Medicare Reform

## Introduction

This Issue Paper identifies and discusses key issues related to older women (age 65 and older) and proposed changes in the Medicare program. There are various reasons why it is useful to view public policy proposals through a lens that clarifies their potential or likely impact on defined population groups, such as women and men, minorities and ethnic groups, age cohorts, or income classes. In general, this type of analysis can inform the development of options that have the greatest prospect of fulfilling policy intentions, while avoiding disproportionately negative impacts on the most vulnerable beneficiaries.

The reasons for viewing Medicare policy alternatives in terms of the possible effects on older women are straightforward. "Old age is a territory populated largely by women," as one commentator wrote in a 1996 issue of the *New England Journal of Medicine* (Butler, 1996). Older women outnumber older men, especially in later years, because of women's greater life expectancy. Women live about six years longer than men, on average (Social Security Administration, 1999). In addition, older women differ from older men in various ways affecting access to needed health care. These differences are identified in more detail throughout the Issue Paper. Given such differences, it is apparent that certain changes in Medicare policy could affect women and men in disparate ways that are not intended or desired; likewise, failure to enact certain policy reforms may exacerbate the negative aspects of existing disparities (see Kaiser, 1999; Older Women's League, 1999). An understanding of these matters may help policymakers and stakeholders evaluate Medicare reform options and weigh their relative merits.

The Issue Paper is organized in two parts. Part I presents an overview of major themes related to older women's access to health care. The term "access" is used broadly to encompass a variety of factors that may determine a person's ability or willingness to seek and obtain necessary health care, or the likelihood of doing so. For the purposes of the Issue Paper, such factors are viewed as either financial or non-financial. Financial factors include income and insurance coverage (coverage status and extent of coverage); examples of other factors that are not chiefly financial include social isolation, immobility, and discrimination or neglect by the health care system.

In addition to summarizing the findings from the literature, Part I incorporates 1997 and 1999 data that compare older women with older men in the Medicare population and in the age group closest to Medicare eligibility. Unless otherwise noted, the Medicare data are 1999 projections from the Medicare Benefits Model, Version 2.0 (MBM) and describe non-institutionalized beneficiaries age 65 and older;<sup>1</sup> the data on health insurance for people age 55-64 were obtained from an analysis of the U.S. Census Current Population Survey (CPS) for 1997.

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<sup>1</sup> The Medicare Benefits Model, Version 2.0, is a microsimulation model developed for AARP by The Lewin Group, Inc. The MBM projects 1999 out-of-pocket health care spending from the 1995 Medicare Current Beneficiary Survey Cost and Use files. For a discussion of the methodology used in making these projections, see

Part II identifies and discusses selected reform proposals of particular relevance to women. Specifically, this part reviews proposals related to “premium support,” age of eligibility, prescription drug coverage, and post-acute care. Concluding comments point out areas of concern for older women that are rarely addressed in the current policy debate. Areas for further research and policy development are also identified.

## **Part I: Older Women and Access to Health Care**

The data and discussion in Part I examine various facets of older women’s access to health care, with comparisons to older men. First, a brief profile of older women summarizes Medicare demographic and socioeconomic data, including information about race, ethnicity, and income. This analysis highlights the fact that for many vulnerable beneficiaries, demographic and socioeconomic factors such as race, ethnicity, and poverty may be as relevant as gender.<sup>2</sup> The remainder of the data and research about older women relate to their health status, their health care financing, and non-financial barriers that may affect their access to health care. Significant findings are identified, set out in bold type.

### **COMPARISON OF OLDER WOMEN AND OLDER MEN IN MEDICARE**

#### ***Key Findings***

**Older women outnumber older men in Medicare.**

**Women are disproportionately represented among poor and low-income beneficiaries age 65 and over.**

**Older Women In General.** Women age 65 and older (“older women”) number 19.4 million of the 34.5 million beneficiaries in this age group. Older women outnumber men by a substantially wider margin after age 85. As Figure 1 illustrates, women make up 56 percent of beneficiaries age 65 and older, and 68 percent of those age 85 and older.

**Gender, Race, and Ethnicity.** The older Medicare population overall is about 89 percent white and 11 percent racial minority, e.g., African-American or Asian.<sup>3</sup> Minority women make up 60

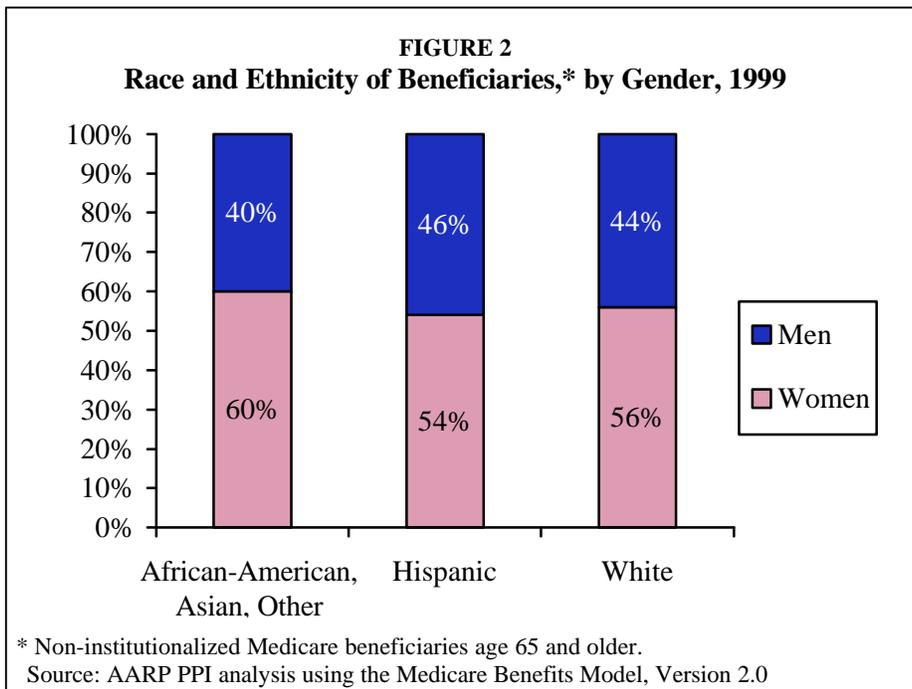
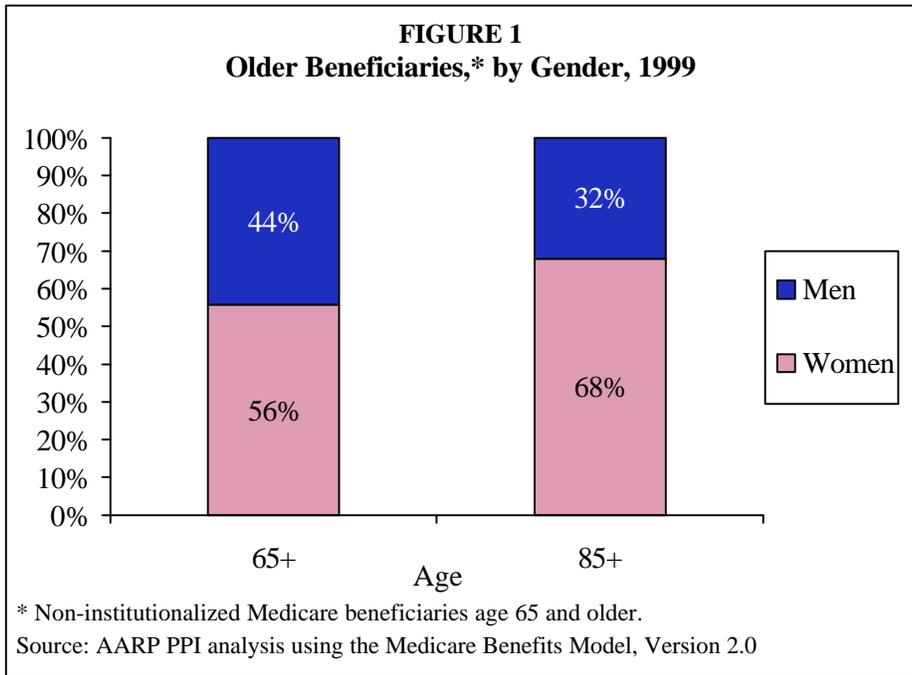
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Gross et al., *Out of Pocket Spending by Medicare Beneficiaries Age 65 and Older: 1997 Projections*, AARP Public Policy Institute, 1997.

<sup>2</sup>Researchers and analysts studying minority women and disabilities sometimes refer to the “triple jeopardy” of race, gender, and disability, pointing to a combination of factors that compound problems for individuals needing health care and other services. (See Glenn, 1995; AIDScriptions, 1996). Similarly, some groups of older women may face the effects of combined socioeconomic or demographic factors such as race, ethnicity, and poverty. And, as data in the next section of Part I suggest, there may also be multiple “jeopardies” for men where low income and health status intersect.

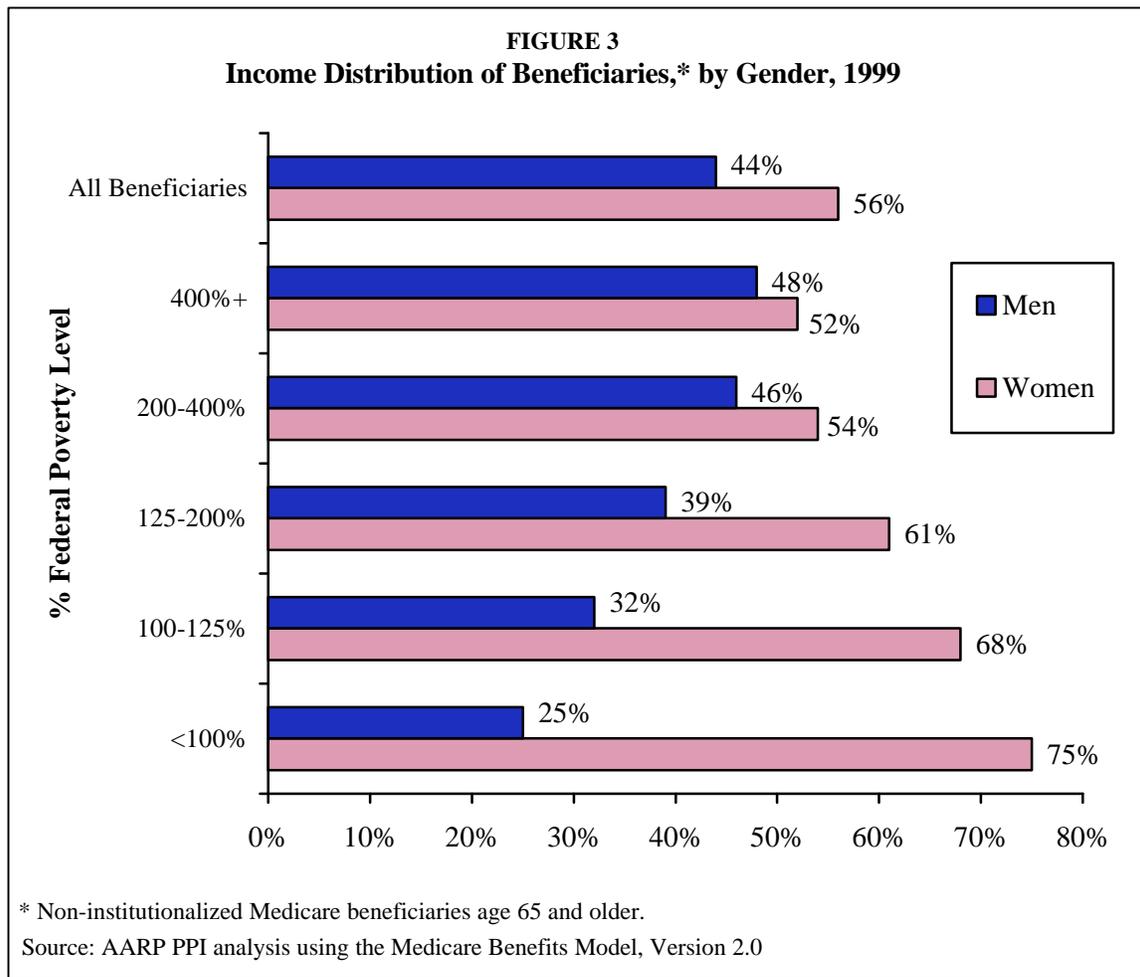
<sup>3</sup> Regardless of ethnicity.

percent of all minority beneficiaries, while white women represent 56 percent of white beneficiaries. Of the 1.9 million Hispanic beneficiaries age 65 and older,<sup>4</sup> 54 percent are women and 46 percent are men. (Figure 2). Hispanic beneficiaries account for 5 percent of older Medicare beneficiaries.



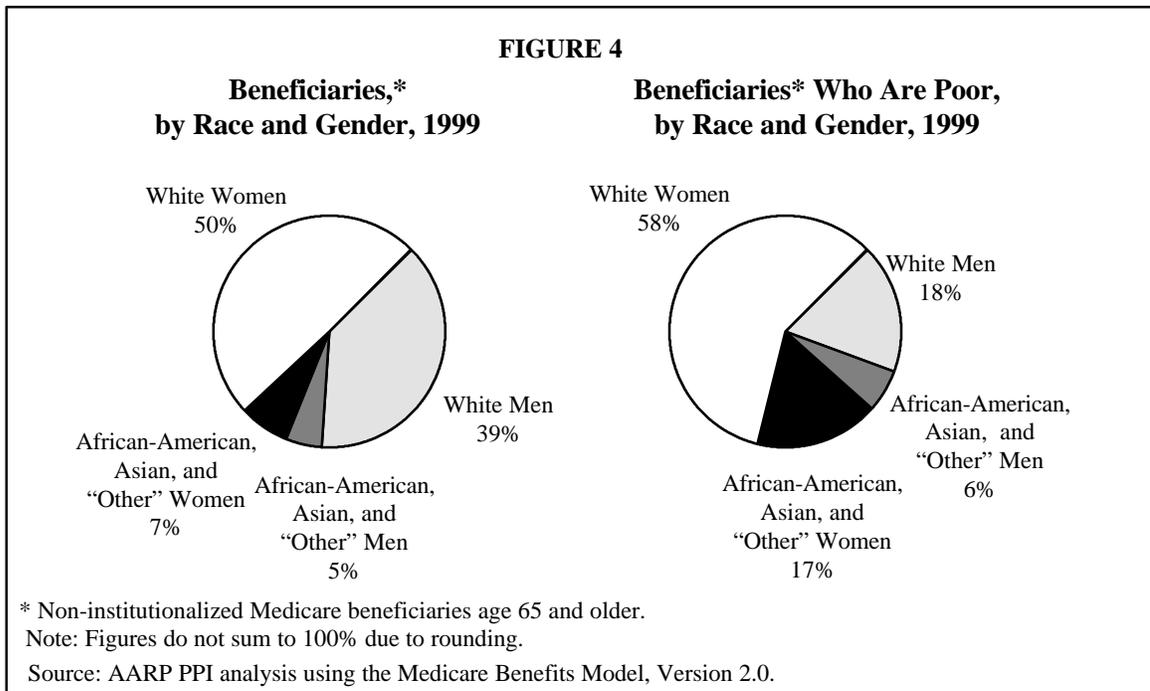
<sup>4</sup> Regardless of race.

**Older Women and Poverty.** About one-third of older Medicare beneficiaries are poor or low income, with family incomes below 200 percent of the poverty threshold.<sup>5</sup> Three million beneficiaries have incomes at or below the poverty threshold. As shown in Figure 3, women make up three-quarters of these poor beneficiaries. Also, women are disproportionately represented among the “near poor” (income between 100 percent and 125 percent of poverty) and low income (between 125 percent and 200 percent of poverty). As Figure 4 shows, a disproportionate share of poor beneficiaries are minority women. Specifically, 17 percent of poor Medicare beneficiaries are African-American, Asian and “other” non-white women, compared to 7 percent of older Medicare beneficiaries overall.<sup>6</sup>



<sup>5</sup> In 1999, the poverty threshold was projected to be \$8,075 for individuals age 65 and older, and \$10,185 for couples.

<sup>6</sup> The intersection of race and poverty among older men is also suggested by the data in Figure 4.



## HEALTH OF OLDER WOMEN

### *Key Findings*

**Older women are more subject than men to chronic illness and health conditions that severely limit their activities of daily living (ADLs) and that may require treatment with prescription medications.**

**Older women are more likely than men to use care in post-acute or non-acute-care settings such as nursing facilities or to receive care from home health agencies.**

Older women face many of the same health risks that older men face, including risks of heart disease and various types of cancer, and stroke (Collins, et al., 1997). However, women's longer life expectancy means that multiple chronic illnesses, disability, and frailty are more prominent among their health concerns (Kaiser, 1999; Bierman and Clancy, 1999; Collins, et al., 1997). Accordingly, preventive and screening services may be more important for women if they are to maintain quality of life as they age (Collins, et al., 1997).

Overall, women have more functional limitations than men, e.g., difficulties with dressing, eating, or bathing. Eleven percent of older women report having one or more severe limitations in activities of daily living (ADLs), compared to 7 percent of men.<sup>7</sup> Among the poorest

<sup>7</sup> In the MBM analysis, a beneficiary is considered to have a limitation in an Activity of Daily Living (ADL) if he or she requires help, supervision, or cueing to perform the activity. This definition of functional limitation is quite narrow compared to that used in many other studies, and it captures only those with more severe limitations.

beneficiaries, 15 percent of women and 10 percent of men report at least one severe ADL limitation.

The chronic conditions prevalent among women include diabetes, heart disease, osteoporosis, arthritis, high blood pressure, and cataracts (Munson, 1999; Collins, 1997; Barnes, 1997). Also, the risk of breast cancer increases with age, and the risks of other cancers of the reproductive system are present throughout women's lives. Women are more likely than men to have osteoporosis and osteoporotic fractures that may lead to serious injury (Collins et al., 1997).

Many of the health problems of older women tend to require coordinated or long-term care (Barnes, 1997; Sofaer and Abel, 1990). As a result, older women are also more likely than older men to receive health care services in non-acute care settings. One recent study concluded that women are more likely to use a post-acute provider (MedPAC, 1998). Others show that women account for as much as two-thirds of home health admissions in Medicare, and significantly predominate among long-term and high-utilization home health users (Centers for Disease Control, 1999; Freedman, 1999; Leon et al., 1997). Further, women make up four-fifths of nursing home residents over age 85 (Stone and Griffith, 1998).

Women also appear to be subject to health risks due to their status as informal caregivers. According to one study, nearly three-quarters of caregivers are women, and informal caregiving is more prevalent in Asian and African-American households than in Hispanic or white households (NAC and AARP, 1997). The stress and strain of caring for a family member has been found to be associated with chronic conditions, depression, and even increased risk of mortality (Schulz and Beach, 1999).<sup>8</sup> The additional impact of caregiving on access to health care is explained below in the discussion of non-financial barriers to access.

It is interesting to contrast the self-described health status of women and men. There is generally little difference between the genders in their self-described health status, except when the data are analyzed by income. Thirty percent of women and 30 percent of men report that their health is "good." Similarly, 29 percent of women and of men report "very good" health. There is only a slight difference among women and men reporting "poor or fair" health (24 percent for women versus 22 percent for men). Seventeen percent of women report "excellent" health, compared to 19 percent of men. There is, however, unexpected variability in self-reported health status when these data are analyzed by income. For instance, among the poorest beneficiaries, i.e., those with incomes less than 100 percent of poverty, 42 percent of older men report "poor" health, compared to 37 percent of women. For the most part, low-income women are consistently more likely than men to report "good" or "very good" health.

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<sup>8</sup> In the NAC/AARP study, a small percentage reported that their caregiving responsibilities caused them physical, emotional, or financial hardships. However, the reported impacts varied by such factors as income (low-income respondents are more likely to cite financial hardships) and intensity of caregiving duties (caregivers providing high levels of care are more likely to report physical or mental health problems, or emotional stress). The 1998 Commonwealth Fund Survey found that women caregivers reported higher incidences of poor health, chronic conditions, and depression, compared to other women. (Collins et al., 1999). A study of grandparents found that custodial grandparents report more of certain functional limitations (e.g., difficulty climbing stairs, completing daily household tasks), poorer health, and lower satisfaction with their health, compared to non-caregiving grandparents (Minckler and Fuller-Thomson, 1999).

It is not clear what conclusions can be drawn from these particular disparities in health status data. Self-reported health status is generally considered to be a reliable indicator of actual health status (Bierman et al., *Effective Clinical Practice*, 1999). Yet for the purposes of studying access, such an indicator is perhaps less helpful than measures like diagnoses, ADLs, and site-of-service patterns, which have more implications for policies affecting access.

## **OLDER WOMEN’S HEALTH COVERAGE AND OUT-OF-POCKET SPENDING**

Health care coverage patterns in the Medicare population are of paramount importance in estimating access to health care, especially for older women. This section analyzes health insurance coverage, and the adequacy of insurance coverage as a protection from health care costs. “Coverage” here generally means having a third-party source of financing; it may also refer to the comprehensiveness of the financing, e.g., types of services and products financed as well as levels of financing. The sense in which the term “coverage” is used will be clarified where not obvious from the context of the discussion. A separate analysis of beneficiary out-of-pocket costs forms the basis for assessing the adequacy of coverage in some detail.

### ***Key Findings***

**Women tend to outnumber men in the ranks of the uninsured in the 10 years preceding Medicare eligibility.**

**Medicaid figures more prominently as a source of health care coverage for older women than older men, while older men are more likely to lack any supplemental coverage.**

**However, among beneficiaries with private sources of supplemental coverage (i.e., Medigap or employer-sponsored), Medigap figures more prominently for older women than for older men.**

**Analysis of out-of-pocket spending for health care reveals certain disparities between older women and older men.**

- **Women, on average, spend a higher percentage of their incomes on health care than do men. The disparity widens with age.**
- **Women, on average, spend substantially more than men on short-term nursing home care, but substantially less on inpatient hospital care.**
- **Women tend to be more burdened by prescription drug costs than men.**

## **Health Insurance Coverage**

Health care insurance reduces the financial impact of receiving health care services; having health insurance may also increase an individual's likelihood of seeking needed care before needs become urgent or life-threatening. In a 1999 report on women's health, the Commonwealth Fund found that lacking health insurance for a period of time in the past year "steeply increase[s] the risk of going without needed health care or having difficulties obtaining health care when needed" (Collins et al., 1999).

**Health Insurance Prior to Age 65.** In the under-65 population as a whole, males are more likely than females to lack health insurance. The patterns of insurance coverage for men and women begin to shift as they grow older. In the 10 years preceding Medicare eligibility, women are more likely than men to be uninsured. In the population age 55 to 64, 16 percent of women and 13 percent of men are uninsured. In this pre-Medicare cohort, private insurance covers 74 percent of women, compared to 77 percent of men. Public insurance such as Medicaid covers 10 percent of women and 11 percent of men.

**Coverage After Age 65.** For women and men, Medicare coverage is essentially universal at age 65 and older. Medicare Part A, generally automatic, covers inpatient hospital and related services, including limited stays in skilled nursing facilities (SNFs) and some home health care. Part B covers physician services, other ambulatory care, and medical equipment and supplies. Part B enrollment is voluntary, and payment of premiums is required to enroll. Most beneficiaries participate in Part B as well as Part A. These two parts comprise the traditional, fee-for-service program. Beneficiaries also have the alternative option to participate in Part C, or Medicare+Choice, which offers other types of coverage through plans such as those sponsored by private managed care organizations.

Medicare as a whole is often credited with keeping many older people out of poverty, extending their life expectancies, and helping them maintain good health for as long as possible. Nonetheless, Medicare's current coverage is far from comprehensive. The program does not pay for outpatient prescription drugs, and beneficiaries are required to pay deductibles and coinsurance for most covered items and services. Indeed, the program covers, on average, only about half of beneficiaries' total personal health care expenditures, exclusive of the cost of insurance premiums (Westat, 1998). Gaps in Medicare coverage lead most beneficiaries to supplement Medicare with coverage from an additional source. Only about 8 percent of beneficiaries age 65 and older rely exclusively on Medicare.

Although weaknesses in Medicare coverage affect both men and women, women are more vulnerable to certain coverage gaps (OWL, 1999; Butler, 1996; Moon, 1990). For instance, while the program covers needed acute care for women and men, there are significant gaps in its coverage of the treatment of chronic diseases, many of which require prescription medications for lengthy or indefinite periods. Similarly, Medicare coverage for care in nursing facilities is extremely limited. Medicare covers no more than 100 days in a skilled nursing facility, following inpatient hospitalization. Between 20 and 100 days, residents are required to pay a high coinsurance amount, i.e., \$106 per day in 2000. Outside of this post-acute framework, Medicare

generally does not cover the costs of long-term care in nursing homes or in the community. The gaps in Medicare coverage are particularly difficult for older women, who are more likely than men to be chronically ill and to have lower incomes. This leaves women with higher out-of-pocket health expenses than men and less income with which to meet those expenses.

**Supplemental Coverage.** Private sources of supplemental coverage include Medigap plans as well as employer-sponsored plans; public sources include Medicaid, a medical assistance program administered by states and financed substantially with federal funding. Medigap coverage must be purchased by the individual, and employer-sponsored plans may require retirees to contribute to premium costs.

Older women are less reliant than men on Medicare as their sole source of health insurance coverage. Overall, 6 percent of women lack any form of supplemental coverage compared to 10 percent of men. Sixty-three percent of women and 65 percent of men in Medicare have private supplemental insurance. Although the majority of both men and women obtain this additional coverage through employer-sponsored plans, women are substantially less likely to do so. Among women with private supplemental coverage, 54 percent have employer-sponsored coverage and 46 percent have Medigap. Among men with private supplemental coverage, employer-sponsored coverage accounts for 62 percent of private supplemental coverage. Fifteen percent of women overall have Medicaid as a source of supplemental coverage, compared to 7 percent of men overall. Older women with incomes below the poverty threshold are much more likely than older men below the poverty threshold to purchase Medigap (20 percent versus 14 percent). Men are slightly more likely than women to be enrolled in Medicare+Choice (17 percent versus 15 percent).

Supplemental coverage, whether private or public, typically reduces and may eliminate beneficiary expenses for deductibles and coinsurance. In addition, Medicaid covers prescription drugs, and some private plans may also do so, to varying extents. However, Medigap does not cover the costs of long-term care, nor do employer-sponsored health plans for the most part.

### **Out-of-Pocket Health Spending**

Beneficiaries incur substantial out-of-pocket costs in the form of cost-sharing, premiums, and personal expenditures for necessary items and services not covered by Medicare. Thus, examining out-of-pocket spending provides a basis for assessing the adequacy of Medicare coverage. The data presented below are 1999 projections of beneficiary spending on insurance premiums (including Part B premiums), deductibles and coinsurance, and health care goods and services not covered by Medicare, such as prescription drugs, dental, and vision care. While the projections include the costs of short-term nursing home care, they do not account for the costs of home care or long-term nursing home care. The analysis compares out-of-pocket spending by women and men for the following categories: (1) overall; (2) insurance status; (3) age; (4) functional status; and (5) categories of spending (e.g., prescription drugs, hospital care, skilled nursing facility care).

**Out-of-Pocket Health Spending Overall.** On average, older women spend more out of pocket than older men, in actual dollars and as a percentage of income. In 1999, older women spent \$2,520, while men spent \$2,320. Moreover, largely because women tend to have lower incomes than men, women’s out-of-pocket spending consumes more of their annual income than is the case for men, 20 percent versus 17 percent, on average. Because of this difference between women and men in out-of-pocket spending ratios, much of the data below are presented in terms of percentage of income rather than actual dollars.<sup>9</sup> Differences in actual dollar spending, however, are reported by category of spending.

**Insurance Status and Source of Coverage.** Older women spend more out-of-pocket than older men, regardless of whether they have any coverage in addition to Medicare or the source of that coverage. As a more detailed analysis shows, Medicaid plays a pivotal role in protecting many older women from burdensome out-of-pocket health costs. The following data compare out-of-pocket spending by women and men in scenarios that first exclude, and then include, Medicaid as a source of coverage.

*Scenario of Beneficiaries Without Medicaid Coverage.* Among beneficiaries in the original fee-for-service program without Medicaid coverage, older women spend considerably more (four to five percentage points) of their income out-of-pocket on health care than men. This finding holds true regardless of whether they have private supplemental coverage (Medigap or employer-sponsored) or have no additional coverage at all (Table 1). Among those in the Medicare+Choice program, the difference is smaller (13 percent versus 11 percent).

*Scenario of Poor Beneficiaries Without Medicaid Coverage.* As shown in Figure 5 below, poor older women (those with incomes less than 100 percent of the poverty level) who do not receive Medicaid and have Medigap or employer-sponsored coverage spend more than half of their income (55 percent) out-of-pocket on health care; poor older men spend even more (61 percent). Poor older women with only Medicare spend 43 percent of their income on health care, compared with 33 percent for men. Poor older women who are in Medicare+Choice plans spend 39 percent of their income on health care. (There are too few poor older men in Medicare+Choice plans to make reliable estimates of their out-of-pocket spending.)

*Scenarios for Beneficiaries With Full or Partial Medicaid Coverage.* Among beneficiaries who are eligible for the entire year for *full* Medicaid benefits (referred to as “dually eligible” for Medicare and Medicaid), older women and men spend about the same

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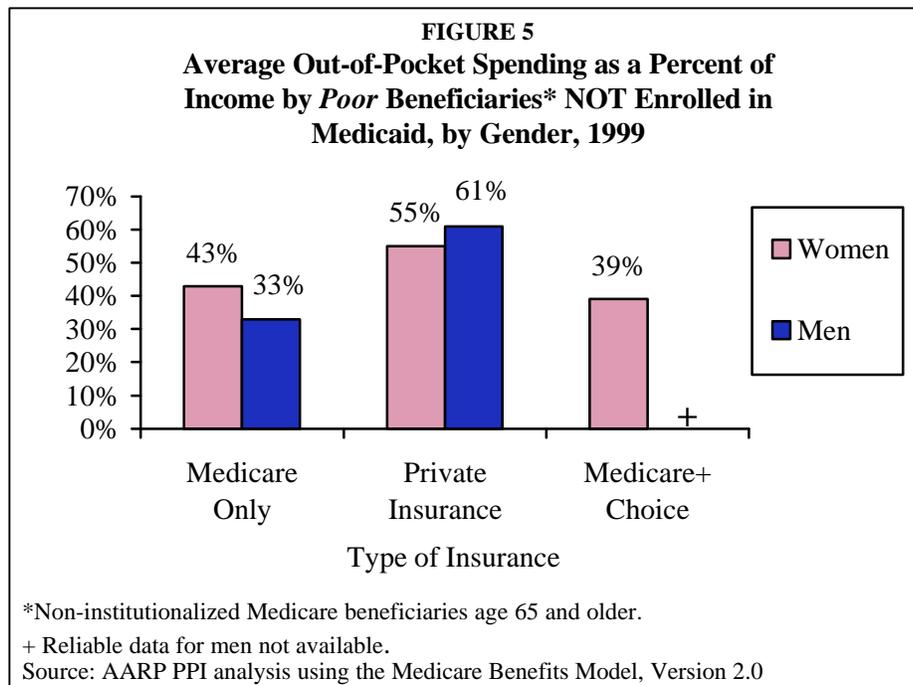
<sup>9</sup> To illustrate the potential burden of out-of-pocket health spending on older women and men, we focus in this section on health spending as a percent of beneficiaries’ income rather than on average out-of-pocket health spending. Because older women tend to have lower incomes than men (as discussed above), these results may imply greater gender differences in average health spending than is the case. For example, the difference in average out-of-pocket health spending between women and men age 85 and older is about \$65 per year (\$3,095 versus \$3,160, respectively). However, this difference becomes much more pronounced when expressed as a percent of income (27 percent of income for women versus 22 percent for men), largely because the income “gap” between older men and women tends to widen with age. Thus, in interpreting the results presented, it is important to bear in mind the differences in income distributions between women and men.

percent of income (5 percent and 4 percent respectively). However, gender differences are pronounced (about five percentage points) among those receiving *partial* Medicaid protection, as shown below. For instance, women receiving Medicaid assistance through the “QMB” program spend 14 percent of their income on health spending, compared to men in the QMB program, who spend 8 percent.<sup>10</sup> (Table 2)

**TABLE 1**  
**Average Out-of-Pocket Spending as a Percent of Income by Beneficiaries\* NOT Enrolled in Medicaid, by Gender, 1999**

	Amount		% of Income	
	Women	Men	Women	Men
<b>Employer-Provided Supplemental</b>	\$2,730	\$2,340	18%	14%
<b>Individual Medigap</b>	\$3,305	\$3,165	28%	23%
<b>Medicare Only</b>	\$2,865	\$2,230	24%	20%
<b>Medicare+Choice</b>	\$1,695	\$1,555	13%	11%

\* Non-institutionalized Medicare beneficiaries age 65 and older.  
Source: AARP PPI analysis using the Medicare Benefits Model, Version 2.0

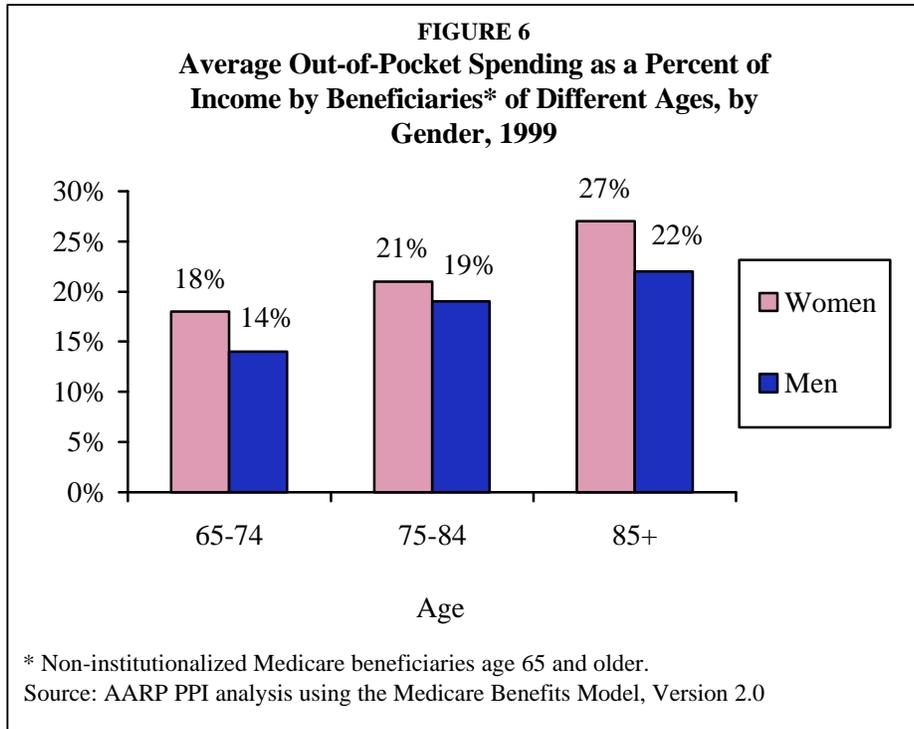


<sup>10</sup> Under the Qualified Medicare Beneficiary (QMB) program, state Medicaid programs pay Medicare Part B premiums and cost-sharing amounts for Medicare beneficiaries with modest resources (up to \$4,000 per individual or \$6,000 per couple) and incomes at or below the poverty level; under the Specified Low-Income Medicare Beneficiary (SLMB) program, Medicaid pays Part B premiums for beneficiaries who meet the QMB resource requirements and have incomes between 100 percent and 120 percent of poverty.

TABLE 2 Average Out-of-Pocket Spending as a Percent of Income by Beneficiaries* Enrolled in Medicaid, by Gender, 1999		
	Women	Men
<b>Full Year Duals</b>	5%	4%
<b>Full Year QMBs</b>	14%	8%
<b>Part Year &amp; SLMB</b>	31%	28%

\* Non-institutionalized Medicare beneficiaries age 65 and older.  
Source: AARP PPI analysis using the Medicare Benefits Model, Version 2.0

**Age.** The burden of out-of-pocket health spending increases with age, regardless of gender; the impact on women and men becomes more disparate, as well. By age 85 and older, women are spending 27 percent of their income out-of-pocket on health care, and men are spending 22 percent (Figure 6).



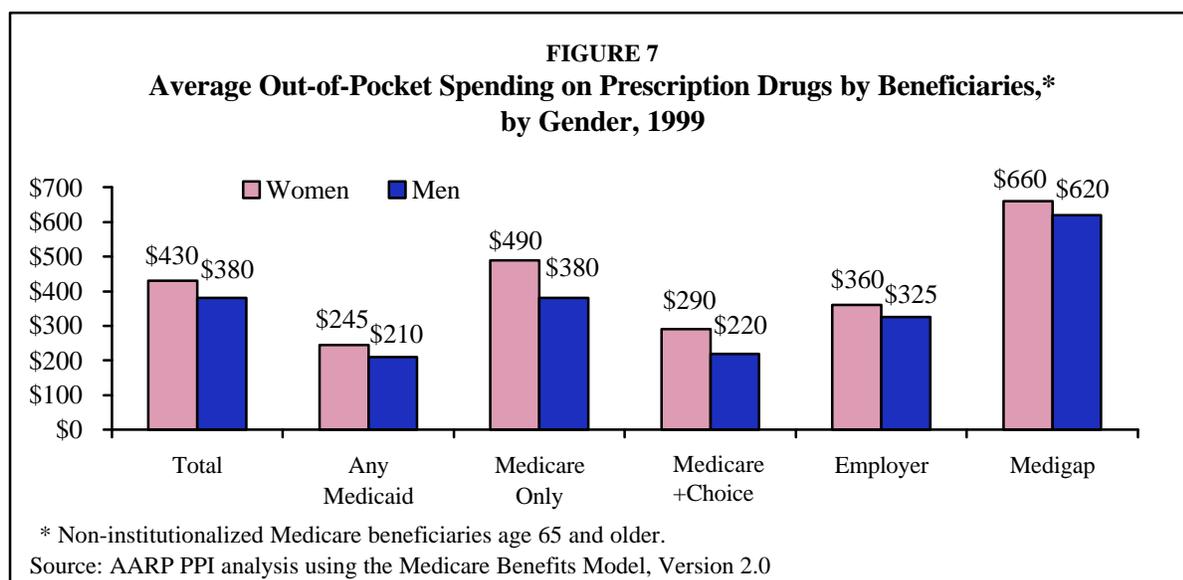
**Functional Status.** Functional status is associated with out-of-pocket spending levels. Older women and men with one or more severe limitations in their activities of daily living (ADLs) spend a much higher share of their income (33 percent and 29 percent respectively) than do those with no ADL limitations (20 percent and 16 percent respectively).

### Out-of-Pocket Spending for Goods and Services

The data below reflect actual health spending, rather than spending as a percent of income. Actual spending data make it possible to identify possible gender-related differences in patterns of service utilization. As noted above, total out-of-pocket spending figures encompass insurance

premium costs as well as payments for goods and services. The data presented below focus specifically on *spending for goods and services*, including inpatient and outpatient hospital care, short-term nursing facility care, physical/supplier/vision services, dental care, and outpatient prescription drugs.<sup>11</sup> Again, the data do not account for the costs of home care or long-term nursing home care.

On average, older women spend about \$160 more on health care goods and services per year than do men (\$1,400 versus \$1,240). Behind these averages, however, there are significant gender-related differences in spending by type of health care services and goods.



Two of the most prominent differences between women and men in their out-of-pocket spending are in the categories of hospital care and skilled nursing facility care. On a per capita basis, women spend less than half of what men spend out-of-pocket on inpatient hospital care (\$40 versus \$95), and about 30 percent less (\$50 versus \$75) on outpatient hospital care. Conversely, women spend over two times more than men on short-term nursing facility care, on average (\$270 versus \$110). (Because the sample used for this analysis does not include beneficiaries who were institutionalized for the entire year; these costs only reflect those for short-term nursing stays). These averages may reflect differences associated with gender in the utilization of these services.

Women also spend more out-of-pocket on prescription drugs, on average, compared to men (\$430 versus \$380). These figures only include direct spending on prescription drugs; they do not include the premium cost of drug coverage obtained through supplemental insurance coverage. Moreover, older women spend more out-of-pocket on prescription drugs, on average, than do older men, regardless of the type of supplemental coverage they have (Gibson and Foley, 2000). (Figure 7).

<sup>11</sup> Older women and men spend about the same (\$1,120 versus \$1,080) on premiums.

## NON-FINANCIAL BARRIERS TO ACCESS

### *Key Finding*

**Older women, even if they have adequate insurance coverage, may encounter barriers to health care, due to factors such as caregiving responsibilities, living arrangements, or provider attitudes.**

Persons who have health insurance may still lack full access to health care because of barriers that are not strictly financial (Reisinger, 1996). There is growing recognition of the importance of examining non-financial barriers, particularly in research about older persons, racial and ethnic groups, low-income groups, and between women and men (see Zuvekas and Weinick, 1999; Bierman et al., 1998; Martinez and Lillie-Blanton, 1996; Lillie-Blanton et al., 1996; Reisinger, 1996). Research and analysis about non-financial barriers that affect access can inform public policy debates as well as assist in the improvement of clinical processes. One researcher points out, “As policy makers strive to reform the U.S. system of financing and delivering health care services, it is important to advance the understanding of a broad range of factors that might affect the use of health services” (Lillie-Blanton et al., 1996).

Numerous non-financial factors may affect access to care – language, geography, education, living circumstances, availability of a regular source of care, and encounters with sexist, racist, or homophobic bias (“social distance”) in the health care system.<sup>12</sup> Older persons may encounter one or more of these non-financial barriers, particularly if they are members of ethnic, minority, or low-income groups.

Medicare data indicate that older women and older men are about equally as likely to report having difficulty obtaining care, and older men are generally more likely to report that they have no regular source of care (Westat, 1998). However, as the following data and discussion show, other non-financial barriers to access may, nonetheless, have specific implications for older women.

**Caregiving Responsibilities.** As mentioned previously, women play a major role as “informal caregivers” (Collins et al., 1999).<sup>13</sup> In 22 million U.S. households, there is an unpaid caregiver, defined broadly as one who performs various daily living or personal care tasks for a person age 50 or older (National Alliance for Caregiving and AARP, 1997). The economic value of informal caregiving has been estimated at \$196 billion (Arno et al., 1999). Caregiving tasks range from household chores to medication management, and might include coordinating the services of formal care providers, and organizing financial matters.

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<sup>12</sup> The term “social distance” is used in Marilyn M. Falik’s introduction to *Women’s Health: The Commonwealth Fund Survey*, 1996. In a subsequent chapter of the same book, Lillie-Blanton refers to the role of a “shared social bond” between a provider and patient that may influence the quality of their interaction.

<sup>13</sup> Women also predominate in the paid caregiving sector. By one estimate, women comprise 90 percent of the providers in long-term care settings. (Hartmann, 1991).

A report of the 1998 survey of women's health by The Commonwealth Fund states: "Caregiving responsibilities appear to fall on women uniformly, regardless of income, race, or even marital status. The extent of their responsibilities, however, does vary with family resources" (Collins et al., 1999). According to another study, nearly three-quarters of caregivers are women, and informal caregiving is more prevalent in Asian and black households than in Hispanic or white households (NAC and AARP, 1997). Although the average age of a caregiver is 46, this study also found that 12 percent of caregivers are age 65 and over, and caregivers who report that they perform the most intensive caregiving tasks are more likely to be at least 65 years old as well. In addition, census data have shown an increase over the last generation of grandparents caring for grandchildren. In one study, 77 percent of caregiving grandparents were women. The mean age of these caregivers was 59 (Fuller-Thomson et al., 1997).

More is known about the impact of caregiving responsibilities on the health status of caregivers than about the impact on their access to health care. However, the 1998 Commonwealth Fund Survey found that caregiving women "were also twice as likely to report problems getting the health care they need for themselves" (Collins et al., 1999).

**Living Arrangements.** Living arrangements are another potentially relevant factor in the broader context of care delivery for older persons. Among older Medicare beneficiaries, women are more likely to live alone, and men are more likely to live with a spouse. In general, slightly less than half (47 percent) of older beneficiaries are living with a spouse, while roughly equal proportions live alone (26 percent) or with others (27 percent). Thirty-five percent of women live alone, compared to 14 percent of men. Women are only slightly more likely to live with others than men, 29 percent and 26 percent respectively. Only 36 percent of women, compared to 60 percent of men, live with a spouse.

Viewed another way, 77 percent of beneficiaries living alone are women. While poor women are especially likely to live alone, a substantial proportion of poor men live alone, too. Seventy percent of poor women and 49 percent of poor men live alone.

Although the possible link between living arrangements and health status is a subject of interest to researchers, study results are inconclusive.<sup>14</sup> In any case, living arrangements may indicate something about the presence of informal support, which is relevant to questions of access to care as well as health risk.

**Sensitive Care.** "Cultural competence" is gaining recognition in the field of public health as an influential factor in health care delivery. According to one definition, cultural (and linguistic) competence is "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (HHS Office of Minority and Women's Health, 1999). A policy paper from the National Center for Cultural Competence asserts:

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<sup>14</sup> It is commonly hypothesized that living alone is associated with social isolation and limited functioning. However, some findings support the assertion that persons living alone may be advantaged by virtue of their freedom from "nurturant responsibilities" that accompany sharing a household. For examples of articles in which these themes are explored, see Anson (1988) and Sarwari (1998).

The delivery of high-quality primary health care that is accessible, effective and cost efficient requires health care practitioners to have a deeper understanding of the socio-cultural background of patients, their families and the environments in which they live (Cohen and Goode, 1999).

Older women, depending upon their age and background, may experience or confront cultural issues in health care delivery that ultimately affect their access to care. In a study of access focusing on persons age 80 and over, researchers noted that “this vulnerable population subgroup has special needs not necessarily addressed in routine practice.” In addition to such factors as adequate health insurance, transportation, and social supports, “physician knowledge of geriatric practice and use of effective physician-patient communication are important mediators of the impact of access on outcomes” (Bierman et al., 1998).<sup>15</sup> Because women strongly predominate among persons age 80 and over, they are more likely than men to experience any access problems that may result from lack of geriatric knowledge or sensitivity in the health care field.

In addition, it appears that lesbian women, at any age, frequently confront insensitive providers to an extent that affects their access to care. A 1999 report from the Institute of Medicine (IOM) suggests that lesbians seeking access to mental and physical health care services encounter “personal and cultural barriers, including attitudes of health care providers and the lack of cultural competency among providers for addressing the needs of lesbian clients” (IOM, 1999; see also Deevey, 1990). The IOM recommends, among other measures, increased public and private support for research to assess and improve lesbians’ access to physical and mental health services.

## **Part II: Implications of Medicare Reform Proposals**

**Framework for Analysis.** Part I of this Issue Paper presents information on demographic profiles, health insurance coverage patterns, levels of out-of-pocket spending on health care, and non-financial factors affecting access to care. These types of information are necessary in formulating Medicare policy that responds to older women’s health care needs. This information also informs initial assessments of recent Medicare reform and restructuring proposals. From a beneficiary perspective, the core questions to be asked about any proposal revolve around the potential impact of reform on benefits and out-of-pocket costs, and whether non-financial access barriers are addressed in any way.

Medicare policy should be subjected to review and analysis in all facets of its impact on access. Without regard to gender, the challenges that policy reformers must address are well defined. These challenges include the persistence of poverty among older people, especially non-whites;

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<sup>15</sup>The authors measured access in three dimensions: primary access is the financial ability to seek, and the practical ability to obtain timely care; secondary access involves the availability of health care appointments and professionals; and tertiary access relates to provider awareness and clinical knowledge and skills, e.g., knowledge of geriatric practice.

the variability of private insurance coverage as population cohorts age; and the high burden of out-of-pocket costs. Moreover, in light of the differences between older women and older men, it is critical specifically to question the potential impact of reform in areas where particular concerns for women have been identified.

Experts reviewing the results of The Commonwealth Fund's 1993 national survey of women's health concluded: "For women, who rely disproportionately on Medicaid and Medicare, the potential restructuring of these programs and constraints on financing them may have an impact on the ability to gain access to health care or on the quality of care received" (Collins and Leiman, 1996). The principal concern is the exposure of older women to high health care costs. This may be explained by various factors or combinations of factors, such as the high rates of poverty among older women, the lack of a full "fit" between Medicare benefits and women's health needs, or the possibility that women have less access to affordable private supplemental coverage. Concerns about the non-financial barriers to access include questions about the cultural competence of providers, and broader issues about burdens that older women may shoulder as caregivers or as older persons living alone.

With these considerations in mind, the following analysis focuses on selected Medicare reform options that have particular relevance for women. One reference point is the work of the National Bipartisan Commission on the Future of Medicare. The Commission was convened in 1998 and adjourned one year later without agreeing on an official recommendation. Through its hearings and deliberations, this body of Medicare experts nonetheless succeeded in developing a number of reform options. Some of these options would incrementally modify the current structure of the Medicare program. Others were developed for consideration as a package of initiatives that would be combined to restructure Medicare entirely. Where these options appear in the discussion below, they are treated as independent reform proposals and not as the product of the Commission. Indeed, a number of the proposals discussed by the Commission continue to be explored by lawmakers and Medicare policy experts.

### **Privatizing Medicare: The "Premium Support" Approach**

One sweeping proposal is to transform Medicare from a "defined benefit" insurance program to a system of "premium support." As a defined benefit program, Medicare guarantees a certain level of financing for a specified package of covered health care services. In general, under a premium support approach, each beneficiary would select an approved private health plan to provide his or her Medicare coverage. Beneficiaries could select among different plan prices as well as benefit designs. Medicare would contribute a share of the plan's premium and the beneficiary would pay the added amount, if necessary, to purchase the plan of her choice. Proposals vary as to the comprehensiveness of Medicare coverage under the selected plan. Various premium support models and designs have been examined (Wilensky and Newhouse, 1999; Aaron and Reischauer, 1995), with special attention focused on the Federal Employee Health Benefits Program (Caplan and Foley, 2000; Merlis, 1999). A Medicare premium support design would likely require plans to cover the existing package of Medicare benefits, and some proposals would call for plan options to include prescription drug coverage. Other design variables relate to possible

differences among approved plans in cost-sharing arrangements and additional benefits offered. Some proposals would leave the traditional Medicare fee-for-service program intact as a continuing option for all beneficiaries, while other proposals would replace or substantially alter the fee-for-service option.

For the most part, proponents of premium support believe that competition among private plans for Medicare enrollees would help contain health care costs in the long run. While some analysts also focus on the prospect for improved benefits offerings under premium support (Aaron and Reischauer, 1995), others are reluctant to endorse restructuring while adding new program costs (Wilensky and Newhouse, 1999). Critics of premium support question that premium support will contribute to health care cost containment, drawing attention to the likely financial impact on beneficiaries (Moon, 1999; Smith and Rosenbaum, 1999). These experts are concerned about how a premium support system would distribute the burden of health care cost increases over time, and whether the value of the core benefits now guaranteed under original Medicare could be maintained. Low-income beneficiaries may be particularly at risk for such problems with premium support.

Premium support also raises a possibility of unmanageable adverse selection (see McClellan and Skinner, 1999). The concern is that healthy individuals with low health care costs would purchase low-cost coverage, leaving higher cost beneficiaries aggregated in expensive risk pools where they may not be able to afford the coverage they need. It has also been suggested that fewer plan options could mean poorer quality of care provided to low-income beneficiaries (Sheils et al, 1999).

It is difficult to assess premium support fully without reference to a specific model or proposal, given the varying design features that could be incorporated. However, in light of the general policy considerations just mentioned, it is clear that premium support may have important implications for women, who are frequently among the most vulnerable Medicare beneficiaries. Because they are more likely than men to be poor or low income, women are more in need of protections from burdensome health care costs. Without specific protections built into a premium support structure, women would feel the effects of cost increases more severely if their premiums and cost-sharing burdens increase. Further, adverse selection in the insurance market could result in fewer plan options and more access barriers for women, who tend to have more chronic, long-term health problems.

Because gaps in the Medicare benefit disproportionately affect older women, they also have more at stake than older men in the debate about Medicare benefits under premium support. Under one scenario, Medicare would offer, at a minimum, the package of benefits now guaranteed under traditional Medicare and Medicare+Choice. Variations on the core benefits package might include a prescription drug benefit. Affordable prescription drug coverage would unquestionably be beneficial to older women in Medicare, as discussed more fully below. However, unless explicitly defined as a core benefit under premium support, prescription drugs might simply be an add-on benefit in some plans, which beneficiaries might choose to finance with higher premiums (Smith and Rosenbaum, 1999). At the same time, existing core benefits do not always adequately cover other types of health care important to women, such as care in skilled nursing facilities

(SNFs). Premium support proposals should be scrutinized for benefit reforms that address a range of existing coverage gaps.

### **Increasing the Age of Eligibility**

Some policy experts support increasing the age of Medicare eligibility from age 65 to age 67 (Wilensky and Newhouse, 1999; American Medical Association, 1997). In addition to modest long-term cost savings that could be achieved, the most frequently cited policy rationale is that Medicare's age of eligibility should be aligned with that for Social Security, for consistency across federal programs. The age of eligibility for full Social Security retirement benefits is being increased by phases to 67. Opponents of this proposal assert that increasing the age of eligibility would only increase the total number of uninsured people, causing particular hardships for aging adults at the time they are likely to experience increased health care costs. Older workers, early retirees, and others nearing age 64 are among the most vulnerable to loss of affordable insurance coverage (see McDevitt, 1998).

Concern about the decline in private insurance coverage in the pre-retirement population has in fact led to proposals to *lower* the age of Medicare eligibility. These proposals typically provide for a voluntary "buy-in" program for certain groups of pre-retired persons, such as those age 62-64. Individuals in these groups who are not otherwise eligible to enroll in Medicare could elect to purchase coverage. The premium rate for someone "buying in" would be determined by actuarial principles, without federal subsidies such as those applied to persons who are eligible for full Medicare benefits. The buy-in opportunity could be extended to the age 65-67 group in conjunction with an increase in the age of eligibility, or simply enacted for some defined under-65 group. In any case, it is not clear that an unsubsidized buy-in program could be designed with a premium structure that would make the option affordable for all who would qualify.

The age of Medicare eligibility has particular relevance for women. Women nearing retirement age (age 55 to 64) are more likely than men of the same age to be uninsured. Thus a change in policy to delay eligibility may disproportionately affect women. In any case, it should be noted that Medicaid is a significant source of coverage for this age cohort, covering 16 percent of women and 13 percent of men age 55 to 64. It is predictable that increasing the age of Medicare eligibility would shift a portion of Medicare costs to Medicaid and other public programs.

As for expanding insurance options prior to Medicare eligibility, women in particular could benefit from an opportunity to buy into Medicare before age 65, again because they are particularly at risk for lack of coverage from age 55 to 64. However, the relevance of a "buy-in" option depends, as already noted, on a program design that is widely affordable by both women and men.

### **Introducing a Prescription Drug Benefit**

Many Medicare reformers have placed heavy emphasis on the need for Medicare to provide a prescription drug benefit. The current lack of such a benefit is considered to be a significant coverage gap. According to some estimates, about one-third of non-institutionalized beneficiaries

lack any coverage for prescription drugs, while many others incur substantial out-of-pocket costs despite having coverage in some form (Gross and Brangan, 1999). Without adequate coverage for prescription drugs, many beneficiaries who are vulnerable to high out-of-pocket costs may forgo needed treatments.

Older women are particularly at risk for poverty or low incomes, high out-of-pocket health costs, and chronic conditions that require prescription drugs to treat. There is little question that prescription drug coverage or improved coverage options would be particularly beneficial for many older women. However, proposals to add a Medicare prescription drug benefit or otherwise expanding coverage for older persons must be analyzed carefully. The potential impact of such reforms depends upon how the program is designed and financed.

Reform options may take several forms, including: proposals for universal Medicare coverage; assistance to lower-income and poor beneficiaries only; a high-option “buy-in” through Medicare or Medigap; and increased roles for state Medicaid programs. Options also vary according to the intended level of government subsidy; cost-sharing and out-of-pocket spending caps; and methods of managing the benefit. Each specific proposal must be evaluated separately for its likely impact on total out-of-pocket costs. For instance, without substantial government subsidies and risk pooling to avoid adverse selection, additional beneficiary premiums could be unaffordable for many women.

### **Assuring Access to Care in Post-Acute Settings**

Some Medicare reform proposals directly address payment policy for care in post-acute settings such as skilled nursing facilities (SNFs), rehabilitation centers, and beneficiaries’ homes.<sup>16</sup> Certain proposals may build on recent reforms or correct their effects, while others are unrelated to the changes already underway in this area of the program. In any case, Medicare policy on post-acute care is particularly relevant for older women, who tend to use these benefits more and for longer periods of time.

**BBA Payment Reform.** As just noted, changes in payment for post-acute care are already under way. Before 1997, the costs of SNF and home health care, including rehabilitative therapies, were among the fastest rising Medicare costs. In an effort to contain these costs, Congress enacted the Balanced Budget Act of 1997 (BBA), which, among its provisions, made significant changes in how home health agencies and SNFs are reimbursed. In 1998 and 1999, Congress made some refinements to the BBA post-acute payment reforms. Once these provisions are fully implemented, SNFs and home health agencies will be paid prospectively, on the basis of estimates of the cost of an individual beneficiary’s care, rather than a cost basis. Currently, officials are studying whether and how to make similar changes in payment policies for rehabilitation facilities and long-term care hospitals.

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<sup>16</sup> For simplicity, the term “post-acute” denotes covered care provided in these settings after hospitalization and “sub-acute” care that may be provided under the Medicare home health benefit.

One purpose of a prospective payment system is to remove provider incentives to provide and bill for excessive or unnecessary care, and to encourage providers to build cost-efficiency into their operating systems.<sup>17</sup> How these new incentives may affect beneficiaries is of some concern. Researchers to date have concluded for the most part that the BBA has not reduced beneficiary access to post-acute care. However, notes of caution have been recorded, warning that the new payment policy could make it more difficult for beneficiaries in “high needs” categories to get all the services they need (MedPAC, 1999; GAO, 1999).

Depending on the results of ongoing research, additional refinements in post-acute payment policy may be necessary to protect beneficiary access to post-acute care in the fee-for-service program. Older women have somewhat more at stake than men in the post-BBA debate because they are more likely to receive Medicare-covered care in post-acute settings. Additional information about the impact of the BBA will clarify if any needed refinements should take the form of payment adjustments, expanded coverage, increased beneficiary rights to reviews and appeals, or other measures.

**Coinsurance in Post-Acute Care.** Some Medicare reform proposals call for changes in the structure of coinsurance in original Medicare. Currently, the requirements for deductibles and coinsurance vary greatly depending upon the specific benefit. For instance, most Part B coinsurance is set at 20 percent of the approved fee charged by a provider. In contrast, SNF coinsurance, required under Part A, is \$106 per day beginning on the 21<sup>st</sup> day of SNF care. Further, home health care services carry no coinsurance requirement. With this variation, site of service as well as utilization may be an important factor in a beneficiary’s coinsurance burdens, whether reflected in direct expenditures or supplemental premium costs.

Reform options range from mandating coinsurance for home health to combining Parts A and B coinsurance requirements, requiring a single annual deductible and a uniform coinsurance rate. Either of these measures could have significant implications for many older women, given their low-income status and post-acute care utilization rates.

A coinsurance requirement for home health care services would affect women, who are predominant users of the home health benefit, more than men. A combined, single annual deductible and coinsurance rate would have to be considered carefully for its potential impact on older women. Further understanding of the differences between older women and older men in site of service and utilization is critical. It appears that post-acute care figures more prominently, and inpatient care less prominently, for older women. Women would benefit from changes in coinsurance requirements that have the effect of making SNF stays more affordable for all. As users of the SNF benefit, older women living alone might have increased access to supportive care following hospitalization. In addition, older men with spouses would have access to more supportive care before needing assistance from their caregivers, most of whom are women.

In assessing proposals to change Medicare cost-sharing requirements, it is important to note that gender differences in cost-sharing burdens remain, despite supplemental coverage, which many

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<sup>17</sup> Hospitals have been paid on a prospective payment basis since 1984.

women purchase in the private market. As the analysis of out-of-pocket costs showed above, women with any form of private supplemental coverage tend to have higher out-of-pocket health expenses than their male counterparts.

## **Conclusions**

Given the financial vulnerabilities of older women, the most important Medicare reforms are the ones that address the availability, adequacy, and affordability of health care. Some of the current reform proposals are encouraging in their approach to deficiencies in Medicare coverage in general and those affecting women in particular. A prescription drug benefit and cost-sharing reform that results in more options for receiving post-acute care are notable in this respect. Other proposed reforms are more problematic, especially ones, such as premium support, that favor privatization. There are serious questions as to whether a Medicare premium support system would be affordable for many beneficiaries in the long run. Furthermore, based on what is currently known about the situation of older women, it appears that premium support could place this group at significant risk for increased out-of-pocket costs and diminishing plan and benefit options. Similar concerns arise in the context of proposals to raise the age of Medicare eligibility. This reform would reduce access for everyone age 65 to 67, but could affect women to a greater degree in that they appear to have fewer coverage options in the years preceding the current age of eligibility. Some form of a Medicare buy-in option would help to offset this potential problem. It appears, however, that policymakers will be challenged to design a buy-in program that would be affordable for women and others who need it most.

One aspect of health coverage that should not be overlooked in the Medicare reform debate is the role of Medicaid. These state medical assistance programs figure prominently for many women throughout their lives. For other women, Medicaid plays a major role for the first time in their later years as a program to cover the costs of long-term care. In addition, federal and state policymakers continue to be challenged to implement effective programs to reduce the out-of-pocket health costs of low-income Medicare beneficiaries (Rosenbach and Lamphere, 1999).

A focus on Medicaid as part of the debate about health care financing for older persons could provide a needed opportunity to confront the challenge of developing policies for long-term care. For the older women who are living with chronic conditions and often without the support of a life partner, access to long-term care is a critical concern, especially as their health and functional status decline. To enact Medicare reform without attention to this concern is to neglect a major weakness in current policy – a weakness with significant implications primarily for women.

As discussed at the end of Part I, gaps in health care coverage are not the only barriers to access. Non-financial barriers may be a problem for poor older women, who face a type of “multiple jeopardy,” which describes the combined factors of age, gender, race, and poverty. Medicare was created primarily to address financial barriers to access. Some policy experts would assert that Medicare’s only purpose is to protect its beneficiaries from unreasonable health care costs that could lead to impoverishment, or further impoverishment, and premature health decline. Yet the program, by its size and scope, affects the health care delivery system in ways that are not strictly financial. For instance, Medicare frequently leads other purchasers in monitoring and

assuring health care quality. Indirectly, by its coverage decisions, the program often influences the direction and pace of medical research. In light of these types of impacts, it is reasonable to question whether or how Medicare policy shapes access to health care in ways not solely limited to coverage.

Recent Medicare proposals, for the most part, fail to address health care access outside the insurance coverage framework. The noted exceptions are a few of the proposals to “modernize” Medicare in the sense of giving the program tools and authorities to act as a large health care purchaser. Proponents of this approach assert that a large “modern” health care purchaser does more than process and pay claims or administer provider agreements. Beyond this fiscal role, a purchaser such as Medicare could act in concrete ways to promote the health and welfare of its beneficiary base. Activities might include aggressively pursuing disease prevention and health promotion, or joining broader public initiatives to improve health care delivery. Medicare has traditionally addressed the broader issues of health care access through its funding of research and demonstration projects, but rarely through its regular programmatic agenda. The Healthy Aging project, a joint effort of HCFA and other divisions of the Department of Health and Human Services, is a model worth studying. Through the Healthy Aging initiative, HCFA is developing tools for health promotion that can be made available to Medicare beneficiaries, providers, and other interested parties. Perhaps a similar approach or another model could be devised for Medicare to play a role in identifying and removing some of the more serious access barriers not solely attributed to lack of insurance coverage. In any case, further research is required to better understand the multiple factors that may interfere with the ability of older women and older men to seek and obtain needed health care.

Current knowledge, however, clearly points in certain directions for many older women. For instance, researchers using the Commonwealth Survey found that less educated and poorer women need targeted health promotion and disease prevention messages, so that they are aware of the importance of seeking timely health care services. Since Medicare covers certain preventive and screening services, such as mammograms, Pap smears, and bone density measurement, there is a clear rationale for developing policies to increase the effective delivery of these services. Non-financial barriers to access may be more difficult to address in the context of Medicare reform. The enduring policy challenge is to maximize Medicare’s value to its more vulnerable beneficiaries. These include many women who are poor, live in ethnic or minority communities, or who live alone and lack informal support. Enhanced insurance coverage would increase, but not necessarily be sufficient to guarantee, their access to health care services.

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