

By Alina Salganicoff

Women and Medicare: An Unfinished Agenda

Gaps in coverage and high out-of-pocket spending on long-term services and supports continue to disproportionately affect older women.

For fifty years, Medicare has played a critical role in promoting economic security for older women in the United States. Today, Medicare serves 24 million women ages 65 and older, representing 56 percent of older adults enrolled in the program, and provides them with financial protection at a time in their lives when they have the greatest need for medical care and often the fewest family and economic resources. The passage of Medicare in 1965 marks a key milestone in women's economic security and a major contribution to reducing income inequality in old age between men and women.

Medicare did not routinely cover Pap smears until 1990 and did not cover screening mammography until 1991.

Viewing Medicare through a gender lens can help illuminate its programmatic strengths and shortfalls, which often are masked when the program is considered in aggregate. There is no doubt the program has made a critical difference in the lives of millions of women. Gaps in coverage, however, notably the lack of coverage for long-term-care services and supports (LTSS) and high out-of-pocket spending continue to place a disproportionate burden on women.

These gaps still can lead to sizable and sometimes crushing financial burdens for many women and their caregivers.

The Status of Older Women Before Medicare

In the years prior to the passage of Medicare, societal norms left many women at a considerable social and economic disadvantage. For older women, these “norms” translated into higher rates of financial insecurity and fewer social supports. Although workforce participation of women had been rising since the 1940s, in 1965, only 39 percent of women were in the paid workforce (compared to 81 percent of men) (Bureau of Labor Statistics, 2014). Among women with full-time jobs, the gender wage ratio, also known as the “wage gap,” was 60 percent (Blau and Kahn, 2007). This meant that women not only were less likely to earn an income through work, but that when employed, they earned a lower wage than men. (You only have to watch an episode of *Mad Men* to see how this discrimination played out in the workplace.)

This meant women not only accrued fewer savings throughout their lives, but also, unless they were married, they had limited access to retiree benefits, particularly pensions. In 1966, the year that Medicare was first implemented, one-third of women ages 65 and older lived in

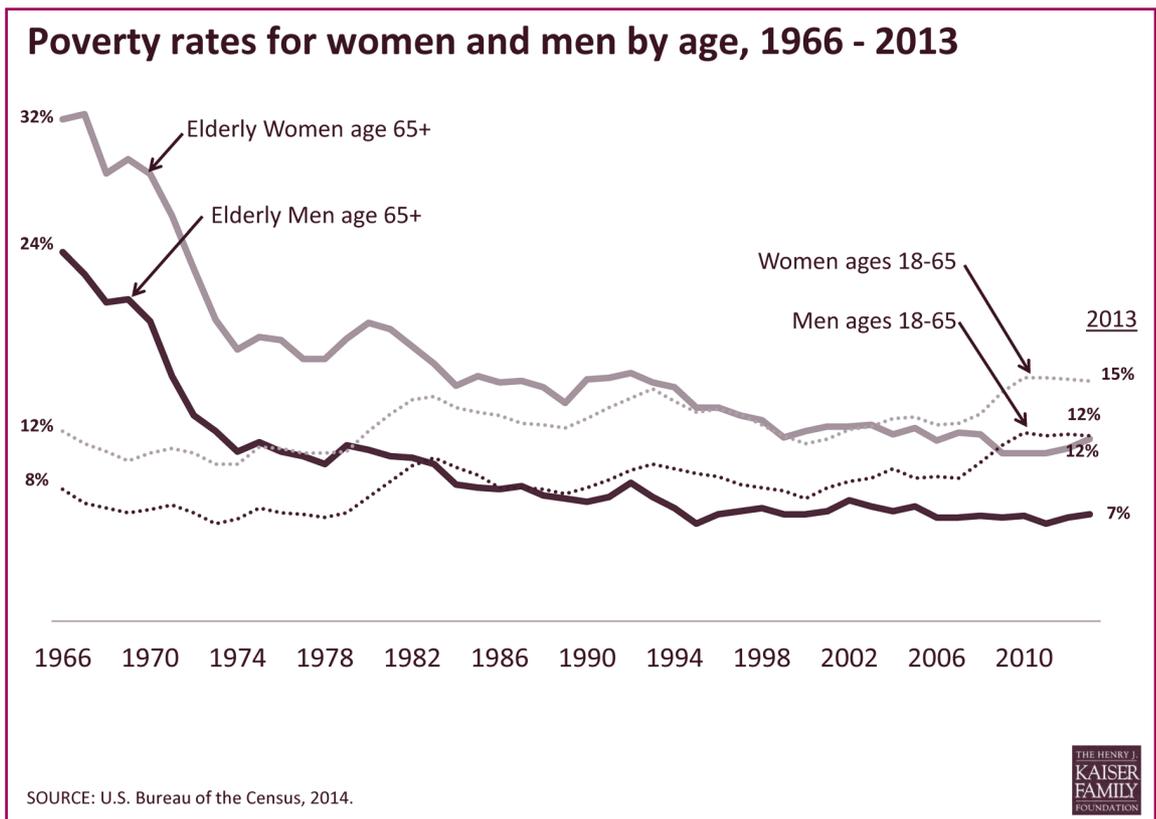
poverty, compared to nearly a quarter of men (U.S. Census Bureau, 2014). The poverty rates of working-age adults were considerably lower at the time. Nearly fifty years later, only one in ten women ages 65 and older live in poverty. That rate is still nearly twice that of men (see Figure 1, below).

In the 1950s and 1960s, the share of working-age Americans with hospital insurance was rising, with nearly three-quarters reporting access to that financial protection. In contrast, coverage rates for older Americans were far lower, with just over half of older adults (56 percent) in 1965 reporting any kind of insurance for hospital care (Harris, 1966). The share of older women with coverage likely was even lower, given their weaker workforce attachment and higher likelihood of living alone or being widowed by the time they passed their prime working years.

There is little published information about gender-based differences in health status, use of healthcare, and the economic burden of healthcare costs for older Americans in the era predating Medicare. What we do know is that in 1960, women turning age 65 could expect on average to live nearly sixteen more years—three years longer than men—and the top five causes of death for women were heart disease, cancer, cerebrovascular disease, accidents, and influenza and pneumonia (National Center for Health Statistics, 1965). These conditions often required medical care and hospitalization, but did not result in protracted periods of disability that necessitated paid or unpaid family care.

Since it was signed into law fifty years ago, the Medicare benefit package has expanded and evolved in ways that have provided additional assistance to older women to cover healthcare.

Figure 1.



When the program was first enacted, the benefit package had a strong focus on hospital care, which was similar to most private insurance plans available at the time. Preventive care and prescription drugs were not typical insurance benefits, as they are today. Medicare did not routinely cover Pap smears until 1990 and did not cover screening mammography until 1991 (Gornick et al., 1996). Once it provided coverage for these services, it required 20 percent co-insurance, which meant that women still could have significant out-of-pocket payments for these preventive services as well as for clinical breast exams, bone density tests, and pelvic exams—sometimes resulting in barriers to care.

Women represent about two-thirds of all residents of nursing homes and residential care communities.

In 2010, when the Affordable Care Act (ACA) was passed, coverage of recommended clinical preventive services under Medicare was broadened by the elimination of any cost-sharing for preventive services rated as highly effective by the independent United States Preventive Services Task Force, including mammograms, Pap smears, and bone density screenings. Also included was no-cost coverage of a personalized health plan with an annual comprehensive risk assessment, which for women is comparable to a “well woman” visit.

Another long-standing gap in Medicare was the absence of drug coverage. While women use more prescription drugs throughout their lifetime, after age 65, men catch up, and by the time they are in their 80s, the use rates are similar (Centers for Disease Control and Prevention [CDC], 2013). In 2003, the Medicare Modernization Act established Medicare Part D, offering prescription drug coverage to Medicare beneficiaries through new private stand-alone drug plans, as well as Medicare Advantage plans. Particularly important to

women who are disproportionately low-income, the drug benefit offered the Low-Income Subsidy of premium and cost-sharing subsidies for low-income beneficiaries. Not surprisingly, women make up the majority of the beneficiaries who qualify for the subsidy, largely because they have lower income and fewer assets (Meijer, Karoly, and Michaud, 2009).

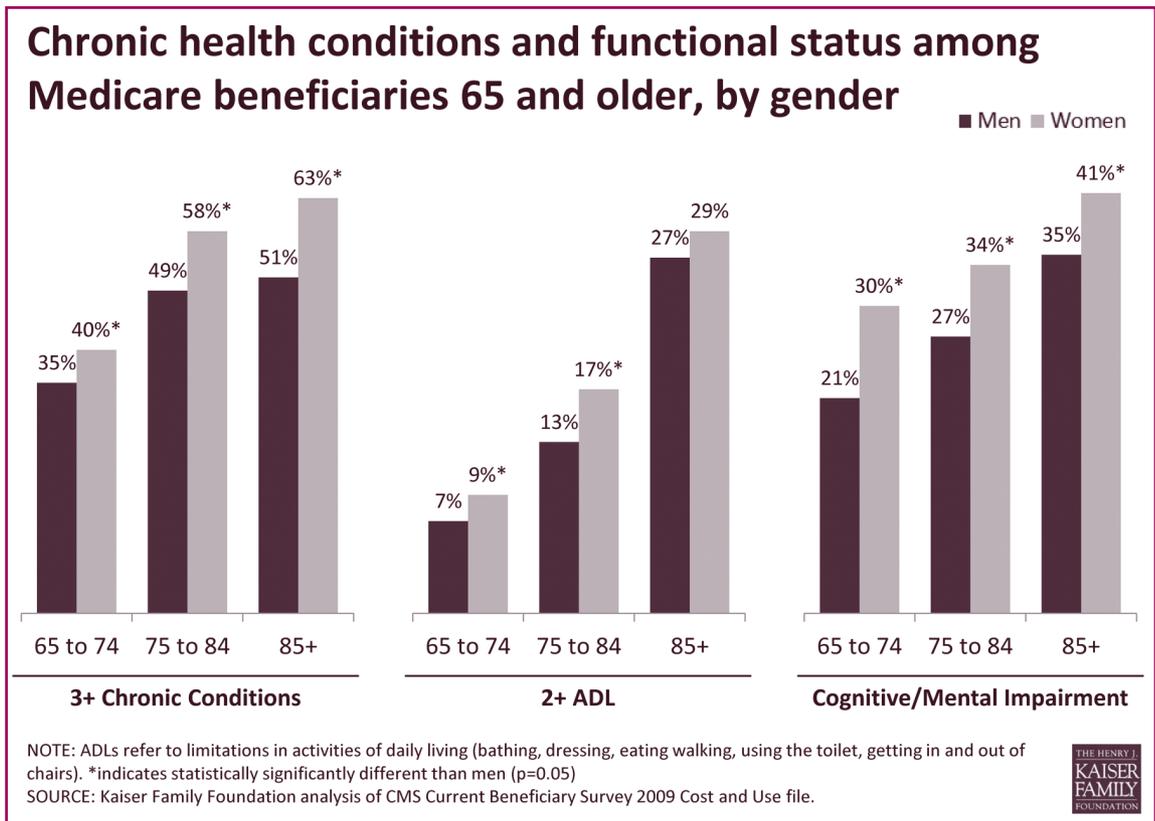
A Profile of Women on Medicare Today

Today, in contrast to fifty years ago, more is known about gender-based differences and disparities, when it comes to health, social supports, and financial security. We know women and men can have differential risks for the same diseases, experience different symptoms for the same conditions, and receive different levels of treatment by healthcare providers (Institute of Medicine [IOM], 2001, 2010).

While older women today still experience longer lifespans than men, the gap has decreased to five years (CDC, 2013). Compared to men, however, women have higher rates of chronic illnesses, often with physical and cognitive impairments such as memory loss or dementia that limit functionality and hinder their ability to live independently (see Figure 2, page 46).

Social and economic circumstances continue to affect women’s need for support. Despite the dramatic fall in poverty rates over the past fifty years, older women still find themselves at an economic disadvantage compared to men. Because women have lower paying jobs than men during their working years, and because many work part time or leave the workforce for periods of time to raise families or care for aging family members, they receive lower average Social Security and pension benefits than men. Among Medicare beneficiaries ages 65 and older, women have lower median per capita income than men (\$21,853 compared to \$27,480), as well as considerably lower median financial assets and retirement savings (\$65,802 versus \$93,371) (Kaiser Family Foundation, 2013). Women older than age 65 are widowed at nearly three times the rate of

Figure 2.



men (44 percent versus 14 percent), attributable to women’s longer life expectancy, the tendency for women to marry men who are slightly older, and higher remarriage rates for widowers (to younger women). Women also live alone at twice the rate of older men (38 percent versus 19 percent). As women age and their health needs grow, these social challenges translate into greater need for informal and paid LTSS.

Out-of-Pocket Costs

Despite providing important benefits, Medicare still falls short for many women and men. On average, it only covers half of healthcare costs, with individual payments and supplemental insurance policies filling in the rest (Centers for Medicare & Medicaid Services [CMS], 2010). It does not pay for hearing aids, eyeglasses, or

dental care, nor does the program cover extended nursing home stays or personal care needs, all critically important to most older adults. In addition,

One quarter of Certified Nursing Assistants and 13 percent of Home Health Aides had Medicaid coverage, which is indicative of their very low incomes.

Medicare charges relatively high cost-sharing, with deductibles in 2015 of \$1,260 per benefit period for Part A inpatient care, \$147 for Part B medical services, and up to \$320 for Part D drug benefits (CMS, 2015). Furthermore, most Medicare benefits, including physician visits and prescription drugs, are subject to copayment or co-insurance. Medicare Parts A and B, which co-

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ver outpatient visits and hospital care, also have no limit on out-of-pocket spending.

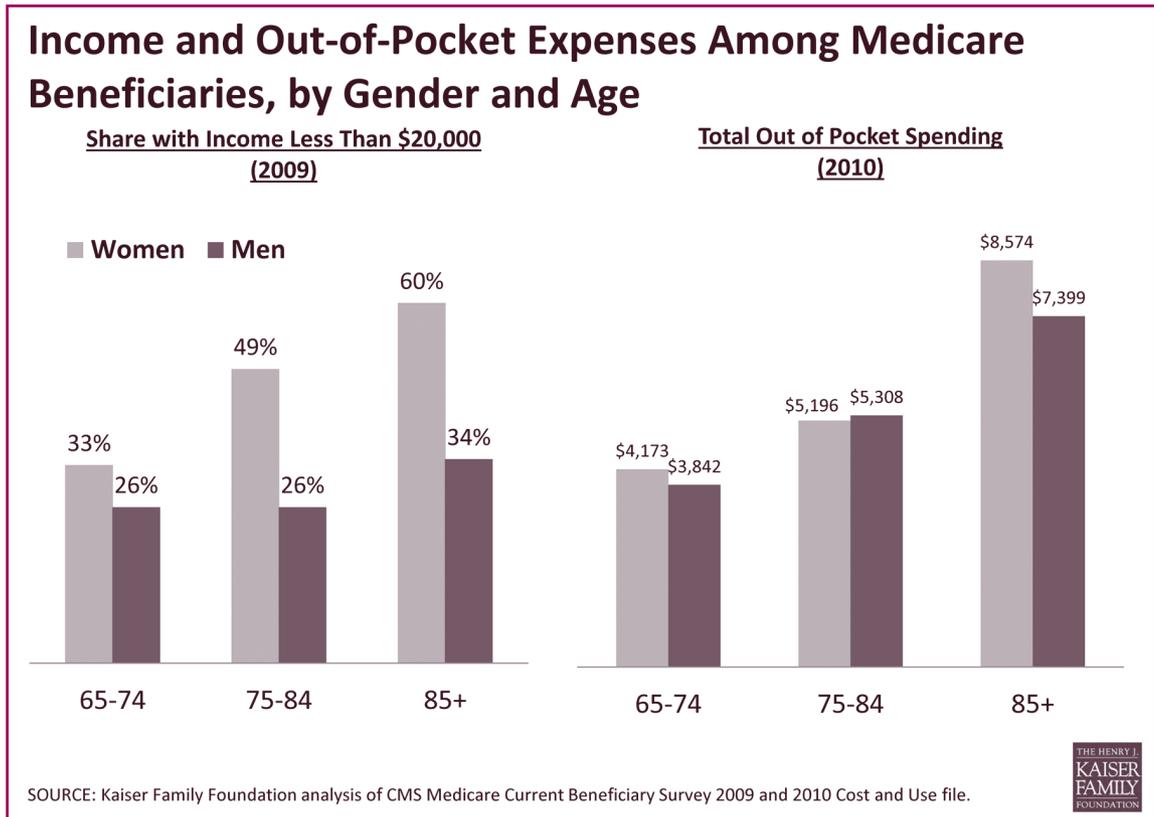
Gaps in benefits and cost-sharing requirements, together with spending for premiums for Medicare and supplemental coverage, result in high out-of-pocket expenses for many people on Medicare. Again, older women shoulder a disproportionate share of the cost. Older women on average in 2010 spent more on healthcare (including premiums) than older men (\$5,036 versus \$4,363) (see Figure 3, below). For all older Medicare beneficiaries, out-of-pocket spending escalates with age, but women ages 85 and older, in particular, have considerably higher out-of-pocket costs than older men, largely due to their poorer health status, greater social isolation, and dependence upon paid LTSS. Notably, among women ages 85 and older, spending on LTSS was 50 percent higher (\$3,954) than it was

for men (\$2,694) (CMS, 2010). Among women ages 85 and older, 60 percent have incomes below \$20,000 per year, which could make the costs associated with LTSS extremely difficult to shoulder.

**Supplemental Coverage:
The Critical Role of Medicaid**

To help cover Medicare’s benefit gaps and cost-sharing charges, most Medicare beneficiaries have supplemental insurance, either as a benefit from their current or former employers, as coverage they purchase separately, or through Medicaid because they are poor. Coverage patterns are largely similar between men and women with the exception of supplemental coverage through Medicaid, where women are more likely to qualify and enroll for this assistance because of their disproportion-

Figure 3.



ately higher rates of poverty (Kaiser Family Foundation, 2013).

Medicaid supplemental coverage provides critical assistance to 17 percent of older women on Medicare, paying for Medicare premiums and cost-sharing, and often covering the costs of eye-glasses, vision care and, even in some states, dental care and hearing aids. Critically, Medicaid also pays for institutional and community-based LTSS for most of these “dually eligible” individuals. Again, because they are more likely to live in poverty and qualify for Medicaid, women comprise more than two-thirds (68 percent) of dually eligible Medicare and Medicaid enrollees ages 65 and older, and nearly 80 percent of those ages 85 and older (CMS, 2011). Reflecting the higher poverty rates among minority women, Medicaid also assists a significant share of African American and Latina women on Medicare. Dually eligible beneficiaries typically face more health problems and have more intensive medical and long-term-care needs than the general Medicare population.

Long-Term Services and Supports

Long-term services and supports either are provided at home by family and friends or through home- and community-based services, such as home healthcare, personal care, and adult daycare; or in formal institutional settings such as nursing homes or residential care facilities. Given their health needs and higher rates of living alone, often without the social supports and resources needed to live independently in the community, women are more likely than men to need LTSS (Salganicoff et al., 2009). Women represent about two-thirds of all residents of nursing homes and residential care communities (Harris-Kojetin, 2013). Furthermore, as women age, a larger share end up permanently residing in a long-term-care facility, with one in five women ages 85 and older living in a long-term-care facility for the full year, twice the rate of their male counterparts (Salganicoff et al., 2009).

Yet, Medicare offers time-limited coverage for long-term-care services provided in facilities or in the community, covering care only in the period following a hospitalization. Only Medicaid and private long-term-care insurance pay for nursing home and home health services—other types of supplemental coverage do not. This type of care is very expensive for older adults and their families. A year in a semi-private room in a nursing home in 2011 cost approximately \$78,000 (\$87,000 for a private room), the average annual cost for personal care is \$9,000, and the average rate for a home health aide is \$21 per hour (MetLife Mature Market Institute, 2011). As a result, given the health and functional status of many older women, Medicare falls far short of meeting their long-term-care needs over time, and exposes many women (and their families) to high out-of-pocket costs when they can no longer live independently and require assistance for extended periods of time.

The LTSS Gap Also Affects Caregivers

The LTSS coverage gap has implications not only for frail elderly women, but also for their unpaid or informal caregivers, who are predominantly women. (A survey of family caregivers finds that nearly two-thirds are women.) Compared to men, they are more likely to provide higher levels of care, for more hours a week, and, not surprisingly, are more likely to report experiencing emotional stress as a result of their caregiving responsibilities (National Alliance for Caregiving and AARP, 2004). They also are less likely to work outside the home than men and are more likely than men to report that their caregiving responsibilities have led them to make adjustments to their work life, including such things as reporting late to work, leaving early, taking time off, taking a leave of absence, or leaving the workforce entirely. Many of the same employment challenges that left their mothers at financial risk are replayed among daughters who are caregivers—departures from the paid work-

force, or taking jobs that have low wages or only part-time hours, and fewer benefits.

Despite the high costs of long-term care, there is projected to be a serious shortage of paid direct care workers (IOM, 2008). Among the paid long-term-care workforce, the vast majority of direct care workers are women, who typically earn just above minimum wage (Khatutsky et al., 2011). A 2007 survey found that 95 percent of home health aides (HHA) and 92 percent of certified nursing assistants (CNA) were women and many of them also were unpaid family caregivers. The survey found that 39 percent of CNAs and 30 percent of HHAs reported that they also care for a child or a family member with a disability or illness. In general, these workers receive low wages, experience high turnover, and have low rates of paid sick leave and retirement benefits or pensions. It is notable that one-quarter of CNAs and 13 percent of HHAs had Medicaid coverage, which is indicative of their very low incomes. This group of working women also is at risk of experiencing significant health problems and high medical expenses when they become eligible for Medicare (Khatutsky et al., 2011).

Conclusion

In the fifty years since the program was enacted, both society and Medicare have evolved. In contrast to working age adults, poverty rates for older adults have plummeted. Medicare has been transformative in terms of promoting access to medical care for millions of women, and lessening the financial burdens associated with that care. Despite progress on a number of fronts, older women still experience relative economic

disadvantage, greater burdens of physical and functional limitations, and lower rates of social and community supports.

For many women, the absence of coverage for LTSS can expose them to crushing costs that cut into the limited resources available to them for basic needs like food and housing. Originally, the ACA established the Community Living Assistance Services and Support (CLASS) Act, a program that provided some assistance with long-term-care costs for older adults (Gleckman, 2011). But this voluntary insurance program ultimately was repealed by Congress, again leaving a large gap for LTSS other than Medicaid, which is still available only to the poorest women.

In the coming years, policy makers will continue to be faced with difficult choices about the structure of Medicare. In particular, solutions still are needed to address the lack of available financing for LTSS—a policy priority for women, both as patients and as caregivers. For caregivers, both family members and paid workers, efforts to ensure equal pay, paid family leave, and living wages could go far to indirectly address the financial challenges faced by these providers. Finally, focusing a gender lens on policy will help policy makers recognize that programmatic changes that could potentially reduce public costs and increase out-of-pocket medical spending could have a disproportionate impact on older women, many with a limited capacity to absorb additional costs. 

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