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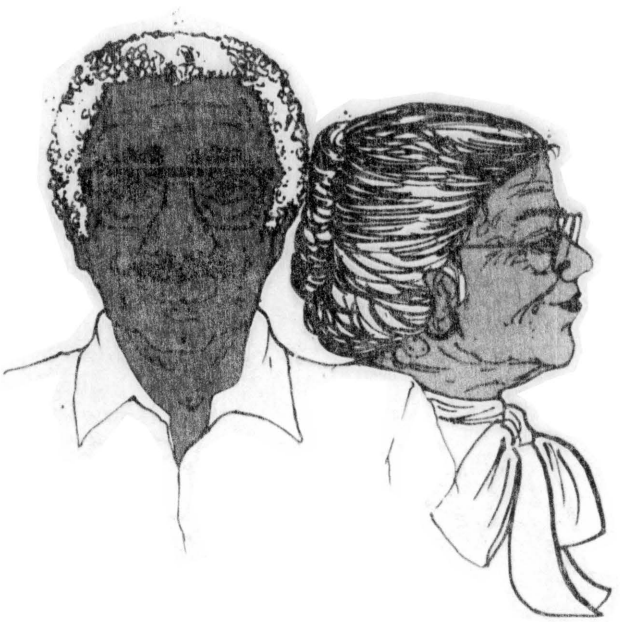

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III

THE EFFECTS OF REAGANOMICS ON HEALTH AND NUTRITION OF THE MINORITY ELDERLY

by

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Members of this audience will not be surprised to learn that the minority elderly are relatively worse off in terms of health and nutrition than are the Anglo elderly. While the average life expectancy at birth for Anglos in the United States is approximately seventy-four years, the average life expectancy for minority groups is only sixty-nine years. Minority elderly are consistently found to be in poorer physical health than their Anglo counterparts, regardless of how health is measured. Despite their poorer health, use of health care services by the elderly is not consistently greater among minorities than among Anglos. Minority elderly report less frequent outpatient visits to physicians and dentists than do older Anglos, but they tend to be hospitalized more frequently and for longer lengths of stay than the Anglo elderly. The greater use of hospital services is due to a combination of factors including poorer health, delaying medical care until the later stages of illness and greater dependence on the hospital biased Medicare and Medicaid programs. Furthermore, the quality of health care services accessed by minority elderly is not equal to that accessed by Anglo elderly. For example, older minorities are less likely than Anglo elderly to use private physicians, and are more likely to use hospital clinics and emergency rooms (Eve and Friedsman, 1980).

The poorer health of older minorities and the inequity of their access to health care services both have their roots in the same place--economics. The cumulative effects of a life-long lower standard of living among minorities results both in poorer health and in fewer financial resources with which to access the health care system when it is needed. Because of their smaller incomes, older minority aged are

even more dependent than Anglo aged on government sponsored health insurance programs like Medicare and Medicaid. Let us turn now to an examination of changes in those programs as well as in the nutrition programs which occurred in 1982 and those changes which are proposed for the 1983 federal budget and explore the possible impact of the changes on the elderly, especially the minority elderly.

MEDICARE

Medicare was enacted in 1965 as Title XVIII of the Social Security Act. It is a federal health insurance program for people 65 and older, for people of any age with permanent kidney failure and for disabled persons under 65 who meet certain requirements. The Medicare program has two parts--hospital insurance (Part A) and medical insurance (Part B). Part A is financed primarily through payroll taxes and pays primarily for hospital care as well as for post-hospital skilled nursing facility care and medically necessary home-health care. Part B is an optional voluntary program which is financed jointly by premium charges to enrollees and the federal government. It pays primarily for 80 percent of reasonable charges for outpatient physician visits. Both the hospital insurance and medical insurance require the beneficiaries to pay deductibles and coinsurance charges. Although Medicare is the primary health insurance program for the elderly, it only covers approximately 40 percent of the total per capita health care costs of the elderly. The major health care expenses which are not covered by Medicare include custodial long-term care, out-of-institution prescription medicines, dental care, eyeglasses and hearing aids (Leadership Council of Aging Organizations, 1981; pp. 6-7; U.S.D.H.H.S., 1982).

Last year, the Congress approved cuts of $1.5 billion in the Medicare program for FY 1982. A large portion of these savings were achieved by increasing the cost-sharing liability for elderly beneficiaries including a 25 percent increase in the Part A and Part B deductibles and coinsurance amounts.

For FY 1983, the President proposed and Congress has approved significant cutbacks in the Medicare program in spite of the fact that public opinion polls indicate that the majority of Americans are opposed to Medicare cutbacks for the elderly under any circumstances (Aging Services News, March 29, 1982; p. 4). As enacted, the FY 1983 budget resolution calls for a $5.25 billion cut in Medicare over the next three years, including a $3.6 billion cut in 1983.

The highlights of the FY 1983 budget cuts in Medicare affecting direct costs to beneficiaries include: (1) indexing Part B Supplemental Medical Insurance deductible to the Consumer Price Index which will raise the deductible from the current $75 to $80 in FY 1983 and $89 in 1985; (2) increasing the Part B premium from $12.20 in 1982 to $13.20 in FY 1983; (3) requiring home health co-payments of 5 percent for all beneficiaries; and delaying eligibility for Medicare to the first day of the month following the month in which a person becomes 65. (Leadership Council of Aging Organizations, 1982; p. 8; Aging Services News, June 25, 1982, pp. 2-3).

According to the Leadership Council on Aging Organizations,

> ". . . these proposals seem predicated on the notion that the elderly should bear a greater portion of their health care costs under Medicare in order to increase their cost-consciousness. However, the elderly already are extremely

> cost-conscious--paying about 45 percent of their total health care expenditures out-of-pocket. They simply cannot afford to absorb additional cost-sharing under Medicare. In addition to further burdening the elderly with increased cost-sharing, the proposal to institute a co-payment for home-health services under Medicare is basically counter-productive. It reduces the incentives for Medicare beneficiaries to use those more cost-effective services rather than more costly skilled nursing facility care." (Leadership Council of Aging Organizations, 1982, p. 8).

The highlights of the FY 1983 cuts in Medicare affecting providers include: (1) limiting routine hospital costs for ancillary services; (2) setting Medicare limits on all physician services in a hospital or Skilled Nursing Facility when Medicare patient charges are involved; (3) freezing the physician fee economic index in 1983 and allowing only a five percent increase in 1984; and (4) reducing reimbursement rates to radiologist and pathologists to 80 percent of reasonable charges for those accepting assignment. (Aging Services News, June 25, 1982, pp. 2-3; Washington Report, July 8, 1982; p. 1).

The Leadership Council of Aging Organizations has summarized the probable impact of these provider cuts as follows:

> "While these cuts are directed at providers, it is extremely questionable whether either hospitals or physicians will absorb the majority of the cuts in reimbursement. Rather, the more likely result will be cost-shifting to private pay patients/private third-party insurers and again, Medicare beneficiaries.
>
> . . . While this proposal may reduce federal Medicare expenditures in FY 1983, it does little, if anything, to address the more serious problem of the hospital cost explosion in general, which will continue to create ever increasing pressure to make future cuts in Medicare.
>
> Many of the proposed 'provider cuts' are targeted on physician reimbursement . . . With only about 46 percent of physicians accepting Medicare assignments (i.e., accept as payment in full what Medicare determines to be the reasonable charge for the service or procedure provided), it is apparent that

> the majority of physicians already consider Medicare reimbursement levels to be inadequate. Therefore, reductions in physician reimbursement rates likely will lead to even fewer physicians accepting assignment, with more beneficiaries being required to pay excess charges in addition to Medicare's $75 annual Part B deductible and 20 percent co-insurance for physician services. In FY 1979, for example, excess charges totalled $1.1 billion; with Medicare reimbursement rates reduced and fewer physicians accepting assignment, this figure could increase dramatically--placing an ever increasing cost-sharing burden on beneficiaires." (Leadership Council of Aging Organizations, 1982, pp. 10-11).

Finally, in FY 1983, employers will be required to extend to older workers the same health coverage offered younger workers and Medicare will become the secondary payer on insurance claims for employees 65-69 and their spouses. This represents a major shift in responsibility from the federal government to the employer and will almost surely serve as a strong disincentive for employers to hire or retain older employees. (Leadership Council of Aging Organizations, 1982; p. 12; Washington Report, July 8, 1982; p. 1).

MEDICAID

The Medicaid program was established in 1965 as Title XIX of the Social Security Act. It is a federal-state matching program which provides medical assistance for low-income persons who are aged, blind, disabled or members of families with dependent children. Of the approximately 22 million persons who are covered by Medicaid, 3.6 million are aged. All states except Arizona currently participate in the program. The federal government's share of the program costs currently varies between 50 and 78 percent of the total costs depending on the per capita income in each state.

There are two categories of beneficiaries in the Medicaid program.

The first category are the categorically needy who must be coffered. The categorically needy are recipients of AFDC and SSI. The second category of possible recipients are the medically needy, whom states have the option of covering or not covering. The medically needy are persons who are aged, blind, disabled or members of families with dependent children whose incomes fall below the state standard for income assistance when medical expenses are deducted. Currently, only 34 states offer this optional coverage.

There are also two categories of services offered by Medicaid, (1) mandatory and (2) optional. Mandatory services which every state must offer include inpatient and outpatient hospital services, skilled nursing facility (SNF) services for those over 21; home health services for those entitled to SNF care, and physicians' services. Optional services that are most directly relevant to older adults include intermediate care, facility care, prescription drugs, eyeglasses and dental care.

Medicaid is the major health care program in the United States which addresses the long term care needs of the elderly although the program is strongly biased in terms of institutionalized care rather than home based care. Currently, 42 percent of the total Medicaid budget is spent on long term care. Approximately half of all nursing home expenditures in the U.S. come from Medicaid. (Leadership Council of Aging Organization, 1982; p. 13).

In the Omnibus Budget Reconciliation Act of 1981, Congress approved major cuts in the Medicaid program for FY 1982. The major change

was a reduction in the federal share of Medicaid payments to states of 3 percent in FY 1982, 4 percent in FY 1983 and 4.5 percent in FY 1984. Prior to implementation of the Reconciliation Act, states were already having serious funding problems with their Medicaid programs. In January 1981 more than half of the states were reporting moderate to serious funding problems with many states taking action to limit services and restrict eligibility in order to ease their funding crises. The changes in the Omnibus Budget Reconciliation Act have only served to exacerbate an already dismal situation (Leadership Council of Aging Organizations, 1982; p. 14).

In the FY 1983 budget request, President Reagan requested and Congress has approved a 5 percent reduction in funds from the FY 1982 budget, which is a drastic reduction considering that Medicaid costs have been escalating at a rate of 15 percent annually in recent years. While legislation to meet the budget resolution's targets has not been passed, the Finance Committee of the Senate has made four proposals for achieving these savings.

The first proposal would permit states to impose nominal co-payments of from $.50 to $3.00 on categorically eligible and medically needy Medicaid beneficiaries for most services, except those to pregnant women and children. While the purpose of this proposal is to increase beneficiary cost-sharing as well as encourage beneficiaries to think twice before using health care services, the copayments, if adopted, could cause beneficiaries to postpone obtaining needed care until their illnesses or injuries reached crisis proportions, resulting in higher treatment costs in the long run. Nursing home residents,

who are already required to spend all their income except a personal needs allowance on their care, would not be affected by the proposal (Leadership Council of Aging Organizations, 1982; p. 16; Washington Report, July 8, 1982; p. 3).

The second proposal would:

> "permit states to attach the real property of Medicaid residents who are 'permanent residents' of long term care facilities. States may recover the cost of medical assistance provided to the recipient only when the property is 'no longer needed' by the recipient, spouse or minor children. To discourage attempts to avoid the provisions of this proposal, the states would be allowed to deny Medicaid eligibility temporarily to long term care residents who dispose of their homes for less than their fair market value . . . This provision would not apply to situations where the resident has a reasonable expectation of being discharged from the facility. Likewise, it would not apply when the title to the home is transferred to a spouse or a minor or a handicapped child. (Washington Report, July 8, 1982; p. 3).

The major effect that this proposal could have is to deter some eligible elderly individuals in need of nursing home care from obtaining that care because of fear of losing their homes (Leadership Council of Aging Organizations, 1982; p. 16).

The third proposal is to require states to reduce their Medicaid rates to 3 percent beginning in fiscal year 1983. The fourth proposal is to eliminate the federal matching payments for the monthly Medicare Part B premium payment, as proposed by President Reagan in his budget proposal in February, 1982. (Washington Report, July 8, 1982; p. 3). The ultimate effects of the third and fourth proposals could be to raise Medicaid costs, which could result in program reductions extending to long term care.

Overall, the effect of the proposed Medicaid cuts is to reduce federal program costs by shifting them to states, beneficiaries and their relatives. As discussed above, states already are having funding problems with Medicaid. The beneficiaries are by definition low income individuals who can least afford increases in out-of-pocket expenditures for health care. Finally, as with the Medicare proposals, these proposals do nothing about the real problem of inflation in the health care sector which will continue to push up the costs of the Medicaid program.

NUTRITION

The three major nutrition programs which affect the elderly are the Food Stamp program, Congregate Nutrition program and Home-Delivered Meals program. The Food Stamp program increases the food purchasing power of low income persons by enabling them to buy food with food stamp coupons. The federal government bears the full cost of the coupons and shares the administrative costs with the states. Of the 20 million current recipients of food stamps, 2 million are over 60 and more than half of those 2 million are minorities. In the Omnibus Budget Reconciliation Act, more than two billion dollars was cut from projected expenditures in FY 1982 by delaying scheduled inflation adjustments for three months, freezing the standard deduction, prorating the first month's benefits, and cancelling the lowering of the amount above which older people could deduct their medical expenses (Leadership Council of Aging Organizations, 1982; p. 21). While President Reagan asked for a $2.3 billion cut for FY 1983, Congress only approved a $900 million cut (Older American Reports, June 25, 1982; p. 4).

These savings will be achieved primarily through delays in cost of living increases in food stamp benefits.

Congregate Nutrition programs and Home Delivered Meals are funded under Title III-C of the Older Americans Act. The proposed changes in those programs have been summarized by the Leadership Council of Aging Organizations as follows:

> "The FY '83 budget request represents a 10 percent cut from the FY '81 appropriation in the combined allotments for congregate and home-delivered meals and USDA commodity support. This reduction will result in 14 million fewer congregate meals and 4.5 million fewer home-delivered meals than were served in FY '81. In addition, if no reduction were proposed, 22 million fewer congregate meals and 9 million fewer home-delivered meals can be funded in FY '83 than were provided in FY '81 due to the loss of purchasing power resulting from an annualized inflation rate of 8 percent. Therefore, the total reduction in service from FY '81 to FY '83 due to both the proposed budget cut and inflationary pressures will be 36 million congregate meals and 13.5 million home-delivered meals. When viewed in the context of other budget proposals which reduce funds for energy assistance, housing, and food stamps, there will be an even greater need to insure that older people are provided congregate and home-delivered meals. (Leadership Council of Aging Organizations, 1982; p. 30).

CONCLUSIONS

In conclusion, while these changes in the funding of health and nutrition programs are color-blind in the sense that all poor elderly are affected, they will have greater impact on the minority elderly than on the Anglo elderly becuase older minorities are more dependent on these programs than are the Anglos. Older Blacks and Hispanics have been and continue to be far more likely to be living in poverty than Anglo elderly. In 1980, nearly 40 percent of older Blacks and one-third of older Hispanics had incomes below the poverty line compared to 14 percent of Anglos. In almost all the program cuts affecting

the elderly poor, minority aging organizations estimate that approximately 40 to 50 percent of those affected will be minority elderly. Unfortunately, under present national policy, it seems that older minorities who can afford it will pay more for health care and food, and that those who cannot pay more will be forced to do without.

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