The WOW-GI National
Elder Economic Security Standard:

A Methodology to Determine Economic Security for Elders

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and

Wider Opportunities for Women

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The National Elder Economic Security Initiative

The Elder Economic Security Initiative (EESI) at Wider Opportunities for Women (WOW) offers a conceptual framework and concrete tools to shape public policies and programs to promote the economic well being of older adults, whether or not they have the capacity to be fully self-reliant or are in need of certain public supports to age in place with dignity and autonomy. The EESI combines coalition building, research, education, advocacy and a media strategy at the community, state and national level.

Undergirding the EESI is the WOW – Gerontology Institute at the University of Massachusetts Boston National Elder Economic Security Standard (Elder Standard), a new tool for use by policy makers, older adults, program providers, leaders in the aging advocacy community and the public at large. Developed by the Gerontology Institute at the University of Massachusetts Boston and WOW, the Elder Standard is a measure of income that older adults require to maintain their independence in the community and meet their daily costs of living, including affordable and appropriate housing and health care.

Through the development and use of the Elder Standard, the Elder Economic Security Initiative will put into action strategies to promote a measure of income that respects the autonomy goals of older adults and their realistic income needs in today's marketplace, rather than a measure of what we all struggle to avoid—abject poverty.

Wider Opportunities for Women

Wider Opportunities for Women (WOW) works nationally and in its home community of Washington DC to achieve economic independence and equality of opportunity for women and girls at all stages of life. For over 40 years, WOW has been a leader in the areas of nontraditional employment, job training and education, literacy, welfare to work and workforce development policy. Since 1995, WOW has been devoted to the self-sufficiency of women and their families through the national Family Economic Self-Sufficiency project (FESS). Through FESS, WOW has helped to reframe the national debate on social policies and programs from one that focuses on poverty to one that focuses on what it takes families to make ends meet. Building on FESS, WOW has expanded to meet its intergenerational mission of economic independence for women at all stages of life with the Elder Economic Security Initiative. For more information about WOW's programs go to www.wowonline.org or call WOW at 202-464-1596.

Gerontology Institute, John W. McCormack Graduate School of Policy Studies, University of Massachusetts Boston

Under the direction of Laura Henze Russell, the Institute researches and calculates the Elder Economic Security Standards for states. For more information about the Institute, or work related to the Elder Economic Security Standard, please contact Laura Henze Russell, Director of the Economic Security Standard Project, Gerontology Institute at the University of Massachusetts Boston, by telephone at (617) 287-7313 or by email at Laura.Russell@umb.edu.

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Copies of the report can be downloaded at www.wowonline.org.

The Wider Opportunities for Women – Gerontology Institute National Elder Economic Security Standard: A Methodology to Determine Economic Security for Elders

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The development and release of the methodology could not have been accomplished without the work of Laura Henze Russell, Director, Elder Economic Security Standard Project, University of Massachusetts Boston Gerontology Institute; Ellen A. Bruce, Associate Director, University of Massachusetts Boston Gerontology Institute; Ramsey Alwin, Associate Director of National Programs and Policy, Wider Opportunities for Women; Deborah Cutler-Ortiz, Director of National Programs and Policy, Wider Opportunities for Women; and Joan Kuriansky, Executive Director, Wider Opportunities for Women.

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PREFACE: The Elder Economic Security Initiative (EESI) And The WOW-GI National Elder Economic Security Standard

The Elder Economic Security Initiative (EESI) at Wider Opportunities for Women (WOW), a multi-year project, offers a conceptual framework and concrete tools to shape public policies and programs to promote the economic well being of older adults, whether or not they have the capacity to be fully self-reliant or are in need of certain public supports to age in place with dignity and autonomy. The EESI combines coalition building, research, education, advocacy and a media strategy at the community, state and national level. The EESI was launched in July 2005 with the generous support of the Retirement Research Foundation.

Undergirding the EESI is the WOW—Gerontology Institute at the University of Massachusetts Boston National Elder Economic Security Standard (Elder Standard), a new tool for use by policy makers, older adults, program providers, leaders in the aging advocacy community and the public at large. Developed by the Gerontology Institute at the University of Massachusetts Boston and WOW, the Elder Standard is a measure of income that older adults require to maintain their independence in the community and meet their daily costs of living, including affordable and appropriate housing and health care. The development and use of the Elder Standard promotes a measure of income that respects the autonomy goals of older adults, rather than a measure of what we all struggle to avoid—abject poverty.

The information developed through the Elder Standard helps us understand that many older adults who are not poor, as defined by the official poverty level, still do not have enough income to meet their basic needs. The Elder Standard answers the following questions: How much income—or combination of personal income and public programs—is needed by older adults living on fixed incomes to cover today's rising living costs? What is the impact of public programs, such as Medicare, Medicaid, or housing assistance on an elder's evolving income and health needs? Will it be necessary for able older adults to continue to work for pay, despite being of retirement age and preferring to retire?

The EESI is guided by a National Advisory Board, which has been a resource in reviewing the design of the EESI and considering the selection of measures and data sets for the Elder Standard to ensure they are replicable and consistent. The National Advisory Board has also helped guide the strategy for maximizing the role of state EESI partners, and ensuring that a broad range of aging and caregiver organizations are included in the state coalitions being formed. State partners include: the Massachusetts Association of Older Americans in Massachusetts, The Health and Medicine Policy Research Group in Illinois, The National Economic Development and Law Center in California, Pathways PA in Pennsylvania, Wisconsin Women's Network in Wisconsin, and the Women's Center for Education and Career Advancement in New York City.

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I. Introduction

The WOW – Gerontology Institute at the University of Massachusetts Boston National Elder Economic Security Standard (Elder Standard) measures the cost of living for older adults in today's economy. What is an adequate income for older adult households to age in place? How does it vary according to their life circumstances: whether they are living alone or with a spouse, rent or own their home, drive a car or use other transportation? How do elders' living costs change as their health status and life circumstances change? What happens if they need long-term care to keep living at home?

The Elder Economic Security Initiative (EESI) will address these questions through the development of a measure of income adequacy for older adults, the Elder Standard. The Elder Standard will benchmark basic costs of living for elder households. It will illustrate how costs of living vary geographically and based on the characteristics of elder households: household size, homeownership or renter, mode of transportation, health status, and the impact of need for long-term care. The expenses are for basic needs of elder households; they are based on market costs and do not assume need based subsidies.

The Elder Standard presented in this report will be used to increase public awareness and influence public policies and programs to benefit elders through the broader Elder Economic Security Initiative. Specifically, the Elder Economic Security Initiative will:

- Provide important new information to illustrate the basic costs that older adults face and how their financial security is affected when their life circumstances change;
- Provide a framework for analyzing impacts of public policies and policy proposals in such areas as retirement security, health and long-term care, taxes, and housing;
- Provide an organizational structure that builds on the interactive relationship among national, state and local stakeholders, many of whom are already recognized as leaders in the field of aging or anti-poverty work to advance the EESI framework through a coordinated and powerful voice;
- Educate elders about actual and projected living costs to inform their financial, employment, and life decisions;
- Provide new tools for elders to advocate policy changes drawn from EESI national and state–specific agendas that will have an impact on their own lives; and
- Help agencies serving seniors set goals, assess needs, and design programs.

Demographics

According to the 2004 American Community Survey, 12 percent of the nation's population, nearly one-eighth, was 65 or older. Looking ahead, the aging of baby boomers will dramatically increase the growth of the older population; projections suggest that the elder population will nearly double over the next 25 years. This population will continue to comprise mostly women, who currently make up 57 percent of the 65 and older group in the nation, and 67 percent of those ages 85 and older.

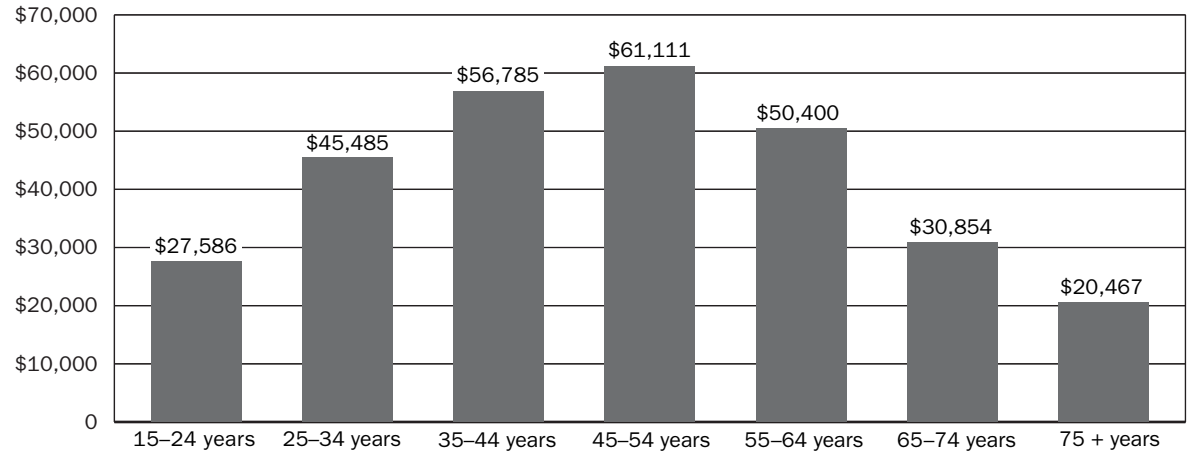
Elders in communities across the nation are a diverse group of people. Their individual circumstances vary from the most fortunate being healthy and economically secure to the least fortunate being poor, ill and/or disabled. In between, there are many variations in elders' circumstances. Housing expenses, health status, and long-term care assistance can vary over an elder's life span having an impact on income need.

Income Trends

Household income levels vary over the life span. Typically, median income levels rise with age until mid-life, and then decline with advancing age, as indicated in **Figure 1**. The median income for householders 65-74 years old, at $30,854, is one-half of the median income of householders in their peak earning years of 45-54, $61,111. For those 75 and over, at $20,467, it is one-third of peak income.

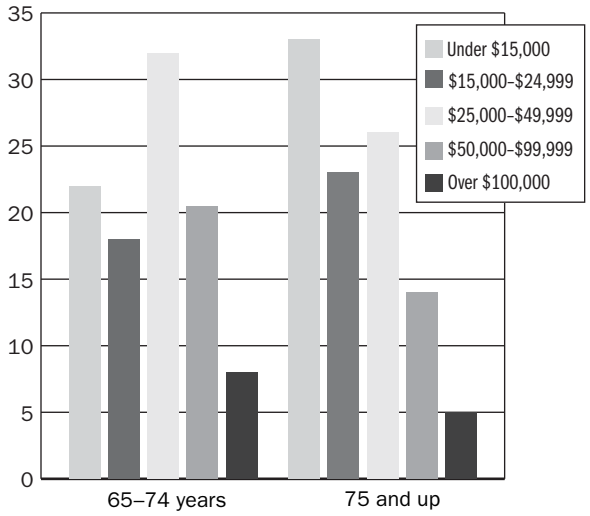
Based on 2000 U.S. Census data, **Figure 2** shows 40 percent of elder households aged 65-74 had 1999 incomes under $25,000 (22 percent under $15,000, and an additional 18 percent from $15,000-$24,999). For elder households aged 75 years and older, 55 percent had incomes under $25,000 (18 percent under $15,000, and an additional 22 percent from $15,000-$24,999). With inflation, $25,000 in 1999 represents $29,307 today.

FIGURE 1
Median Income by Age, U.S., 2004



Source: U.S. Census Bureau, Effects of government taxes and transfers on income and poverty. Feb. 2006.

FIGURE 2
U.S. Elder Household Income Distribution by Age, 1999



Source: U.S. Census 2000, Summary File 3, Table P55 for the United States.

The Federal Poverty Measure

Much of current policy and program design for low-income elders is based upon the federal poverty thresholds. The poverty thresholds are the original version of the federal poverty measure.[1] The poverty thresholds are used for statistical purposes to prepare estimates of the number of Americans in poverty each year. They were calculated by taking the cost of food needed to meet the minimum nutritional needs of adults of different ages, and multiplying this by three to calculate the total needed to live at a basic level, as U.S. households spent about one-third of their incomes on food 40 years ago. Since that time, the thresholds are updated each year by the change in the consumer price index (CPI).

The U.S. Department of Agriculture calculations assume that older adults have lower caloric requirements than younger adults. As a result, the official U.S. poverty thresholds are lower for adults 65 and older than for younger adults. **Figure 3** compares the U.S. poverty thresholds by age for 1- and 2-person households. Elders living alone are not considered officially poor unless they have $793 per year less than younger adults, and elder couples are not poor unless they have $1,328 per year less than younger couples.[2]

Since the poverty thresholds are based on such an antiquated formula, there are many elders with incomes above the federal poverty thresholds who nonetheless lack sufficient resources to adequately meet their basic needs. The U.S. Census Bureau itself states, "The official poverty measure should be interpreted as a statistical yardstick rather than as a complete description of what people and families need to live."[3]

[1] The federal poverty thresholds were developed by Mollie Orshansky of the Social Security Administration in 1963-64 and are updated each year by the U.S. Census Bureau. For more information on the federal poverty measures, see http://aspe.hhs.gov/poverty/06poverty.shtml.

[2] The poverty guidelines are a second version of the federal poverty measure. Issued each year in the Federal Register by the Department of Health and Human Services, they are a simplification of the poverty thresholds for administrative uses, such as determining eligibility for certain federal programs. The federal poverty guidelines for 2006 are $9,800 for one-person households, and $13,200 for two-person households. They are the same in 48 states and adjusted for living costs only in Alaska and Hawaii.

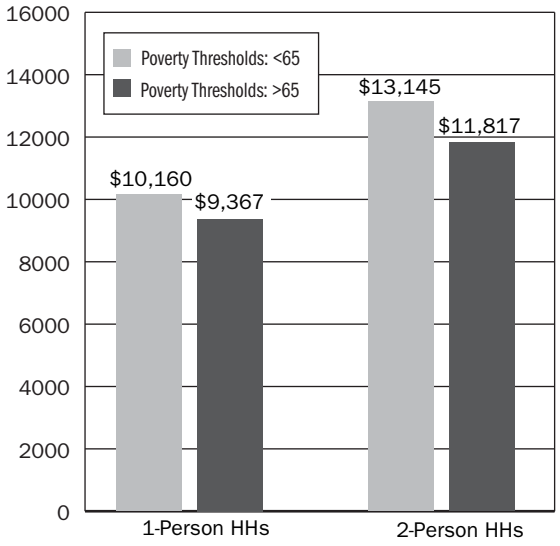
[3] Proctor, B. & Dalkar, J. (2003). Poverty in the United States: 2002. *U.S. Census Bureau, Current Population Reports*, Series P60-222,5. http://census/gov/prod/2003pubs/p60-222.pdf

Inadequacies of the federal poverty thresholds are as follows:

- The federal poverty thresholds are based on the cost of a single item, food, not on a market basket of basic needs.
- The poverty threshold is computed nationally, thus does not capture the wide range of housing and other cost differentials across the country; nor does it vary by seniors' age, health, or life circumstances.
- The official poverty threshold is also lower for elders, reflecting an inaccurate assumption that elders need less to live on than younger people.
- Moreover, the federal poverty threshold does not take into account medical out-of-pocket costs, which the elderly disproportionately face.

There are a number of problems with the federal poverty measure. The first is that it is based on outdated spending patterns, assuming households spend a fixed ratio of one-third of their incomes on food. In addition, it does not allow for different rates of inflation for different living costs—health care and housing costs have risen much more than food costs. Finally, it does not reflect variations in regional living costs.[4]

FIGURE 3
Comparison of Annual U.S. Poverty Thresholds by Age, 2005



Sources: U.S. Census Bureau, http://www.census.gov/hhes/www/poverty/threshld/05prelim.html.

Defining the Elder Standard: A Framework for Economic Security for Elders

The Elder Standard has been developed as a measure of the income required to meet the basic needs of elder households. The Elder Standard draws upon the work of Wider Opportunities for Women and Dr. Diana Pearce, who created the Family Self-Sufficiency Standard in the last decade.[5] The Elder Standard builds on the concept developed through the Family Self-Sufficiency Standard and adapts it to characteristics and spending patterns of elder households. The Elder Standard is proposed as a more realistic measure of income adequacy than the federal poverty measure. Economic security implies that elders have sufficient income (Social Security, pension, retirement savings, and other income) to cover living costs. The Elder Standard illustrates the basic costs that elders face, and the interplay between living costs and elders' income adequacy. The Elder Standard also illustrates how elders' income needs change as their life circumstances change.

While both the Elder Standard and the official poverty threshold assess income adequacy, the Elder Standard differs from the federal poverty threshold in three important ways. The Elder Standard:

- *Identifies the actual and basic costs of living.* The Elder Standard uses cost data from federal and state sources to assemble a realistic household budget which includes expenses such as housing, transportation, food, and health care.
- *Takes into account that real costs of living vary by life circumstance.* The Elder Standard addresses the unique life circumstances of elders using variables through different "tracks" of elder households, including different housing, transportation, and health status scenarios as well as household composition and long-term care need.
- *Accounts for regional differences.* The national Elder Standard methodology will be used to calculate state and county level Elder Standards using state and county data. Data points such as housing will vary based on geography.

Our objective is to develop the Elder Standard as a visible, objective, and widely used cost-of-living measure for

[4] For an analysis of problems with the federal poverty measures and information on a proposed alternative measure, see Constance F. Citro and Robert T. Michael, Measuring Poverty: A New Approach (Washington, DC: National Academy of Sciences, 1995). Their proposed measure is based on household spending patterns from the Consumer Expenditure Survey, and adjusts household incomes for transfer payments (subsidies) as well as taxes. The Census Bureau from time to time calculates the number of households that would be in poverty under the alternative poverty measure, but the recommendation to substitute the new measure has not been adopted.

[5] The methodology embodied in the Self-Sufficiency Standard was developed by WOW's research partner, Dr. Diana Pearce, when she directed the Women and Poverty Project at WOW. Today she teaches at the School of Social Work, University of Washington. The Self-Sufficiency Standard undergirds the six strategies of the Family Economic Self-Sufficiency Project (FESS). The FESS Project is led by Wider Opportunities for Women and was created to provide tools to communities to help low income working families make ends meet.

elders that reflects their geographic and life circumstances to help shape public understanding, policy discussion, and individual decisions. It is timely, as the aging of the population fuels "the graying of America" as a significant demographic, economic, social, and public health trend. As the nation debates restructuring private pensions, Social Security, Medicare and Medicaid, and as elders across the country face rising housing, property tax, fuel, health care, and long-term care costs, a new measure of economic security is needed.

The Elder Economic Security Initiative and Its Roots in the Family Economic Self-Sufficiency Project

The Elder Economic Security Initiative draws upon the work of Wider Opportunities for Women and Dr. Diana Pearce, who created the Family Economic Self-Sufficiency Standard (FESS) in the last decade.[6] The FESS Project put a number of tools in the hands of local, state, and national policymakers and advocates to increase economic opportunities for low-income working families.

In 1996, in response to the devolution of power and resources on issues related to low-income families from the federal to the state and local levels, WOW launched the FESS Project. With the FESS Project in place in states and counties throughout the country, WOW and its partners have been able to redefine who needs help and emphasize the importance of wages and work supports to build prosperity for America's families.

Since the inception of FESS, WOW has established statewide FESS coalitions in 35 states and the District of Columbia. Today, more than 2,000 local and state agencies and organizations belong to WOW's national FESS network. FESS partners include women's commissions, community action agencies, child advocates, job training programs, welfare rights groups, and state fiscal policy organizations. The common link among these groups is the use of a common framework—economic self-sufficiency—to design, implement, and advocate for programs and policies that move low-income families toward economic independence.

A cornerstone of the FESS Project is the development of the state-specific Self-Sufficiency Standard, a tool that calculates how much income working families need to meet their basic expenses of housing, child care, food, health care, transportation, and taxes, depending on where they live and in the composition of their families.

WOW supports the lead state partner organizations in bringing together a diverse coalition of groups that reflects the issues and needs of their respective communities. In state legislatures around the country, the Standard has been used to preserve a range of programs including Medicaid, childcare, children's mental health services, and an indexed minimum wage. WOW's combination of national and local experience provides valuable resources and organizing skills to its partners and fosters replication of innovative state-level policies and programs. WOW helps partners meet with their Congressional offices, participate in federal regulatory processes, locate information and resources to meet their local needs, and publicize their accomplishments to help shift the public policy debate at both the local and national levels.

For more information on the Family Self-Sufficiency Standard and the policy applications of the FESS project, see www.wowonline.org.

[6] The methodology embodied in the Self-Sufficiency Standard was developed by WOW's research partner, Dr. Diana Pearce, when she directed the Women and Poverty Project at WOW. The Self-Sufficiency Standard undergirds the six strategies of the Family Economic Self-Sufficiency Project (FESS). The FESS Project is led by Wider Opportunities for Women and was created to provide tools to communities to help low income working families make ends meet.

II. Cost Components of The WOW-GI National Elder Economic Security Standard

The cost components and methodology for the WOW-Gerontology Institute National Elder Economic Security Standard (Elder Standard) have been developed with input and guidance from the National Advisory Board for the Elder Economic Security Initiative convened by Wider Opportunities for Women. The National Advisory Board is comprised of leaders in the fields of aging research and advocacy. WOW and the University of Massachusetts Boston Gerontology Institute also gathered input and guidance from a select group of national women's organizations, national policy organizations, and aging direct service organizations in the Washington, D.C. area. WOW held focus group sessions in which feedback was gathered on the Elder Standard cost components and methodology. The national policy groups included the National Human Services Assembly, Older Women's League, Women's Institute for a Secure Retirement, National Research Council for Women and Families, Rural Poverty Research Institute, Medicare & Social Security division at the Campaign for America's Future, Retirement Capital Project, and Senate committee staff working on Social Security and Medicare. The direct service providers included the D.C. Office of Aging, D.C. Commission on Aging, Adult Services for the City of Alexandria, the Senior Center at the Educational Organization for United Latin Americans and the aging division at the United Planning Organization.

Criteria to guide the decision-making process in building the cost components of the Elder Economic Security Standard, and in selecting the data sources, include:

The Elder Standard uses cost data from public federal and state sources that are comparable, geographically specific, easily accessible, and widely accepted. In areas where existing public data sources are not currently available, such as long-term care costs, we use a consistent methodology to derive comparable measures for costs.

Some of the assumptions currently built into the prototype include:

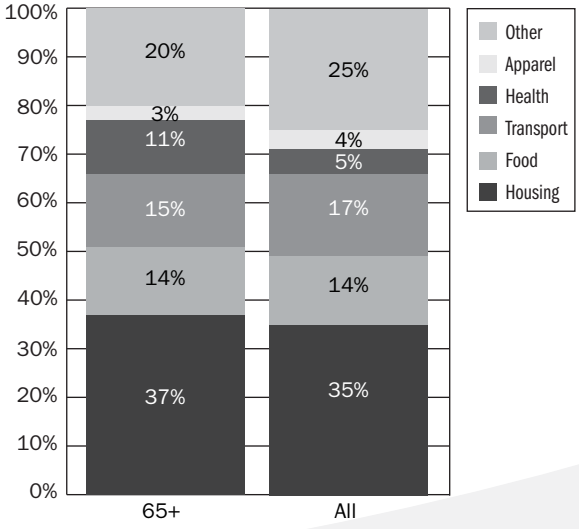
- The Elder Standard measures basic living expenses for seniors in the community (not in institutions such as skilled nursing facilities or assisted living facilities).
- The Elder Standard measures costs for elder households to live independently (vs. living in intergenerational households).
- The Elder Standard is designed to measure living expenses for elders ages 65 and over. This is the age at which Medicare begins.
- Medicare is included in the Elder Standard because elders qualify for and receive it based on age, not income eligibility, making it nearly a universal program.
- The Elder Standard models costs for retired elders, who no longer face costs of working, such as payroll taxes and commuting to work.
- The Elder Standard measures costs in today's marketplace. Economic security implies that seniors can meet their basic needs without income-eligible public subsidies, such as food stamps, subsidized housing, or Medicaid.

The Big Picture: Elders' Spending Compared to All Households

For context, we present data on elder households' spending patterns in **Figure 4**. Consumer Expenditure Survey data show that elder households spend about the same percentage of their budgets on housing and food as all households, and twice the percentage of all households on health care. Elders spend less on transportation, apparel, and all other goods and services. Similar spending patterns are reported in the Health and Retirement Survey (HRS).[7]

[7] Butrica et al., Understanding Expenditure Patterns in Retirement (Washington, DC: Urban Institute, 2005).

FIGURE 4
Household Spending as a Percentage of Total Budget: Elder vs. All Households, 2003-2004



Source: U.S. Department of Labor, Bureau of Labor Statistics, Consumer Expenditure Survey 2003-2004, U.S., updated using CPI for each expenditure category.

Cost Components

The basic cost components developed for the Elder Economic Security Standard are:

Housing — includes housing (rent or mortgage payment, if any), and related costs (heat, utilities, insurance, and property taxes) for elder renters and elder owners, based on latest available elder median housing costs as reported by the U.S. Census, and latest available HUD Fair Market Rents.

Food — costs of food prepared at home, based on USDA Low-Cost Food Plan for older adults. Food costs can be adjusted by relative changes in the Consumer Price Index for food in the region, or by the ACCRA Cost of Living Index for groceries.

Health Care — premiums for Medicare Parts B, C (Medicare Advantage Plan), and D (Prescription Drug Plan), and out-of-pocket costs (including co-pays and deductibles), based on median 2006 Medicare rates and Medicare supplemental insurance rates for Medicare Advantage and Part D plans, and latest available median out-of-pocket cost data from the Medical Expenditure Panel Survey (MEPS).

Transportation — costs for private auto ownership and use, and public transportation (where available), cost data from IRS mileage reimbursement studies and AAA, elder auto usage patterns from latest available National Household Transportation Survey.

Miscellaneous — all other goods, such as clothing, paper goods, cleaning products, personal and household needs, etc. and any other costs not captured elsewhere. Based on the elder spending patterns in **Figure 4,** we estimate miscellaneous expenses at 20 percent of all other costs (excluding taxes and long-term care).

Elders' living costs in each of the cost components are added to determine household budgets for each of the respective "tracks" of elder households. This gives a measure of the Elder Economic Security Standard, the after-tax income required to cover elders' living expenses based on where they live and the characteristics of their household.

The Impact of Long-Term Care

The costs of home- and community-based long-term care services, for those who require them to remain living in the home, are presented for three services packages along the continuum of care in Section III. Long-term care is not a need experienced by all elders therefore, it is provided as an add-on component to the basic Elder Standard.

A Note on Taxes

Local property taxes are included in the housing cost component for homeowners, and state sales tax (if any) is covered by the miscellaneous category.

A significant portion of Social Security income is exempt from the federal income tax when elders' combined incomes are under certain limits. Income tax treatment and rates vary by source of income; elders typically rely on a combination of Social Security, pension, and savings. Because most of the Elder Standard household basic budgets are below the no-tax limits, and because tax rates vary by income source, we do not include income taxes in the basic model.

A. Housing Costs

Housing costs for elders are determined by a number of factors: whether they rent or own; location, as costs vary widely across communities; housing unit size; length of residence; and related costs such as and heat and utilities (which may or may not be included in rent), as well as property taxes, insurance, maintenance, and repairs for homeowners.

The Elder Standard measures median housing costs in the community, not in institutions such as skilled nursing facilities. The Elder Standard is focused on costs of aging in place. Because assisted living "bundles" housing with food and supportive services, we do not include it in the basic model.

Housing Cost Component of the Elder Standard

As **Table 1** shows, the housing cost component for the Elder Economic Security Standard has three options: fair market rent, owner without a mortgage and owner with a mortgage.

TABLE 1
Housing Component of the Elder Economic Security Standard, U.S. Average, 2006

	Fair Market Rent	Owner without Mortgage	Owner with Mortgage
Per Month	$655	$349	$978
Per Year	$7,858	$4,189	$11,736

Sources: U.S. Department of Housing and Urban Development, Fair Market Rents for U.S. HUD Fair Market Areas, in FY2006, 40th percentile rent for 1-bedroom units on the market, weighted average FMRs for cities and towns using 2000 Census population data.

U.S. Census Bureau, 2004 American Community Survey, Table: S0103. Population 65 Years and Over http://www.factfinder.census.gov. Selected monthly owner costs (with and without mortgage) inflated by 2005 CPI-U Housing Index for U.S.

Rationale for Selection of Elder Housing Cost Measures

Elders have higher rates of homeownership than younger adults in the U.S., 79 percent vs. 67 percent respectively, for all households. Cities have higher shares of elder renters than elder homeowners. There is a good deal of diversity among older renters and among older homeowners in terms of housing costs. In light of the substantial proportion of both elder owner and renter households, the Elder Standard includes "tracks" for both renters and homeowners.

Because the Elder Standard seeks to benchmark costs of living for elders in today's market, we use the Fair Market Rent for 1-bedroom units in the geographic area from the U.S. Department of Housing and Urban Development for 2006. The fair market rent is the 40th percentile rent for units currently on the market; it includes utilities but not telephone. The fair market rent data results in a higher figure than Census data on median rents reported by those 65 and older, because Census rents include both private and subsidized rents.

For elder homeowners, housing costs are the expenditures to retain their current housing. Because of this focus, we use actual elder owner housing cost data from the U.S. Census, instead of costs of housing currently on the market. The Census reports Selected Monthly Owner Costs (SMOC) as the sum of payment for mortgages, real estate taxes, insurance, utilities, fuel, and condominium fees. Homeowner costs are reported separately for elder owners with and without mortgages.

Many low- and moderate-income homeowners bought their homes many years ago, when housing prices were much lower, and have paid off their mortgages. However, refinancing to tap home equity has become increasingly common when needed to pay off debts or generate cash for other expenses. In addition, some elders choose to downsize, move closer to family, or move to a warmer climate, which may lead to a mortgage. Therefore, we include tracks for both sets of elder homeowners: those with and without a mortgage.

A Note on Elder Owner Housing Costs: Taxes, Utilities, Insurance and Repairs

The homeowner cost figure, especially for owners without a mortgage, is conservative. In many areas, homeowners' property taxes are increasing far more rapidly than the consumer price index for housing. Heat and utility costs have gone up markedly during the past year with the increase in oil, gas, electricity, and energy costs, and home insurance costs have risen in response to market adjustments from weather damage and other factors. As energy costs, home insurance rates, maintenance and repair costs, and property taxes continue to rise, elder homeowners will continue to face growing pressures on their budgets for housing.

B. Food Costs

The Consumer Expenditure Survey reports that elders spend a similar percentage of their budget on food (14 percent), as all households: a bit more on food at home and less on food away from home. This is in contrast to the federal poverty measure that assumes elders require less to eat than younger adults, per person.

Food Cost Component of the Elder Standard

The Elder Standard uses the U.S. Department of Agriculture (USDA) Low-Cost Food Plan as its measure of basic food costs for elders,[8] shown in **Table 2.**

TABLE 2
Food Costs for the Elder Economic Security Standard, 2006[9]

	Individual Elder	Elder Couple
Per Month	$ 206	$ 378
Per Year	$2,328	$4,536

Source: http://www.usda.gov/cnpp/FoodPlans/Updates/foodjan06.pdf

Rationale for Selection of Elder Food Cost Measure

The U.S. Department of Agriculture (USDA) develops official USDA Food Plans to measure the cost of a minimally adequate diet that meets nutritional standards for different age groups and genders, reflecting different caloric requirements needed to meet minimum nutritional standards. There are four plans: Thrifty, Low-Cost, Moderate-Cost, and Liberal, measuring the cost of meals and snacks that are purchased at stores and prepared at home.

The official Food Plan budgets are scaled to family size to reflect economies of scale for purchasing in larger quantity. The Thrifty Food Plan is quite austere,

[8] When desired, food costs can be adjusted for regional price variations, using the ratio of increase of CPI-U Index for Food in the area to the national average, or ACCRA's comparative cost of living for groceries for 297 cities.

[9] Food costs for a couple are less than the sum of two individuals' food costs because the USDA food plans build in economies of scale for purchase of food as household size increases.

allowing under $5 per day for all three meals. It is used as the basis for Food Stamp allotments. Its predecessor, the Economy Food Plan, was used to calculate federal poverty thresholds for U.S. households.[10] The USDA Low-Cost Food Budget for older adults is $206 per month, about $7 per day; we average the food plan budgets for men and women. This plan is more realistic than the Thrifty Food Plan about food preparation times, such as allowing purchase of canned beans vs. dry beans.

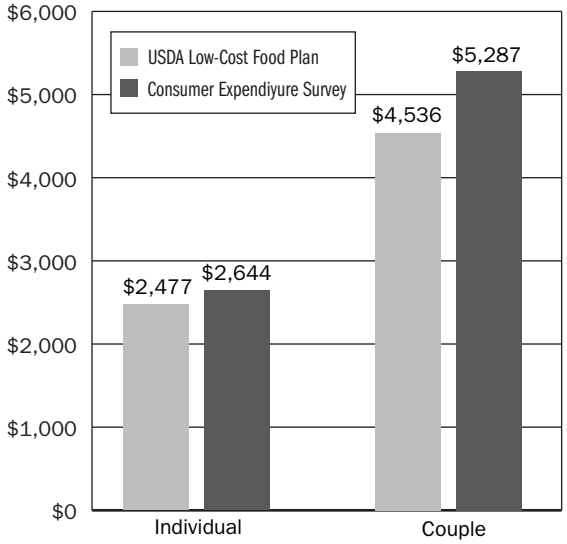
Elder food spending patterns reported in the Consumer Expenditure Survey are quite similar to the USDA Low-Cost Food Plan for individual older adults, as illustrated in **Figure 5.** Annual food costs for elder couples given by the Low-Cost Food Plan and the Consumer Expenditure Survey diverge a bit more, reflecting that the Low-Cost Food Plan builds in economies of scale.

Although the Consumer Expenditure Survey reports somewhat higher food expenses than the USDA Low-Cost Food Plan, we have used the USDA Low-Cost Food Plan to calculate the Elder Standard because it is a standardized and credible data source. In addition, it is based on realistic assumptions about food preparation time and consumption patterns. Even so, it is a conservative estimate of the level of food expenditures required to meet minimal nutritional standards.

The USDA Food Plan budgets do not take into account special dietary needs. Elders may have special dietary needs, based on medical conditions such as diabetes, high cholesterol or high blood pressure. Managing a special diet raises the cost of buying and preparing food. Transportation and mobility also affect elders' shopping patterns; for example, use of public transit limits the ability to carry larger loads. Unless they drive or have convenient transportation, elders may have to shop closer to home, and are less able to take advantage of larger superstores and discount grocery stores with better prices. As noted above, elders in smaller households are less able to make use of economies of scale—buying in larger quantities—when purchasing food.

[10]Because elders' nutritional needs are lower according to the USDA, the poverty thresholds are lower for older adults than for younger adults.

FIGURE 5
Elder Spending on Food: USDA Low Cost Food Plan January 2006 vs. Consumer Expenditure Survey, Adjusted Per Person, and to 2006 Dollars



Sources: USDA, Official USDA Food Plans: Cost of Food at Home at Four Levels, U.S. Average, January 2006. http://www.usda.gov/cnpp/FoodPlans/Updates/foodjan06.pdf. US Bureau of Labor Statistics, Consumer Expenditure Survey, 2003-2004, Table 3850. Consumer units with reference person age 65 and over by region of residence: Average annual expenditures and characteristics. Adjusted to the present using CPI-U for Food and Beverages. http://www.bls.gov/cex/2004/CrossTabs/AGEbyREG/r65orup.PDF.

C. Health Care Costs

Elders' health care costs include premiums, deductibles, co-pays, and expenses for non-covered services. Elders' health care costs are determined by a number of factors such as whether they have supplemental health plan coverage to augment the basic Part A & B Medicare program; their health status and how it changes over time; and how many prescription medications they use.

Health Care Cost Component of the Elder Standard

To get health care costs for elder households, we calculate the total premium costs for Medicare and supplemental health insurance and prescription drug costs for each household member. For two-person households we add them together. Data from the Medical Expenditure Panel Survey (MEPS) were used to calculate various aspects of the Elder Standard. MEPS data are deemed the industry gold standard for calculating out-of-pocket costs by health status. **Table 3** provides an example of the health care component of the Elder Standard using U.S. average premium costs.

TABLE 3
Health Care Costs for the Elder Economic Security Standard, 2006
U.S. Premiums plus Median Out of Pocket Costs Per Household Member

Health Status:	Excellent	Good	Poor
Per Month	$197	$220	$241
Per Year	$2,363	$2,639	$2,896

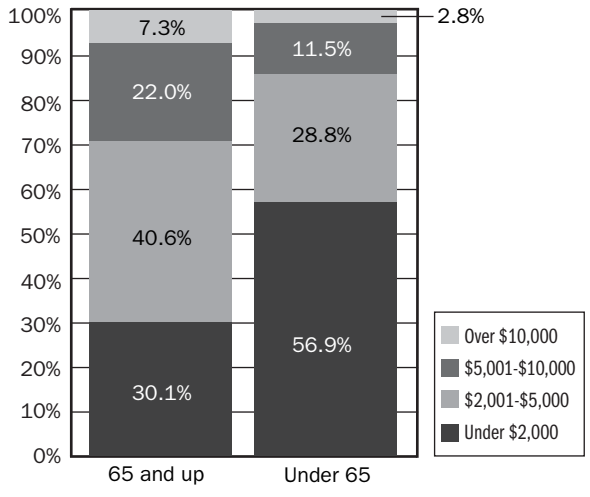
Source: Calculations based on data from Table 4 and Table 6.

Rationale for Selection of Health Care Cost Measures

The vast majority of people over the age of 65 are covered by Medicare. Yet even with Medicare, elders face higher health care expenditures than younger adults. For economic security as well as to meet future health needs, many elders purchase supplemental coverage in addition to basic Medicare coverage. The Elder Standard includes these premium costs of supplemental insurance.

According to the Consumer Expenditure Survey, elders spend more in absolute dollars than people under 65 on health care. Bernard and Banthin, using MEPS data, found that nearly 30 percent of elders spent over $5,000 per year in out-of-pocket health costs and health plan premiums in 2003, and 7.3 percent of elders spent over $10,000.[11] See **Figure 6**.

FIGURE 6
Distribution of Out-of-Pocket Health Care Expenses, Elderly vs. Non-Elderly in Households, 2003



Sources: Bernard, D. and Banthin, J. Out-of-Pocket Expenditures on Health Care and Insurance Premiums among the Elderly Population, 2003. Statistical Brief #122. March 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/papers/st122/stat122.pdf and Bernard, D. and Banthin, J. Out-of-Pocket Expenditures on Health Care and Insurance Premiums among the Nonelderly Population, 2003. Statistical Brief #121. March 2006. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/papers/st121/stat121.pdf.

Overview of the Medicare Program

Medicare is a federal insurance program for disabled and elderly individuals. Launched with passage of the Social Security Amendments of 1965, it is financed through a payroll tax for (Part A) hospitalization coverage, and general revenue plus a monthly premium for supplementary coverage (Part B), which covers doctors' visits, diagnostic and lab work, physical and occupational therapy, and limited home care services. Medicare does not cover all health care expenses. For instance, Medicare does not covers expenses such as hearing aids, non-emergency ambulance rides, eye glasses, dental care, certain medical supplies and equipment, nursing home care, and most home- and community-based long-term care services.

Gaps in Medicare coverage are partially addressed by private insurers offering "Medigap" plans. These plans are regulated by the state and federal governments. The Balanced Budget Act of 1997 created Part C, "Medicare Advantage," which offers a range of supplemental plan options for seniors, including health maintenance organization (HMO) and preferred provider organization (PPO) plans. The Medicare Modernization Act of 2003 added a prescription drug benefit effective in 2006 (Part D), offered through private insurance companies. The landscape of coverage, costs, and impact of rising health costs is complex, and in flux.

Premium Costs of Medicare: Parts A, B, C, and D

For most people, there is no premium charge for Part A; however there are out of pocket costs if hospitalized. The Part B premium is $88.50 per month or $1,062 per year in 2006 for an individual. Monthly premiums for Part C, supplemental Medicare Advantage Plans,[12] vary by insurer, geographic area, and plans offered.[13] Monthly premiums for

[11] Adjusted for inflation to mid-2006, these amounts would be $5,648 and $11,296.

[12] Medicare Advantage Plans (Part C) are HMO-type plans that use a network of physicians, have premiums that vary based on their schedule of co-pays and deductibles. Medicare Advantage Plans reduce but do not eliminate co-pays and deductibles under Parts A and B; they typically require treatment by network physicians and hospitals. There is often some coverage for dental, hearing, and vision services, and an annual physical (Traditional Medicare only covers a one-time Medicare physical at entry). They can also include a Part D prescription drug plan.

[13] Medigap supplemental plan premiums also vary; we use Medicare Advantage premiums because they are lower. Medigap Supplement Plan 1 policies are available for seniors who chose not to participate in a Medicare Advantage Plan but instead remain in traditional, fee-for-service Medicare. Comprehensive Medigap plans cover co-pays and deductibles for Medicare-covered services and cover some of the gaps in services. Medigap Supplement Plan 2 policies with prescription drug coverage are no longer open to new members. Seniors purchasing a Medigap Supplement Plan 1 also need to purchase a Part D Prescription Drug Coverage Plan to have adequate coverage.

stand-alone Medicare Prescription Drug plans (Part D) also vary by insurer, geographic area, and plans offered.

The combined premium costs for Medicare and full supplemental health care coverage are shown in **Table 4** using national average costs as an example. The Elder Standard is calculated using a Medicare Advantage plan instead of a Medigap Supplemental plan as they are typically less expensive where available.

Premium costs apply to each member of an elder household.

Additional Out-of-Pocket Health Care Costs

In addition to the premiums elders pay for Parts B, C, and Part D, elders experience substantial out-of-pocket costs because of the gaps in Medicare coverage and the co-pays and deductibles under Medicare Advantage and prescription drug plans.

Medicare Prescription Drug Plan Costs- Part D

Traditional Medicare does not cover prescription drugs. With the inception of Medicare Part D some elders can get a portion of their drugs covered. However, elders with a Medicare Part D prescription drug plan can still have sizeable out-of-pocket costs. These include deductibles and co-pays built into the national plan as shown in **Table 5**. Elders with a Part D plan will also incur out-of-pocket costs for drugs not in the plan's formulary (list of approved drugs).

Elders with prescription drug costs between $2,250 and $5,100 annually ($187.50-$425 per month) must pay the full burden

TABLE 4
Medicare Premium Costs: Medicare Advantage Plan and Prescription Drug Plan, U.S. Average, 2006

	Part A	Part B	Part C*	Part D	Total
	Hospitalization	Out-Patient Doctor & Therapy Visits	Medicare Advantage Plan* (Medicare HMO)	Prescription Drug Plan (MA Benchmark $)	
Per Month	no premium; out of pocket hospitalization expenses vary	$88.50	$34	$16	$138.50
Per Year	no premium; out of pocket hospitalization expenses vary	$1,062	$408	$192	$1,662

Source: Medicare Part B premium from Centers for Medicare and Medicaid, Medicare & You, 2006. http://www.medicare.gov/publications.

Medicare Part C and Part D average premiums (unweighted) for HMOs for U.S. from Kaiser Family Foundation Medicare Health and Prescription Plan Tracker. http://www.kff.org/medicare/healthplantracker/georesults.jsp?r=1.

TABLE 5
The National Medicare Part D Prescription Drug Plan Cost Sharing Formula

Prescription Costs/Year	Range ($)	Medicare Part D Pays %	Elder Co-Pays %	Cumulative Cost to Part D Plan	Cumulative Cost to Elder
$250	up to $250	0%	100%		$250.00
$1,250	$250-$2,250	75%	25%	$750.00	$500.00
$2,250				$1,500.00	$750.00
$3,250	$2,250-$5,100	0%	Elder pays 100% of costs in the "donut hole"	$1,500.00	$1,750.00
$4,250				$1,500.00	$2,750.00
$5,100				$1,500.00	$3,600.00
$5,250	over $5,100	95%	5%	$1,642.50	$3,607.50
$10,250				$6,392.50	$3,857.50

Source: Centers for Medicare and Medicaid (2006) Medicare & You, 2006. http://www.medicare.gov/publications

of their prescription drug costs in that range. Only when their costs exceed $3,600 per year or $300 per month do they receive additional help with paying for their medications.

Co-Pays, Deductibles, and Other Medical Charges: Medical Expenditure Panel Survey

The Medical Expenditure Panel Survey (MEPS), conducted by the U.S. Department of Health and Human Services' Agency for Healthcare Research and Quality, tracks health status, health insurance coverage, health care use and expenditures, and sources of payment for health services by members of the civilian non-institutionalized population through its household component. It is the most frequently used database on household medical costs for the nation.

MEPS data illustrate how out-of-pocket medical costs vary by age, sex, health status and other factors. Generally, out-of-pocket medical costs for elders vary as expected. Costs increase with declining health status. Costs for women are typically higher than for men. There is also variation among costs by age, but those patterns are not consistent. The greatest and most consistent variation is by health status. Therefore, to estimate health care costs, we use three "tracks" of out-of-pocket health costs by health status: excellent, good, and poor.

To project total health care costs for elders to be economically secure, we add premium costs for Parts B, C, and D (there is no Part A premium cost) to the out-of-pocket costs for health services. **Table 6** provides an example using U.S. average premium data. The costs are doubled in a two-person elder household.

The goal of the Medicare Prescription Drug Plan (Part D) is to reduce out-of-pocket costs for elders compared to prior

Table 6
Median Out-of-Pocket Medical Costs Of Elders by Health Status, with U.S. Average Premiums, 2006

Health Status	Excellent	Good	Poor
Per Month:			
Out-of-Pocket Costs (MEPS):	$58	$81	$102
+ Premium Costs (Parts B, C, D):	$138.50	$138.50	$138.50
= Total Health Care Costs:	$197	$220	$241
Per Year:			
Out-of-Pocket Costs (MEPS):	$701	$977	$1,234
+ Premium Costs (Parts B, C, D):	$1,662	$1,662	$1,662
= Total Health Care Costs:	$2,363	$2,639	$2,896

Sources: Out-of-pocket costs generated from MEPSnet/HC using 2003 MEPS Household Component public use files. http://www.meps.ahrq.gov/MEPSNet/HC/MEPSnetHC.asp Updated by Medical CPI for area. Adds U.S. average premium costs from Kaiser Family Foundation Medicare Health and Prescription Plan Tracker. http://www.kff.org/medicare/healthplantracker/georesults.jsp?r=1 .

Inflation factor was calculated from the numbers from the BLS site: http://data.bls.gov/cgi-bin/surveymost?cu .

years. If this occurs, these savings should be reflected in future MEPS data as the Elder Economic Security Standard is updated.

In calculating the Health Care Cost Component, the Elder Standard reports developed for each state will note any additional state health care plans and/or additional prescription drug coverage for elders. Some states have stand-alone prescription drug plans that they have converted to wrap-around plans to supplement Part D coverage and further reduce out-of-pocket costs for qualifying elders.

D. Transportation Costs

Transportation costs for older adults are influenced by a number of factors: how many trips they take, distance traveled, and mode of transportation, for example, automobile, public transit, or specialized transportation due to mobility and medical needs.

Transportation Cost Component of the Elder Standard

To construct the transportation component of the Elder Economic Security Standard, we include tracks for public transit (where available) and private automobile costs.[14] Due to limitations of the data sets we found to be most credible, we are using average transportation costs to calculate the Elder Standard.

[14] Areas without public transit but with a paratransit system can calculate those costs for a second track instead. Cost estimates can be derived from average usage patterns and fees charged.

TABLE 7
Transportation Costs for the Elder Economic Security Standard, Private Automobile, U.S. Average, 2006

	Individual	Couple
Per Month	$276	$337
Per Year	$3,309	$4,045

Sources: U.S. Department of Transportation, National Household Travel Survey, https://nhts.ornl.gov/2001

Internal Revenue Service, per mile costs, "Revenue Procedure 2005-78," Dec. 2, 2005.

Rationale for Selection of Elder Transportation Cost Measures

For areas with sizable public transit systems, we use the monthly cost of a senior transportation pass. Seniors who own and drive their own car face substantially higher transportation costs. There are several data sources to draw on. The U.S. Department of Transportation conducts a National Household Travel Survey (NHTS) periodically. The most recent survey data available are from 2001.

While recognizing these data are likely to have changed in the past five years, we can learn from the basic trends they indicate. Retired adults drive less than younger households, and make a greater proportion of trips for shopping, social and recreational activities, and personal and family needs.

According to Dr. Sandra Rosenbloom of the University of Arizona, younger adults with the greatest mobility are most likely to use conventional public transit, while elders "may be unable to board or ride public transit, or walk to a bus stop or train station." With advancing age, older adults are more likely to drive, ride as a passenger in a car, and use special transit services when available.[15]

To develop the Elder Standard, we use the annual mileage travel information reported by the National Household Travel Survey for older adults and apply the per-mile travel costs calculated by the Internal Revenue Service (IRS). Each year, the IRS calculates a standard mileage rate based on the annual variable and fixed costs of operating an automobile. For 2006, the mileage rate allowed for travel for charitable deduction purposes is 14 cents per mile (operating costs only), while the mileage rate for business deduction purposes and reimbursement (operating plus ownership costs) is 44.5 cents per mile.[16]

Elders in cities likely drive fewer miles than those in the state as a whole; this is offset in part by higher auto insurance rates. Thus, we apply $0.445 to the mileage figures from NHTS giving $3,309 for a single elder and $4,045 for an elder couple. See **Table 8**.

The Consumer Expenditure Survey 2003-2004 reported that elder households in the U.S. spent on average, adjusting for inflation, $1,964 on vehicle purchase costs, $1,502 on insurance, maintenance and repair, and $798 on gas and oil per year, for a total of $4,265 excluding public transit. See **Table 9.** We provide the Consumer Expenditure Survey here only for purposes of comparing rates.

[15] Sandra Rosenbloom, "The Mobility Needs of Older Americans: Implications for Transportation Reauthorization," (Washington, DC: The Brookings Institution, Transportation Reform Series, July 2003). p. 11.

[16] Per mile costs from Internal Revenue Service, "Revenue Procedure 2005-78," Dec. 2, 2005.

TABLE 8
Estimated Cost of Private Automobile Ownership and Usage for U.S. Elders, Based on U.S. Average Elder Driving Patterns, 2006

	1 Adult 65+	2 Adults 65+
Average Annual Mileage in U.S.	7,435	9,091
Operating + Ownership costs per mile	$.445	$.445
Operating + Ownership Costs @ $.445/mi.	$3,309	$4,045

Sources: U.S. Department of Transportation, National Household Travel Survey, https://nhts.ornl.gov/2001 .

Internal Revenue Service, per mile costs, "Revenue Procedure 2005-78," Dec. 2, 2005

TABLE 9
Elder Household Spending on Transportation, U.S., 2005

	Average Spending, Households 65 and over
Vehicle Purchase	$1,964
Gas & Oil	$798
Insurance, Maintenance & Repair	$1,502
Subtotal Auto	$4,265
Public Transit	$383
Total Transport	$4,648

E. Miscellaneous

This expense category includes all other essentials such as clothing, shoes, paper products, cleaning products, household items, personal hygiene items, and telephone service. It does not allow for recreation, entertainment, savings, or debt repayment.

Miscellaneous expenses were calculated by taking 20 percent of all other costs except for long-term care services. This percentage is conservative in comparison to other basic needs budgets as it does not account for expenses such as birthday and holiday gifts.

III. The Elder Economic Security Standard

The four components: housing, food, health care, and transportation, plus 20 percent for miscellaneous expenses are added together to calculate the Elder Standard for each geographic area. These costs vary according to household size (2 options), housing tenure (3 options), health status (3 options), and public or private transportation (2 options). There are 54 elder household combinations in total for which the Elder Standard can be calculated.[17]

Table 10 on the following page illustrates the Elder Standard using the U.S. cost data for four selected elder household types: an individual elder homeowner who owns a home without a mortgage, an elder tenant in a market rate apartment, an elder couple who own their home without a mortgage, and an elder couple in a market rate apartment. The first block calculates the Elder Standard for those in good health. The second and third blocks illustrate the impact of changes in health status.

[17] For areas with significant public transportation systems, otherwise there are 27 elder household combinations.

TABLE 10
The Elder Economic Security Standard, US Average, 2006
Monthly Expenses for Selected Household Types

	Elder Person		Elder Couple	
Monthly Expenses/Monthly and Yearly Totals	Owner w/o Mortgage	Fair Market Rent 1BR	Owner w/o Mortgage	Fair Market Rent 1BR
Housing	$349	$655	$349	$655
Food	$206	$206	$378	$378
Transportation (Private Auto)	$276	$276	$337	$337
Health Care (Good Health)	$220	$220	$440	$440
Miscellaneous @ 20%	$210	$271	$301	$362
Elder Standard Per Month	**$1,261**	**$1,628**	**$1,805**	**$2,172**
Elder Standard Per Year	**$15,134**	**$19,541**	**$21,658**	**$26,064**

Impact of Changes in Health Status

Health Care (Excellent Health)	$197	$197	$394	$394
Miscellaneous @ 20%	$206	$267	$292	$353
Elder Standard Per Month	**$1,234**	**$1,601**	**$1,750**	**$2,117**
Elder Standard Per Year	**$14,803**	**$19,210**	**$20,995**	**$25,402**

Health Care (Poor Health)	$241	$241	$482	$482
Miscellaneous @ 20%	$214	$276	$309	$370
Elder Standard Per Month	**$1,286**	**$1,654**	**$1,855**	**$2,222**
Elder Standard Per Year	**$15,437**	**$19,843**	**$22,262**	**$26,669**

Comparative Income Benchmarks	Elder Person		Elder Couple	
Federal Poverty Guidelines, 2006	**$9,800**	**$9,800**	**$13,200**	**$13,200**
Average Social Security Payment, 2006	**$12,024**	**$12,024**	**$19,776**	**$19,776**
Elder Standard as % Federal Poverty Guidelines	151%	196%	159%	192%
Elder Standard as % Average Social Security Pmt.	123%	160%	106%	128%

IV. Benchmarking the Cost of Home- and Community-Based Long-Term Care Services

Long-term care is a continuum of care that can start at a couple of hours per week and increase to round-the-clock, year-round care.[18] Using national long-term care utilization data, we constructed three packages of home- and community-based long-term care services: low, medium, and high. The cost of long-term care services, specific to the geographic area, is inserted to determine the total cost of providing the chosen level of care. The high package has two variations, one with Adult Day Health (ADH) care and one without ADH care. ADH, available in select communities, can be a cost-effective way to provide care and is included for the communities that have it. The high level of care represents someone who is nursing-home eligible.

Table 11 gives an example of the long-term care component using the public reimbursement rates in a sample urban area. Public reimbursement rates are only applicable when an elder is eligible and enrolled in Medicaid.

Rationale for Selection of Home- and Community-Based Long-Term Care Measures

Long-term care is not a need experienced by all elders; therefore, it is provided as an add-on component to the basic Elder Economic Security Standard. Research has found that two-thirds of seniors will need long-term care at some point in their later years; half will have out-of-pocket expenses for care, and 5 percent will spend as much as $100,000 during their lifetime.[19]

The three packages we have selected are only representative of the continuum. The packages assume that the care is formal, paid care, as the Elder Standard measures the costs of goods and services needed by elders in the marketplace. Much of the long-term care provided in the United States is informal care provided by family members.

It has been projected that by 2020 at least 12 million Americans 65 years and older will need either institutional or community-based long-term care. At present, about 70 percent of older adults requiring community-based long-term care receive it from family or friends. The rest receive paid care, either subsidized or out-of-pocket, or defer getting help as long as possible.[20]

Functional Limitations and Aging

Eligibility for home- and community-based long-term care programs is typically measured by ability to perform Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs).

- ADLs are activities related to personal care such as bathing, dressing, eating, getting in and out of bed or a chair, and toileting.
- IADLs are tasks related to daily living such as preparing meals, using the telephone, shopping for groceries and necessities, performing light and heavy household chores, and managing money.

Among elders 65 and older in the United States who live in the community, 37 percent experience some type of physical limitation, 19 percent report one to two ADL limitations, and 9 percent report three to six ADL limitations.[21]

[18] At higher levels of need for care, the likelihood increases of receiving care in a nursing home.

[19] Kemper, P., Komisar, H. & Alecxih, L. (2006). Long-term care over an uncertain future: What can current retirees expect? Inquiry, 42, 335-350.

[20] Centers for Medicare and Medicaid. 2005 http://www.medicare.gov/LongTermCare/Static/Home.asp

[21] Centers for Disease Control. Functional Limitations of Medicare beneficiaries by age, residence, sex, race, ethnicity: 2003. Trends in Health and Aging. http://209.217.72.34/aging/TableViewer/ tableView.aspx? ReportId341

TABLE 11
Home- and Community-Based Long-Term Care Costs for the Elder Economic Security Standard, 2006 Sample Area

Level of Need for Long-Term Care:	Low	Medium	High with Adult Day Health*	High without Adult Day Health
Hours Per Week	6 hours	16 hours	36 hours	36 hours
Cost Per Month	$610	$1,510	$2,618	$3,489
Cost Per Year	$7,322	$18,118	$31,421	$41,871

* 3 days at 6 hours/day = 18 hours/week in Adult Day Health Program (= 1/2 total hours)

The Big Picture: Likelihood of Need and Patterns of Long-Term Care Usage

A recent study of the need for long-term care found that elders 65 years old today will need an average of three years of long-term care (nursing facility, home care, or informal care). Women will need an average of 3.7 years and men, 2.2 years.[22] These averages reflect considerable variability among older adults, as noted above. Generally, among those receiving paid personal or homemaker care, the higher the number of ADL limitations, the greater the number of paid hours of care. However, the amount of limitation in the ability to perform an ADL may influence hours of paid care. Impairment may vary from minimally to maximally limiting. The elder may need cueing, supervision, or physical assistance with that activity. Also, the type of ADL may influence hours of paid care. Assistance with mobility and bathing in particular have been associated with high number of paid hours of care.[23]

A recent Urban Institute study of frail elders found that among elders receiving paid help, the least functionally limited, with one ADL or IADL, on average, received 20 hours of paid assistance (median 10 hours) per week and those with the highest functional limitations, with more than three ADLs, received on average, 36 hours of paid assistance (median 14 hours).[24] A recent AARP Public Policy Institute study found that elders with one ADL limitation (many cognitively impaired) received on average 21 hours of paid help, those with two to three ADLs received an average of 32 hours, and those with four ADLs received an average of 46 hours of paid help.[25]

In **Figure 7** summarizing these data, the two clusters to the right represent average weekly paid hours of care, and median weekly paid hours of care, respectively. Average weekly paid hours of care range from 20 to 36 hours depending on number of ADLs, and median weekly paid hours of care range from 10 to 14 hours. The difference between average weekly paid hours and median weekly paid hours shows the wide range of utilization of paid care among those with similar ADLs.

[22] Kemper, P., Komisar, H., & Alecxih, L. (2006). Long-term care over an uncertain future: What can current retirees expect? Inquiry, 42, 335-350.
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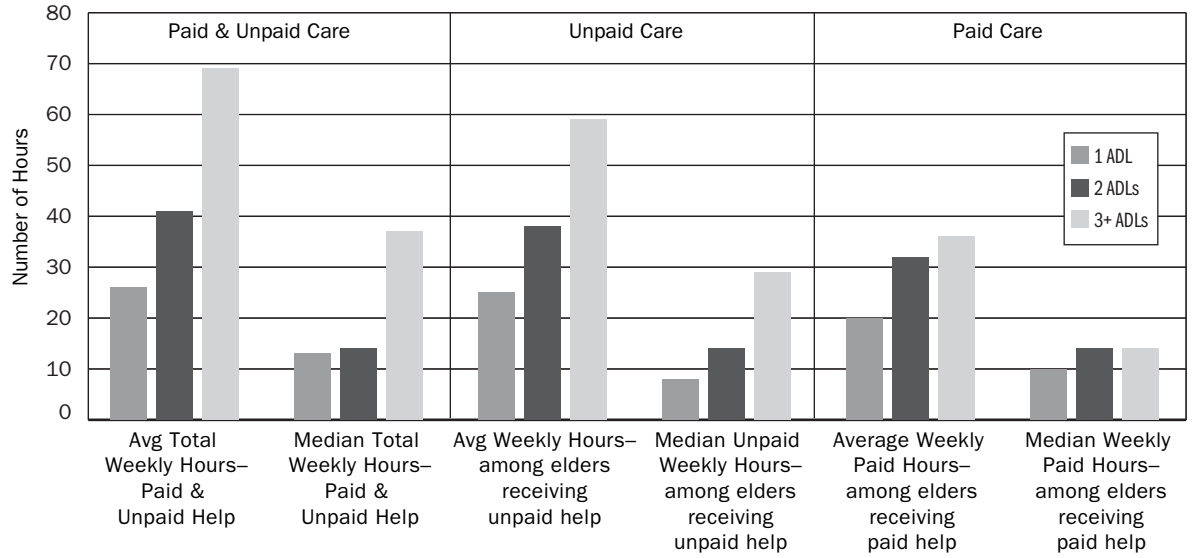
FIGURE 7
by ADL Level, National Health and Retirement Survey 2002



Source: Adapted by author from: Johnson, R. & Wiener, J. (2006). A profile of frail older Americans and their caregivers. Urban Institute. Occasional Paper Number 8. The Retirement Project.

Types of Home and Community Long-Term Care Services

Personal Care Services — The provision of help (hands-on or standby with cueing) with activities such as bathing, dressing, eating, toileting, walking, and getting in and out of bed. These services are provided by Personal Care Aides or Home Health Aides.

Home Health Aide Services — The same kinds of services included in personal care, but provided by Home Health Aides, who are certified in many states, are considered more skilled than Personal Care Aides, and are supervised by RNs or therapists (speech, PT, OT).

Homemaking Services — The provision of assistance with tasks (IADLs) such as shopping, menu planning, meal preparation, laundry, and light housekeeping.

Chore Services — The provision of help with heavy household work such as washing floors, changing storm windows, yard work, shoveling snow, cleaning oven, defrosting refrigerator, etc.

Home Accessibility Modifications Services — Adaptations and/or renovations that make the home safer and easier to navigate, such as installation of grab bars, tub transfer benches, handrails, or lighting; replacing handles on doors with levers and light switches with paddles; and widening doorways or minimizing thresholds.

Case Management, Geriatric Care Management — The case manager assesses the elder for service needs, obtains services, monitors elder's progress, coordinates service providers, and communicates regularly with other professionals, the elder client, and their families.

Skilled Nursing and Therapy Services — Specialized service provided by a Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse. Nursing services include assessment of support needs, development of care plans, monitoring health status, and performing specialized procedures and treatments. Physical, occupational, and speech therapists or certified therapy assistants provide evaluation and treatment as needed.

Personal Emergency Response System — A wearable signaling device that sends a digital message over phone lines to a central monitoring station for help in case of an emergency. An enhanced service includes a telephone with enlarged numbers and reminder features, for example, signaling to take medication.

Adult Day Care Services — The provision of nursing services, health oversight, assistance with ADLs, therapeutic recreation, meals, family support, case management, and rehabilitative and preventative care in a structured group setting for adults with functional or cognitive impairments. This includes adult day health care, social day care, and special and separate care programs for elders with dementia.

Assistive Devices and Supplies — This may include one-time purchases such as bath chair, raised toilet seat, or hand-held shower, as well as monthly expenses for incontinence pads, disposable gloves, or skin-care ointments and dressings.

Sources of Payment for Long-Term Care Services

Medicare – Medicare does not generally pay for long-term care. Home health services are available only to those who require skilled nursing care, therapists or aides/homemakers in a post-acute situation and part-time or intermittently. Since Medicare is included in the health care costs component of the standard, skilled care is not included in the long-term care costs.

Medicaid – Medicaid is a federal and state government-funded program of health care for low-income Americans. Medicaid provides a full range of health care benefits, including nursing facility care and home and community-based services. Home and community long-term care services available to older Medicaid enrollees include home health (skilled nursing and home health aide care), adult day health services, hospice services, consumer-directed personal care attendant services, adult foster care, group adult foster care, and personal emergency response systems.

Older Americans Act – The Administration on Aging (AoA) and Area Agencies on Aging fund services such as home-delivered and congregate meals, food shopping assistance, and family caregiver services.

Long-Term Care Insurance – Today, two-thirds of long-term care insurance policies cover home and community care, as well as nursing home care. Nationally, approximately 2 percent of nursing home costs and 8 percent of home health costs are covered by private long-term care insurance. Approximately 9 percent of adults 55+ and 7 percent of those 55-64 had LTC insurance policies in 2002. Because utilization of long-term care insurance is relatively low, we do not include it in the Elder Standard. It is, however, a potential source of financial protection for elders who are able to afford the premium costs, and who meet underwriting criteria for coverage by it.

Donated or Unpaid Care – Recent Congressional Budget Office (CBO) testimony (2005), focusing on the cost and financing of home and community long-term care, revealed that if the value of donated or unpaid care were included, substituting the cost of formal care for donated care, over two-thirds of home-based long-term care expenditures for elders would be for informal caregivers. The economic value of donated care was estimated to be $50 billion to $103 billion in 2004 dollars.[26]

Out-of-pocket – Savings, other retirement income sources, and home equity are potential sources to offset the cost of home and community long-term care.

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Constructing a Model of Home- and Community-Based Long-Term Care Costs

We selected the following components of a home- and community-based long-term care services package to construct the monthly cost estimates:

- personal assistance with care of the body and everyday tasks; these are provided primarily by personal care aides and home health aides
- help by a homemaker with regular household tasks, such as laundry, food shopping, meal preparation, and housekeeping
- a case manager to assess, coordinate, and monitor the need for assistance by providing supports or augmenting help of informal caregivers in the home
- personal emergency response system
- disposable supplies (such as wound care or incontinence products)
- adult day health care; for urban areas where this service exists, such care provides meals, social recreation, medical oversight, and informal caregiver respite

There are a number of valuable services that may be needed but are not included in the basic package because their utilization was low or the service overlapped with other elements of the Elder Standard[27]

Table 12 presents the costs of a long-term care package for the sample area at three service levels chosen along the continuum of care needs, using public reimbursement rates. It provides detail on the service packages at the different levels of care. It also gives private pay rates for the same long-term care service packages for comparison. Public reimbursement rates are only applicable to individuals eligible and enrolled in Medicaid. If an individual does not qualify for Medicaid, private rates are applied.

Low Service Package
The monthly cost for the low service package at six hours per week of assistance using the sample area's public pay rates is $610/month. For simplicity, and because the rates are very similar, personal care and homemakers are combined. We present both the public and private rates for comparison because public rates are relevant to public policy, and private rates to individuals' and family members' planning. A personal emergency response system is included for the safety of an individual living alone. Case management is included to oversee services and manage needs of the disabled elder; costs of this service are included at negotiated public reimbursement rates and at hourly private pay rates.

Medium Service Package
The monthly cost for the medium service package is $1,510 at 16 hours per week of assistance using the sample area's public pay rates. The medium package reflects the need for disposable items such as incontinence supplies, often needed as one becomes more disabled.

High Service Package
The high level package provides for 36 hours of care per week. At this level, two options are introduced, one with a mix of in-home care provided by a combination of a personal care/homemaker and additional care provided by a more skilled home health aide. The second option substitutes three days per week of basic Adult Day Health (ADH) care for some of the personal care/homemaker hours and some of the skilled home health aide hours, at six hours per ADH day plus transportation costs. The cost of the in-home plus Adult Day Health care package at sample area private rates is $2,618 month, 25 percent less than the $3,489/month package without ADH care. An elder receiving the high services package is likely nursing-home eligible.

The Impact of Long-Term Care Costs on the Elder Economic Security Standard

Long-term care costs can nearly equal or more than double the costs of all other components in the Elder Standard, leading to a severe financial impact on elders' budgets. It is a cost that can vary considerably over time, and it is not universally incurred. We therefore include the impact of long-term care as a separate, potentially catastrophic cost for elders. The Elder Standard models long-term care services for two types of elders 1) a single elder living alone and 2) an elder living in a two person elder household.

[27] Companions provide attendance and supervision for the frail elder, but they are not in the package because their cost is highly variable and many are volunteers. Regular services by skilled nurses and therapists are also not in the core package since they are mostly covered under Medicare. Also, the cost of the supervisory responsibilities of nurses for direct care workers and of case managers for coordination of care is often factored into the hourly cost of the direct care workers by agencies providing those workers. Heavy chores, durable goods, and supplies not covered by Medicare, and home accessibility modifications do not appear in our package. Although all can be crucial to remaining in the home, they are typically occasional and/or one-time capital expenses.

TABLE 12
Home- and Community-Based Long-Term Care Services Package Costs at Public Reimbursement Rates*
Sample Area: Cost of Care at 6, 16, and 36 Hours/Week

Public Rate		Low (6 hrs/wk)		Medium (16 hrs/wk)		High w/Adult Day Health** (36 hr/wk, 1/2 = ADH)		High All In-Home Care (36 hr/wk)	
		Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost
Personal Care/Homemaker	$18.34	25.8	$473	68.8	$1,262	51.6	$946	103.2	$1,893
Home Health Aide	$23.48		—		—	25.8	$606	51.6	$1,212
Adult Day Health (6hrs/day)**	$7.83		—		—	77.4	$606		—
ADH Transport (# days)***	$25.00					3	$75		
Case Management***	$107-$275		$107		$138		$275		$275
Supplies	$80		—		$80		$80		$80
PERS*****	$30		$30		$30		$30		$30
Subtotal Hours/Month		**25.8**		**68.8**		**154.8**		**154.8**	
Total Cost/Month			**$610**		**$1,510**		**$2,618**		**$3,489**
Total Cost/Year			**$7,322**		**$18,118**		**$31,421**		**$41,871**

Home- and Community-Based Long-Term Care Services Package Costs at Private Pay Rates
Sample Area: Cost of Care at 6, 16, and 36 Hours/Week

Private Rate		Low (6 hrs/wk)		Medium (16 hrs/wk)		High w/Adult Day Health** (36 hr/wk, 1/2 = ADH)		High All In-Home Care (36 hr/wk)	
		Hours	Cost	Hours	Cost	Hours	Cost	Hours	Cost
Personal Care/Homemaker	$20.50	25.8	$529	68.8	$1,410	51.6	$1,058	103.2	$2,116
Home Health Aide	$22.20		—		—	25.8	$573	51.6	$1,146
Adult Day Health (6hrs/day)**	$11.67		—		—	77.4	$903		—
ADH Transport (# days)***	$25.00					3	$75		
Case Management****	$100-$300		$100		$200		$300		$300
Supplies	$85		—		$85		$85		$85
PERS*****	$34		$34		$34		$34		$34
Subtotal Hours/Month		**25.8**		**68.8**		**154.8**		**154.8**	
Total Cost/Month			**$663**		**$1,729**		**$3,028**		**$3,680**
Total Cost/Year			**$7,955**		**$20,753**		**$36,331**		**$44,161**

*Public reimbursement rates are only available to those enrolled in Medicaid.

**Adult Day Health is included as an option in the High package, at 3 days/week; each day is 6 hours of care. As of May 1, 2006, Public Daily Rate of $47 or $7.83/hour. Private Daily Rate of $70 or $11.67/hour. Note that the Public Daily Rate for Complex Adult Day Care is higher, at $59.

***Adult Day Health Transport public and private rates range from $10-$15 one way, depending on geographic area, distance traveled, type of van (regular or chair), etc.

**** Case management based on negotiated rates for public reimbursement rates and for private hourly rates for private pay rates.

****** PERS is personal emergency response system.

Source: Authors' calculations based on data, surveys, and interviews with MA Elder Affairs, Mass Home Care, trade associations, and numerous agencies, providers, and stakeholders.

V. Conclusion

The Elder Economic Security Standard, with its respective "tracks" for seniors living in different circumstances, illustrates that seniors with low and modest incomes are challenged to cover their living expenses today, as costs for basic needs are rising much faster than incomes. In addition, it illustrates that seniors with moderate and somewhat higher incomes may be prepared for the present, yet face uncertain futures when expenses outpace income: Costs may rise markedly as life circumstances change.

Many aging boomers are grappling with care, living options, and economic realities for their aging parents. The Elder Economic Security Standard provides a framework to help guide public, private, and elders' decisions that will shape the health and well being of today's elders, and impact the aging boomers and families that care for them, and follow in their footsteps.

The Elder Standard also provides a tool for determining the expenses a senior individual or elder couple will experience in providing for their basic needs. Using the framework outlined in this paper, cost data can be inserted for specific geographic areas to determine the minimum standard for that area. In this way the tool may be adapted for individual planning purposes and used as a targeted tool for state and local policy makers, community agencies, and advocates.

Appendix A: Data Sources

Data Type	Source	Assumptions
Housing	Rent: U.S. Department of Housing and Urban Development. Fair Market Rents - Fiscal Year 2006. Adjusted for more specific geographic areas using ratios based on median gross rents by town from the 2000 census. Retrieved from http://www.huduser.org Owner Costs: US Census: American Community Survey 2004 and 2000 Census, Public Use Microdata Areas (PUMS data). Median Selected Monthly Owner Costs (SMOC) for each geographic area reported separately for owners 65+ with, and without a mortgage. Adjusted by CPI-U for housing in the region. http://www.census.gov/Press-Release/www/2003/PUMS5.html	Fair Market Rents (FMRs) for 1-bedroom units by HUD statistical area (region or county). Median Selected Monthly Owner Costs (SMOC) for owners 65+ with, and without a mortgage. SMOC includes property taxes, insurance, heat & utilities, condo fees, & mortgage payment (if any)
Food	U.S. Department of Agriculture, Low-Cost Food Plan: http://www.usda.gov/cnpp/FoodPlans/Updates/foodjan06.pdf ACCRA. Cost of Living Index. (2004, First, Second and Third Quarter average). Available at http://www.accra.org	Food budget costs for older men and women are averaged to determine food costs for elder households. Food costs can be adjusted for regional differences using area CPI-U for food or ACCRA Index
Total Health Care Costs (premium and out of pocket cost)	Medicare Part B Premiums: CMS, Medicare & You. http://www.cms.hhs.gov/default.asp? Medicare Advantage and Prescription Drug Plan Premiums: Kaiser Family Foundation, United States: Entire Medicare Advantage Profile http://www.kff.org/medicare/healthplantracker/georesults.jsp?r=1 Out-of-Pocket Costs: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey. Household Component Analytical Tool (MEPSnet/HC). August 2003. Rockville, MD. Retrieved from: http://www.meps.ahrq.gov/mepsnet/HC/MEPSnetHC.asp Inflation Factor: http://data.bls.gov/cgi-bin/surveymost?cu	Premium costs are Part B 2006, & 2006 premiums for Part C Medicare Advantage, and Part D Prescription Drug Plans, by Local HMOs. Out-of-pocket costs calculated for elders 65+ by health status, data is updated with the Medical CPI.
Transportation	Private Automobile Cost: National Household Travel Survey (NHTS) http://www.bts.gov/programs/national_household_travel_survey/ Per Mile Cost: US Internal Revenue Service http://www.irs.gov/newsroom/article/0,,id=151226,00.html Public Transportation Cost: Public Transit Authority (if any) http://www.apta.com	Annual mileage driven by retired adults x IRS reimbursement rate for operating and owner costs Cost of Senior Transit Pass (for communities with public transit)
Miscellaneous	Miscellaneous expenses are estimated at 20% of costs of other basic expenditure categories: housing, food, health care, and transportation.	Includes all other essentials: clothing, shoes, paper products, nonprescription medicines, cleaning products, household items, personal hygiene items, and telephone.
Long-Term Care	Data, surveys, and interviews with state and federal agencies, trade associations, and numerous agencies, providers, and stakeholders.	Authors' calculations using area costs for three prototypical levels of long-term care services packages.

Appendix B: National EESI Advisory Board

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Wider Opportunities for Women

Appendix C: About Wider Opportunities for Women

Founded in 1964, Wider Opportunities for Women (WOW) has helped girls, women, and their families achieve economic security through a series of innovative training and education projects. For more than 40 years, WOW has helped women learn to earn, with programs emphasizing literacy, technical and nontraditional skills, the welfare-to-work transition, career development, and retirement security. WOW opened the first employment resource center for women in the United States, played a leadership role in establishing the concept of 'nontraditional' occupations for women, piloted contextual education for women, and advocated for the passage and implementation of key federal policies to increase educational, training, and employment opportunities for women. WOW's work is grounded in the experience of its local project in Washington, D.C. and that of its partners across the country.

WOW is recognized nationally for its skills training models, technical assistance, and advocacy for women workers at all stages of life. WOW leads the National Women's Workforce Network which is comprised of organizations committed to increasing women and girls access to well-paid work, the Family Economic Self-Sufficiency Project (FESS), and the Elder Economic Security Initiative (EESI). For the last several years, WOW has been devoted to its Family Economic Self-Sufficiency Project (FESS), through which WOW put tools in the hands of community organizations, public agencies, and policy makers to address the needs of low-income families. Through this project, WOW has helped to reframe the national debate on social policies and programs from one that focuses on poverty to one that focuses on what it takes families to make ends meet. WOW partners with key state organizations to develop and implement this project. Today, WOW has partners in 35 states and the District of Columbia. In turn, these partners form or participate in state-wide coalitions organized around the concept of self-sufficiency. These programs focus on a range of issues including employment, aging, welfare, tax policy, child advocacy, and women's issues; more than 2,000 organizations are part of this network. You can learn more about WOW by visiting the WOW website: www.wowonline.org.

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Appendix D: The Gerontology Institute at the University of Massachusetts Boston

University of Massachusetts Boston®

Gerontology Institute
Phone: 617-287-7300
Fax: 617-287-2080
www.geront.umb.edu

THE GERONTOLOGY INSTITUTE
John W. McCormack Graduate School of Policy Studies
University of Massachusetts Boston

The Gerontology Institute addresses social and economic issues associated with population aging. The Institute conducts applied research, analyzes policy issues, and engages in public education. It also encourages the participation of older people in aging services and policy development. In its work with local, state, national, and international organizations, the Institute has five priorities: 1) productive aging, that is, opportunities for older people to play useful social roles; 2) health care for the elderly; 3) long-term care for the elderly; 4) economic security for older adults; and 5) social and demographic research on aging. The Institute pays particular attention to the special needs of low-income and minority elderly.

The Gerontology Institute was created in 1984 by the Massachusetts Legislature. In 2003, the Gerontology Institute became a founding member of the John W. McCormack Graduate School of Policy Studies at the University of Massachusetts Boston. The School brings together two Institutes and several policy-oriented graduate programs to advance their shared educational and public service missions.

Programs housed at the Gerontology Institute include the Pension Action Center, the Social Demography Program, and the Elder Economic Security Standard Project. Founded in 1994 by Institute Associate Director Ellen A. Bruce, the Pension Action Center has assisted over 4000 clients, securing over $27 million in pensions for retirees. The Elder Economic Security Standard Project, co-led by Ellen A. Bruce and Laura Henze Russell, is piloting the development of a reality-based benchmark of elder living costs.

The Institute furthers the University's educational programs in Gerontology. One of these is a multidisciplinary Ph.D. program in Gerontology. Through the Institute, doctoral students have the opportunity to gain experience in research and policy analysis. Another program is a Master of Science in Gerontology that focuses on management issues for working professionals who are looking to upgrade their skills or to advance in new directions within the field.

The Institute also supports undergraduate programs in Gerontology. Foremost among these is the Frank J. Manning Certificate Program in Gerontology, which prepares students for roles in aging services. Each year the Institute assists this program in conducting an applied research project in which students administer a large telephone survey. In addition, the Institute sponsors the Osher Lifelong Learning Institute, (OLLI), a non-credit educational program for adult learners ages 50+.

The Institute houses the editorial office of the Journal of Aging & Social Policy, a scholarly, peer-reviewed quarterly journal with an international perspective. You can obtain information about recent Institute activities by visiting the Gerontology Institute's web pages: www.geront.umb.edu or email gerontology@umb.edu.

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