

The Poor, the Rich, and the Insecure Elderly Caught in Between

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ECONOMIC WELL-BEING DEPENDS BOTH ON THE ability of current income and in-kind services to meet consumption needs and on future income flows, assets, and insurance holdings that can be drawn upon to cover the costs of uncertain contingencies. Private insurance can be purchased to cover specific health-care costs, the sudden death of an income earner, or job-related disability. Publicly funded disability, retirement, survivor, and health insurance provides basic protection against those risks to most elderly. Finally, cash and in-kind, means-tested transfers insure that individuals' economic status will fall no further than a minimum floor.

The adequacy of coverage of our mixed public and private insurance system against late-life contingencies is appropriately measured, not just by looking at the current status of the older population, but also by assessing the insurance they possess—either through public or private sources—against a sharp change in economic status if an uncertain, but probable event should occur. Indeed, Lampman (1984) argues that the reduction of economic insecurity (with respect to income loss or extraordinary and irregular expenditure) is the primary goal of the American system of social welfare transfers, coming before reduction of poverty and fair sharing of financial burdens. Further, Garfinkel (1989) asserts that reduction of uncertainty and insecurity was the key driving

force behind the U.S. Social Security system for the aged and disabled, and is a major argument for a national system of insurance against other contingencies, such as health care or child support (Arrow 1963).

In this article we move away from the more traditional current income and asset measures of resource adequacy and evaluate the insurance, which may be self-financed, that the elderly possess against probable and potentially catastrophic events. Unlike the more extensive social welfare states of Western Europe, where the economic security afforded by public social insurance far dominates that from private resources among the elderly, the United States system of economic security for the elderly depends crucially on the *combination* of private and public sources of economic security, and so we look at this combination.

Measures that focus specifically on economic *security* may come to different conclusions about relative economic status from those that look only at current resources and characteristics. For instance, a healthy 22-year-old graduate student with an annual income of \$6,000 and a negative net worth is by one measure economically worse off, but may be much more secure than a single 85-year-old woman living alone on an annual income of \$8,000 with assets of \$20,000. The graduate student is likely to face a more secure economic future owing to the possibility of full-time work and a low likelihood of severe changes in health status, with the consequent ability to purchase low-cost comprehensive group health and life insurance. The elderly woman is probably unable to work, is a poor risk for a loan, and may have no close family members to call on for financial or physical assistance should the necessity arise. Her only formal means of meeting unforeseen needs are her current income and private assets and her Medicare benefits. If faced with a catastrophic illness, these resources would be rapidly depleted by the incomplete coverage of Medicare: only when her resources are nearly expended will she be eligible for the public-assistance safety net of Supplemental Security Income (SSI), food stamps, public housing, and Medicaid.

This scenario illustrates our thesis that current income and assets measures are an incomplete indicator of economic well-being; an overall measure must take account of the *security* of those assets and income *relative* to the economic and health-related hazards that the elderly are likely to face. The most volatile potential sources of economic insecurity for the elderly concern the adequacy of their health insurance

vis-à-vis their health condition and the adequacy of their incomes and assets to meet potential but uninsured exigencies (e.g., severe inflation, long-term-care expenses). Good public and private health insurance and adequate personal savings add to the economic security of the elderly by insulating them against unfortunate contingencies. On the other hand, inadequate health insurance and undependable income flows, often coupled with poor health and the financial powerlessness to react to such changes, all increase economic insecurity by reducing the ability of the elderly to cope with either expected or unexpected economic change.

The purpose of this article is to explore the chinks in the economic armor of the elderly in the form of economic insecurities against which many of them feel (and actually are) powerless. The first part defines the general conditions that characterize the insecure elderly. The second section outlines the data we will use to explore these insecurities. The third section indicates the separate factors that we consider to be important in determining the economic insecurity of the elderly and how we go about using these factors to define the insecure. The next section of the article presents the results, while the final section summarizes the findings and discusses their policy implications.

Finding the Insecure Elderly

Recent studies indicate that the elderly as a group are as well or perhaps better off on average than are the nonelderly (due largely to the improved money and nonmoney incomes of more recent cohorts of retirees) and that overall elderly poverty rates, while not far above those of younger adults, are far below those of children (Hurd 1989; Preston 1984; Smeeding 1990). However, there is a much higher percentage of elderly than nonelderly living on incomes between 1.0 and 2.0 times the poverty line (a money income range in 1989 of \$5,900 to \$11,700 for single persons and \$7,500 to \$14,900 for couples) (Ruggles 1987). This income group faces the highest risk of financial insecurity. They are at risk because, without private insurance, their income and assets alone are insufficient for them to withstand a run of economic misfortune, yet their assets and incomes are too high for them to be protected by the means-tested welfare safety net. Smeeding (1986) dubbed

these at-risk individuals "the 'tweeners" to emphasize their positioning between the public and private income security systems.

We identify several sources of economic insecurity: potentially high out-of-pocket bills for acute health care, economic disaster in the form of long-term-care costs, Social Security as a constraining force on achieving Medicaid eligibility, and unexpected inflation in housing costs. In addition to these financial measures of insecurity, we also investigate insecurity due to chronic disabilities that limit normal activities and increase the potential time and money cost of such activities. To the extent that the economically insecure are also physically insecure, they are in a situation of double jeopardy; the inadequacy of their financial resources is compounded by the additional income needs associated with chronic physical disability.

While any one of the types of financial insecurity may spell disaster, we define the insecure as those meeting two or more of our insecurity conditions. Our major thesis is that disproportionate numbers of the insecure are in the lower-middle-income ranges, those with "welfare ratios" (ratio of money incomes plus food stamps to the poverty line) of between 1.0 and 2.0. As we show, insecurity does extend into higher income categories. If the catastrophic events examined here should strike, the insecure in all welfare groups will by definition be unable to finance them for any length of time without reducing other forms of consumption. For example, a higher-income individual may have a physical disability that leads to rejection by private health insurance. Likewise, some elderly families who are just below the poverty line are also insecure because of their ineligibility for means-tested programs. For instance, as many as one-third of the elderly poor may be asset ineligible for means-tested benefits from SSI and Medicaid (Leavitt and Schulz 1988). We estimate that 40 percent of the poor in our sample are not eligible for SSI, with 22 percent of the poor ineligible on the basis of assets alone. These poor as well will have publicly provided economic security only after their current source of security (i.e., their liquid assets) is depleted. But, as we show, it is the middle-income range in which the insecure are most likely to be found. For these people, nonmoney income in the form of medical care and housing subsidies could help replace higher cash incomes as a potential source of protection against adverse economic situations, if they so qualified. In actuality, lack of adequate nonmoney income or asset protection for this group places them at risk, and hence, we argue, current private

and public insurance policy implicitly imposes the greatest financial insecurity on this income group.

Data

In order to examine the factors that affect risk status of the elderly, we need data for a nationally representative sample with information on cash and noncash income, on wealth and its composition, on expenditures for housing (utilities, mortgages, property tax), on medical-insurance coverage, and on the chronic health status of the elderly.

The data set we use is the 1984 Panel of the Survey of Income and Program Participation (SIPP) database (U.S. Bureau of the Census 1987). This longitudinal panel survey interviewed the members of a nationally representative sample of about 20,000 households. These individuals were interviewed at four-month intervals for about two and one-half years. Basic core demographic, household structure, and income data were gathered at each interview and special "topical modules" were administered on a nonrecurring basis. In particular, information from topical modules in waves 3 (health and disability) and 4 (assets, shelter costs, energy usage) complete the data necessary to carry out the needed analyses.

The sample selected for this study consists of the 5,225 individuals who were 65 or older in the beginning months of the panel.¹ The SIPP data have been used fairly extensively to examine wealth and income status (Radner 1987) and changes over time (David and Fitzgerald 1986), poverty status and dynamics (Ruggles 1987; Hanushek and Williams 1985; Williams 1986), and program participation (Doyle and Long 1988). In this study we take a somewhat different approach and look specifically at the protection provided by program *eligibility* relative to expected catastrophic needs.

Sources of Economic Insecurity

The five specific sources of economic insecurity among the middle-income elderly that we consider most crucial to their economic vulnerability are interrelated but separable:

1. Medicare as the only acute health-insurance subsidy (or, in very rare cases, reliance on no health insurance at all)
2. Insufficient financial resources to cover two years (the median length of stay) in a long-term-care facility
3. Ineligibility for SSI even if all income other than Social Security should cease
4. Housing costs as a percent of income above the accepted maximum
5. Higher costs of living due to one or more sources of physical disability

Acute Health (Medical) Care

The two largest sources of nonmoney income among the elderly are housing and health-care benefits (Smeeding 1989; U.S. Bureau of the Census 1988a). Food stamps are important to the poorest elderly, but they are dominated by Medicare, Medicaid, and other health-care subsidies, and by public housing and implicit rent on owner-occupied homes. The level and distribution of each of these types of benefits are crucial to alleviating the insecurities facing the elderly. We deal with acute health care first, then chronic health-care needs, and finally housing.

Overall expenditures on acute health care for the elderly (excluding long-term care) reached \$4,200 per person by 1984 (Waldo and Lazenby 1984). Of this total, the elderly paid about 36 percent out of pocket, either directly or via private health-insurance premiums (Gordon 1986). In 1961, before Medicare, the income share spent on medical care by the elderly was no higher than 11 percent, even at poverty-line income levels. Paradoxically, while a larger proportion of the medical-care outlays of the elderly are now covered by subsidized insurance plans, out-of-pocket health-care expenditures for the old reached 15 percent of elderly household income in 1984—and continue to rise (Gordon 1986). The variance in out-of-pocket expenditures across the income spectrum is also now larger. In 1984 the poor and near poor spent over 16 percent of income (although Medicaid helped the poorest of these) while the richest 20 percent of elderly families spent less than 2 percent of their incomes on health care that year (Moon 1983). About 12 percent of the elderly spent 20 percent or more of their incomes on acute-

health-care out-of-pocket costs in 1984 (Feder, Moon, and Scanlon 1987).

Virtually everyone among the elderly has Medicare (Smeeding and Straub 1987). While Medicare covered 69 percent of all doctor and hospital bills, it paid less than 44 percent of the total health-care outlays of the elderly in 1984. The rest was covered by Medicaid, the U.S. Veterans Administration, or by employer subsidies for retiree health-care insurance. The important question, then, is what *else* elderly individuals have to help cover the 56 percent of total health-care costs that Medicare does *not* cover? Persons now burdened with high medical outlays relative to income have either high acute or chronic medical needs or are paying hefty private supplemental insurance (medigap) premiums to protect them at least partially against these exigencies. Those who escape these burdens, and who are thus more secure, either have high enough incomes to cover medical costs, or have an additional form of health-insurance subsidy (beyond Medicare) to help purchase adequate coverage. This added subsidy can take three forms: Medicaid, VA health coverage, or employer-subsidized health insurance. Those with the first two added subsidies are protected against the cost of almost every medical contingency, including nursing-home care. These programs cover the poor (Medicaid) and elderly male veterans at virtually all income levels (VA health care). Those with employer-subsidized insurance tend to have broad and substantial coverage, including not only Medicare deductibles and coinsurance, but also benefits not covered by Medicare.

Those without such subsidies must either rely on Medicare alone or purchase largely substandard supplementary insurance with their own funds. Although researchers have shown that this Medicare-only elderly group has fewer visits to doctors, fewer hospital stays, and buys fewer drugs than do other elderly, lower utilization is due primarily to financial barriers to care and not to better health status (Berk and Wilensky 1983). So, lack of any health-insurance subsidy beyond Medicare is a sign of economic insecurity due to risk of high medical bills and possibly even medical economic catastrophe.

We define those at risk due to inadequate health-insurance protection against high acute-care out-of-pocket expenditures as those reporting no employer-subsidized health insurance and who are eligible for neither VA care nor Medicaid. VA eligibility is inferred from SIPP

data on locus of care, VA insurance coverage, VA disability ratings, and reported service disability and injury. Medicaid eligibility is assumed for all SSI recipients and eligibles, where eligibility is estimated using federal rules applicable in 1984. Note that some SSI eligibles may reside with noneligible relatives (and thus may be found in nonpoor families), although SSI benefits will be reduced in such cases.

Table 1 shows the elderly individuals in our SIPP sample who are at risk of high acute-care out-of-pocket expenditures, ranked by welfare ratio. Individuals are ranked by family poverty status; money income here and in the remainder of this article includes reported gross cash income plus the cash value of food stamps. (Income is not adjusted for payroll, income, and property taxes.)

TABLE 1
Elderly Persons at Risk Because of Incomplete Health-care Coverage

Health-care category	Economic position			Total sample
	Poor ^a	Lower middle class ^b	Middle and upper class ^c	
Percent meeting criteria ^d				
0 Total in economic group	100%	100%	100%	100%
1 Medicaid eligible	58	17	5	14
2 Covered by VA health care	13	23	23	22
3 Covered by employer-subsidized insurance	2	10	32	22
4 At risk ^e	28	51	40	42
(Percent of those at risk:)	(100%)	(100%)	(100%)	(100%)
(6) No insurance beyond Medicare	(48)	(38)	(21)	(29)
(7) Private unsubsidized medigap insurance	(52)	(62)	(79)	(71)

Source: Authors' calculations using 1984 Panel of SIPP.

^a Money income welfare ratio less than 1.0.

^b Money income welfare ratio 1.0 to 1.99.

^c Money income welfare ratio 2.0 or greater.

^d Criteria are incremental, indicating additional in each welfare ratio group meeting the criteria.

^e At risk are those having no subsidized insurance beyond Medicare [= rows (0)-(1+2+3)].

We find that 51 percent of the lower-middle-income group (welfare ratio of 1.0 to 1.99) is at risk for high acute-health-care bills compared with 28 percent of the poor and 40 percent of the higher-income group (welfare ratio 2.0 or higher). Medicaid eligibility removes 58 percent of the poor from being at risk, but only 17 percent of the lower middle class. Veteran's care removes an additional 22 percent of those at risk (all males) from the pool. The additional impact of employer-subsidized insurance is decidedly tilted in favor of the middle and upper classes as expected.

The Risk of Chronic Health-care Expenses

As Rice and Gabel (1987) have recently argued, nursing-home and related long-term-care costs are responsible for the largest share of out-of-pocket health-care costs for the elderly population. For those facing out-of-pocket medical bills of more than \$2,000 in 1986, over 80 percent of those outlays were for nursing-home care. Nursing-home costs in 1984 averaged about \$1,500 per month or \$18,000 per year (Waldo and Lazenby 1984). Although nursing-home stays vary significantly in length, Moon and Smeeding (1989) argue that the average period of stay for all but short-stay (less than three months) patients is just over 2.0 years. Hence, we might use 2.0 years of cost or \$36,000 in 1984 as our criterion of adequacy against nursing-home protection. Those with less than this amount of protection could be deemed to be at risk of catastrophic outlays for long-term-care costs.

Kemper and Murtaugh (1989) report that although 37 percent of the elderly will be institutionalized at least once, the chance of being institutionalized for over two years of one's remaining lifetime at age 65 is about 14 percent for today's elderly. But the chance is 20 percent for women, compared with 7 percent for men. Hence sufficient assets and/or income to cover two years of nursing-home care would protect 6 out of 7 elderly persons: 4 of 5 women and more than 12 of 13 men.

What resources should be counted against this potential cost? The answer to this question is not simple, particularly for elderly couples. In order to meet the cost of long-term care, both assets and incomes can be used. But to what extent can a single elderly person rely on home-equity conversion to liquidate part of their home? How much income (and assets) can an elderly man (woman) use without impoverishing his (her) spouse? How plentiful and prevalent are whole or term

life-insurance policies on elderly adults, especially male spouses? Although no one has firm answers to these questions, recent data from the Congressional Research Service using the 1984 SIPP data (House Ways and Means Committee 1988, table 22, p. 746) shown in table 2 indicate that median total net worth among the elderly, even those 85 or over, could pay for two years or more of nursing care. But excluding home equity, the median net worth of remaining (mainly financial) assets of the elderly is *not* enough to assure more than one year of nursing-home costs (\$18,000) for those aged 65 to 79, and less than that for those 80 and over.

We experimented with several options and report on three here. The basic assumption made in all simulations is that an individual not already eligible for Medicaid is at risk if sufficient assets are not available to cover the cost of a median (two-year) nursing-home stay. A single individual is considered at risk if assets, including his or her home, are valued at less than \$36,000 in 1984. A couple, on the other hand, may have sufficient assets for the care of one spouse, but in paying nursing-home costs could exhaust those needed in the future by the other, leaving the survivor at risk.² We consider both spouses at risk if liquid assets would not cover the nursing-home (or equivalent at-home care) costs of the husband and would leave the wife with insufficient assets (including her home and the face value of any life insurance held by her husband) to cover an equivalent stay for herself. The implication is that the wife of a couple is at risk (the wife, because she is most likely

TABLE 2
Comparison of Median Household Net Worth, Home Equity, and Net Worth Less Home Equity among Elderly Households: 1984

Age of head	Median total net worth	Median home equity	Median total net worth less home equity
65 to 79	\$65,900	\$38,000	\$27,900
70 to 74	59,900	30,000	29,900
75 to 79	58,200	28,000	30,200
80 to 84	52,100	30,000	22,100
85 plus	47,600	25,000	22,600

Source: House Ways and Means Committee 1988, table 22, p. 746.

to be the survivor) if his care “eats” into her ability to finance her own long-term health care.

The second simulation is based on the same division of assets as is the first, but deems only the wife at risk if her husband’s health-care costs require depletion of her remaining assets below the prescribed level. The husband is not at risk in the sense that his care costs will be provided by his spouse or eventual Medicaid eligibility, requiring no change in his nursing-home care. His “community spouse” will be the one who suffers from a sharp diminution in available assets to finance her consumption. The data in Kemper and Murtaugh (1989) seem to support this treatment. Whereas the wife has a 20 percent chance of a greater than two-year stay, the man’s chances are only 7 percent. The joint probability that both would need a stay of more than two years is only 14 percent.

This second simulation can also be compared with the distribution of risk if the spousal impoverishment provisions of the Catastrophic Health Care Act of 1988 had been in place in 1984 (U.S. Congressional Budget Office 1988). This bill specified a division of the non-home assets of a couple such that, until a specified level (at least \$12,000 of assets) is allocated to the community spouse, none can be deemed to the institutionalized spouse. We simulate this division of assets for our sample, but assume that only up to \$36,000 will be spent on an institutionalized husband, with the rest inherited by the wife for her eventual needs.

The first definition of risk resulted in 31 percent of the poor, 53 percent of the lower middle class, and 33 percent of the remaining being at risk (table 3, row 1). Counting only wives to be at risk—the second definition of risk (row 2)—reduced the percentage in all income groups, but by more in the higher-income group where women and men are more likely to be married and, if married, to have younger (nonsample) spouses.

The spousal impoverishment provisions of the Catastrophic bill are all that remain from that legislation. We simulate those provisions (row 3) because they are in fact current policy and because some states are taking similar approaches to dealing with spousal impoverishment due to long-term-care costs. However, the provision has only a modest impact in all three age groups, with individuals in the upper income group disproportionately benefited. This is due to the fact that wives—and not single individuals—benefit and married women are more likely

TABLE 3
Definitions of Vulnerability to Long-term-care Expenses

	Economic position			Total sample
	Poor ^a	Lower middle class ^b	Middle and upper class ^c	
Percent meeting risk criteria				
0 Total in economic group	100%	100%	100%	100%
1 Current definition ^d (both spouses at risk)	31	53	33	39
2 Current definition ^d (only wife of couple at risk)	26	36	16	23
3 Catastrophic definition ^d (only wife of couple at risk)	26	32	11	19
Gainers from catastrophic provision (married women only)				
4 Number in economic group (percent of row)	34 (3)	283 (24)	873 (73)	1190 (100%)
5 Asset position improves (percent of row)	33 (4)	265 (30)	591 (66)	889 (100%)
6 Removed from risk group (percent of row)	4 (2)	70 (31)	154 (68)	228 (100%)

Source: Authors' calculations using 1984 Panel of SIPP.

^a Money income welfare ratio less than 1.0.

^b Money income welfare ratio 1.0 to 1.99.

^c Money income welfare ratio 2.0 or greater.

^d At risk if insufficient liquid assets are available to pay for two years of health-care costs. See text for differences across definitions.

than single women to have higher family income. In addition, only couples with assets to divide can benefit, and a high proportion of those at risk cannot finance even one year of nursing-home care out of their combined assets. Thus, whereas only 42 percent of the at-risk group has income greater than two times the poverty threshold, two-thirds of the women who gain (row 5) or are moved out of risk (row 6) by this provision are in this category.

We adopt the second, more conservative definition of risk in our basic simulations. We do not use the first definition, which would leave a greater number insecure. Table 4 shows the protection provided against long-term-care risks—and conversely the reasons those at risk

TABLE 4
Elderly Persons at Risk Because of Inadequate Protection
Against Long-term-care Expenses

Projection category	Economic position			Total sample
	Poor ^a	Lower middle class ^b	Middle and upper class ^c	
0 Total in economic group	100%	100%	100%	100%
1 Medicaid eligible ^d	58	17	5	14
2 Sufficient assets ^e	16	53	79	63
3 At risk ^f	26	36	16	23

Source: Authors' calculations using 1984 Panel of SIPP.

^a Money income welfare ratio less than 1.0.

^b Money income welfare ratio 1.0 to 1.99.

^c Money income welfare ratio 2.0 or greater.

^d Including current recipients.

^e Including all husbands.

^f At risk are single individuals and wives only among couples who are income and asset ineligible for Medicaid and who do not have sufficient assets to finance a median nursing-home stay [=rows 0-(1 + 2)].

are so disadvantaged. Asset sufficiency was the major cause of not being at risk for all but the poor, for whom Medicaid eligibility or receipt was the major factor that eliminated them from this insecurity (table 4).

Social Security (OASI)

Among the various sources of income of the elderly, the one thought to be most secure is Social Security (or Old Age and Survivors Insurance [OASI]). However, for some elderly beneficiaries these relatively fixed benefits, which change only with prices, are paradoxically a source of insecurity if other types of incomes fall. For the very poor elderly, SSI reduces the insecurity (although obviously not the inadequacy) of other sources of income because in the event of a change in non-OASI income or some other unmet need, those eligible for SSI would be compensated by increased SSI benefits. For example, if income should fall because interest-bearing assets are depleted to pay high out-of-pocket medical-care costs, or because disability causes cessation of part-time work, SSI would compensate for some of that fall, and more

important, confer Medicaid eligibility. But for some poor and most of the near poor, their heavy dependence on "secure" OASI signals that there is little *else*—including SSI—on which the individual could draw in case of unexpected income needs.

Table 5 shows the degree to which elderly individuals in our SIPP sample are dependent on OASI. The first panel shows that the overwhelming share of income for those with incomes below poverty and those in the lower-middle-income range comes from OASI. OASI accounts for at least 65 percent of income of 68 percent of the poor and 64 percent of the lower-middle-income group. In comparison, only 12 percent of those in the higher-income group depend on OASI for

TABLE 5
Reliance on OASI as a Source of Income before Taxes in 1984^a:
Individuals 65 and Older

SSI income category	Economic position			Total sample
	Poor ^b	Lower middle class ^c	Middle and upper class ^d	
Percent in economic group and with OASI				
above 50	82	80	30	51
above 65	68	64	12	34
above 80	54	39	3	19
Percent not SSI eligible and with OASI				
above 50	41	73	30	44
above 65	38	59	12	29
above 80	32	36	3	16
Percent not SSI eligible based on OASI alone and OASI				
above 50	37	63	22	36
above 65	34	54	10	26
above 80	28	34	3	15

Source: Authors' calculations using 1984 Panel of SIPP.

^a Reliance is indicated by whether OASI income is 50%, 60%, or 85% of total before tax income.

^b Money income welfare ratio less than 1.0.

^c Money income welfare ratio 1.0 to 1.99.

^d Money income welfare ratio 2.0 or greater.

65 percent or more of their income. OASI secures a substantial share of the income of these individuals.

Among the poor, almost half of those who are dependent on OASI are currently either recipients or eligible for SSI (second panel). For them, unexpected changes in other income would be offset by increases in SSI. But for almost all of those who are not now eligible for SSI (and Medicaid), the third panel shows that SSI is unlikely *ever* to be an option under current rules. Their OASI benefits alone would make them ineligible. These individuals would be eligible for Medicaid only if deemed "medically needy" and allowed to "spend down" in the states with such an option. Among the lower-middle-income group an even higher percentage (54 percent) are dependent on OASI and neither currently eligible for SSI nor eligible if all other sources of income ceased.

Based on these considerations, we define those at risk due to overdependence on OASI to be those with more than 65 percent of total income from OASI and who would not be eligible for SSI based on OASI alone. Insecurity comes from inability to qualify for SSI if other income sources fall, and so for this condition we evaluate SSI eligibility on the basis of OASI benefits alone. (Note we do not allow earners to be at risk because they may not be collecting full OASI pension benefits.) Table 6 indicates that 54 percent of the lower middle class fall into this category compared with 34 percent of the poor and only 10 percent of the higher welfare ratio group. Actual and potential SSI eligibility buttresses the poor elderly who are dependent on OASI (29 percent), but has only a minor impact on the remaining groups.

Housing Costs

The role of housing in generating nonmoney income is very important to the elderly. Over 80 percent of all elderly households, and almost 90 percent of all elderly couples, receive some form of housing income in kind, which shields them from substantial rental housing costs or unexpected change in those costs (Smeeding 1986). Over 75 percent of the elderly own their own homes; about three-quarters of these have no mortgage owing. While owning one's home outright still leaves open the possibility of economic vulnerability to upkeep, rising utility bills, or property taxes, other housing costs are virtually zero.

Benefits from public housing reached 40 percent of all elderly poor

TABLE 6
Elderly Persons at Risk Because of Dependence of OASI

OASI category	Economic position			Total sample
	Poor ^a	Lower middle class ^b	Middle and upper class ^c	
0 Total in economic group	100 %	100 %	100 %	100 %
1 OASI greater than 65% of money income	68	64	12	34
2 OASI greater than 65% and no earnings	63	58	10	30
3 SSI eligible ^d	29	5	0	4
4 At risk (= 2-3) ^e	34	54	10	26

Source: Authors' calculations using 1984 Panel of SIPP.

^a Money income welfare ratio less than 1.0.

^b Money income welfare ratio 1.0 to 1.99.

^c Money income welfare ratio 2.0 or greater.

^d Based on OASI income alone but including those currently receiving SSI.

^e Those with OASI greater than 65% of family income and not eligible for SSI based on OASI income alone.

renters in 1984 and 43 percent in 1986 (House Ways and Means Committee 1988, table 17, p. 700). Another 16 percent of renters lived in rental housing units for which they paid no cash rent in 1984. Because public-housing rents rarely exceed 25 percent of net cash income, and because living rent free means zero rent, these renters are significantly better off than those who pay full market rent in an unsubsidized dwelling. Although the latter may apply for housing subsidies, waiting lists in most areas are long and for the nonpoor income may be too high to meet state-determined eligibility standards.

Since 1979, home ownership among the elderly has risen slightly with the average equity in owned homes. The *median* value of net worth in one's own home in 1984, reflected in the SIPP database that we use in this article, was more than \$30,000. Income in kind from owned homes, which comes in the form of "implicit" rent, averaged near \$1,100 per year among elderly homeowners in 1979 (Smeeding 1989a) and \$3,120 in 1986 (U.S. Bureau of the Census 1988a). Although the asset value of owned homes may (or may not; see Venti and Wise 1989) be an important source of funds in time of need (e.g., via a reverse annuity mortgage [RAM]), the important point to note at this

juncture is the substantial added in-kind income that accrues to owner occupiers from implicit rent.

Still, even homeowners may face property tax bills (net of local circuit-breaker rebates), utilities, and mortgages, which force them to pay an inordinately large share of their incomes for shelter costs. In 1984, only 6 percent of all owners paid more than one-third of their money income for shelter costs. But even among these, high housing costs might be a matter of choice, not necessity. In other words, among owners already in jeopardy due to high housing costs—those who are truly at risk because they have no alternatives—are those whose home equity is also below some minimum amount. For such persons, selling the home would put them at risk in the rental market but yield them only a small net gain in assets.

To summarize, housing costs among unsubsidized elderly renters are generally higher and definitely more volatile than those facing elderly owners or subsidized renters. The unsubsidized renter is thus presented with economic vulnerability to both rents and rising utility bills as well as a substantially higher real cost of living. On these grounds we argue that households with no in-kind housing income from implicit rent or public housing are vulnerable to high housing costs and that these costs are a source of economic insecurity. To these we would add homeowners who have below \$36,000 in net equity and are already paying more than 33 percent of their incomes for housing costs. Subsidized renters are at least partially protected by their subsidy arrangements, while elderly homeowners not burdened by high costs and low equity are also enjoying the advantage of their home as an asset *per se*.

Those at risk due to being market renters or spending a large fraction of income on a low-equity home were 35 percent of the poor, 24 percent of the lower-middle-class group, but only 13 percent of the remainder (table 7, row 5). As expected, ownership of housing that did not require excessive shelter costs eliminated the largest percentage from the at-risk category (row 3). Public housing and living rent free are important among the poor especially, but also among the lower middle class. Among those at risk for housing costs, most were full market renters, and more likely to be in poverty where home ownership is less likely. But still, among the poor, half of those at risk (18 percent of all elderly living in poverty) were so classified because as owners they spent more than 33 percent of their incomes on a home that had a net equity value of less than \$36,000.

TABLE 7
Elderly Persons at Risk Because of Actual or Potential High Housing Costs

Housing category	Economic position			Total sample
	Poor ^a	Lower middle class ^b	Middle and upper class ^c	
Percent meeting criteria				
0 Total in economic group	100%	100%	100%	100%
1 No cash rent paid	8	4	2	3
2 Living in public or subsidized housing ^d	18	11	1	6
3 Owner with housing expenses less than 33% income	31	54	82	68
4 Owners with expenses greater than 33% of income but equity above \$36,000	9	7	2	4
5 At risk ^e	35	24	13	19
(Percent of those at risk:)	(100%)	(100%)	(100%)	(100%)
(6) (Full market renters)	(50)	(83)	(94)	(81)
(7) (Owners with expenses greater than 33% of income & equity < \$36,000)	(50)	(17)	(6)	(19)

Source: Authors' calculations using 1984 Panel of SIPP.

^a Money income welfare ratio less than 1.0.

^b Money income welfare ratio 1.0 to 1.99.

^c Money income welfare ratio 2.0 or greater.

^d Including those on waiting list for public housing.

^e At risk are full market renters and those owners with less than \$36,000 in housing equity who are spending greater than 33% of income on housing costs.

Health and Functionality

The major definitional criteria for the insecure have so far been economic in nature. But the physical needs of elderly people can affect well-being and security in both economic and noneconomic ways. Recent research (Manton 1987; Kovar 1987; Harris 1987) indicates that many elderly persons, particularly those aged 75 and over who are living in the community, have chronic disabilities and significant difficulty in performing the usual activities of daily living (eating, bathing, moving about, etc.). For those people, insecurity comes not only from

financial factors, but also from the fear of being unable to function independently. Moreover, the home-based elderly with functional disabilities also face greater time and money costs in performing usual tasks such as shopping, cooking, and cleaning. For these persons, the extra unsubsidized costs of home and neighborhood help can reduce their economic as well as their physical well-being.

Physical insecurity can thus compound the economic disaster from high acute-care medical bills or long-term care costs. Disability reduces the ability of individuals to adjust through behavioral changes to such disasters, and, more seriously, are likely to increase the likelihood and the duration of costly medical care.

Of the five chronic disability items in SIPP, we counted as disabled those suffering from one or more of the following three limitations of daily activities:

1. Need help of another person to get in or out of bed
2. Need help in preparing meals or to do housework
3. Need assistance in looking after personal needs such as eating, dressing, or personal hygiene

This resulted in 16 percent of the elderly being classified as disabled (table 8), with higher proportions disabled among the poor and in the lower-middle-income group. About half of all individuals with at least one disability had another as well.

Results

Having determined the number of elderly families (or persons) in each of the five at-risk situations, the calculation of the multiple incidence of these sources of insecurity is straightforward. Although facing only one of these five conditions would not signal economic insecurity, combinations of these conditions (e.g., two or more) will almost surely create an insecure and unstable economic state for affected households. The presence of a large fraction of the elderly facing potentially high acute medical-care costs without medical insurance beyond Medicare and modest assets is not consistent with reports in the literature of the well-off elderly household.

Those subject to three of five sources of insecurity are also high-

TABLE 8
Elderly Persons at Risk Because of Inability to Perform Daily Tasks

Task-performance category	Economic position			Total sample
	Poor ^a	Lower middle class ^b	Middle and upper class ^c	
0 Total in economic group	100%	100%	100%	100%
Inability to:				
1 Care for personal needs	6	6	4	5
2 Get in and out of bed	16	11	7	9
3 Perform housework	19	17	11	14
At risk				
4 At least one condition	24	20	13	16
5 At least two conditions	13	10	6	8
6 All three conditions	5	5	3	4

Source: Authors' calculations using 1984 Panel of SIPP.

^a Money income welfare ratio less than 1.0.

^b Money income welfare ratio 1.0 to 1.99.

^c Money income welfare ratio 2.0 or greater.

lighted. We call these the extremely insecure. Typically, they will be unable to cover high acute medical-care costs either by subsidized insurance (beyond Medicare), their own assets, or by spending down to Medicaid eligibility limits.

Approximately one in three elderly persons (35.5 percent of all people 65 and over) faced at least two sources of insecurity. But of those living in the lower-middle-income range, two in three (60.8 percent) were subject to at least two of the sources of economic insecurity. Even among the poor, 43 percent faced these same insecurities, in contrast to only 22 percent of the higher income group.

The bottom half of table 9 shows those who are extremely insecure, facing three or more sources of economic risk. They total more than one-quarter of the lower middle class, and smaller proportions of the poor and upper middle class.

Who should be protected against sources of insecurities is a major social issue. Political and financial constraints on the ability of the government to extend benefits to all the aged would dictate less concern for those in higher income groups who are insecure. Their higher in-

TABLE 9
Economic Insecurity Among Persons Aged 65 and
Over by Welfare Ratio Status in 1984

Degree of insecurity	Economic position			Total sample
	Poor ^a	Lower middle class ^b	Middle and upper class ^c	
All persons in sample (Percent of row)	531 (10.2)	1579 (30.2)	3115 (59.6)	5225 (100.0)
Insecure ^d				
Basic definition (Percent of column) (Percent of row)	227 (42.7) (12.2)	<u>960</u> (60.8) (51.7)	669 (21.5) (36.0)	1856 (35.5) (100.0)
Extremely insecure ^e				
Basic definition (Percent of column) (Percent of row)	124 (23.4) (16.8)	<u>426</u> (27.6) (59.0)	179 (5.7) (24.2)	739 (14.1) (100.0)

Source: Authors' calculations using 1984 Panel of SIPP.

^a Money income welfare ratio less than 1.0.

^b Money income welfare ratio 1.0 to 1.99.

^c Money income welfare ratio 2.0 or greater.

^d Insecure are subject to at least two of the five sources of insecurity.

^e Extremely insecure are subject to three or more of the five sources of insecurity.

comes by definition enable them better to withstand financial exigencies. The 43 percent of the poor who are so situated are of greater policy concern. Under 1984 rules and regulations, these persons were income and/or asset ineligible for SSI and Medicaid. However, some steps have been taken since that time to reduce economic insecurity among the poor elderly who find themselves at risk. Although the national SSI income guarantee has not yet risen to the poverty line, it has increased faster than the Consumer Price Index (CPI) during the Reagan era. Moreover, the Catastrophic Health Care Act of 1988, even as amended in 1989, extends acute health-care coverage to all of the poor. Ironically, because these efforts concentrate only on the poor, they make the contrast with the insecure who live just above the poverty line even more stark.

Inflating these numbers, based on SIPP sample weights up to 1984 population estimates, we find 4.5 million elderly individuals in the

insecure lower-middle-income level—these are the 'tweeners identified by Smeeding (1986). This is probably an underestimate because we excluded from our sample individuals who failed to respond to the survey over a full calendar-year period. These can be compared with the 3.3 million elderly officially counted as poor in 1984 and the 2.4 million poor represented by our sample. Of the 'tweeners, 2.1 million, more than 45 percent, are extremely insecure. These can be compared with the 1.6 million elderly whom the Census Bureau classifies as poor after counting noncash benefits, including implicit rent, as income (U.S. Bureau of the Census 1988). In fact, then, economic insecurity among the elderly in the United States today is a problem of greater magnitude than is poverty status.

The prevalence of each source of insecurity among the 'tweeners—the insecure in the lower-middle-income range—is shown in table 10. The two most prevalent sources were lack of protection through subsidized insurance against acute health-care costs and heavy reliance on Social Security for over 65 percent of income, but ineligible based on that income alone for SSI. These were followed by exposure to chronic-care costs and finally by housing and disability. The three most prevalent sources of insecurity demonstrate the jeopardy faced by individuals due to the lack in the United States of universal access to broad health-care coverage.

The demographic composition of the 'tweeners is shown in table 11. The 18.4 percent of all elderly persons who are 'tweeners are more

TABLE 10
Sources of Insecurity among the 'Tweeners

Type of insecurity	Percent of 'tweeners ^a having given type
Social Security	75.5
Acute health care	70.2
Chronic health care	56.7
Housing	32.1
Disability	24.5

Source: Authors' calculations using 1984 Panel of SIPP.

^a 'Tweeners are those in the lower-middle-income range with two or more sources of insecurity.

TABLE 11
Demographic Composition of the 'Tweeners

Demographic group	Percent of 'tweeners ^a	Percent of elderly population
Total 'tweeners	100.0	18.4
Females 65 or older	69.6	59.5
Persons 75 or older	49.3	38.5
Unmarried persons	58.4	46.3
Single and 75 or older	32.4	23.4

Source: Authors' calculations using 1984 Panel of SIPP.

^a 'Tweeners are those in the lower-middle-income range with two or more sources of insecurity.

likely to be female, disabled, over 75, or unmarried, as compared with the entire elderly population. This is a group that—as suggested in the scenario at the beginning of the article—is least likely to be able to recover from a health and financial crisis.

Summary and Policy Implications

Whereas the overall data on elderly poverty and income levels indicate an increasingly better-off elderly population, static poverty data do not reflect the economic insecurity the elderly face owing to the inadequacy of resources to meet highly probable events. Almost one-fifth of all elderly, and over one-quarter of all single persons aged 75 and over in 1984 were living with cash incomes between the poverty line and twice the poverty line, and were subject to two or more conditions of economic insecurity related to poor health-insurance protection, risk of destitution for a nursing-home stay, chronic disabilities, high housing costs, or inability to qualify for SSI because of high and relatively stable OASI income. These insecure elderly totaled 60.8 percent of the elderly living on incomes between 1.0 and 2.0 times the poverty line. Much smaller fractions of the poor and the higher income group suffered from two of these five conditions of insecurity.

Some of the poor may be in poverty because they have already suffered the events we define as potential sources of insecurity; with SIPP

data it is impossible to discover for how many this may be the case. There is no doubt that their current resources may be sorely inadequate to meet current consumption needs. But looking at another dimension of well-being, their *current* insecurity is diminished by their nearness to the income thresholds at which the means-tested safety net kicks in. Likewise, the higher-income insecure may also be moving down the economic ladder as realized sources of insecurity diminish their resources. But the snapshot provided by the 1984 panel of SIPP indicates their having the wherewithal to better sustain these contingencies.

Simultaneously high average total incomes, relatively low poverty rates, and significant numbers of insecure among the elderly are not contradictory. In general, tax and transfer policy benefits the elderly much more than any other group. Virtually all elderly benefit from OASI and Medicare. In addition, the poor receive substantial means-tested and cash-in-kind transfers while the well-to-do receive enough additional subsidies and tax-free income to leave them better off after government intervention than before it. Among the lower-middle-income elderly, the insecure basically get OASI and Medicare. Other than these benefits, the nonmoney income system has largely passed them by. They are more likely to rent unsubsidized private dwellings, less likely to have non-Medicare health-care subsidies, more likely to rely on OASI as the primary source of their incomes than are any other group.

Several features of the (1988) Catastrophic Health Care Act were designed to reduce the insecurity of the elderly from large long-term health-care bills, which is the primary source of insecurity among the 'tweeners. Most provisions were repealed (e.g., 150 days of nursing-home care without prior hospitalization), but the features of spousal impoverishment and low-income protection via Medicaid payment of Medicare premia for poor elderly were retained. The spousal impoverishment provision of the Catastrophic Act provides a more liberal exclusion of assets in the case of married couples where one needs medical or nursing-home care, thus increasing the Medicaid eligibility of the institutionalized spouse. But we have shown that the spousal impoverishment provision reduces the total number of insecure by very little. The reason is that the insecure are less likely to be married and, even if married, to have assets sufficient for the surviving spouse to gain substantially. Ironically, the division of assets in favor of the community spouse reduces her Medicaid eligibility, even if income eligible.

The institutionalized spouse may be Medicaid eligible, but the low federal asset limits means that community spouses are less likely to be. The largest numbers of gainers are among those with higher assets to begin with, and they are much less likely to be subject to *any* of our defined sources of insecurity.

The Catastrophic Act's provision that Medicaid coverage of Medicare cost sharing be extended to all persons below the poverty threshold does reduce the percentage of poor who are at risk for large hospital and physician bills (from 35 to 26 percent). But the number subject to two or more risks in the lower-middle-income category does not, of course, change at all.

The small net effect of this legislation on the at-risk group only reiterates our point: The insecure near poor are not poor enough to benefit from the Medicaid extension, but neither do they have sufficient assets (or are they enough married) to gain from the spousal impoverishment provisions. Hence the provisions remaining from the Catastrophic Act do little for the majority of the insecure. If Congress reconsiders this piece of legislation, it might do well to consider ways to target the most insecure elderly—those who are just barely nonpoor. Extension of Medicaid coverage for Medicare deductibles up to 185 or 200 percent of poverty, even on an income-related sliding scale, would add to their security. A precedent for such coverage on a similar basis already exists for mothers and their children participating in the Aid to Families with Dependent Children (AFDC) program. And, of course, provisions (akin to those in the Catastrophic Act that caused the most controversy) that would improve the health-insurance protection provided by Medicare would also reduce insecurity.

Until such policy changes are enacted, we will find that although the 'tweeners by definition have more money income than the poor—and therefore are better off in this sense—they also face a significantly greater degree of economic uncertainty that should be accounted for by policy makers. The provisions of the current Catastrophic Act only make this difference more striking.

Soldo and Longino (1985) predict that, absent any change in the current policy mix,

[the] public sector will continue to focus on the needs of the economically most vulnerable and the private sector on those of the economically most adequate, both sectors inching gradually toward the

socioeconomic middle, as the political and economic climates permit. The future of the very old who are economically positioned in the center will continue to have the least resources available to them, as they do now.

Hence near poverty is likely to remain associated with insecurity. Unless deliberate policy action is taken to alleviate the insecurities of the lower middle class, the economically insecure 20 percent of the elderly whom we call the 'tweeners will circumstantially remain just about where they are today: caught in the middle.

Notes

¹ Individuals must have been at least 65 in either wave 2 or 3, the first interview from which we gather income data. Because we use an annual income measure of household welfare, each individual must have remained in the sample for three consecutive waves. We gathered data from the early waves of SIPP in order to have concurrent data on income, health and medical insurance status (wave 3), and assets (wave 4) and to minimize sample reduction due to attrition. Asset data are also available from wave 7, but these are for up to one year after the time to which health and medical insurance data refer. When married, the individual's spouse's income and assets will be counted in estimating household income and assets (and hence the individual's economic vulnerability), but only if the spouse is also over 64 will he or she be included in the sample.

² We make the assumption that only if the spouse is also in the sample can his or her risk trigger a risk to the other spouse. Thus, even if the costs of health care for the in-sample spouse drastically reduce the assets of a younger spouse, the couple is not considered at risk. Only if there are insufficient liquid assets to cover the nursing-home fees of the in-sample spouse will that spouse be considered at risk. This implies that the younger spouse has other resources that are yet untapped to finance his or her older years.

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