



JUSTICE IN AGING
FIGHTING SENIOR POVERTY THROUGH LAW

JUNE 2023 | ISSUE BRIEF

The Economic Security and Health of Older Women of Color

Denny Chan, Amber Christ, Tracey Gronniger, Sarah Hassmer, Sarah Javaid, Dorianne Mason, Amy Matsui, and Shengwei Sun

Even before the global health and economic crisis unleashed by COVID, a lifetime of systemic disparities deeply impacted the health and economic security of older women of color—especially those with low incomes, who have disabilities, who are immigrants, and who are LGBTQ people. Throughout the pandemic, older women of color experienced high levels of unemployment, lost household income, were overrepresented among essential workers, and served as caregivers. Older women of color, moreover, weathered illness and struggled to afford food, shelter, and health care during the pandemic.

In 2023, older women of color are dealing with the ongoing effects of COVID—all while experiencing an uneven economic recovery, rising costs of food and housing, and continued barriers to accessing needed health care, including reproductive health care. They are also negatively impacted by the persistent failure of policymakers to make critical improvements to income supports and robust public investments in the care infrastructure, affordable and accessible housing, and universal, comprehensive health care.

This issue brief analyzes recent data about the employment, incomes, and health of older women of color and highlights policy solutions that are targeted to support the economic security and health of older women of color.

METHODOLOGY:

In this issue brief, we use the general term “older” to typically indicate people over the age of 50. Different age ranges are used in different data sets utilized in this issue brief. Please refer to individual source notes for information about the relevant age categories or ranges.

Within these multiple data sources, there are a wide range of terms used to refer to people of different racial or ethnic groups. In this brief, we use the following terms to refer to women and households: Asian, Black, Latina/e, Native American, and white, non-Hispanic because these terms most closely align with the categories found in the Census and CDC surveys. The “Asian” race category includes those who identified themselves as Asian in the U.S. Census Bureau. While we use “Asian” rather than “Asian American and Pacific Islander” (AAPI) throughout because it best reflects the data, we want to acknowledge that the failure to disaggregate AAPI people by more specific ethnicity obfuscates the diversity of this community. The “Black” race category includes those who identified themselves as Black or African American. The “Latina” category includes women of any race who identified themselves to be of Hispanic, Latino, or Spanish origin. We use the term “Latine” to discuss households of any race who are of Hispanic, Latino, or Spanish origin because this term allows for more gender inclusivity. The “Native American” race category includes those who identified themselves as American Indian or Alaskan Native. The “white, non-Hispanic” race category includes those who identified themselves as white, but not of Hispanic, Latino, or Spanish origin. Please refer to each individual source note for more information on racial and ethnic categories.

For the purposes of this issue brief, the term LGBT is used (instead of LGBTQIA+) because these data are specifically from lesbian, gay, bisexual, and transgender individuals. People who indicate they are transgender and/or who indicate they are lesbian, gay, or bisexual are counted as “LGBT.” People who indicate they are not transgender, lesbian, gay, or bisexual are counted as “non-LGBT.” This issue brief uses the term “women” to refer to any person whose current gender identity is “female.” This includes cisgender women, and it may also include some transgender women (since some transgender women may have selected “female” rather than “transgender” to best describe their gender identity). This follows methodology created by the Center for Disease Control.¹ Please refer to individual source notes for more information on sexual orientation and gender identity.

Finally, the data sources for this issue brief define “disability” differently. Please refer to individual source notes for more information.²

THE ECONOMIC SECURITY OF OLDER WOMEN OF COLOR

Women, and women of color in particular, face deep inequities in the workforce, economy, housing, and health care systems throughout their lives.

Women of color are more likely to face health care discrimination, suffer from health disparities, and encounter insurmountable barriers to care. Women of color who are family caregivers often experience financial strain, and women of color are overrepresented among the poorly paid care workforce. Lower lifetime earnings translate into lower incomes and less wealth for older women of color. Older women of color also face a critical shortage of accessible, affordable housing. And high housing and food costs consume a larger share of their budgets, often forcing them to forego other necessities, like medical care.

POVERTY

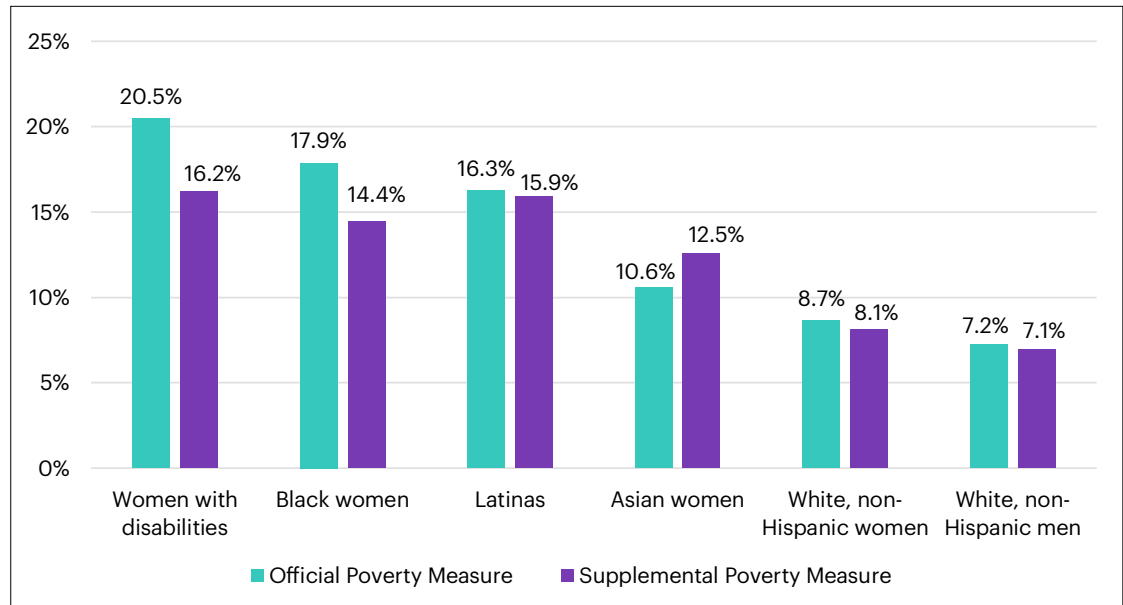
Older women of color, and older women more generally, are more likely to be poor than older men. In 2021, poverty rate using the official poverty measure (OPM) for women 50 and older was 10.9%, compared to 9.1% for men in the same age range. The OPM poverty rates were higher for older Black women (17.9%) and Latinas (16.3%) than for older Asian women (10.6%) and older white, non-Hispanic women (8.7%), and almost double the poverty rates for older white, non-Hispanic men (7.2%). Over one in five (20.5%) older women with disabilities fell below the official poverty line (Figure 1).

Poverty rates for women ages 65 and over were even higher. In 2021, the official poverty rate for women 65 and older was 11.6%, compared to 8.8% for men in the same age range. Nearly one in five Latinas (19.8%) and Black women (19.1%) ages 65 and over lived in poverty, more than double the poverty rate for white, non-Hispanic women (9.1%) and almost triple the poverty rate for white, non-Hispanic men (6.7%) in the same age range (Figure 2). In addition, 14.9% of Asian women and 17.2% of women with disabilities ages 65 and over fell below the official poverty line.

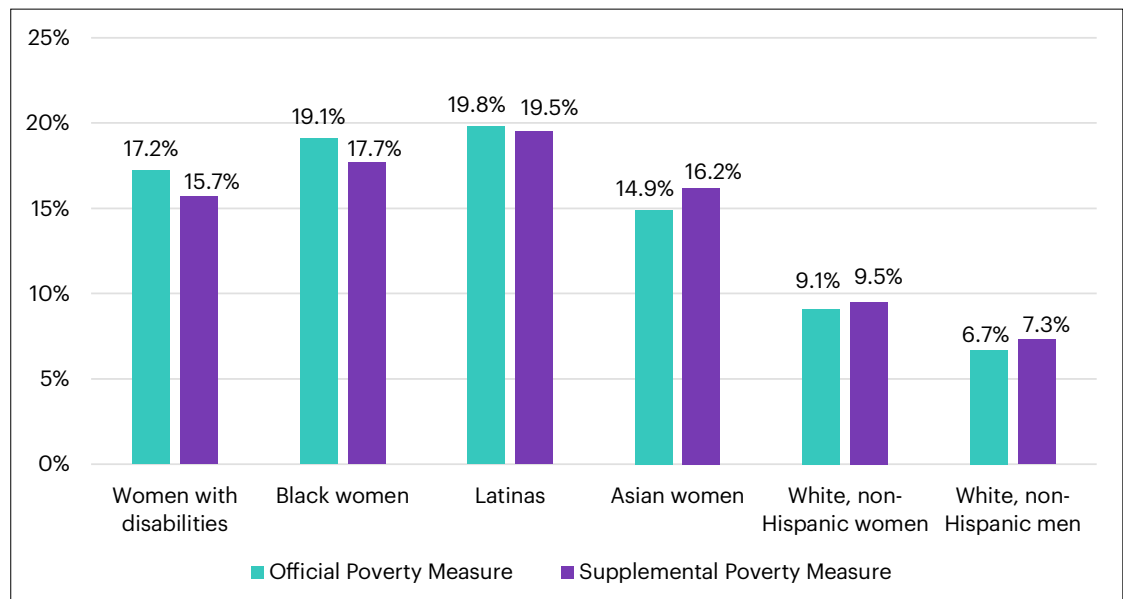


FIGURE 1

Share of Adults
Ages 50 and
Over in Poverty
by Selected
Demographics
(2021)

**FIGURE 2**

Share of Adults
Ages 65 and
Over in Poverty
by Selected
Demographics
(2021)



Source: NWLC calculations based on U.S. Census Bureau, Current Population Survey Annual Social and Economic Supplements microdata using Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren, and Michael Westberry. Integrated Public Use Microdata Series, Current Population Survey: Version 9.0 [dataset]. Minneapolis, MN: IPUMS, 2022. www.ipums.org.

Unlike younger women and children, older women experienced an increase in poverty between 2020 and 2021.³ In addition, the small difference between the Supplemental Poverty Measure (or SPM, which includes income supports such as refundable tax credits and Unemployment Insurance) and the Official Poverty Measure (or OPM, which only includes income from Social Security) suggests that older women received limited support from pandemic relief.⁴

EMPLOYMENT

At the peak of the pandemic recession (spring 2020), older women had higher rates of unemployment than older men across all races/ethnicities, with the highest rates among Latinas (Figure 3). Unemployment rates have since declined more slowly for older Black women and Latinas than for older white, non-Hispanic men and women.

Racial and ethnic disparities in unemployment rates corresponded to disparities among households reporting lost employment income. In 2022, older women of color were more likely to be in households that lost employment income than older white women or older white men.

Nearly one in seven women (14.0%) and men (14.5%) ages 50 to 64 report they or someone in their household lost employment income in the last four weeks (Figure 4).⁵ Latinas (23.3%), Black women (17.8%), and Asian women (13.7%) were more likely than white, non-Hispanic men (12.1%) and white, non-Hispanic women (10.9%) to report they or their household lost employment income.

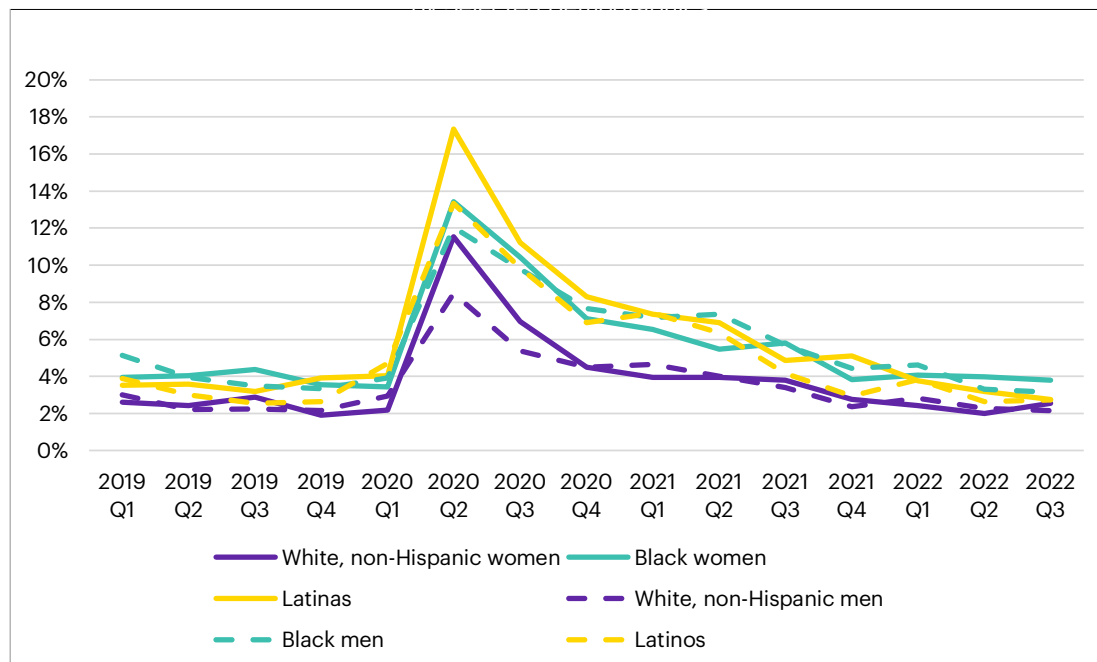
Over one in five disabled women (21.3%) and disabled men (22.8%) ages 50 to 64 reported being in a household that lost employment income in the last four weeks. Disabled Latinas (29.5%), disabled Black women (24.0%), and disabled Asian women (23.7%) were more likely than disabled white, non-Hispanic women (18.3%) to report they or someone in their household lost employment income. In comparison, over one in 10 white, non-Hispanic nondisabled men (10.5%) report being in a household that lost employment income.

LGBT adults ages 50 to 64 (16.4%) were more likely than non-LGBT adults (13.9%) to report they or someone in their household lost employment income in the past four weeks. Among LGBT adults ages 50 to 64, Latine adults (27.9%), LGBT Black adults (18.7%), and LGBT Asian adults (14.6%) were more likely than white, non-Hispanic adults (12.1%) to report losing employment income.

While overall shares of those who lived in households that lost employment income were lower among those ages 65 and over than among those ages 50 to 64, racial, disability, and LGBT disparities persisted. Among

FIGURE 3

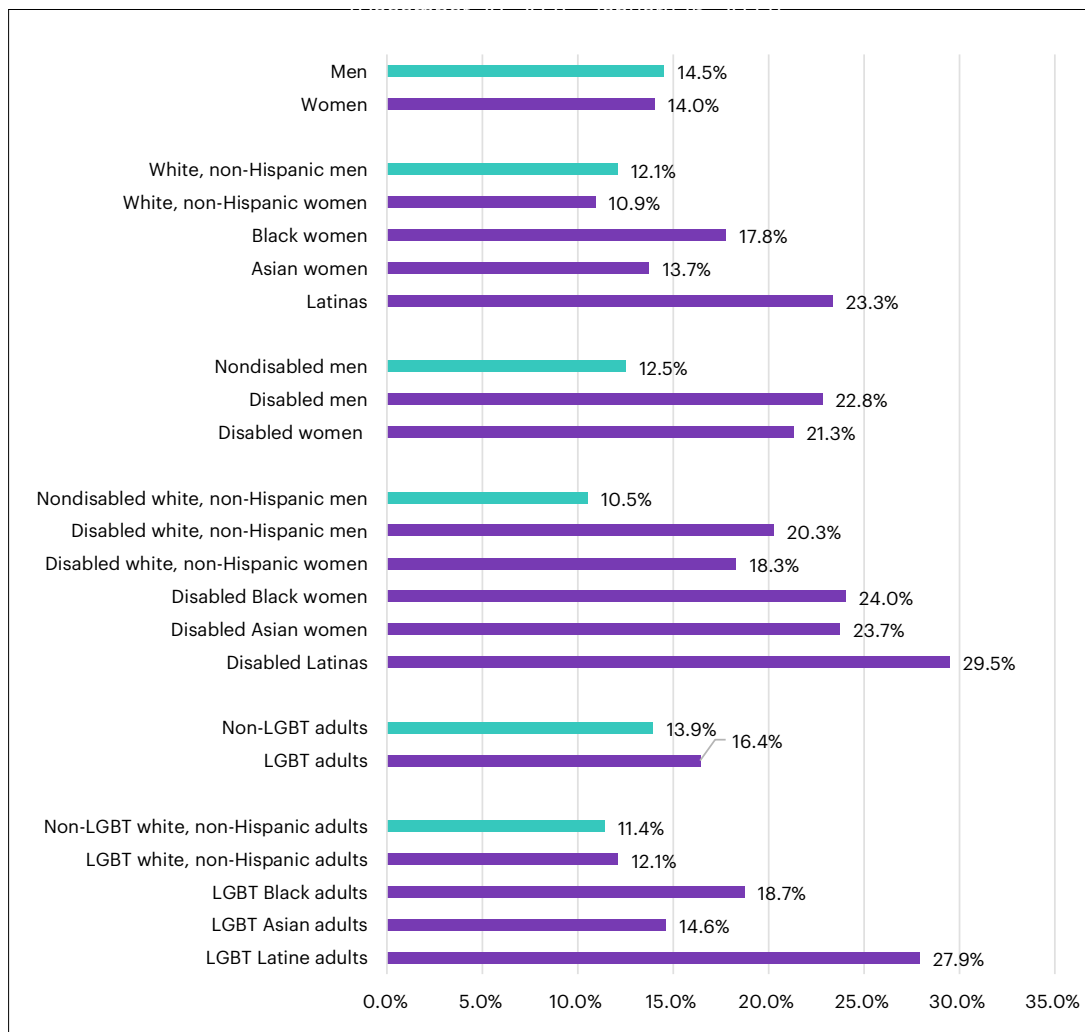
Unemployment Rates (not seasonally adjusted) for Adults Ages 50 and Over by Selected Demographics (quarterly data, 2019 – 2022)



Source: NWLC calculations based on U.S. Census Bureau, Current Population Survey Basic Monthly microdata using Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren, and Michael Westberry. Integrated Public Use Microdata Series, Current Population Survey: Version 9.0 [dataset]. Minneapolis, MN: IPUMS, 2022. www.ipums.org.

FIGURE 4

Share of Adults Ages 50 to 64 Who Reported Losing Employment Income in Their Household in the Past Four Weeks by Selected Demographics (December 29, 2021 – January 16, 2023)



Source: NWLC calculations based on U.S. Census Bureau, 2020-2023 Household Pulse Survey, using data from weeks 41 to 53 (collected December 29, 2021 – January 16, 2023). Survey respondent self-identified as male, female, transgender, or none, self-identified their sexual orientation, self-identified their race and whether they were of Hispanic, Latino, or Spanish origin, and self-identified via six questions if they had a disability. Refer to the “About the Data” section for more information.

adults ages 65 and over, Latinas (11.5%) and Black women (10.0%) were over two times more likely than white, non-Hispanic men (5.0%) and white, non-Hispanic women (4.6%) to report they or someone in their household lost employment income in the past four weeks (Figure 5). Asian women (9.0%) were nearly two times more likely than white, non-Hispanic men and white, non-Hispanic women to do so.

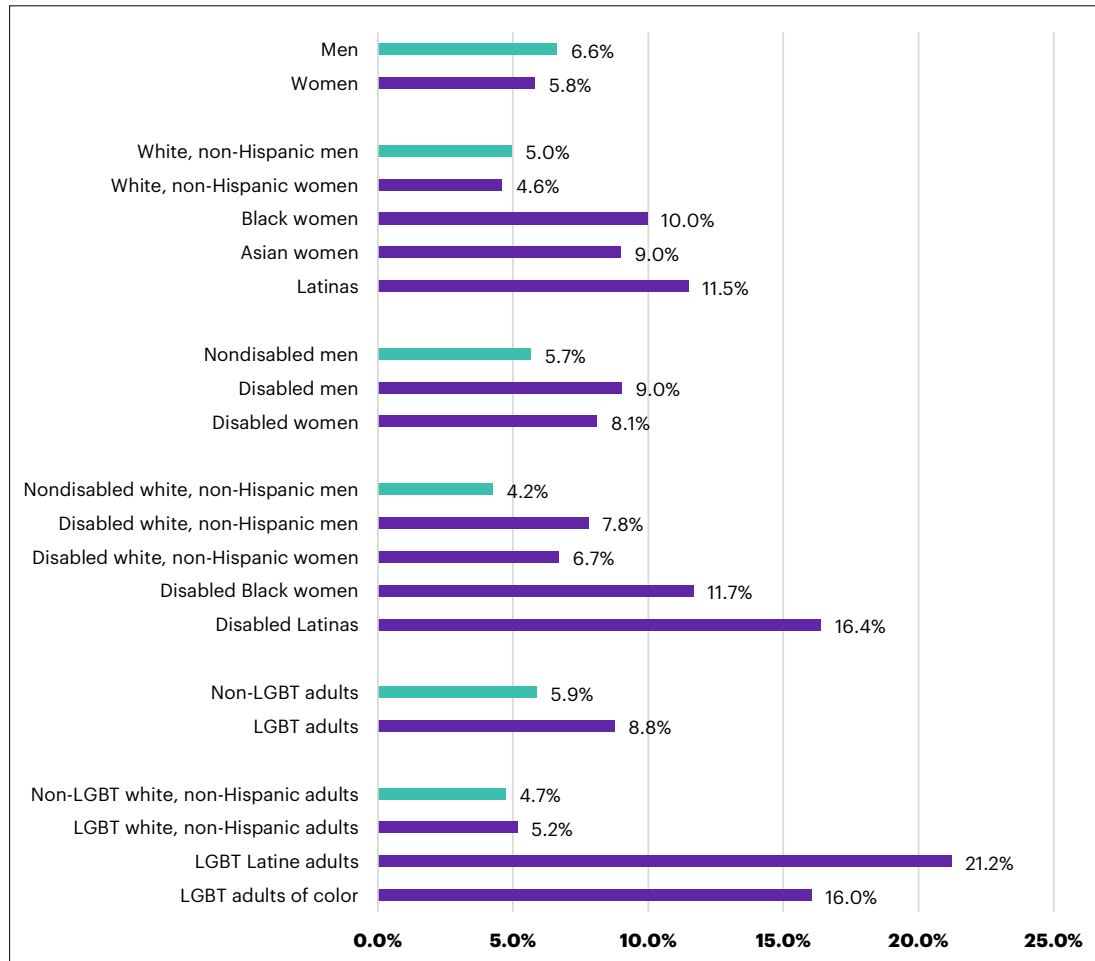
Among adults ages 65 and over, 8.1% of disabled women and 9.0% of disabled men report losing employment income in the past four weeks while 5.7% of nondisabled men report the same. Among disabled adults 65 and over, disabled Latinas (16.4%) and disabled Black women

(11.7%) were more likely than disabled white, non-Hispanic men (7.8%) and disabled white, non-Hispanic women (6.7%) to report they or someone in their household lost employment income. In comparison, only 4.2% of nondisabled, white, non-Hispanic men did so.

LGBT adults (8.8%) ages 65 and over were more likely than non-LGBT adults (5.9%) the same age to report they or someone in their household lost employment income in the past four weeks. Among LGBT adults ages 65 and over, Latine adults (21.2%) were over four times more likely and LGBT adults of color overall (16.0%) were over three times more likely than LGBT white, non-Hispanic adults (5.2%) to report being in a household that lost employment income.

FIGURE 5

**Share of Adults
Ages 65 and
Over Who
Reported Losing
Employment
Income in Their
Household in the
Past Four Weeks
by Selected
Demographics
(December 29,
2021 – January
16, 2023)**



Source: NWLC calculations based on U.S. Census Bureau, 2020-2023 Household Pulse Survey, using data from weeks 41 to 53 (collected December 29, 2021 – January 16, 2023). Survey respondent self-identified as male, female, transgender, or none, self-identified their race and whether they were of Hispanic, Latino, or Spanish origin, and self-identified via six questions if they had a disability. Refer to the “About the Data” section for more information.



OCCUPATIONAL SEGREGATION

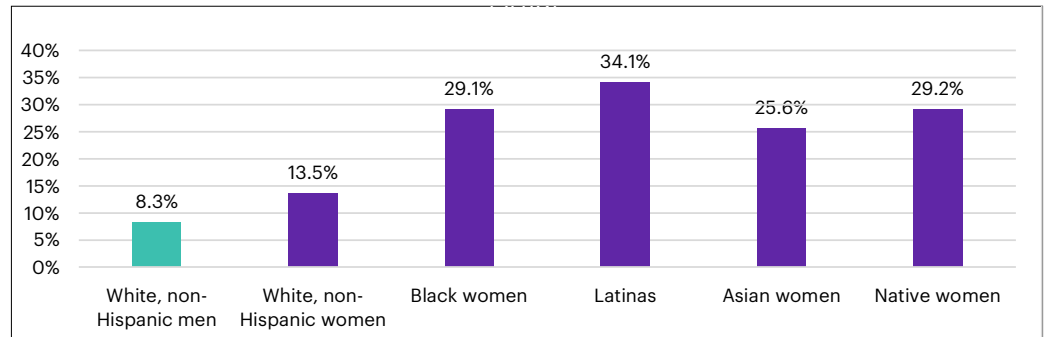
Unemployment rates for older women of color were likely affected by the overrepresentation of older women of color in jobs that were particularly vulnerable to the recession. In 2019, shortly before COVID struck, older women of color were disproportionately employed in service occupations. Among employed workers, over one in three older Latinas (34.1%), nearly one in three older Native women (29.2%) and older Black women (29.1%), and one in four older Asian women (25.6%) worked in service occupations in 2019, compared with 13.5% of older white, non-Hispanic women and 8.3% of older white, non-Hispanic men (Figure 6).

In particular, older women of color constituted a disproportionate share of care workers (9.5% of employed workers in care occupations, compared to 4.8% of the employed population overall) in 2019.⁶ The care sector was especially devastated by COVID, and still has not recovered jobs lost. Those remaining on the job during the pandemic faced elevated health risks.

Among employed workers ages 50 and over, one in four Black women (25.3%) and one in five Asian women (20.0%) worked in care occupations, followed by 17.6% of Native women, 15.9% of Latinas, and 14.7% white women, in 2019 (Figure 7). Only 3.5% of white men were care workers.

FIGURE 6

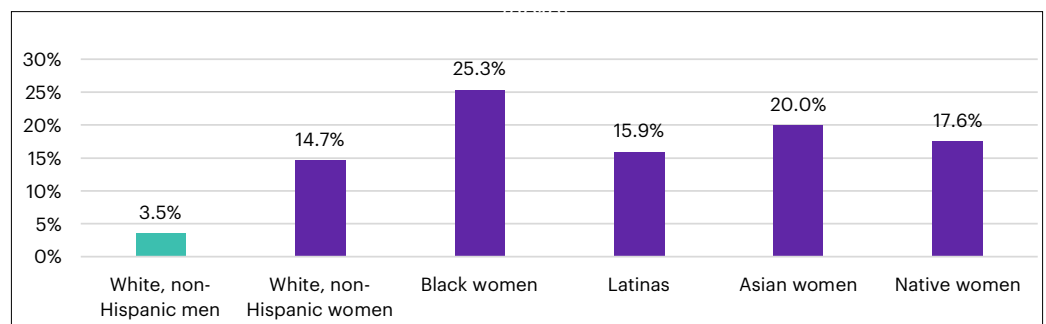
Share of Employed Workers Ages 50 and Over in Service Occupations by Selected Demographics (2019)



Source: Service occupations include health care support occupations, protective service occupations, food preparation and serving related occupations, building and grounds cleaning and maintenance occupations (e.g., janitors, housekeepers), and personal care and service occupations (e.g., child care workers, hairdressers, personal care aides, etc.). NWLC calculations based on U.S. Census Bureau, Current Population Survey Basic Monthly microdata (January to December 2019, pooled) using Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren, and Michael Westberry. Integrated Public Use Microdata Series, Current Population Survey: Version 9.0 [dataset]. Minneapolis, MN: IPUMS, 2022. www.ipums.org.

FIGURE 7

Share of Employed Workers Ages 50 and Over Who Were Health Care Workers, Child Care Workers, and Personal Care Aides by Selected Demographics (2019)



Source: NWLC calculations based on U.S. Census Bureau, Current Population Survey Basic Monthly microdata (January to December 2019, pooled) using Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren, and Michael Westberry. Integrated Public Use Microdata Series, Current Population Survey: Version 9.0 [dataset]. Minneapolis, MN: IPUMS, 2022. www.ipums.org.

CAREGIVING

The employment and incomes of older women are also impacted by caregiving responsibilities. Women shoulder a disproportionate share of unpaid family caregiving throughout their lives.

Among adults ages 50 and over in 2021, women (26.7%) were more likely than men (20.0%) to be regular caregivers.⁷ Native women (32.5%), Black women (27.1%), and white, non-Hispanic women (27.2%) were all more likely than white, non-Hispanic men (20.8%) to be regular caregivers (Figure 8). Additionally, 22.7% of Latinas and 19.8% of Asian women report being regular caregivers. Native women were also more likely than white, non-Hispanic women to be regular caregivers. In addition,

LGBT adults (28.0%) were more likely than non-LGBT adults (23.7%) to be regular caregivers.

Many caregivers spend significant time per week on caregiving responsibilities. Among caregivers ages 50 and over, women (33.4%) were more likely than men (26.9%) to spend at least 20 hours per week on caregiving (Figure 9). Asian women (51.1%) who were caregivers were two times as likely as white, non-Hispanic men (25.5%) to spend 20 or more hours per week on caregiving. Latinas (44.9%), Native women (43.4%), Black women (35.2%), and white, non-Hispanic women (31.6%) were all more likely than white, non-Hispanic men to provide caregiving for at least 20 hours per week. Additionally, among caregivers ages 50 and over, 33.9% of LGBT adults and 30.2% of non-LGBT adults spent at least 20 hours per week on caregiving.

FIGURE 8

Share of Adults Ages 50 and Over Who Were Regular Caregivers by Selected Demographics (2021)

Source: NWLC calculations from Centers for Disease Control, 2021 Behavioral Risk Factor Surveillance System. Participants self-identified their sex, race and ethnicity, sexual orientation, and self-identified if they are transgender.

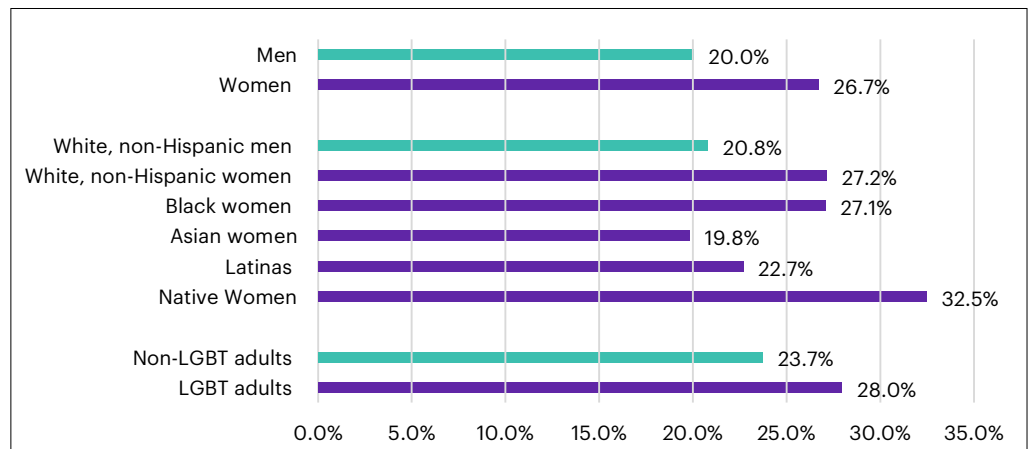
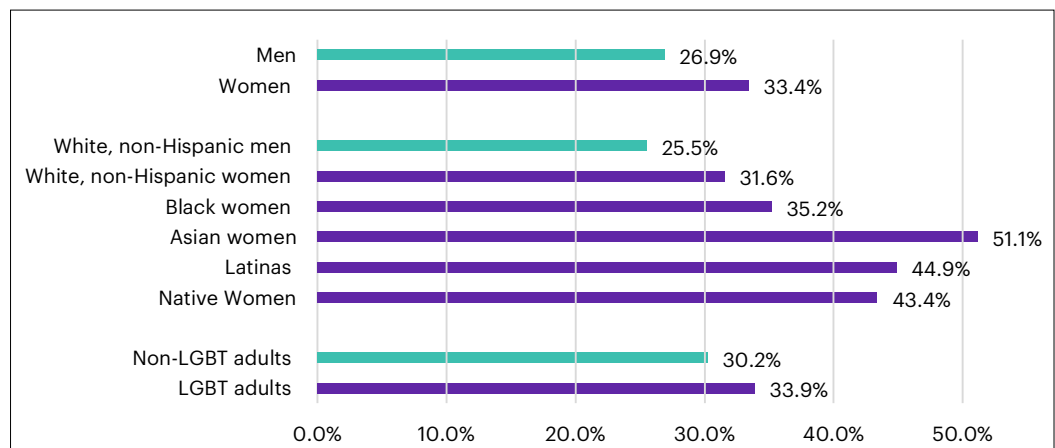


FIGURE 9

Share of Caregivers Ages 50 and Over Who Spent at Least 20 Hours Per Week on Caregiving by Selected Demographics (2021)

Source: NWLC calculations from Centers for Disease Control, 2021 Behavioral Risk Factor Surveillance System. Participants self-identified their sex, race and ethnicity, sexual orientation, and self-identified if they are transgender.



HOUSING INSECURITY

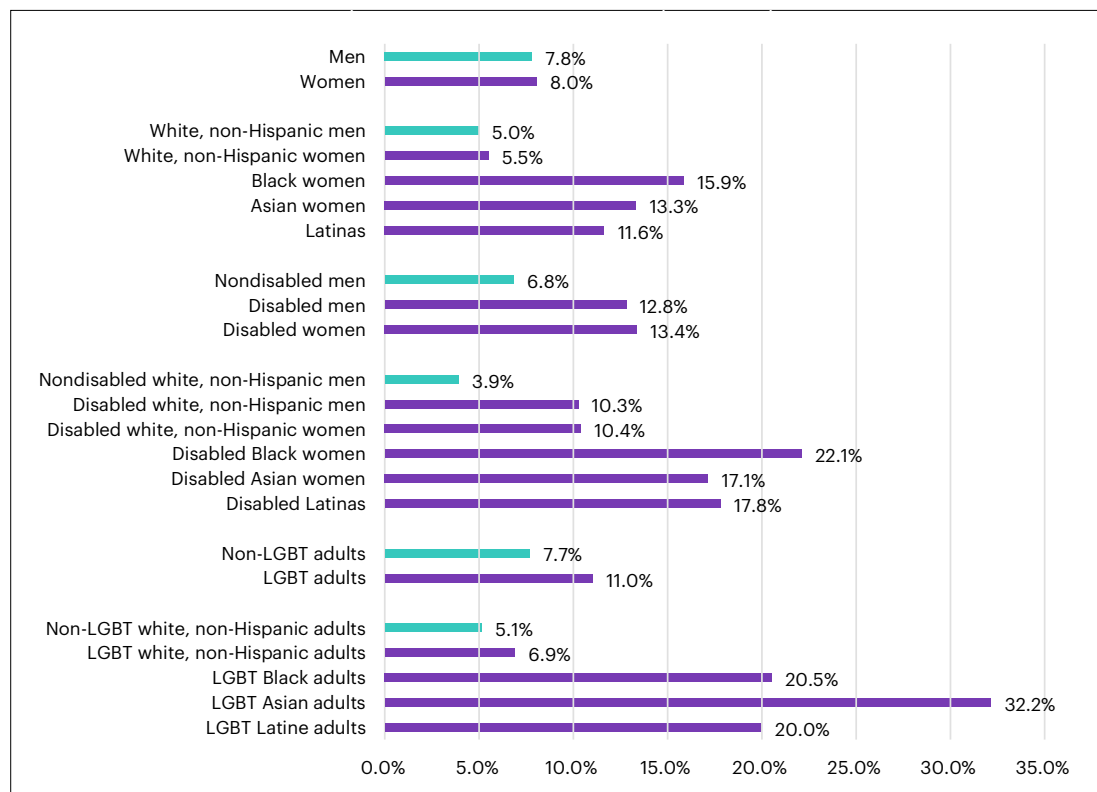
Household Pulse data from the U.S. Census Bureau on housing insecurity and applications for the Emergency Rental Assistance Program (ERAP) are important indicators of the differences in rental cost burdens and housing precarity experienced by women-headed households, particularly Black and Latina women, LGBT people, and women over 50. Many adults ages 50 and over, including 8.0% of women and 7.8% of men, report being behind on their rent or mortgage payments (Figure 10).⁸ Black women (15.9%) were over three times more likely than white, non-Hispanic men (5.0%) and nearly three times more likely than white, non-Hispanic women (5.5%) to be behind on their housing payments. Asian women (13.3%) and Latinas (11.6%) were both over two times more likely than white, non-Hispanic men and white, non-Hispanic women to be behind on their rent or mortgage payments.

More than one in eight disabled women (13.4%) and disabled men (12.8%) ages 50 and over report being behind on their housing payments. Among disabled adults, disabled Black women (22.1%), disabled Latinas (17.8%), and disabled Asian women (17.1%) were more likely than disabled white, non-Hispanic men (10.3%) and disabled white, non-Hispanic women (10.4%) to report being behind on their rent or mortgage payments. In comparison, 3.9% of white, non-Hispanic nondisabled men did so.

About 11.0% of LGBT adults and 7.7% of non-LGBT adults ages 50 and over report being behind on their housing payments. LGBT Asian adults (32.2%) were nearly five times more likely than LGBT white, non-Hispanic adults (6.9%) to be behind on their rent or mortgage payments. LGBT Black (20.5%) and Latine adults (20.0%) were both nearly three times more likely than LGBT white, non-Hispanic adults to report being behind on their housing payments. In comparison, 5.1% of non-LGBT white, non-Hispanic adults report the same.

FIGURE 10

**Share of Adults
Ages 50 and
Over Who
Reported Being
Behind on
Their Housing
Payments
by Selected
Demographics
(December 29,
2021 – January
16, 2023)**



Source: NWLC calculations based on U.S. Census Bureau, 2020-2023 Household Pulse Survey, using data from weeks 41 to 53 (collected December 29, 2021 – January 16, 2023). Survey respondent self-identified as male, female, transgender, or none, self-identified their race and whether they were of Hispanic, Latino, or Spanish origin, and self-identified via six questions if they had a disability. Refer to the "About the Data" section for more information.

Nearly one in seven women (14.0%) ages 50 and over who rent their homes applied for emergency rental assistance programs (ERAP) during the pandemic, and they were more likely than men (10.7%) to apply (Figure 11). Among renters, Black women (23.2%) were nearly three times more likely than white, non-Hispanic men (8.4%) and over two times more likely than white, non-Hispanic women (10.2%) to apply for ERAP. Latinas (14.8%) who rent were more likely than both white non-Hispanic men and white, non-Hispanic women to apply for ERAP. Additionally, 8.8% of Asian women who rent their homes applied for ERAP.

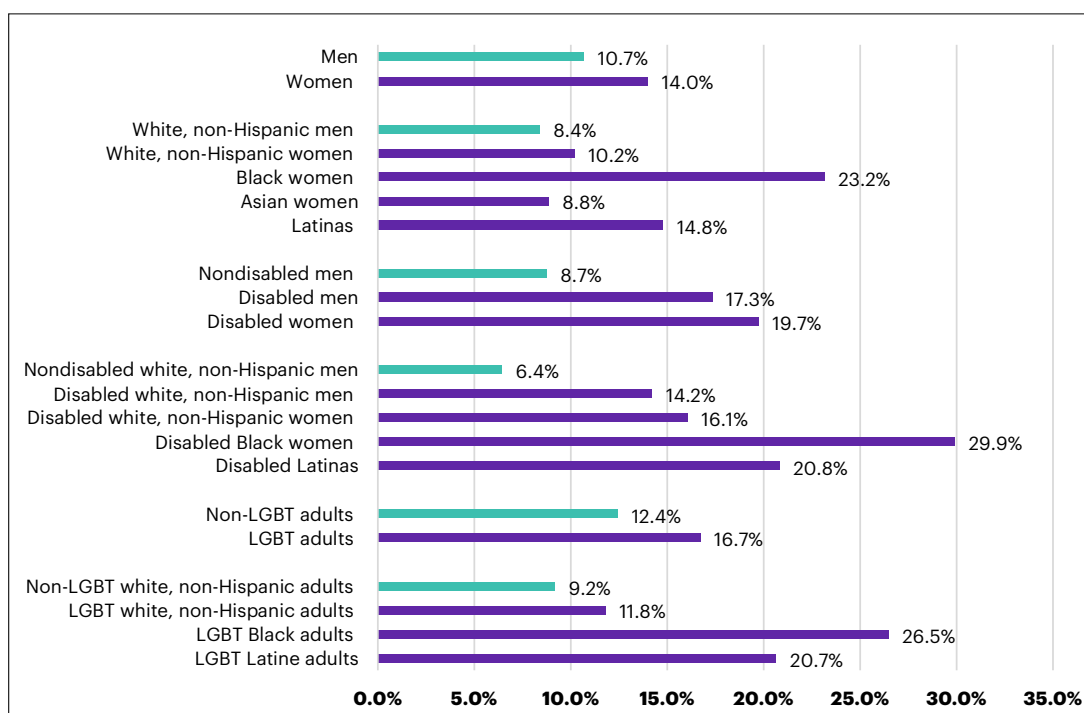
Nearly one in five disabled women (19.7%) ages 50 and over who rent applied for ERAP. Among disabled renters, disabled Black women (29.9%) who rent were

over two times more likely than disabled white, non-Hispanic men (14.2%) and nearly two times more likely than disabled white, non-Hispanic women (16.1%) to apply for ERAP. Disabled Latinas (20.8%) were also more likely than disabled white, non-Hispanic men to apply. In comparison, 6.4% of white, non-Hispanic nondisabled men applied for ERAP.

LGBT adults (16.7%) ages 50 and over were more likely than non-LGBT adults (12.4%) to apply for ERAP. Among LGBT renters, Black adults (26.5%) were over two times more likely and Latine adults (20.7%) were nearly two times more likely than white, non-Hispanic adults (11.8%) to apply for ERAP. In comparison, 9.2% of non-LGBT white, non-Hispanic adults applied for ERAP.

FIGURE 11

Share of Renters Ages 50 and Over Who Applied For Emergency Rental Assistance by Selected Demographics (December 29, 2021 – January 16, 2023)



Source: NWLC calculations based on U.S. Census Bureau, 2020-2023 Household Pulse Survey, using data from weeks 41 to 53 (collected December 29, 2021 – January 16, 2023). Survey respondent self-identified as male, female, transgender, or none, self-identified their sexual orientation, self-identified their race and whether they were of Hispanic, Latino, or Spanish origin, and self-identified via six questions if they had a disability. Refer to the "About the Data" section for more information.

FOOD INSUFFICIENCY

Among adults ages 50 and over, 8.9% of women and 7.9% of men sometimes or often did not have enough food to eat in the past seven days (Figure 12). Black women (17.5%) and Latinas (16.4%) were nearly three times more likely than white, non-Hispanic men (5.9%) and over two times more likely than white, non-Hispanic women (6.4%) to not have enough food to eat. In addition, 5.6% of Asian women report not having enough food to eat.

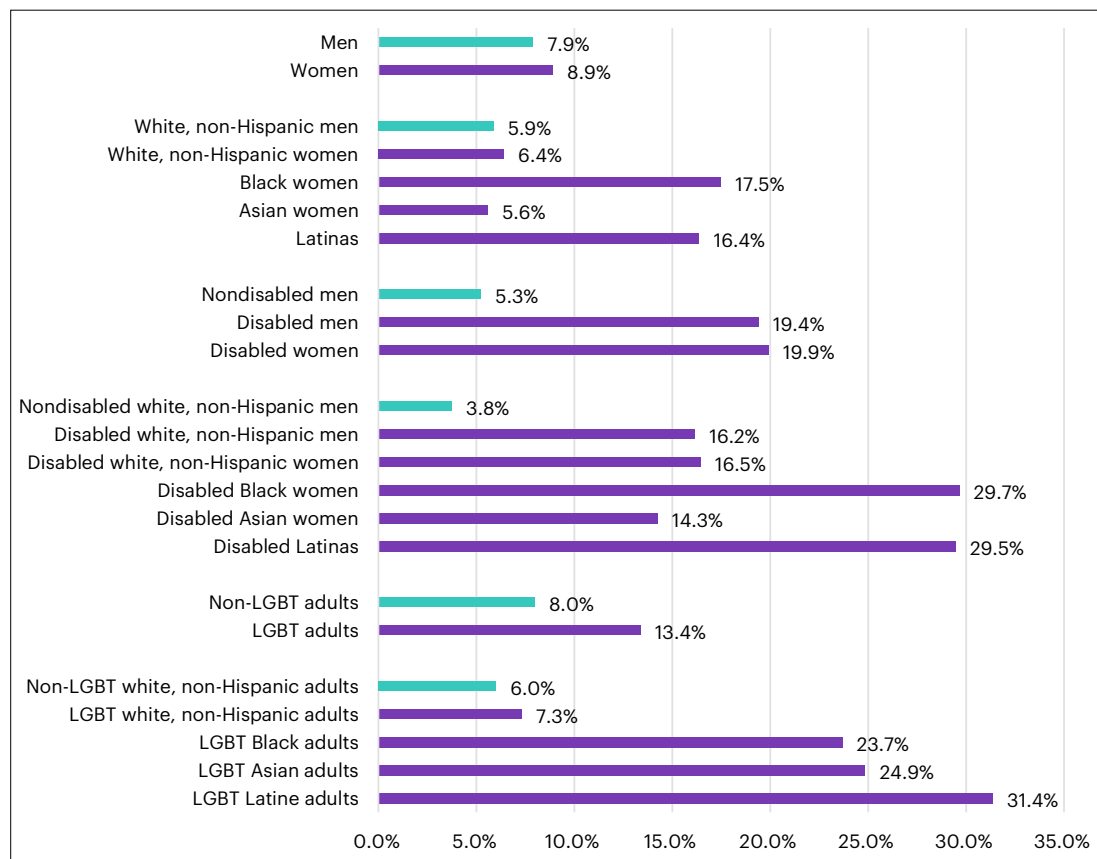
Nearly one in five disabled women (19.9%) and disabled men (19.4%) ages 50 and over sometimes or often did not have enough food to eat in the past seven days.⁹ Among disabled adults ages 50 and over, Black women (29.7%) and Latinas (29.5%) were both nearly two times more

likely than white, non-Hispanic men (16.2%) and white, non-Hispanic women (16.5%) to lack enough food to eat. Additionally, 14.3% of disabled Asian women did not have enough food to eat. In comparison, 3.8% of white, non-Hispanic nondisabled men lacked enough food to eat in the past seven days.

LGBT adults (13.4%) ages 50 and over were more likely than non-LGBT adults (8.0%) to not have enough food to eat in the past seven days. Among LGBT adults ages 50 and over, Latine adults (31.4%) were over four times more likely and Asian adults (24.9%) and Black adults (23.7%) were over three times more likely than white, non-Hispanic adults (7.3%) to lack enough food to eat. In comparison, 6.0% of non-LGBT white, non-Hispanic adults did not have enough food to eat in the past seven days.

FIGURE 12

Share of Adults Ages 50 and Over Who Report Not Having Enough Food to Eat in the Past Seven Days by Selected Demographics (December 29, 2021 – January 16, 2023)



Source: NWLC calculations based on U.S. Census Bureau, 2020-2023 Household Pulse Survey, using data from weeks 41 to 53 (collected December 29, 2021 – January 16, 2023). Survey respondent self-identified as male, female, transgender, or none, self-identified their sexual orientation, self-identified their race and whether they were of Hispanic, Latino, or Spanish origin, and self-identified via six questions if they had a disability. Refer to the "About the Data" section for more information.

WAYS TO SUPPORT OLDER WOMEN OF COLOR AND IMPROVE THEIR ECONOMIC SECURITY

IMPROVING DATA COLLECTION

The first step is improving our collection of data on the well-being of older women, and in particular older women of color. Data that combines information about all older adults as a monolith and fails to disaggregate information for older adults by race and sex can paint an unrealistic picture of the status of older women and masks the harmful impacts of discrimination at the intersection of race and gender. This makes it difficult to identify the problems most pressing for older women and to create and implement relevant policies that effectively address them.

REDEFINING ECONOMIC SECURITY

We should also redefine what it means to be economically secure in our society. Simply having income above the poverty level is insufficient. The 2023 federal poverty level for a household of one, at just \$14,580 per year, or \$1,215 per month,¹⁰ is so low that almost no one could actually afford to live in dignity on this minimal amount of income. The Elder Index is a tool that calculates the amount of income an older adult would actually need, taking into account geographic location, to meet their basic needs for housing, health care, food, and other essentials.¹¹ The national average is more than twice the federal poverty level, indicating that current programs must do more to actually help older adults, and older women, truly achieve economic security.

EXPANDING KEY INCOME SUPPORTS

We must also expand federal and state benefits, including Social Security, SSI, refundable tax credits like the Earned Income Tax Credit, Unemployment Insurance, SNAP, and housing assistance programs for low-income older adults so that they have the income and resources to actually meet their needs.

The Social Security program, which looks only at wage-earning work, should be expanded to include the work of caregivers in its calculation of benefits so that older women who have taken time away from the official workforce are still compensated in retirement for the value of the unpaid caregiving they provided. We should also increase Social Security and Supplemental Security Income (SSI) benefits so that the minimum benefit level is above the (already too low) federal poverty level.

SSI is an important federal companion to Social Security, also administered by the Social Security Administration, that provides cash assistance to very low-income older adults and people with disabilities who do not receive significant income through Social Security Retirement, Survivors, or Disability Insurance. At only \$914 per month in 2023,¹² the maximum SSI benefit is only 75% of the federal poverty level, leaving older adults to struggle to meet their basic needs despite qualifying for the program. Amendments to the program proposed in legislation such as the Supplemental Security Income Restoration Act of 2021¹³ would not only increase SSI benefits but would also modernize the SSI program to update rules that haven't been changed in over 40 years and ensure that eligible low-income older adults and people with disabilities were better able to access the program.

The Earned Income Tax Credit (EITC) is a refundable tax credit that supplements the wages of low- and moderate-income workers. Restoring the American Rescue Plan Act (ARPA) expansions to the EITC for workers not claiming children would also boost the economic security of older women of color. ARPA not only increased the value of the credit for workers with very low incomes, but also eliminated the age limit, for tax year 2021. The ARPA improvements should be restored so that low-paid workers over age 65 who do not claim children can once again become eligible to claim the EITC.

Unemployment Insurance (UI) is a joint federal-state program that protects workers against income loss when they lose a job through no fault of their own.

UI is especially important during economic crises. However, older workers may receive limited assistance from UI, including because they are more likely to be unemployed for longer periods of time than UI benefits are available, and because they may have higher costs when unemployed.¹⁴ In addition, older workers may not be eligible for UI benefits if they are engaged in nonstandard work. The fact that older workers were harmed by the expiration of pandemic UI benefits reflects their greater representation in gig work, independent contractor work, and self-employment.¹⁵ Improvements to UI should include improvements that address barriers faced by older workers, especially older women of color who may not be able to afford to retire but face discrimination on the basis of age, race, and sex in the job market.

Supplemental Nutrition Assistance Program (SNAP) improvements can also help reduce food insecurity among older women of color. For example, shifting from the Thrifty Food Plan to the Low Cost Food Plan will boost the value of benefits and help them last through more of

the month. The United States Department of Agriculture (USDA) can also establish standardized excess medical deductions for older adults and people with disabilities to overcome burdensome verification requirements. Additional funding for outreach and streamlining SNAP application processes would also help more older women of color access SNAP.

Our housing policies must include a plan to provide safe, accessible, and affordable housing. Because of underfunding, only one in four eligible households for housing assistance receive it.¹⁶ Congress should increase funding for housing assistance so every eligible household can access it. We must increase the stock of accessible and affordable housing so that there are enough housing units available to meet the needs of low-income renters, including seniors. We should consider the particular needs of older renters by providing the accessible housing and linked services that allow low-income older adults to age in place, remaining close to their friends, families, and communities.

HEALTH CARE OF OLDER WOMEN OF COLOR

Older women face significant challenges to their health and well-being. Deeply entrenched, ongoing inequities in our workforce, housing, and economy, as discussed above, result in increased economic insecurity, chronic stress, and access to fewer resources over a woman's lifespan. Inequities also exist within our health care delivery systems. When accessing care, many women, especially women of color, experience sexism, racism, and other forms of discrimination. Women are more likely than men to report feeling dismissed, ignored, or mistreated by providers. This discrimination compounds over a lifetime and contributes to poorer health outcomes for older women of color. Barriers to reproductive health care—especially those imposed by politicians—are also more likely to harm women of color and keep them from accessing the care they need.

Higher and/or unmet health needs and lower financial resources cause women, particularly women of color, to not only forgo or deny themselves care and prescription medication at higher rates than men, but also to worry about medical debt and billing associated with care.

These inequities, compounded by women's disproportionate long COVID representation, can have devastating consequences for women's health.

LONG COVID

Women who have had COVID-19 are more likely than men to experience long-term effects from their infection. These long-term effects are known as long COVID. Long COVID can include a range of ongoing, returning, or new health problems that may last weeks, months, or years. Common symptoms include tiredness or fatigue, respiratory and heart symptoms, brain fog, difficulty breathing or shortness of breath, headache, sleep problems, lightheadedness, depression or anxiety, and joint or muscle pain.

Over one in three women (35.4%) ages 50 and over who had a COVID infection reported having long COVID symptoms lasting three or more, and they were more likely than men (24.9%) the same age to have long COVID (Figure 13).¹⁷

Latinas (39.1%), Asian women (35.6%), Black women (35.2%), and white non-Hispanic women (34.5%) ages 50

and over were all more likely than white, non-Hispanic men (24.9%) to have long COVID symptoms. Latinas were also more likely than white, non-Hispanic women to report long COVID symptoms.

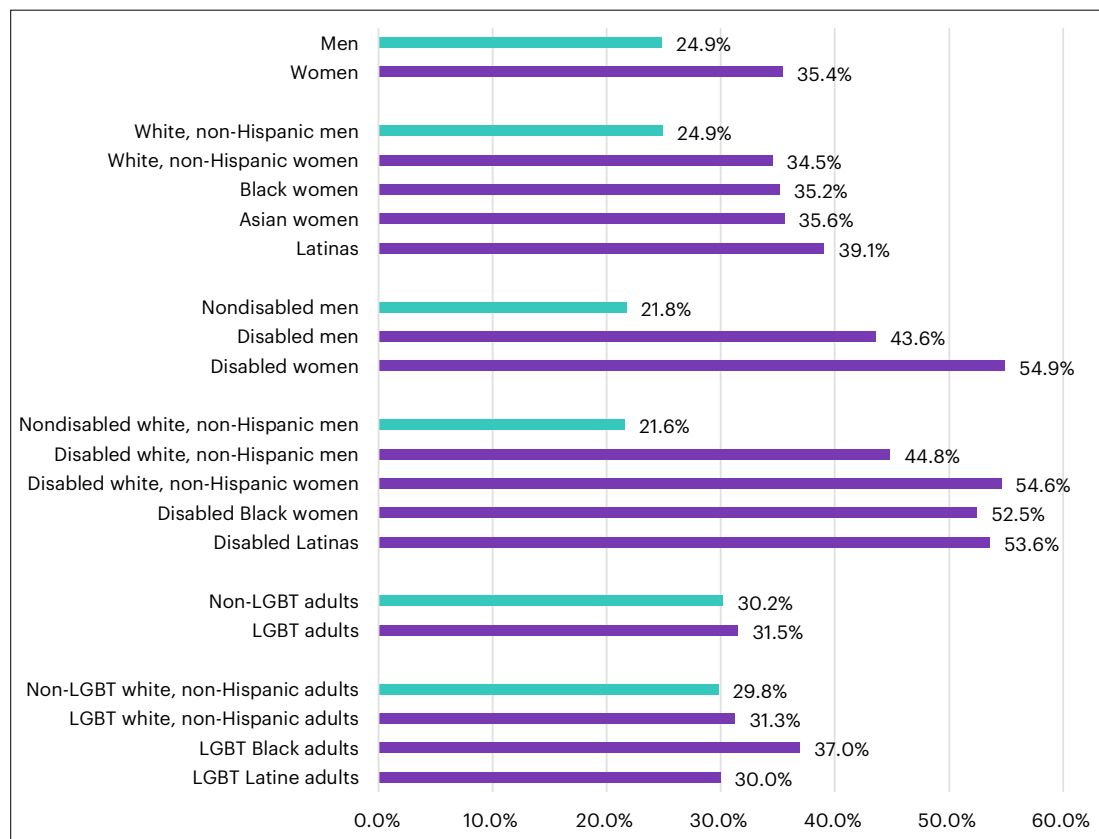
Rates were also significantly higher among older disabled women, as compared to older nondisabled men and older disabled men. Among disabled adults, white, non-Hispanic women (54.6%), Latinas (53.6%), and Black women (52.5%) were more likely than white, non-Hispanic men (44.8%) to report long COVID symptoms. In comparison, 21.6% of white, non-Hispanic nondisabled men reported long COVID symptoms.

A similar share of older LGBT adults (31.5%) and non-LGBT adults (30.2%) who had a COVID infection reported long COVID symptoms. Additionally, 37.0% of LGBT Black, 31.3% of LGBT white, non-Hispanic, 30.0% of LGBT Latine, and 29.8% of non-LGBT white, non-Hispanic adults reported long COVID symptoms.

FIGURE 13

Share of Adults Ages 50 and Over Who Reported Having Long COVID-19 Symptoms by Selected Demographics (June 1, 2022 – January 16, 2023)

Source: NWLC calculations based on U.S. Census Bureau, 2020-2023 Household Pulse Survey, using data from weeks 46 to 53 (collected June 1, 2022 – January 16, 2023). Survey respondent self-identified as male, female, transgender, or none, self-identified their sexual orientation, self-identified their race and whether they were of Hispanic, Latino, or Spanish origin, and self-identified via six questions if they had a disability. Refer to the "About the Data" section for more information.



Long COVID symptoms can cause significant mental and physical distress and limit day-to-day activities. A majority of adults who experience long COVID symptoms report that the symptoms impact their day-to-day functioning. Over one in four women (26.6%) and men (27.6%) ages 50 and over who had long COVID symptoms reported they experience a lot of limitations in their day-to-day functioning (Figure 14).¹⁸ Nearly 36.3% of Latinas, 25.8% of Black women, 24.3% of white, non-Hispanic women and 26.1% of white, non-Hispanic men report their long COVID causing a lot of limitations in their daily life. These shares were much higher among disabled and LGBT people.

Over two in five disabled women (41.7%) and disabled men (47.0%) ages 50 and over report their long COVID symptoms causing a lot of limitations in their day-to-day functioning. Comparatively, 18.3% of nondisabled men reported the same. Among disabled adults who had long

COVID symptoms, 44.7% of women of color, 40.4% of white, non-Hispanic women, and 45.4% of white, non-Hispanic men report a lot of limitations in their daily life. In comparison, 17.2% of white, non-Hispanic nondisabled men reported the same.

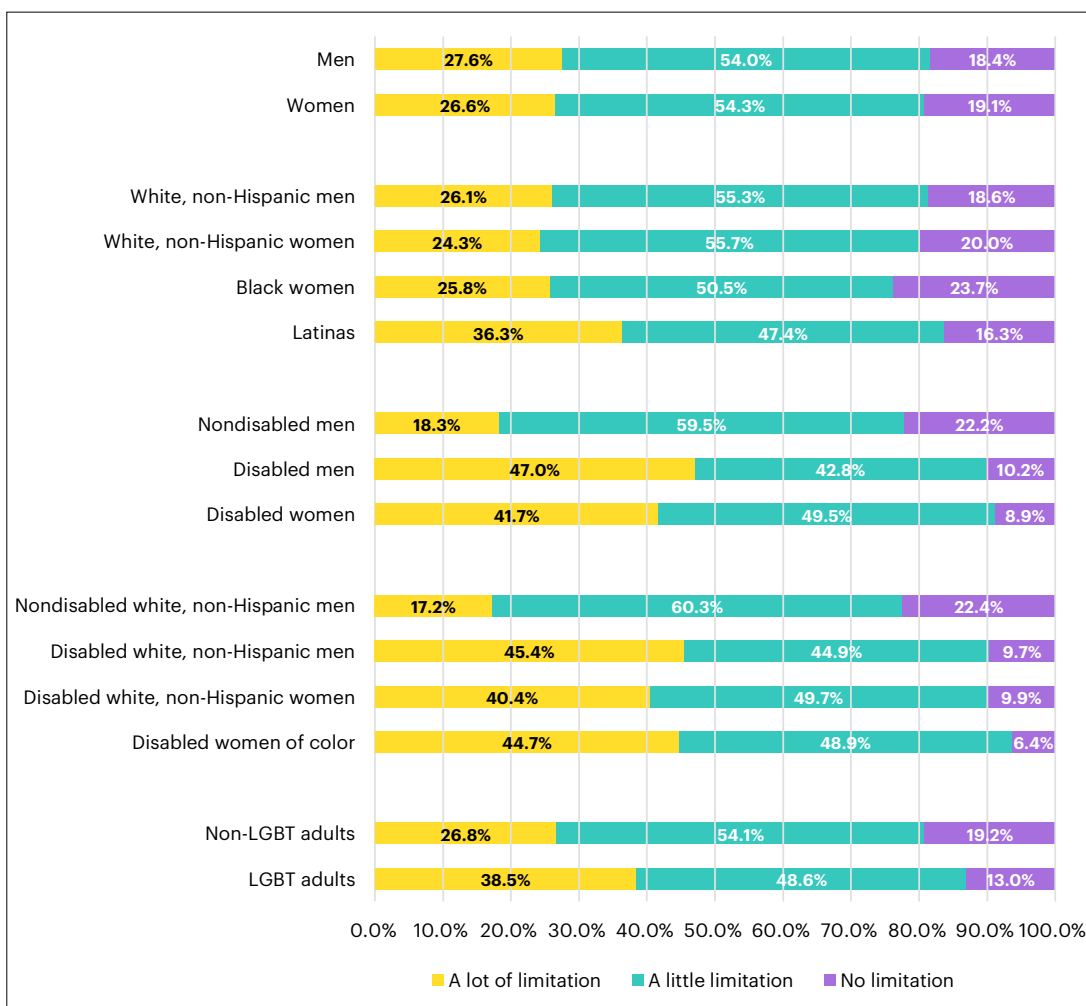
Additionally, 35.8% of older LGBT adults and 26.8% of non-LGBT adults reported a lot of limitations in their day-to-day functioning from long COVID symptoms.

Long COVID may also impact patient-provider interactions. Long COVID can be difficult to explain, diagnose, and manage. As discussed above, women,¹⁹ especially women of color,²⁰ already report higher rates of feeling discriminated against, dismissed, or ignored by providers, as do LGBT people²¹ and disabled people.²² When health care providers do not believe patient symptoms and experiences, it can result in delayed diagnosis and care.

FIGURE 14

Share of Adults Ages 50 and Over With Long COVID-19 Symptoms and Their Reported Day-to-Day Limitations by Selected Demographics (September 14, 2022 – January 16, 2023)

Source: NWLC calculations based on U.S. Census Bureau, 2020-2023 Household Pulse Survey, using data from weeks 49 to 53 (collected September 14, 2022 – January 16, 2023). Survey respondent self-identified as male, female, transgender, or none, self-identified their sexual orientation, self-identified their race and whether they were of Hispanic, Latino, or Spanish origin, and self-identified via six questions if they had a disability. Refer to the "About the Data" section for more information.



HEALTH CARE AFFORDABILITY

Stark racial and ethnic disparities in health care affordability persist among older adults. In 2021, older Black, Native, and Latina women were two to three times more likely than older white men and women to say they needed, but could not afford, care.

Among adults ages 50 to 64, women (9.8%) were more likely than men (8.6%) to need but not be able to afford health care in 2021 (Figure 15).²³ Native women (18.1%) and Latinas (17.8%) were nearly three times more likely than white, non-Hispanic men (6.1%) and over two times more likely than white, non-Hispanic women (7.9%) to need but not be able to afford health care. Black women (12.3%) were two times more likely than white, non-Hispanic men to need but not be able to afford health care and they were also more likely than white, non-Hispanic women to report not being able to afford health care. In addition, 8.7% of Asian women reported needing but not being able to afford health care.

LGBT older adults ages 50 to 64 (10.1%) and non-LGBT older adults (9.2%) have similar, but substantial, shares

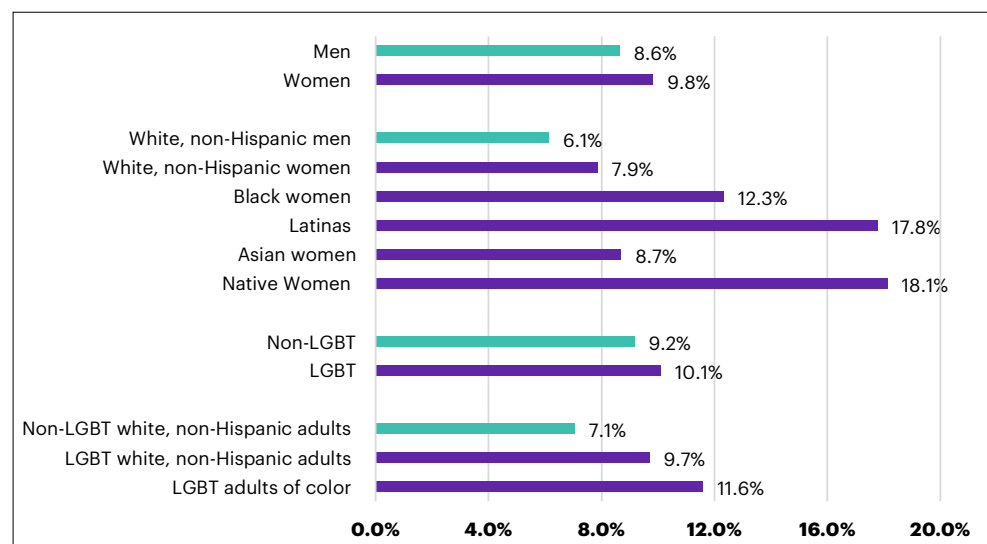
who needed but could not afford health care. Among LGBT older adults, 11.6% of older adults of color and 9.7% of white, non-Hispanic older adults needed but could not afford health care. In comparison, 7.1% of non-LGBT white, non-Hispanic older adults reported the same.

Among those ages 50 to 64 who needed but could not afford health care, 72.7% of women and 68.9% of men had health insurance coverage.²⁴ A greater share of Black women (83.3%) ages 50 to 64 than white, non-Hispanic women (76.5%) and white, non-Hispanic men (74.6%) had insurance and still reported they needed but could not afford health care. Half (50.0%) of Latinas who could not afford health care had health insurance coverage.

Adults aged 65 and older are often covered under Medicare health insurance and fewer adults in this group experience affordability issues when compared to adults aged 50 to 64.

FIGURE 15

**Share of Adults
Ages 50 to 64
Who Needed But
Could Not Afford
Health Care
by Selected
Demographics
(2021)**



Source: NWLC calculations from Centers for Disease Control, 2021 Behavioral Risk Factor Surveillance System. Participants self-identified their sex, race and ethnicity, sexual orientation, and self-identified if they are transgender.

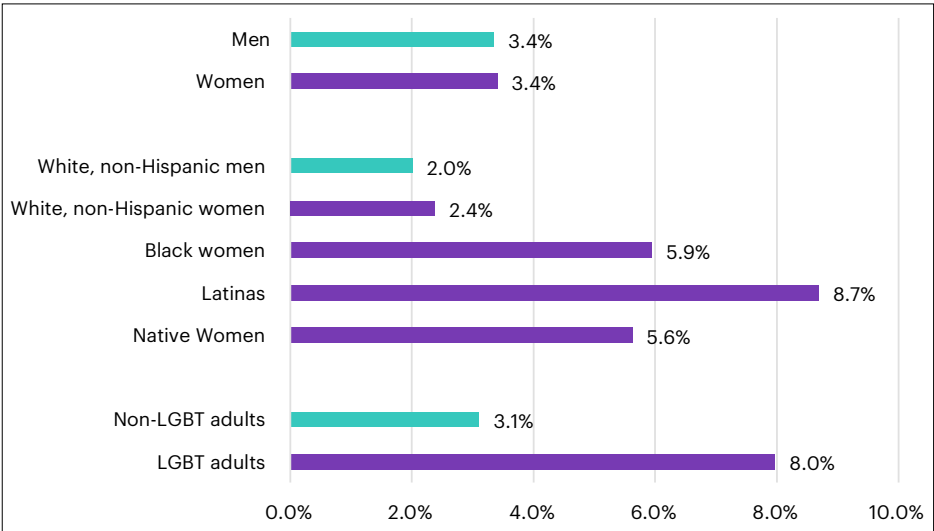


Among adults ages 65 and over, 3.4% of women and 3.4% of men reported needing but not being able to afford health care in 2021 (Figure 16). Disparities for health care affordability were even greater among women of color ages 65 and over. Latinas (8.7%) were over four times more likely than white, non-Hispanic men (2.0%) and over 3.5 times more likely than white, non-Hispanic women (2.4%) ages 65 and older to report needing but not being able to afford health care. Black women (5.9%) and Native women (5.6%) were nearly three times more likely than

white, non-Hispanic men and over two times more likely than white, non-Hispanic women to need but not be able to afford health care. In addition, 8.0% of LGBT and 3.1% of non-LGBT adults ages 65 and over report needing but not being able to afford health care.

Nearly all—93.6% of women and 86.2% of men—adults ages 65 or over who needed but could not afford health care had health insurance coverage, primarily Medicare coverage.²⁵

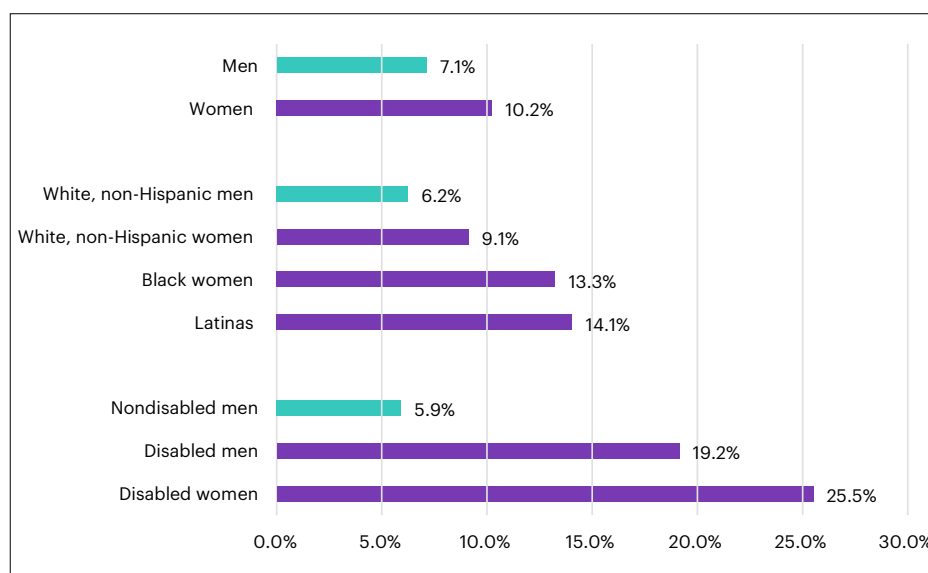
FIGURE 16
Share of Adults
Ages 65 and
Over Who
Needed But
Could Not Afford
Health Care
by Selected
Demographics
(2021)



Source: NWLC calculations from Centers for Disease Control, 2021 Behavioral Risk Factor Surveillance System. Participants self-identified their sex, race and ethnicity, sexual orientation, and self-identified if they are transgender.

FIGURE 17

Share of Adults Ages 50 to 64 Who Needed a Prescription But Could Not Fill It, Skipped Doses, Took Less Medication, or Delayed Filling the Prescription Because of Cost by Selected Demographics (2020 – 2021)



Source: NWLC calculations from Centers for Disease Control and Prevention, 2020 – 2021 National Health Interview Survey. Participants self-identified their sex, race and ethnicity, and self-identified via six questions if they have a disability.

Older women also faced affordability issues related to prescription medication, with women of color reporting the greatest barriers to access. In 2020–2021, Latinas (14.1%) and Black women (13.3%) ages 50 to 64 were over two times more likely than white, non-Hispanic men (6.2%) to skip doses, take less medication, delay filling their prescription, or not fill a prescription at all because of cost (Figure 17).²⁶ Latinas and Black women were also more likely than white, non-Hispanic women (9.1%) to report skipping doses, taking less medication, delaying filling a prescription, or not filling a prescription due to cost. Overall, one in five women ages 50 to 64 (10.2%) reported skipping medication doses, taking less, delaying filling a prescription, or not filling a prescription medication because of cost, compared to 7.1% of men.

Older disabled women were also more likely than older disabled men to experience prescription disruptions. 25.5% of older disabled women and 19.2% of older disabled men ages 50 to 64 skipped medication doses, took less medication, delayed filling a prescription, or couldn't get a prescription because of cost in the last year as compared to 5.9% of older nondisabled men.

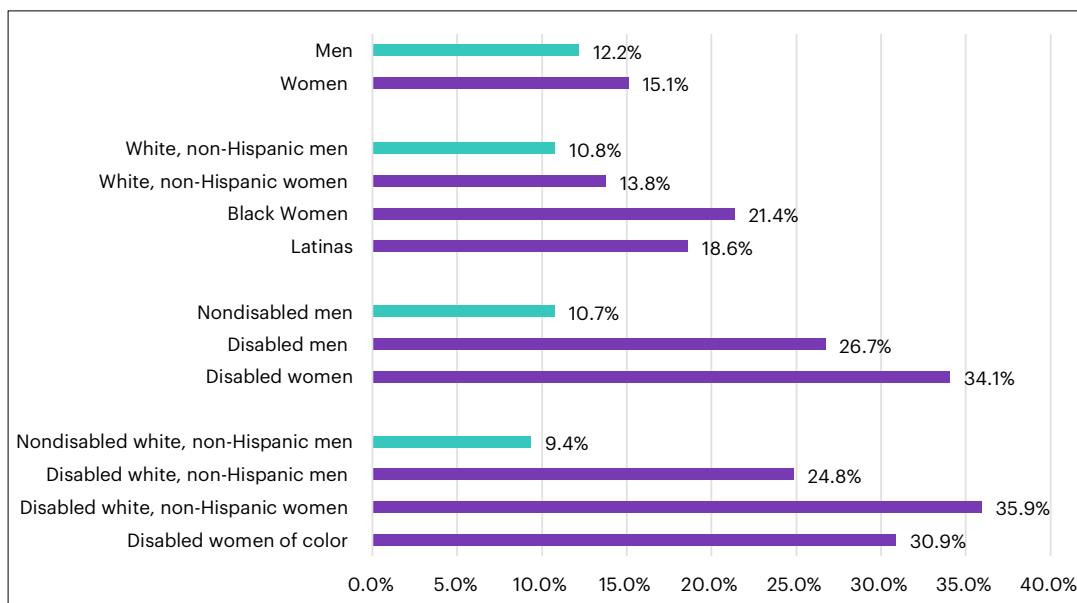
The majority of women who had trouble affording a prescription had health insurance coverage. Among those ages 50 to 64 for whom cost disrupted their prescription use, 80.9% of women and 74.4% of men had health insurance coverage.²⁷

Due to a lack of data, the share of adults 65 and older who had their prescription use disrupted because of cost could not be calculated.

Many older women also experienced difficulty paying a medical bill. Between 2020–2021, women ages 50 to 64 were more likely (15.1%) than men (12.2%) to report they or someone in their family had trouble paying for a medical bill over the past year (Figure 18).²⁸ Black women (21.4%) were nearly two times more likely than white, non-Hispanic men (10.8%) to have trouble paying a medical bill in their family. In addition, a higher rate of households containing older disabled women, 34.1%, had trouble paying a medical bill in their households in the past year, compared to 10.7% of older nondisabled men, and 26.7% of older disabled men.

FIGURE 18

**Share of Adults
Ages 50 to
64 Who Had
Trouble Paying
a Medical Bill in
Their Household
in the Past Year
by Selected
Demographics
(2020 – 2021)**



Source: NWLC calculations from Centers for Disease Control and Prevention, 2020 – 2021 National Health Interview Survey. Participants self-identified their sex, race and ethnicity, and self-identified via six questions if they have a disability.

Older Black women were also more likely than older white, non-Hispanic women (13.8%) to report they or someone in their family had trouble paying a medical bill. Older Latinas (18.6%) were more likely than white, non-Hispanic men and white, non-Hispanic women to have trouble paying a medical bill in their family.

Among older disabled women, 35.9% of white, non-Hispanic women and 30.9% of women of color report they or someone in their family had trouble paying a medical bill. In comparison, 24.8% of disabled white, non-Hispanic men and 9.4% of nondisabled white, non-Hispanic men reported the same.

The majority of older women (84.1%) and men (80.8%) who had trouble paying a medical bill have health insurance coverage.

Due to a lack of data, the share of adults 65 and older who had trouble paying for a medical bill for themselves or someone in their family could not be calculated.

And about eight in 10 (79%) of those with medical debt report skipping or delaying care or medications in the prior year due to cost, compared with 49% of those without medical debt.²⁹ Medical debt not only impacts one's ability to pay for necessary health care and other basic necessities, but also impedes access to future care. For example, a survey found that one in seven (15%) people with medical debt are denied care by a provider because of their debt, a rate that rises to 22% among Black adults.³⁰

Finally, older women of color were more likely than men to worry about paying a medical bill if they became sick or injured. Over half of women (53.1%) ages 50 to 64 reported being somewhat or very worried about paying a medical bill if they get sick or have an accident and they were more likely than men (47.3%) to have this worry (Figure 19).³¹ Over two in three Latinas (66.9%) report being worried about having to pay a medical bill and were more likely than white, non-Hispanic men (42.8%) and white, non-Hispanic women (50.2%) to report being

worried in this way. Black women (54.5%) and Asian women (53.3%) were also more likely than white, non-Hispanic men to report being somewhat or very worried about paying a medical bill.

Over six in 10 disabled women (62.9%) ages 50 to 64 report being somewhat or very worried about paying a medical bill if they get sick or have an accident. In addition, 58.8% of disabled men and 46.2% of nondisabled men report the same. Among disabled women, 63.1% of women of color and 62.7% of white, non-Hispanic women report being worried about having

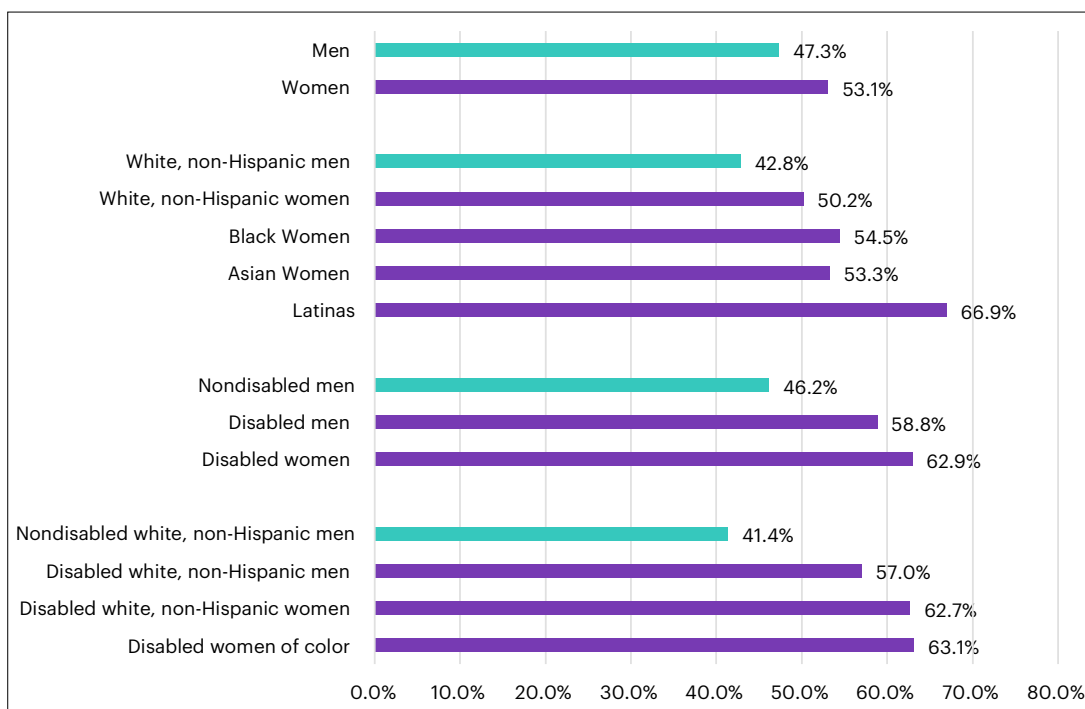
to pay a medical bill. Additionally, 57.0% of disabled white, non-Hispanic men and 41.4% of nondisabled white, non-Hispanic men report the same.

The majority of older women (87.0%) who were worried about paying a medical bill if they became sick or injured had health insurance coverage.

The shares of adults 65 and over who were somewhat or very worried about having to pay a medical bill could not be calculated due to a lack of data.

FIGURE 19

**Share of Adults
Ages 50 to 64
Who Were Worried
About Paying
a Medical Bill if
They Get Sick or
Have an Accident
by Selected
Demographics
(2020 – 2021)**



Source: NWLC calculations from Centers for Disease Control and Prevention, 2020–2021 National Health Interview Survey. Participants self-identified their sex, race and ethnicity, and self-identified via six questions if they have a disability.

WAYS TO SUPPORT OLDER WOMEN OF COLOR AND IMPROVE THEIR HEALTH AND WELL-BEING

INVESTING IN THE PAID CARE AND HOME- AND COMMUNITY-BASED SERVICES INFRASTRUCTURE

The COVID-19 pandemic made clear how critical it is that we invest in our home and community-based care infrastructure. More than 163,000 residents in nursing facilities died from COVID-19, with disproportionately higher rates of deaths occurring in facilities with more residents of color.³² Most older women do not want to reside in a facility to receive their care. Instead, most want to age in their homes and communities and remain as independent as possible. Paid caregiving and home and community-based services (HCBS) allow older women to do just that.

Medicaid is the primary payer for HCBS. Unfortunately, while Medicaid coverage for care in a nursing home is guaranteed if you are otherwise eligible, care or services provided at home or in the community are not. Making HCBS an entitlement equal to nursing facility coverage is essential for older women of color to stay in their homes and maintain ties to their communities.³³ The optional structure of HCBS leads to significant disparities in access to services depending on what state a person lives in, their age, disability, and race.³⁴ Without access to HCBS, older women of color are either forced to receive the care they need in a nursing facility or rely on their family to fill in the gaps—most often their daughters, who risk falling into poverty themselves when they either cease or reduce their paid work to act as a caregiver. As a result, women of color are harmed across generations.

Even when HCBS is available, research has found that there are disparities in the amount of services rendered. Even though women are more likely to access HCBS services and to have worse health indicators than men,³⁵ more money is spent on services for men.³⁶ For women of color, race compounds this disparity. One study found that HCBS expenditures were disproportionately higher for white women than Black women.³⁷ Another study found

that Black HCBS users received less case management, equipment, technology and modification services, and nursing services compared to whites.³⁸

To address these inequities, HCBS enrollment and expenditures data must be collected by race, gender, and disability, cross-tabulated, and released consistently. Further, once specific inequities are identified, policies must be crafted to address barriers and bias and achieve equitable enrollment and access.³⁹

EXPANDING ELIGIBILITY FOR MEDICAID AND MEDICARE SAVINGS PROGRAMS

Medicaid plays a critical role for older women by providing access to vital services that Medicare does not pay for, including long-term services and supports and transportation. Medicaid is also crucial in making Medicare more affordable for low-income recipients. Through Medicare Savings Programs (MSPs), Medicaid pays for the costs associated with Medicare, including premiums and cost sharing. Unfortunately, current MSP income eligibility and resource limits in most states force aging adults and people with disabilities to live in poverty to access care.⁴⁰

Although low-income women may be dually covered by Medicare and Medicaid, states' variation in Medicaid benefit packages and Medicare's lack of coverage for basic services like dental, vision, and hearing leaves many dual beneficiaries with burdensome out-of-pocket costs, which can greatly press budgets of older women with fixed incomes, few financial resources, and other financial obligations. States have the option to set their Medicaid eligibility income and resource limits at levels that allow older women to access critical health care benefits while also maintaining enough income to cover basic needs and save for an emergency.

California and New York, for example, have raised their income limits for their aged and disabled programs

to 138% of the federal poverty limit, and California eliminated its resource limit for all Medicaid programs effective January 2025. Meanwhile, Washington state just eliminated its resource limit for MSPs in 2023.⁴¹ A number of other states have expanded income limits for their MSPs, including, for example, Alaska, Connecticut, the District of Columbia, Hawaii, and Maine.⁴² States can continue to expand access to MSPs so that more older women could reduce their out-of-pocket spending on health care.⁴³ Federally, expanding and aligning eligibility for MSPs and the Part D Low-Income Subsidy would ensure more women enrolled in Medicare with limited income can get help with premiums and cost-sharing.

EXPANDING MEDICARE BENEFITS

In addition to expanding access to Medicaid HCBS and MSPs, expanding the benefits Medicare covers is necessary to ensure lower-income women who are not eligible for Medicaid can afford care. By including coverage for oral health, vision, and hearing, older women will have these unmet basic medical needs covered by Medicare, eliminating high out-of-pocket medical expenses that contribute to their economic insecurity. Adding these benefits to Medicare would also act to reduce health disparities since women—and particularly women of color—are more likely to be low-income and unable to access these services.⁴⁴

LOWERING PRESCRIPTION DRUG COSTS

In 2022, the Inflation Reduction Act was signed into law, which included prescription drug reforms and changes to the Part D program to protect people with Medicare from high out-of-pocket costs. Notably, the law caps Medicare out-of-pocket spending for drug coverage to \$2,000 starting in 2025; allows Medicare to negotiate the prices of certain high-cost prescription drugs; caps insulin costs for people with Medicare to \$35 a month; expands no-cost coverage of vaccines for people with Medicare; and expands the full Part D low-income subsidy known as “Extra Help” to more people.⁴⁵ These changes will act to significantly lower the prescription drug costs

older women currently face. Moving forward, ongoing robust outreach and education on the Part D Low-Income Subsidy is needed to increase enrollment in the program.

INCREASING ACCESS TO MENTAL HEALTH

The Consolidated Appropriations Act (CAA) increased access to mental health support for older adults. Access to mental health is a significant need for older adults experiencing mental health challenges such as depression, anxiety, or dementia. At least one in four older adults experiences some mental health disorder, and the number of seniors with mental disorders is expected to double by 2030.⁴⁶ CAA expanded access to mental health services by addressing barriers to the mental health workforce, continuing to fund crisis support, and providing grants to outpatient community-based organizations providing necessary mental health service capacity.⁴⁷ It also expanded Medicare coverage for behavioral health services to include marriage and family therapists and licensed mental health counselors; funded telephonic assistance and mobile crisis units; and increased access to intensive outpatient mental health care.⁴⁸ However, more is needed to address existing deficiencies in mental health care for older adults. Mental health must be incorporated into existing care delivery systems, the number of geriatric professionals in behavioral health must increase, and payment models must incentivize providers to care for older adults.

ENSURING ACCESS FOR ALL TO LOW COST, QUALITY HEALTH CARE ACROSS THE LIFETIME

Women of color must have access to comprehensive, low-cost health care, free from discrimination, at every stage of life. Without this, older women of color experience more complicated and more expensive health care throughout their lives, compounding health issues as they age. Presently, women of color are more likely than white non-Hispanic men and women to live without health coverage,⁴⁹ to have coverage that does not adequately meet their needs,⁵⁰ “to deny or delay care due to cost,”⁵¹ and to report discrimination in health care.⁵² For women

of color, barriers related to coverage, cost, and care begin before birth, persist throughout their lives, and fuel health inequities later in life. Guaranteed access to comprehensive health care, including reproductive health care, that is low-cost, and free from discrimination, would reduce coverage and care inequities, eliminate many barriers to good health, and yield significant health benefits over the lifespan of women of color.

ELIMINATING MEDICAL DEBT

Medical debt causes significant economic and emotional hardship for older women. Policies that expand health care affordability and benefits like those outlined above can reduce the amount of medical debt older women accrue. Similarly, states must preserve Medicaid retroactive coverage protections to ensure older women are not subject to high medical costs when they face a sudden medical emergency or need long-term services and supports unexpectedly.⁵³ Federal investment in financial literacy programs and consumer protection programs, for example, services to assist older women in managing their debt, protecting their assets, and ultimately reducing or having their debt forgiven, is also key.⁵⁴



CONCLUSION

These data clearly demonstrate that we do not have a moment to lose to address the economic security and health of older women of color.

While there is still time to enact systemic solutions in the wake of the pandemic, older women of color cannot wait for those solutions to take effect: they need immediate policy solutions so they can retire with economic dignity and with the health supports they need.

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