Baby Boomer Women:
Secure Futures or Not?

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Baby Boomer Women: Secure Futures or Not? is a *pro bono* public service publication whose mission is to develop and implement national policies that will ensure a dignified, sustainable quality of life for our nation's aging baby boomer women.

Fading Health, Fragile Health Policy: Will Shame Spur Action?

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The ad shows a smiling face, bleached teeth and stylishly cut white hair, atop a trim body in colorful tennis clothes (white is no longer required). After congratulating the new grandmother, her friends start offering advice on how to rock and hold the infant without straining her shoulder and what pain reliever to take when the need arises. The generation of women about to enter their 60s—the baby boomers—is staying young much longer than their mothers did by keeping active and taking care of their bodies. But they will age. They will face many of their mothers' health problems as well as some new ones, and they will live longer with the discomforting consequences of their fading health. When we look more closely at the details, this general picture of health among aging women in the United States becomes a mosaic of contrasts and contradictions. Its dominant theme is the failure of our health-care system to provide for our more vulnerable citizens.

The generation of women about to enter their 60s—the baby boomers—is staying young much longer than their mothers did by keeping active and taking care of their bodies. But they will age.

Take, first, the increasing life expectancy rates that governments everywhere laud as a sign of improvements in health care. Currently, American women live an average of 79.9 years, more than four years longer than men.[1] Yet, according to the World Health

Organization's (WHO) healthy life expectancy measure, we are 29th in the world.[2] Furthermore, the differences among racial, ethnic, and socioeconomic groups in the United States are wide; for example, white women live an average of 80.3 years, African-American women 75.6 years. The WHO's measure incorporates the increasing incidence of chronic illness and disability that accompanies longevity, conditions that disproportionately affect women and racial/ethnic minorities.

Consider the following:

- Although death rates from heart disease, the leading cause of death among both women and men, are decreasing, so too is the gap between women and men. The magnitude of improvement has been much greater for men than for women. Women are still treated for heart disease less and less aggressively than men. Heart disease is more prevalent among African-American women than white women.
- Deaths from cancer continue to decrease, but in the last decade the rate of decrease was lower for women than for men. Women's death rates have actually increased for leukemia and cancers of the genital system, urinary system, and digestive system (where death rates are substantially higher than for men).
- More disheartening, the incidence of cancer has increased for both women and men. The greatest increases in women's cancer rates are for the digestive and endocrine systems (both rates of increase are higher than for men), leukemia, skin cancer, and breast cancer. A noteworthy anomaly in cancer rates is that although the incidence of certain types of cancer (for example, breast) is lower for African-American women, the death rate is higher.

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Heart disease and cancer are two of the high profile diseases that siphon our research and development expenditures. Left to self-care are chronic illnesses such as arthritis, back conditions, diabetes, hypertension, and osteoporosis—many of which encumber women more than men. Their rates are

expected to grow as the population ages. Also, these chronic illnesses as well as other conditions leave more women than men disabled, in all age groups except for those aged 5–15. And with increasing age, more women report that their disability is severe compared with not severe. Furthermore, while the proportion of the population reporting their health to be fair or poor has decreased, the improvement has been greater for men.

Given that heart disease, cancer, chronic illness, and disability have a greater effect on women, and in particular racial/ethic minorities and the poor, how well prepared is our health-care system to meet the challenges of a rising generation of aging boomer women?

To answer this question more fully, we have to redraw the Madison Avenue snapshot of women and their healthy, active lives. The United States remains the most inegalitarian of the world's wealth nations, with significant consequences for deteriorating health as women in lower socioeconomic groups age. The situation is exacerbated for those who lack health insurance prior to age 65. Nearly 20 percent of women currently aged 18–64 are uninsured. Although many of them work and many are poor or near poor, strict Medicaid rules make them ineligible. The following tables (1 and 2) present additional characteristics of uninsured and insured women.

Table 1: Uninsured Rate of Women, by Selected Characteristics, Ages 18 to 64

Demographic Group	% Uninsured	Demographic Group	% Uninsured
Total	19%	Nativity	
Age Group		U.S.-Born	17%
18 to 24 years	24%	Foreign-Born	34%
25 to 34 years	24%	Region of U.S.	
35 to 44 years	19%	Northeast	14%
45 to 54 years	14%	Midwest	15%
55 to 64 years	13%	South	21%
Race/Ethnicity		West	23%
African American	20%		
Latina	37%		
White	16%		

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey,* 2001.

Table 2: Characteristics of Women, by Insurance Status, Ages 18 to 64

	Total	Private Coverage**	Medicare	Uninsured
	100%	100%	100%	100%
Income Level				
Poor	14%	5%	57%*	26%*
Near-Poor	21%	17%	20%	33%*
Non-Poor	52%	66%	9%*	25%*
No Information	13%	12%	14%	16%
Age Group				
18 to 29 years	26%	22%	43%*	35%*
30 to 49 years	49%	52%	38%*	46%*
50 or more years	25%	27%	18%*	19%*
Dependent Children				
Yes	48%	45%	61%*	55%*
Employment				
Employed Full-time	50%	60%	17%*	35%*
Employed Part-time	17%	15%	17%	23%*
Self-employed	2%	2%	2%	4%*
Not Employed	31%	23%	64%*	39%*
Health Status				
Excellent/Very Good/Good	84%	90%	62%*	77%*
Fair/Poor	16%	10%	38%*	23%*

Source: The Henry J. Kaiser Family Foundation, *Kaiser Women's Health Survey*, 2001.

Note: Poor is defined as 100% of the federal poverty level, which was $14,255 for a family of three in 2001. Near-poor is 100% to 199% of poverty; non-poor is 200% or more of poverty.
Totals may not equal 100% due to rounding.

*Significantly different from reference group (private coverage) at $p<.05$.

**Employer-based or individually purchased.

In Table 2, note that among those women who rate their health as fair or poor, more are Medicaid recipients than uninsured. Receipt of Medicare at age 65 most likely improves the health status of previously uninsured women, but it is doubtful that Medicaid recipients benefit significantly.

And what can boomer women, who will contribute to the feminization of Medicare, expect from this program? They will witness increases in Medicare expenditures, but they will not be the primary beneficiaries—providers will secure that honor. Instead, recipients will bear ever-growing increases in annual premiums, deductibles, and co-insurance payments, as summarized in Table 3.

Table 3: Medicare Payments (2005)

Part A:[1]

Premiums:[2]

- $206 per month for those with 30–39 quarters of Medicare-covered employment
- $375 per month for those not otherwise covered and with less than 30 quarters of Medicare-covered employment

Deductibles (for each benefit period):

- $912 total for hospital stays of 1–60 days
- $228 per day for stays of 61–90 days
- $456 per day for stays of 91–150 days (lifetime reserve days[3])
- All costs beyond 150 days
- Coinsurance for 21–100 SNF days ($114 per day)

Part B:[4]

- Deductible of $110 per year
- 20% copayment for certain services (after deductible)
- Premium of $78.20 per month

[1] Mandatory coverage for inpatient hospital days, skilled nursing facility (SNF) after a 3-day hospital stay, and some home health care following a hospital or SNF stay.

[2] Only for those who (or whose spouse) did not contribute through payroll deductions for 40 or more quarters.

[3] A total of 60 lifetime reserve days can be used for stays over 90 days.

[4] Voluntary supplementary insurance covering physician services, outpatient hospital services, diagnostic tests, certain home health services, and durable medical equipment.

Beginning in 2007, premiums for individuals with incomes of more than $80,000 per year ($160,000 for couples) will be higher than for those with lower incomes. Most services for Medicare recipients who are not in HMOs currently require a 20 percent copayment, and some are subject to an annual deductible ($110 in 2005). These amounts are likely to increase (see Table 3).

The biggest recent change in Medicare policy that will affect future generations of retirees is the inclusion of prescription drug coverage. Following legislation passed in 2003 and partial implementation in 2005, all Medicare beneficiaries are eligible for Medicare Part D as of January 2006. They only receive coverage, however, after they select from a bewildering array of drug plans and sign up for one. Aside from basic standards stipu-

lated in the legislation, plans vary in the amount of monthly premiums (an estimated average of $35 in 2006), drugs covered, and participating pharmacies. In addition to monthly premiums, recipients pay a standard annual deductible ($250 in 2006), plus copayments based on a complicated and potentially costly formula—25 percent of the costs of the drugs up to $2,000 (amounting to $500), after which they are fully responsible for the next $2,850 of expenditure, followed by a 5 percent copayment for the rest of the year.

Women of all ages use prescription drugs more than men. Medicare Part D might help reduce some of the out-of-pocket expenses of older women. But older women are poorer than men, so the relatively high ceilings on beneficiaries' expenditures will continue to impose a heavy toll on women. In addition, women will be more negatively affected by policy shortcomings in the current legislation, such as limits on the comprehensiveness of coverage, reliance on the private insurance market, and lack of sound financing.[3]

Women already benefit less than men from retiree health programs; they will also be more hard-hit by cuts.

Prescription drug coverage aside, Medicare is less than generous in its coverage, offsetting only a little more than one-half of an average recipient's health-care expenditures. Of the remaining expenses, approximately 20 percent are out-of-pocket, 15 percent come from private insurance (Medigap), and the rest accumulate from various sources, including employment-based retirement benefits.[4] These proportions are expected to change significantly in the coming years, to the detriment of the elderly. For example, retrenchment in employment-based benefits is rampant. Women already benefit less than men from retiree health programs; they will also be more hard-hit by cuts.

In addition, the fairly large proportion (85 percent) of retirees with some type of Medigap coverage is expected to decline, for two main reasons: (1) Plans will no longer offer prescription coverage for new enrollees, although current enrollees may chose to remain in their plan's program. (2) Increasingly, more managed-care plans are participating in the Medicare Advantage program, and more Medicare beneficiaries are joining them. In contrast

to the Medicare Advantage program, managed-care programs tend to offer more comprehensive health care, including prescription drugs. Managed-care programs may also benefit women by offering more preventive services, such as regular mammograms.

Arguably the most damning indicator of shortcomings in U.S. health-care policy for older women is the number enrolled in both Medicare and Medicaid (the dual-eligibles). Fully 63 percent of dual-eligibles were women in 2000, a time when they represented just 55 percent of Medicare beneficiaries and 60 percent of Medicaid enrollees. Besides being disproportionately female, dual-eligibles are also more likely to be nonwhite, unmarried, institutionalized, alone, and less educated; to report fair or poor health; and to suffer from functional and cognitive impairments, such as limitations in instrumental and basic activities of daily living.[5] Having two sources of health-care coverage improves utilization, especially among minorities.[6] Nevertheless, the preponderance of chronic conditions and disabilities among dual-eligibles taxes the current capacity of managed-care programs.[7] And this situation will worsen with the aging of boomer women. These programs need much more government support to overcome administrative and delivery constraints, so as to achieve their potential to integrate previously fragmented services for this population.

More responsibility is being left to retirees themselves to save for their retirement and, in particular, for their health-care costs.

Given the drastic cuts under way in the Medicaid program, poverty-stricken boomer women should not harbor high expectations for public assistance in meeting the costs of health care as they age. Nor will remaining employer benefits go as far as they once did in filling gaps in coverage for recipients in general. More responsibility is being left to retirees themselves to save for their retirement and, in particular, for their health-care costs. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 has a provision encouraging the use of health savings accounts (HSA). But the complexity of this provision and the limitations it imposes has led two analysts to conclude: "An HSA

is not a viable option to save for health-care expenses in retirement for a 55-year-old today."[8]

Shifting more responsibility for health-care costs on to consumers is not unique to the United States. What does distinguish the United States is the amount of personal funds the government expects us to pay and the added insecurity that retirees will face. If, as they age, individuals find that long-term or nursing home care is necessary, and this is a greater likelihood for women than for men, they can expect major financial hardship. The role of government in the regulation and provision of residential and nursing care for senior citizens in the United States has always been limited. It contrasts sharply with countries that are wisely preparing for future demographic change. Several years ago Germany instituted long-term care insurance within its health and social insurance system. Sweden decided to finance its extraordinary high level of eldercare through taxation revenue. We can no longer simply dismiss their efforts as "socialist" when the consequence of our ideology jeopardizes the ability of boomer retirees in the United States—especially women, minorities, and the poor—to age in dignity. Will shame spur action? Or must we wait for the growing rates of disease, illness, and poverty that will soon beset us?

NOTES

1. All of the U.S. health information cited here derives from the U.S. Department of Health and Human Services, 2004.

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