A Poor Prognosis:

Healthcare Costs and Aging Women

THE VOICE OF MIDLIFE AND OLDER WOMEN

2004 Mother's Day Report

Table of Contents

A Message from OWL's President

Joan B. Bernstein

Happy Mother's Day!

Every year in May we pay tribute to our mothers . But our tributes are hollow, if we as a society fail to ensure that all mothers and older women live in dignity, free of anxiety over adequate healthcare.

Yet, ever increasing numbers of Americans lack health insurance. As of 2002, 43.6 million Americans had no health insurance. Indeed, throughout any one year, at some point, 60 million people lack protection. Women constitute a large segment of the uncovered. This report demonstrates that the fragmented hodgepodge of private and public health plans relied upon before one qualifies for Medicare—employer-sponsored health insurance, Medicaid, and a patchwork of state and federal programs—increasingly fail to provide health care coverage.

The mounting costs of these myriad systems account for declining coverage. Non-benefit costs eat up 30 percent of private insurance premiums. According to a study by the Physicians for a National Health Program, as much as $300 billion of the nation's health insurance outlays of $1.4 trillion go for unnecessary provider and insurer administrative, case processing, and selling costs. A single payer system, such as Medicare, has the lowest administrative costs of any health insurance plan and virtually no acquisition costs. Without those costs, melding all public and private programs into a single system would save enough to pay for universal and comprehensive coverage, including prescription drugs.

The Institute of Medicine, one of the Academies of Science, released a report which concluded that this lack of health insurance "has serious negative consequences and economic costs not only for the uninsured themselves but also for their families, the communities they live in, and the whole country." The Institute urged Congress and the Administration to act immediately to solve the problem by providing universal, continuous, affordable, and high quality medical care for all.

OWL embraces the concept of a universal system of affordable and quality healthcare. It recommends that the nation craft a single payer system—possibly based on a Medicare-for-all model. At the very least we should enable those approaching retirement without health insurance to buy into Medicare.

Mothers—and everyone mothers care about—need and deserve assured, affordable and comprehensive health care!

Joan B. Bernstein
President, OWL
May 2004

Executive Summary

It has been over a decade since there has been any serious discussion about universal healthcare to ensure quality, comprehensive health coverage for all. Without this type of healthcare system, growing numbers of midlife and older women will be among the most vulnerable people who are unable to get the care they need. The wage gap, time out of the work force for caregiving, and lower Social Security benefits all play a role in reducing women's financial security in old age and their consequent inability to afford care. Currently, the health insurance system is based primarily on employ-ment, but as data illustrate, even a full-time job does not guarantee health insurance coverage. This report examines the deficiencies of various types of insurance that make up our complicated and unstable healthcare system: Medicare, Medigap, employer-sponsored insurance, and direct purchase (i.e., individual private insurance policies).

OWL has advocated for change in the American healthcare system since its inception in 1980. Over the past 24 years, health insurance coverage has been expanded to cover certain vulnerable groups in the population, but it is now time for a major overhaul. We can no longer afford to settle for a system that utterly fails millions and partially fails millions more.

The current healthcare system is increasingly inadequate and unstable.

- The number of people with no health insurance at all has grown to a near-record high of 43.6 million.
- This year, the cost of healthcare is projected to reach nearly 1.8 trillion dollars—up 47 percent from just five years ago.
- Out-of-pocket spending on prescription drugs has increased 77 percent from five years ago.

Working people are increasingly losing health insurance coverage or unable to afford the coverage offered by their employer.

- Nearly three-quarters of the adults who were uninsured in 2002 were working people—more than half worked full time.
- In 1993, 63 percent of American workers in private industry had health insurance through their own jobs. As of last year, this number had dropped to less than half.
- The average monthly contribution required of employees for health insurance premiums rose about 75 percent between 1992–93 and March 2003. Median family income increased by only 41 percent during that time period.
- In private sector workplaces, employees' share of health insurance premiums averaged more than $60 a month for single coverage and $229 for family coverage in 2003. Employees in small establishments paid the highest premiums.

- Since women are more likely than men to work in low-wage, service occupations, they are less likely to have health insurance through their jobs.

Midlife women often fall into the "gap" between Medicare eligibility and employer-based insurance.

- People age 55–64 were more likely than children to lack health insurance entirely (12.9 percent vs. 11.6 percent).

- Fifteen percent of women age 60-64—one in seven—had no health insurance.

- Midlife women are more likely than midlife men to be insured through a spouse's job (40 percent versus 14 percent), more likely than men to have a spouse old enough to retire, and more likely than men to have their own employment options limited by caregiving responsibilities.

There are many healthcare expenses that Medicare does not cover. Because women live longer, poorer lives than men, they are more likely to fall through the cracks of the "three-layered" health insurance system for seniors.

- Two-thirds of all seniors with household incomes between 125 and 200 percent of poverty—and three quarters of those who live alone—are women.

- Fifty-one percent of widowed, divorced, or never-married women over 65 receive more than half of their income from Social Security; of these, about half have income from Social Security only.

- The average woman over 65 who lived alone spent more of her after-tax income on healthcare than on food.

- While Medicare insures nearly everyone age 65 and over, women age 65 and over were less likely than their male counterparts to augment their Medicare coverage with private insurance.

- Between 1998 and 2004, the Medicare Part B monthly premium increased 52 percent, while Social Security cost of living adjustments only increased 13 percent.

OWL believes we need real healthcare reform that does not privatize existing state and federal programs or shift risk entirely onto individuals. It's time to:

- Adopt a universal, single payer healthcare system.

- Offer a Medicare early "buy-in" option for men and women age 55 and over.

- Bring Medicare into the 21st century by increasing benefits without privatizing the system.

- Repeal and replace the recently signed Medicare Prescription Drug and Modernization Act of 2003.

Introduction

Americans are growing uneasy about the country's healthcare system. Wide cracks and crumbling are increasingly apparent in what seemed at one time to be a reasonably sturdy structure for ensuring that most people have access to affordable healthcare (Figure 1).

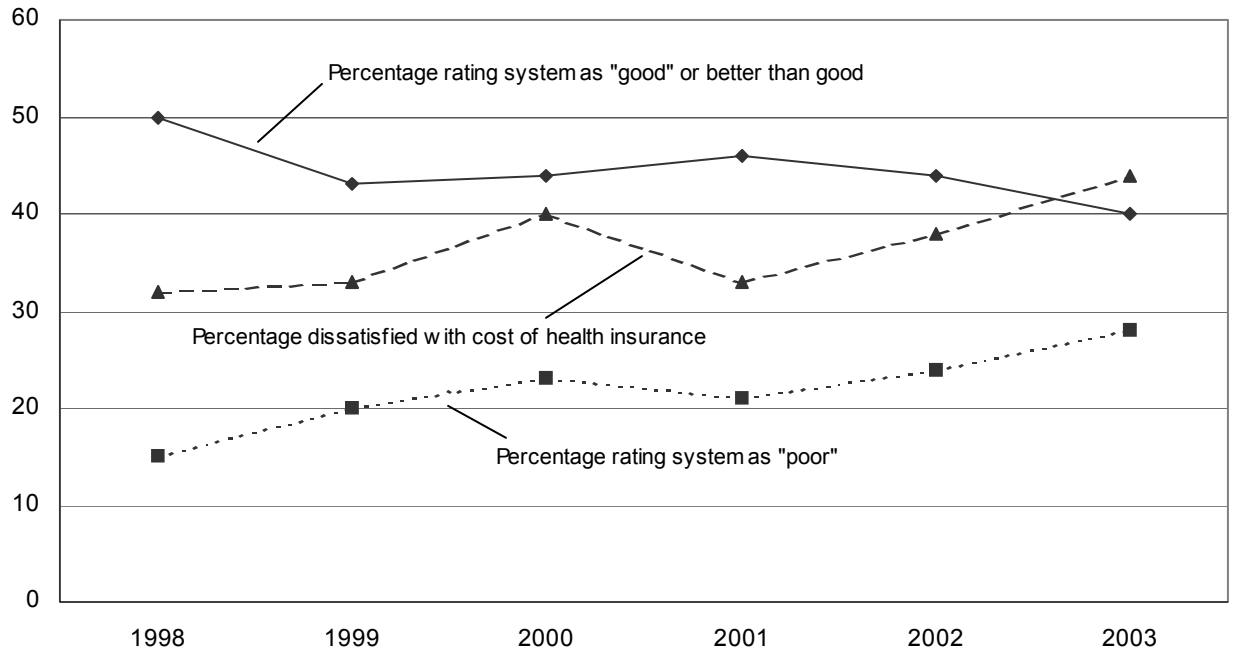
The cost of healthcare is again rising at an alarming rate—this year it's expected to be nearly 1.8 trillion dollars—up 47 percent from just five years ago. The national bill for prescription drugs is projected to be close to double what it was five years ago, and out-of-pocket spending for prescription drugs alone will be up to 77 percent.[1]

It is hard to escape the conclusion that the costs of administering our multi-payer system are staggering. One of the best-known experts in health policy has observed that it is difficult to pin down the overall administrative costs incurred.[2]

Nevertheless, a recent study that—unlike some other analyses—took into account the administrative costs to doctors and other health services providers, estimated that administrative costs account for 31 cents out of every dollar of the nation's health expenditures, compared with around 17 cents in Canada.[3] (Canada has a single-payer system of health insurance.) In any case, most people who visit a medical office can see that an enormous amount of its staff's time is devoted to dealing with the differing requirements of many different insurance plans. Indeed, there is often red tape involved in simply getting a referral to a specialist or in filling a non-formulary prescription.

While this report is primarily concerned with the healthcare system's particular deficiencies with respect to women in late midlife or old age, many of the problems they encounter arise from systemic failings that affect—or could affect—women and men of any age.

Figure 1. **Americans' confidence in the country's healthcare system is waning**



Source: Employee Benefit Research Institute and Matthew Greenwald & Associates, 1998-2003 Health Confidence Surveys

Part One: Employer-sponsored Insurance: Does it work for women?

The foundation of our healthcare system—employment-sponsored private health insurance—is crumbling.

The American system counts heavily on employers to provide health insurance to working-age people and their families. But less than half of American workers in private industry had health insurance through their own jobs as of last year, a proportion down from nearly two-thirds (63 percent) a decade ago.[4] While the majority of private-sector employers still offer health benefits to at least some of their workers, and the majority of Americans under 65 still have coverage through their own or a family member's employment, ***the number of people with no health insurance at all has grown, reaching a near-record 43.6 million as of 2002.***

At the same time, ***the cost of healthcare has soared***. As of 2002, per capita spending on healthcare had already reached $5,440—a record amount in real (i.e., inflation-adjusted) terms and an increase of more than 40 percent over the figure of a decade earlier.[5] This year total healthcare spending in this country will amount to upwards of $6,000 per capita[6], but more than 43 million people don't even have health insurance.[7] Faced with rising

Profile: Harriet

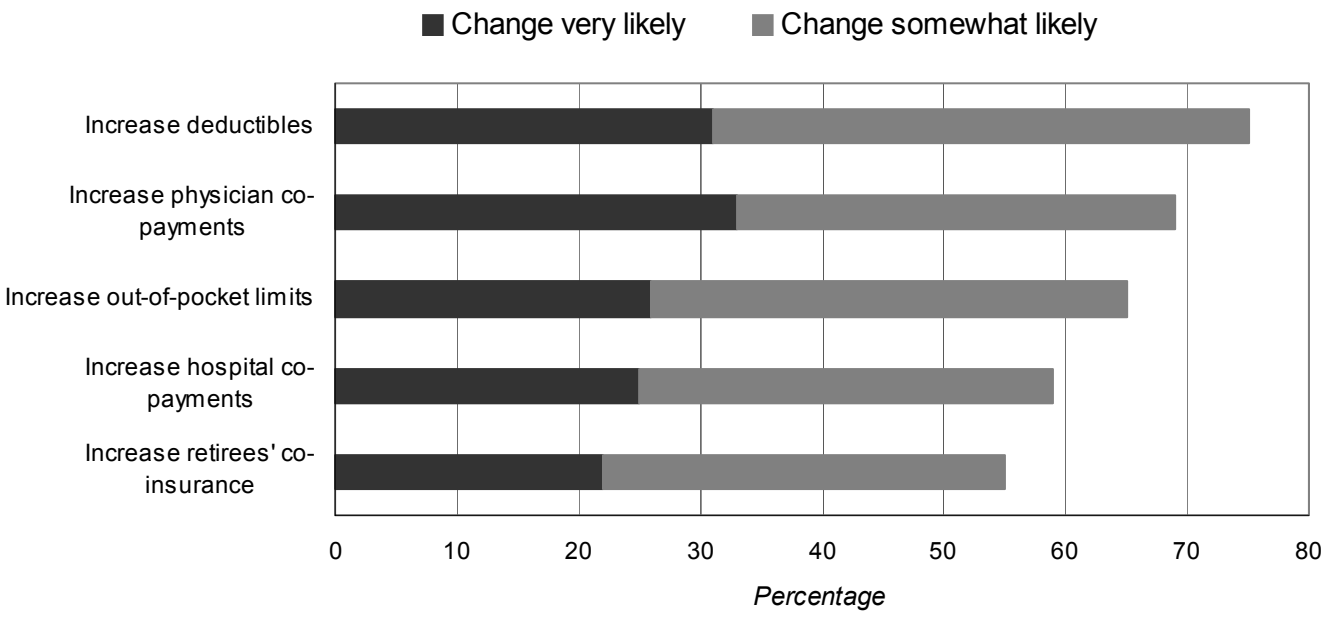
Harriet, 49, is an administrative professional who currently receives health insurance through her employer. She considers her health insurance coverage good—and she considers herself lucky to have it, because she knows what it's like to go without.

In 2001, after working for over 20 years, Harriet left her job to care for her infant niece. At first, she continued under COBRA the health insurance she had when she was working. After six months, however, the premium began to increase, and she could not afford it any more. When Harriet lost her COBRA health insurance coverage, she looked into Medicaid coverage, but was ineligible because she had some savings and a small monthly income from unemployment insurance (during the first few months after she left her job, Harriet received $268 a week in unemployment benefits). Left without other options, since she was not employed and did not have a husband through whose job she might have had insurance coverage, Harriet went without health insurance while she provided uncompensated care for her niece.

Harriet has several chronic conditions, including high blood pressure and osteoarthritis, which require regular medication and monitoring by physicians. During this time Harriet had "to make hard choices about [her] health." For over a year, she had no health insurance and paid all of her healthcare costs out of pocket. To make do, she would fill prescriptions for her blood pressure medicine only sporadically and take over the counter medications to control the arthritis pain. During this time she was frustrated, "because I knew that I could feel better if I had the care I needed; it was exhausting feeling sick but not being able to go to the doctor."

There are thousands of single midlife and older women who, like Harriet, do not have spouses to rely on for financial support and/or health insurance. If they must take time out of the workforce to care for family members, they may jeopardize not only their health insurance but also their health.

Figure 2. **Some of the cost-sharing changes that employers offering health insurance consider likely**



Source: Kaiser Family Foundation, Employer Health Benefits Survey, 2003

healthcare costs, employers who offer insurance pass the increases on to their workers. As a result, workers whose employers offer health insurance must pay a considerably larger share of their income for coverage and care than used to be required.

Premium increases in job-related coverage have outpaced increases in family income. According to the Bureau of Labor Statistics, the average monthly contribution required of employees for health insurance premiums rose about 75 percent between 1992-93 and March 2003.[8] Median family income also increased, but by not nearly as much (41 percent).[9]

Last year, the Kaiser Family Foundation reported that employees' share of health insurance premiums in private-sector establishments overall—not counting out-of-pocket spending on deductibles, co-payments, prescriptions and so forth—averaged more than $60 a month for single coverage and nearly $229 for family coverage. In workplaces with fewer than 100 employees, workers' contributions were much higher, averaging about $67 a month for single coverage and $263 for family coverage. Employers expect that further increases are in the offing (Figure 2).

These days, negotiations on union contracts are likely to center more on the protection of health benefits than on wages—workers know that protecting health benefits is, in itself, a form of wage protection. In many industries, the health benefits offered employees are being chipped away, as managements argue that they otherwise can't compete with firms that offer few or unaffordable benefits. Wal-Mart, the world's largest private employer, is such a firm.[10]

Wal-Mart is representative of the fundamental trouble with a health insurance system constructed on a foundation of voluntary employment-based coverage: a substantial percentage of employers opt not to offer insurance at all, or offer it only to full-time employees, or offer it at a price that many workers simply cannot afford.

The result is the widest crack in the U.S. healthcare system and the one into which most of the uninsured have fallen. They are workers and the families of workers whose employers either do not offer them health insurance or, if they do offer it, require employees to pay so much for coverage that low-wage workers cannot afford it. ***Nearly three-quarters of the adults who were uninsured in 2002***

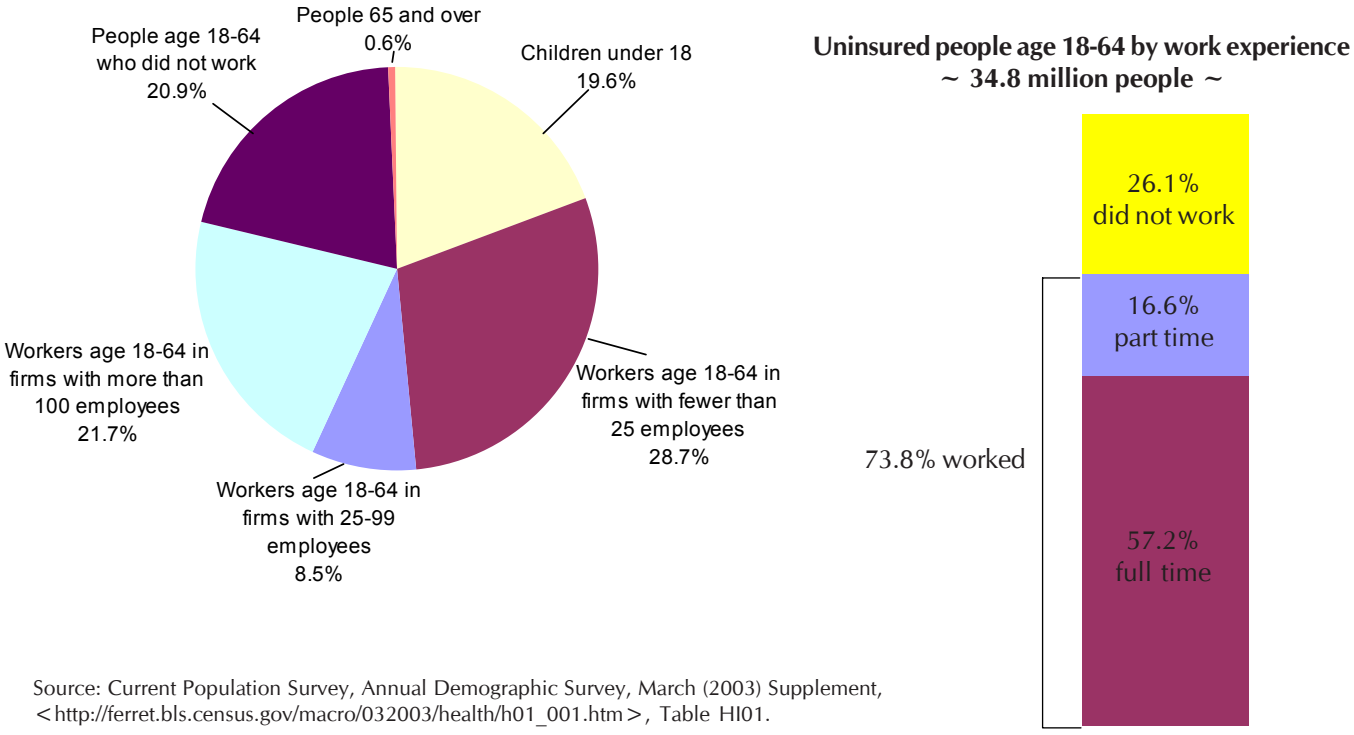
were working people—more than half worked full time (Figure 3).[11]

This situation can be expected to worsen. Although the employers most likely to provide health benefits are in unionized, goods-producing industries, manufacturing jobs account for a steadily shrinking share of U.S. jobs. The services-producing sector (which includes the retail industry), where only 42 percent of workers have health benefits, is where most people work now[12] and where future jobs will be. Moreover, over half of all American workers work in establishments with fewer than 100 employees[13] and only 56 percent of such establishments offer health benefits.[14] The smaller the firm, the more likely it is that its employees have no health insurance coverage at all (Figure 4).

The odds of having health insurance through employment also depend on the kind of work you do and how well it pays. In service *occupations*, for example, where 57 percent of the 22 million workers are female and wages are typically low,[15] only 22 percent of workers had employer-provided coverage in 2003. ***The old saying "them as has, gits" applies to employee benefits.*** Over 60 percent of workers who were paid at least $15 an hour had healthcare benefits through their jobs, compared with only 35 percent of workers earning less than $15 an hour. Moreover, the low-wage workers who did have coverage had to pay more for it, on average, than their higher-wage counterparts.[16]

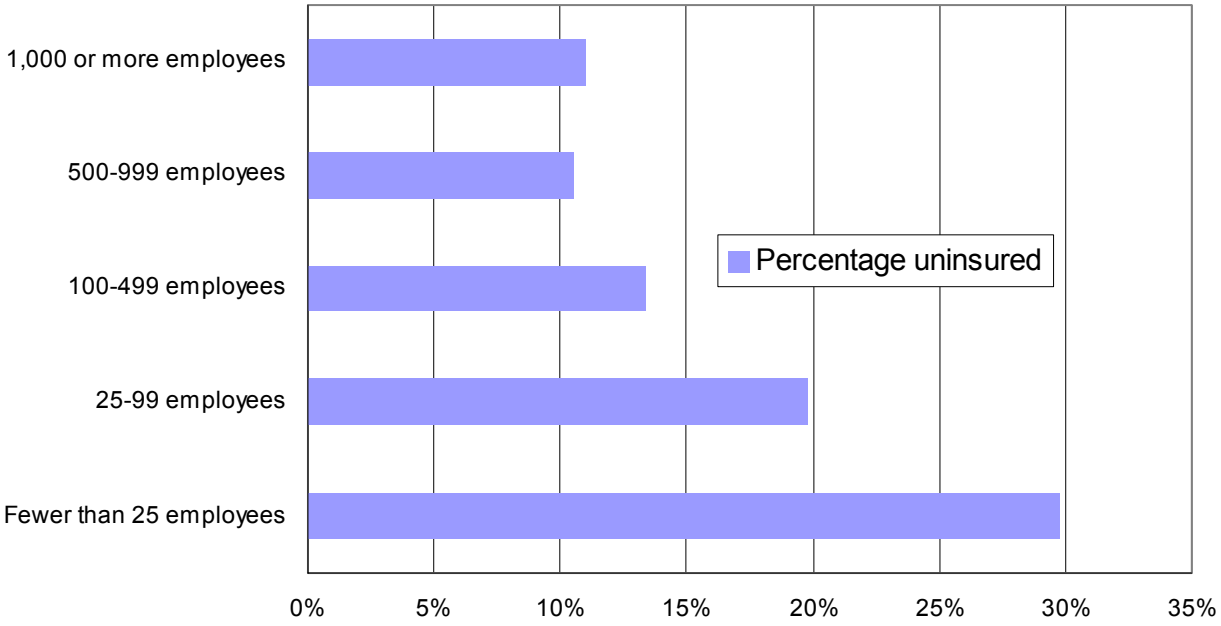
To be sure, many workers—particularly married women—who don't have health insurance through their own jobs are covered through a husband's or another family member's job. Most children with coverage have it through a parent's job. This arrangement worked reasonably well when there were plenty of jobs available that provided health benefits with relatively affordable family coverage: if both spouses and the children could count on coverage through one spouse's job, the other spouse didn't need to be covered through work. But ***when the job through which the family is insured is lost and few of the available jobs offer health benefits, the likelihood of becoming uninsured is very real.***[17]

Figure 3. The uninsured population in 2002
~ 43.6 million people ~



Source: Current Population Survey, Annual Demographic Survey, March (2003) Supplement, <http://ferret.bls.census.gov/macro/032003/health/h01_001.htm>, Table HI01.

Figure 4. **Employees in the smallest firms are the workers most likely to have no health insurance coverage at all**



Source: Current Population Survey, Annual Demographic Survey, March (2003) Supplement, <http://ferret.bls.census.gov/macro/032003/health/h01_001.htm>, Table HI01.

Part Two: Healthcare Financing: the multi-layered system for seniors

Health insurance for seniors falls short for those with modest means.

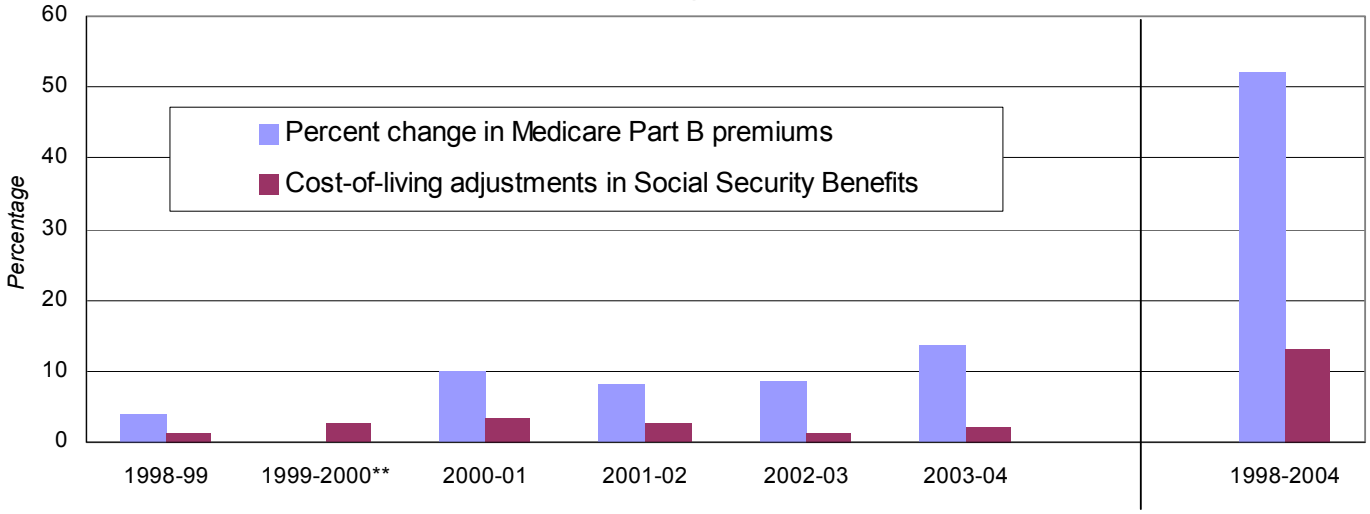
People who have reached the age of 65 are comparatively fortunate because nearly all of them are guaranteed a basic level of hospital insurance coverage through Medicare, and most elect to pay for additional Medicare (Part B) coverage for physicians' bills. The majority of seniors also pay for private policies to cover certain of the healthcare costs that Medicare does not cover. For the poorest seniors, a federal-state program known as Medicaid plays this role.

For relatively well-off older people, this three-layer arrangement works pretty well, although one might question why three layers of insurance should be required to achieve a reasonably adequate level of coverage. In any case, for the less well-off, this arrangement is far less satisfactory because the third layer—especially one that is reasonably comprehensive—may be unaffordable.

Medicare

Medicare is the federal program that insures nearly everybody age 65 and over. Younger people with a severe disability or end-stage kidney disease are also eligible. The basic layer, Part A, is primarily coverage for inpatient care in a hospital or skilled nursing facility. Throughout their working lives, workers and their employers each contribute 1.45 percent of every paycheck to Part A but pay no premium for it once they reach age 65 (assuming they are retired). The second layer, Part B (officially entitled "Supplementary Medical Insurance"), is voluntary. It covers a substantial proportion of

Figure 5. **Medicare Part B premiums have increased at a faster rate than Social Security benefits***

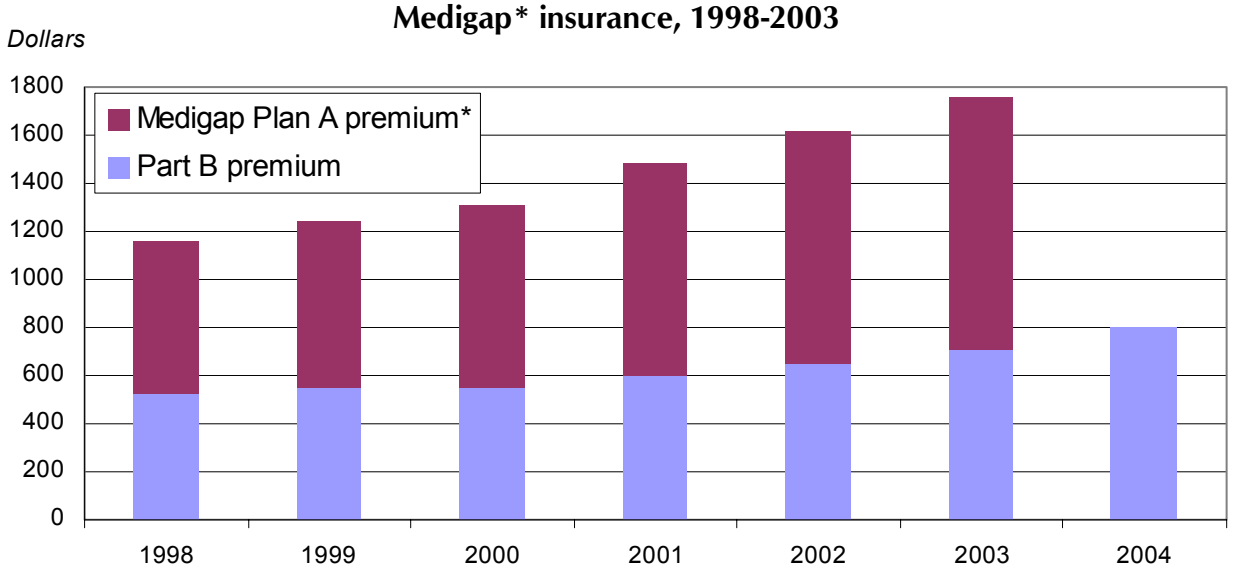


*Comparison of annual increases in Medicare Part B premiums with annual cost-of-living increases in Social Security benefits. Changes in Part B Premiums take effect in January of the year. Benefits COLAs take effect in December of the year. This analysis begins with the December 1998 COLA and the difference between the January 1998 and the January 1999 Part B premiums.

**No increase in Part B premiums.

Source: Social Security Administration, Social Security Bulletin, Annual Statistical Supplement 2002, Tables 2.C1 and 2.A19, and <www.ssa.gov/regulations/articles/cola-2003.htm> and <. . . /cola-2004.htm>.

Figure 6. **Annual premiums for Medicare Part B, 1998-2004, and Plan A Medigap* insurance, 1998-2003**



* Average annual premiums for a 65-year-old woman.

Sources: Weiss Ratings, Inc. <http://www.weissratings.com/News/Ins_Medigap/20020807medigap.htm> and Social Security Administration, Annual Statistical Supplement 2003.

physicians' fees, outpatient hospital services, and the like. According to the Social Security Administration, almost everybody who is enrolled in Medicare Part A also enrolls in Part B. The premium for Part B, which is deducted from the Social Security benefit, is currently $66.60 per month (or $799 per year). Between 1998 and 2004, the Part B monthly premium increased from $43.80 to $66.60, a 52 percent rise.[18] It is interesting to note that, over the same period, cost-of-living adjustments increased Social Security benefits by only 13 percent (Figure 5).

"Medigap" insurance

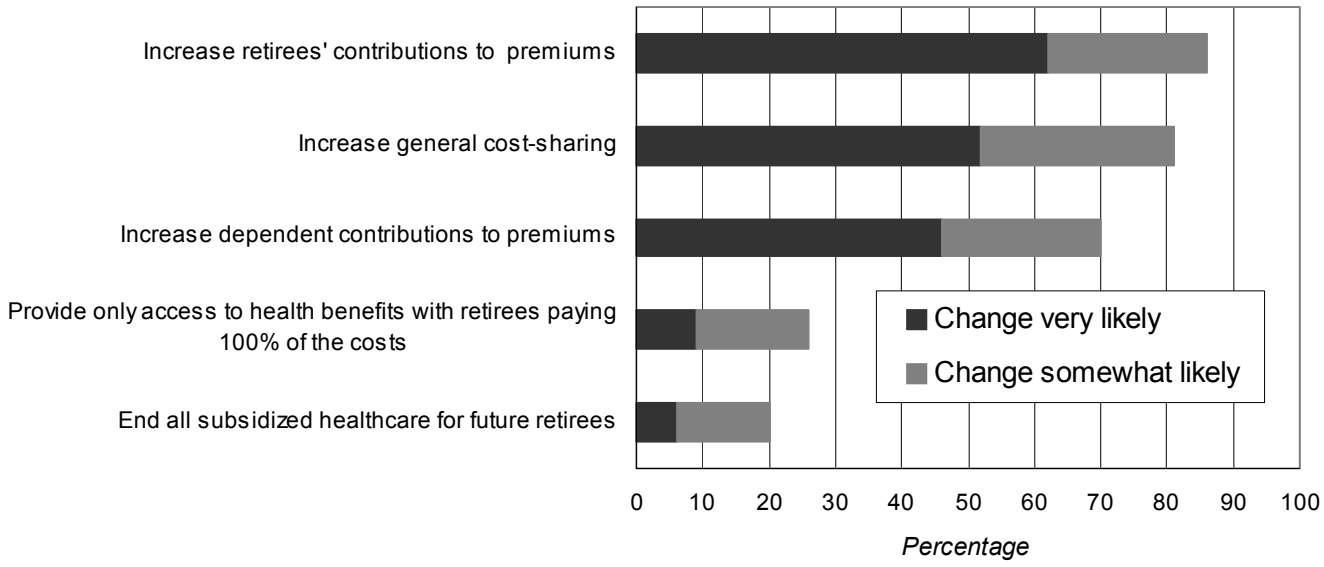
As critically important as Medicare is to people over 65, there are many things it does not cover. Part A requires, for example, a large initial hospital deductible ($876 in 2004), and hefty per diem deductibles for hospital stays beyond the first 60 days up to 150 days.[19] After 150 days, Medicare Part A coverage ceases entirely. Part B deductibles and co-payments include 20 percent of Medicare-approved charges for physicians' services.

Thus the third layer: to patch the cracks and holes in Medicare coverage, a number of private insurance companies offer so-called Medigap policies.[20] In 2002 (the latest year for which these data have been compiled), not quite 60 percent of the seniors enrolled in Medicare had private insurance coverage as well.[21] (Five million of the 40 million people who were enrolled in Medicare in 2002 participated in a Medicare+Choice plan, which obviates the need for "Medigap" insurance. It is not clear whether people who are enrolled in a Medicare+Choice plan would consider that "private insurance" when surveyed about their health insurance coverage.)

Average premiums for the various Medigap plans differ depending on how thoroughly they patch the cracks and fill the holes, but premiums for the same plan can differ substantially depending on geographical area and, even in the same area, may differ from company to company. In 2003, the premium charged a 65-year-old woman averaged between slightly over $1,000 annually for the "barebones" Medigap policy (Plan A, which provides the basic benefits only) to over $2,700 for Plan J, the most comprehensive policy.[22]

Like Part B premiums, average Medigap premiums have risen, with most plans having annual increases. Ironically, the largest percentage increase (67 percent) over the 1998-2003 period was in the

Figure 7. **Retirees with employer-sponsored health insurance can expect their share of the cost to rise***



*Percentage of large private-sector employers considering these changes likely within the next several years.

Source: Kaiser/Hewitt 2003 Survey on Retiree Health Benefits, January 2004

average premium for a Plan A policy.[23] In 2003, a 65-year-old woman covered by both Medicare Part B and the barebones Medigap policy would have spent, on average, over $1,700 on her health insurance premiums alone (Figure 6).

For older people fortunate enough to have retired from one of the small percentage of establishments—less than five percent of private-sector establishments overall[24]—which provide health insurance coverage to retirees, that insurance serves as the Medigap policy. These retirees are not, however, immune from increasing costs. They are already paying—or can expect soon to pay—more out of pocket than they had probably anticipated or budgeted for. A casual reading of newspapers shows that private firms are reducing or eliminating Medigap coverage promised to current retirees. And workers nearing retirement from the companies that have historically provided retirees with subsidized health insurance coverage may have reason to worry that it won't be there when they retire (Figure 7).

Medicaid

People 65 and over whose incomes are low and assets few may be eligible to have their Medicare coverage supplemented—in whole or in part—by Medicaid. This is a jointly funded federal-state program that provides healthcare to the elderly and disabled poor as well as to certain low-income children and—in some cases—their parents. In recent years, over three million (or close to 10 percent) of the seniors with Medicare coverage have also been covered by Medicaid.[25] Two-thirds were women.[26] For the elderly poor, it has bridged the gaps in Medicare coverage fairly well. For those who are not quite poor (those with incomes between 100 and 120 percent of poverty), Medicaid has provided more limited assistance. Having Medicaid coverage has been found to "greatly improve access and use of health services by low-income women."[27]

Part Three: The Middle-age Gap

The Healthcare structure can be dangerously rickety for women in midlife.

Nearly everybody who has relied on employer-sponsored health insurance is affected by rising out-of-pocket costs and growing uncertainties about coverage, but people nearing or in retirement—and the spouses of those people—can be in an especially worrisome position, if only because as people age, the likelihood increases that they will develop a serious health problem or a chronic condition requiring regular care. Most workers who retire before the age of 65, when they become eligible for Medicare, must bridge the intervening years with coverage in the private insurance market (if it's available and affordable) or go without.

In the 55-64 age group overall, over one-quarter of the women and over one-fifth of the men were either covered by "direct purchase" insurance (i.e., individual policies) or were entirely without coverage in 2002.[28] ***People in 55-64 age group were more likely than minor children to lack health insurance entirely (12.9 percent vs. 11.6 percent).*** And women in their early sixties are more likely than either their male contemporaries or slightly younger women to lack health insurance: 15 percent of women age 60–64—one in seven—had no coverage at all in 2001[29], compared with 12.7 percent of men in the age group and 13.4 percent of women age 55-59.

The comparatively higher rate of uninsurance among midlife women is probably largely attributable to life circumstances more typical of women than of men. For example, a woman whose husband retires at 65 is at risk of becoming uninsured if she is younger than he (most wives are several years younger than their spouses) and she has been

Profile: Gayle

Gayle, 59, has two jobs. She works part time in a museum and she is the primary caregiver for her husband, who is recovering from three strokes and a seizure. Fortunately, Gayle's husband had a generous disability policy with his former employer. This currently provides a substantial monthly payment but it will stop when he turns 65.

Before her husband became disabled in 1998, Gayle was insured through his employer. This was comprehensive, affordable, coverage that she was able to continue for 18 months under COBRA. After her 18 months of COBRA eligibility ran out, however, she could find only high-premium, high-deductible insurance because she has a pre-existing condition. She now has a barebones individual policy for which she pays $318 per month with a $800 deductible. Gayle's husband is covered by Medicare because of his disability, but he must also pay $258 per month for a supplemental insurance policy—a policy that does not include prescription drug coverage. Since he uses nine medications, and Medicare pays for only two of them, his drug costs are approximately $10,000 per year even though he imports them from Canada (otherwise, his medication costs would reach $20,000 per year). The couple's combined out-of-pocket medical costs are almost $18,000 per year.

Once Gayle's husband turns 65 two years from now, their income will drop. And until Gayle turns 65, she will have to rely on her current insurance policy, which costs almost half as much as the monthly Social Security payment she expects to receive at age 62. Taking a full-time job is not an option, because her husband needs her assistance often during the day.

insured through his job. He is covered by Medicare, she is not. For 18 months, she may able to stay insured through COBRA. But after that she must find affordable health insurance—which could mean getting a job or changing jobs—that will cover her until she reaches 65, or she must cross her fingers and pray that no health disaster will befall her before then.

The same problem faces a midlife woman who has had coverage through her own job but loses or leaves that job—perhaps for health reasons, or to care for a family member, or because her older husband wants her to join him in retirement. Again, COBRA may keep her insured for a while, but after that finding affordable coverage from a private insurer may be difficult if not impossible, especially if she has a pre-existing condition.[30]

And having a pre-existing condition means that access to affordable care and continuity of care are particularly important. Losing insurance coverage even temporarily may jeopardize both. A Commonwealth Fund study found that women who had been uninsured for only part of the year were nearly as likely as those uninsured throughout the year to have no regular doctor and to have had difficulty getting the medical care they needed.[31]

Part Four: Older Women at Risk

The three-layer health insurance structure for seniors leads to incomplete protection for many older women.

Seniors who can easily afford to supplement their Medicare coverage with a comprehensive Medigap policy, are on the whole, well-served by the system. Older women—especially married women—who are in comfortable financial circumstances at retirement are likely to remain so as long as their husbands live and are healthy and fit. But people who are comfortable at 65 or 70 may well find themselves financially stretched as they grow older and frailer, or become sick.

Millions of others are already just scraping by. In a particularly poignant situation are older people whose means are very modest but not low enough to qualify for Medicaid. The majority of these people are women.

The poverty threshold for elderly people is very low: in 2002, for example, a householder over 65 who lived alone wasn't officially "poor" unless her annual income was $8,628 or less. If she was in a two-person household with no minor children, the poverty threshold was $10,874.[32] People over 65 whose assets are minimal and whose household incomes are at or below the poverty threshold are likely to qualify for Medicaid. In the past, Medicaid served as Medigap insurance for the poorest seniors, and covered their prescription drugs. For the almost poor (up to 120 percent of the poverty threshold), Medicaid helped with at least some of the healthcare costs that Medicare does not cover.

Although there is much confusion about how the new law will affect people with both Medicare and Medicaid coverage, it seems clear that people who now receive Medicaid prescription drugs will

Profile: Suzanne

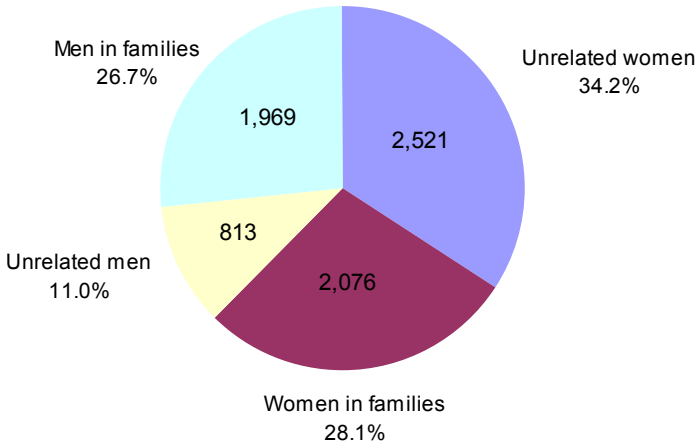
Suzanne, 62, works part-time for a nonprofit organization. She and her husband have spent over 35 years saving for retirement and have accumulated enough money for a comfortable retirement. They will receive Social Security once they retire, but neither has a pension because both have been self-employed for most of their working lives. And, since the health insurance system in the United States is tied to employment and Suzanne and her husband have usually been their own employers, they have had to pay for their own health insurance most of the time and do so now.

They currently pay a premium of $450 per month for a policy with a $2,500 per-person deductible that applies to all services including emergency room care. Suzanne and her husband chose to pay a high deductible to keep their health insurance affordable, but they put off getting regular check-ups because of the out-of-pocket cost.

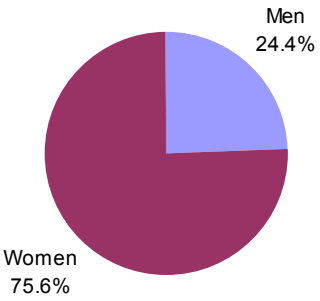
Suzanne worries about their future financial security because she fears that she or her husband will have a health problem that "could confiscate the dollars we have saved for years for retirement." She recalls that a trip to the emergency room following a minor head injury ended up costing $1,400 out of pocket, even though the treatment consisted of a few stitches and a CAT scan.

Once she and her husband are 65, they will be eligible for Medicare. Of course, even then they will be required to pay for Medicare Part B and—if they want comprehensive coverage—for "Medigap" insurance, as well.

Figure 8. Women account for more than 60 percent of the over seven million seniors whose household incomes are between 125% and 200% of poverty (numbers in thousands)



and for 76 percent of the more than three million "unrelated" seniors* who have household incomes between 125% and 200% of poverty



Source: Census Bureau, Table POV01, <http://ferret.bls.census.gov/macro/032003/pov/new01_200_01.htm>

*Most unrelated individuals live alone; a small percentage live with nonrelatives.

be required, instead, to sign up for the new Medicare drug benefit. This will mean out-of-pocket drug costs for people who had full prescription drug coverage through Medicaid.

The most dangerous hole in the structure of health insurance coverage for older people is the one facing those of modest means—particularly people with incomes of between 120 and 200 percent of poverty. Unfortunately, the available Census Bureau data showing the income-to-poverty ratios of various groups in the population "break" at 125 percent rather than 120 percent. Consequently, the following discussion necessarily uses 125 percent rather than 120 percent.

For a person age 65 or over who lived alone, this translated into a household income of between $10,785 and $17,256 in 2002[33], when the median income for U.S. households overall was over $42,000. ***Two-thirds of all seniors with household incomes between 125 and 200 percent of poverty—and three-quarters of those who live alone—are women*** (Figure 8).

The death of her partner can precipitate a drastic decline in an older woman's financial circumstances. Her household's Social Security income immediately drops. If she and her partner were not a married couple, she is not entitled to any part of her late partner's benefit. If she is a widow, her household's Social Security benefits are reduced by at least one-third. While her husband was alive he received his benefit and she received either 50 percent of his benefit (dependent's benefit) or—assuming she had been employed for at least 10 years—a benefit based on her own employment (retired worker's benefit), whichever was greater. When her husband died, she could choose to receive either 100 percent of his benefit, or 100 percent of her own (assuming she had been employed), but not both.

Moreover, if her husband had a pension, it may not have included a survivor's benefit, and even if it did—unlike Social Security—it probably does not provide automatic cost-of-living increases. It is largely because there are more and more widows among them that the economic situation of the elderly population deteriorates with advancing age. As the percentage of women in the population rises—and at the upper ages, most women are widows[34]—median income goes down. The table (right and above) shows the situation in 2000.[35]

Widows and other unmarried older women depend far more heavily on Social Security than men do. Fifty-one percent of widowed, divorced, or never-married women over 65 receive more than

Median Income by Age in 2000

half of their income from Social Security; of these, about half have income from Social Security only. Those who are totally dependent on Social Security are likely to have incomes low enough to qualify for Medicaid. But many of the others are certain to fall into the not-quite-poor enough for Medicaid category.[36]

For them, out-of-pocket expenditures on healthcare can be a heavy burden indeed. As this decade began, ***the average woman over 65 who lived alone spent more of her after-tax income on healthcare than on food.***[37]

Her expenditures for healthcare alone amounted to $2,589 and her total expenditures exceeded her after-tax income by nearly that amount ($2,489). If she was drawing on her savings to pay her bills, what will happen when her savings run out?

For some elderly women, having a Medigap policy as well as Medicare Part B may be unaffordable. Women 65 and over were less likely than their male counterparts to augment their

Profile: Marilyn

Marilyn, 69, raised five children. She was primarily a homemaker, although she has held jobs on and off. Both retired, she and her husband receive about $2,000 per month from Social Security. They own the house they live in, but have no other investments.

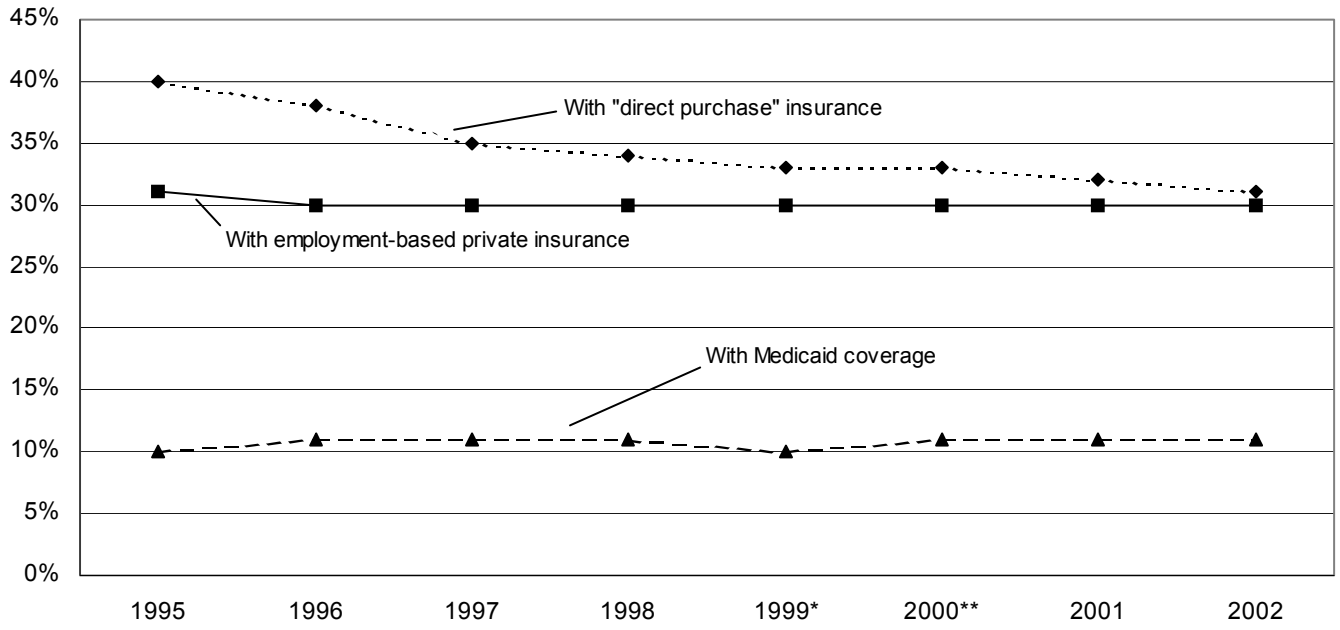
Before he retired, Marilyn was insured for the most part through her husband's employer-sponsored insurance. At 65 she enrolled in Medicare (Parts A and B) and purchased a supplemental insurance (Medigap) policy. Currently, her Medicare Part B premium is $66.60 per month and her supplemental insurance is $130.40 per month, but in July, when she turns 70, her Medigap premium will increase to $160.40. Her husband also pays $66.60 for Medicare Part B, and $160.40 for Medigap, so together they spend $424 per month on insurance premiums alone. Marilyn's Medigap plan includes very limited coverage for prescription drugs: it has an annual $6,250 deductible, and, even after the deductible has been met, pays only 80 percent of prescription drug costs.

Marilyn was found last May to have inoperable lung cancer. One drug that has been prescribed to treat her cancer costs $2,000 per month, and the drug prescribed for pain costs $1,200 per month. Added to other medications she must take, these would bring Marilyn's monthly out-of-pocket costs to $640 a month even after she met the $6,250 deductible. Marilyn and her husband do not qualify for low-income programs, but they simply cannot afford these costly drugs. Marilyn is able to take them once in a while only because her daughter, who works for a medical company, can sometimes get free samples. Marilyn is one of the millions of Americans who must engage in a dangerous balancing act, having to weigh the cost of prescription drugs against the need for treatment.

Medicare coverage with private insurance coverage (58.9 percent versus 64.2 percent for people 65 and over overall; 56.2 percent versus 63.6 percent for those 75 and over[38]). The percentage of women age 65 and over with "direct purchase" coverage has gradually declined, while the percentages with insurance from likely alternatives—employment-sponsored coverage or Medicaid—have been flat (Figure 9).[39]

It should also be pointed out that the least expensive Medigap policy (Plan A) leaves the insured totally responsible for many expenses, including the Medicare Part A deductible for the first day of a hospital stay ($840 in 2003), the annual Part B $100 deductible for physician's services, not to mention prescription drugs.[40]

Figure 9. **Percentage of women age 65 and over with insurance coverage in addition to Medicare by source of coverage, 1996-2002***



*Coverage at any time during each year shown. More than 99 percent of women age 65 and over were covered by Medicare.

Source: Census Bureau, Historical Insurance Tables <http://census.gov/hhes/hlthins/historic/hihistt2.html>

Part Five: Policy Recommendations

Midlife and older women are economically vulnerable. As they age, many will face unexpected financial hardship. OWL believes it's time to have a serious debate about the future of our nation's health care system. Critical to this debate is an understanding of the straitened financial circumstances faced by midlife and older women. However, while this report focuses primarily on how the present healthcare system fails midlife and older women, the following policy recommendations will benefit Americans of all ages.

We should adopt a universal, single payer, healthcare system.

OWL, which has for years advocated a universal, single payer healthcare system, is in distinguished company. In January 2004, the Committee on the Consequences of Uninsurance of the Institute of Medicine called for the President and Congress to develop a plan for universal insurance coverage for all by 2010.[41]

Estimates are that, in any year, 18,000 people die prematurely and 8 million people with chronic illnesses grow sicker because they lack insurance.[42] However, the uninsured do use healthcare services, which are paid for by a convoluted system of public and private sources. In 2001, uncompensated care for the uninsured totaled approximately $35 billion; between 75 and 85 percent of that amount was funded by the taxpayers.[43]

In 2003, the Journal of the American Medical Association (JAMA) published a proposal—endorsed by over 8,000 physicians and two former surgeons general—calling for an enhanced Medicare for all.[44] While the American Medical Association (AMA) did not endorse the concept, the AMA believes that the healthcare crisis in this country warranted a serious debate of the proposal. Some opponents of universal healthcare argue that it would increase health care spending astronomically. In reality, covering the uninsured would cost less than the average annual revenue loss from the federal tax cuts enacted since 2001.[45]

A single payer system would benefit women. Women are more likely than men to take time out of the workforce to care for children or parents, and more likely to work in low-wage jobs that do not offer affordable health insurance. And, since women are also more likely than men to be alone as they age, they need health insurance that they can depend on throughout their lives, including time out of the workforce, low-wage jobs, divorce, and widowhood.

Until a universal healthcare system is put into place, OWL recommends that the following measures be adopted:

- ***Enact Medicare early "buy-in" policies for midlife people.***
  Uninsurance rises among people between 55 and 65—indeed, even children are more likely than they to have health insurance coverage. Women in particular need an affordable health insurance option to carry them across the gap from retirement (or their husband's retirement) to Medicare eligibility at age 65. For a variety of reasons, including husbands retiring (since most wives are

younger than their husbands), loss of employment, pre-existing health conditions, and the type of employment women tend to have, one in seven women in this age group goes without health insurance. An easy, relatively affordable, solution would be to allow men and women over 55 to buy into Medicare.

An early "buy-in" option would allow people lacking affordable health insurance to pay a reasonable premium and receive Medicare part A and B benefits. For people who have lost their jobs, coverage under COBRA may help for a while, but it lasts for only 18 months and can be very expensive, since the individual must pay both employer and employee portions of premium. There are "high-risk" pools that guarantee insurance coverage, but they exist in only 30 states and typically require very high premiums and large deductibles. Previous studies have shown that, to be effective and have significant participation rates, premiums in a "buy-in" program must be affordable.[46]

- ***Increase benefits in Medicare.***
  There are currently three levels of insurance for people over age 65: Medicare Part A, Medicare Part B,[47] and supplemental "Medigap" insurance, the last either employer-sponsored or direct purchase. Most Medicare beneficiaries over 65 have some sort of Medigap insurance. Employer-sponsored health insurance for retirees is becoming less common and less generous than it used to be. As a result, more and more seniors must rely on direct purchase supplemental insurance—i.e., individual private insurance policies. Medigap insurance premiums have continued to increase over time, and in 2003 the barebones policy (Plan A) cost over $1,000 per year—a heavy burden for an elderly person of modest means who is already paying about $800 a year for Medicare Part B. Instead of requiring seniors wanting reasonably comprehensive coverage to have three layers of health insurance, the Medicare program should be expanded to cover more of the costs.

- ***Repeal and replace the recently signed Medicare Prescription Drug and Modernization Act of 2003.***
  For years, OWL has called for a prescription drug benefit that is universal, comprehensive, affordable, and ***in*** Medicare. Those who say, "this is an imperfect law, but at least it's a start," are right about one thing: it ***is*** a start—the beginning of Medicare privatization and an ending to one of the greatest aspects of Medicare, its consistency. Serious concerns about the law include the following:

  - It privatizes Medicare;
  - It forces seniors who stay in traditional Medicare to buy stand-alone, privately run, drug plans thus, putting them at risk of arbitrary decisions by private insurers;
  - It does nothing to address the high cost of prescription drugs;
  - It provides no guaranteed premiums;
  - It allows seniors to be bounced from plan to plan every one to two years;
  - It permits employers to drop existing retiree prescription drug coverage.

  Most Medicare beneficiaries are older women who have enjoyed simplicity in program design and administration for 40 years. No matter where you lived, or how much you or your spouse earned, your Medicare payments and benefits were the same. Now Medicare costs and benefits will shift to meet the demands of for-profit industries rather than the needs of the beneficiaries. OWL urges a concerted and focused effort to repeal and replace this bad law.

Part Six: Conclusion

America's healthcare structure fails many men as well as women. Nevertheless, its deficiencies are likely to have a more severe and widespread impact on women—especially on midlife and older women—than on men because the patterns and circumstances of women's lives have made them more vulnerable.

Losing the health insurance provided by a job is a possibility for most people, and would be disturbing for most. When it happens to people in late middle age, it can be a calamity. And it's more likely to happen to a midlife woman than to a man, simply because she is more likely than her male contemporaries to be insured through a spouse's job (40 percent versus 14 percent), more likely than they to have a spouse old enough to retire, and more likely than they to have her own employment options limited by care giving responsibilities.[48]

And if she loses job-related insurance, she may not be able to replace it with an individual policy if she has had a serious health problem or an ongoing chronic condition. Even if coverage is available, it could cost more than she can afford.

For women over 65, being entirely without health insurance of some kind is not an issue because virtually everybody age 65 and over has guaranteed coverage under Medicare, most under both Part A and Part B. But because there are many healthcare expenses that Medicare does not cover, seniors of modest means may not be able to afford

Profile: Ernesta

When her husband retired in 2000, Ernesta—then 60—retired as well. She extended her employer-sponsored healthcare coverage for 18 months under the Consolidated Omnibus Budget Reconciliation Act (COBRA). Two months after retiring, her husband died, leaving her with an income of $1,200 a month in pension and Social Security benefits. Ernesta's main asset is her home (her husband had owned stock in the company that he worked for, but the company went bankrupt and the stock became worthless).

While covered under COBRA, Ernesta found out she had breast cancer. The tumor was removed early and she received radiation treatment. The disease is in remission and she is on only one medication. Before her COBRA coverage was due to run out, Ernesta started looking for another insurance plan. She decided on a health insurance company and was told that all she had to do to receive coverage was to have her doctor write a letter stating that her cancer was in remission. Her doctor did so. Nevertheless, despite its previous assurances, the insurance company rejected her because of her pre-existing condition. With no other options, Ernesta enrolled in the Missouri Health Insurance Pool, which covers "high-risk" individuals. She pays $515 per month for a policy with a $5,000 deductible. It's expensive, but she feels fortunate to live in a state that has a high-risk health insurance program. Twenty states do not offer any type of program for individuals who are classified as "high-risk" by insurance companies.

Ernesta considers herself, "very lucky to have gotten breast cancer while I was still covered by COBRA. My total bill for treatment was over $50,000, but I only had to pay $2,500 out of pocket." Now, she pays most of her health care costs out of pocket and fears getting sick again. She is counting the days until she turns 65 and will be eligible for Medicare: "You will never meet anyone who can't wait to be 65 more than me."

all the care they need, and most of the older people in this situation are women. Again, the life patterns and societal constraints typically experienced by today's older women have led to this situation.

Most look back at years of financial dependence on their spouses, their own employment at low wages with few benefits and often interrupted by child-rearing and, later, other caregiving responsibilities. Indeed, that our healthcare system depends so heavily on unpaid care for the frail elderly—most of whom are women—can have serious long-term consequences for the caregivers, most of whom are women. People who take time off from work or cut back to part-time work or even quit their jobs entirely to care for a family member put a comfortable old age for themselves at financial risk.

In the days when most workers and their families were covered by employment-related health insurance—and when healthcare was much more affordable even without insurance than it is now—America's leaders were troubled that people over 65, who then accounted for less than 10 percent of the population[49], typically lacked the means to pay for care. Our leaders then saw a responsibility on the part of the government to guarantee that people who were unlikely to have health insurance through employment would nevertheless be able to afford the healthcare they needed. Thus was Medicare created in 1965.

Today, over 43 million people—15 percent of the population, the majority of them working people or their family members—lack health insurance of any kind. More and more American jobs lack health benefits. Several million vulnerable older women likely lack the means to pay for all the care they need. Where is our leaders' vision now?

Part Seven: Notes

[1] National Health Expenditures By Type of Service and Source of Funds: Calendar Years 1960–2002, Centers for Medicare & Medicaid Services, http://www.cms.hhs.gov/statistics/nhe, (for Prescription Drug spending; accessed January 2002).

[2] E-mail from Marilyn Moon to the author (Anne Stone), March 22, 2004.

[3] S. Woolhandler, T. Campbell, and D. U. Himmelstein, "Costs of Healthcare Administration in the United States and Canada," *New England Journal of Medicine* 349 (2003): 768-775.

[4] Bureau of Labor Statistics (BLS), "Employee Benefits in Private Industry, 2003," *News*, September 2003.

[5] National Health Expenditures By Type of Service and Source of Funds: Calendar Years 1960–2002, Centers for Medicare & Medicaid Services, http://www.cms.hhs.gov/statistics/nhe, (for Healthcare spending; accessed January 2002).

[6] The calculation of 2004 per capita health expenditures was based on total health expenditures per CMS divided by Census Bureau estimate of the total U.S. population as of 3/31/04 (292,916,423) [Census Bureau website—www.census.gov].

[7] Bureau of Labor Statistics, "Employee Benefits in Private Industry, 2003," *News*, September 2003. According to the BLS, the increase was calculated in current dollars—i.e., not adjusted for inflation.

[8] U.S. Census Bureau, "Historical Income Tables—People," Table P-8, http://www.census.gov/hhes/income/histinc/p08.html. To parallel the BLS calculation of the rise in employees' contributions to health insurance premiums, the income increase was calculated in current dollars.

[9] The employing unit on which the Bureau of Labor Statistics (BLS) bases its data on private-sector employee participation in various types of benefit plans is "establishment," which is not synonymous with either "employer" or "firm." "Workplace" is the closest parallel. See the technical notes in the BLS *News* of September 17, 2003.

[10] Andrea K. Walker, "Wal-Mart, Target Able to Drive Most Competition Out of Business with Dominance," *The Baltimore Sun, Knight Ridder/Tribune Business News*, March 21, 2004, and United Food and Commercial Workers, http://www.ufcw.org/press_room/fact_sheets_and_backgrounder/walmart/benefits.cfm.

[11] U.S. Census Bureau, "Annual Demographic Survey, March [2003] Supplement," Current Population Survey, Table HI01, http://ferret.bls.census.gov/macro/032003/health/h01_001.htm.

[12] In 2003, 78 percent of workers overall, and 89 percent of female workers, were employed in the services-producing sector (BLS, Annual Averages for 2003).

[13] Bureau of Labor Statistics, "Small establishments employ majority of private industry workers," *MLR: The Editor's Desk*, http://www.bls.goc/opub/ted/2003/jan/wk3/art02.htm.

[14] Bureau of Labor Statistics, "Employee Benefits in Private Industry, 2003," Table 1, *News*, September 2003.

[15] Bureau of Labor Statistics, Annual Averages-Household Data: 2003, Table 9.

[16] Bureau of Labor Statistics, "Employee Benefits in Private Industry, 2003," Table 1, *News*, September 2003.

[17] The law (COBRA) requires that workers who lose jobs with health benefits be allowed to continue coverage under the employer's plan, entirely at their own expense, for up to 18 months. Although an employer's group plan is likely to be less expensive than "direct purchase" health insurance, COBRA coverage, especially for a family, is not cheap.

[18] Social Security Administration, *Social Security Bulletin, Annual Statistical Supplement*, 2002, http://www.ssa.gov/, and author's personal knowledge re: 2004 premium.

[19] As of 2004, the deductible is $219 per day for days 61 through 90 of a hospital stay; $438 per day for days 91-150.

[20] By law, all Medigap plans must cover certain basic benefits. They are: coinsurance for days 61 through 150 of hospital stays; the cost of 365 more hospital days in the insured's lifetime; 20 percent of doctor's bills and 50 percent of mental health services; and the first three pints of blood. (Note that the basic benefits do not include the $876 deductible for the first day of a hospital stay). There are ten possible plans (A through J), each offering a different number, level, or combination of benefits. (Residents of Massachusetts, Minnesota, and Wisconsin have different standard Medigap plans to buy.) Insurance companies are not required to offer the full range of plans, but by law all must offer the same benefits in a particular plan—i.e., for example, the benefits in Company X's Plan C must be identical to those in Company Y's Plan C. AARP, "Medigap Plans: Coverage Listing by Plan," http://www.aarp.org/Articles/a2003-06-03-medigapcharts2/tools/printable.

[21] U.S. Census Bureau, "Annual Demographic Survey, March [2003] Supplement," Current Population Survey, Table HI01, http://ferret.bls.census.gov/macro/032003/health/h01_001.htm.

[22] Weiss Ratings Inc., "Consumers Face Huge Disparities in Medigap Rates, According to Weiss Ratings Study," http://www.weissratings.com/News/Ins_Medigap/20030714medigap.htm and telephone conversation with OWL staff.

[23] Analysis by OWL staff based on average premiums for a 65-year-old woman as reported by Weiss Ratings, Inc., "Rate of Medigap Premium Increases Slows Dramatically in 2002," and "Prescription Drug Costs Boost Medigap Premiums Dramatically," http://www.weissratings.com/News/Ins_Medigap/.

[24] Bureau of Labor Statistics, "Employee Benefits in Private Industry, 2003," Table 10, *News*, September 2003. See Note 10 above pointing out that the "establishments" surveyed by the BLS are not synonymous with "firms." Much higher percentages were reported by the Kaiser Family Foundation's 2003 Annual Survey of Employer Health Benefits (Exhibit 11.2), but it is important to note that these percentages were of *employers* that offered health benefits to active workers and included state and local governments among the "firms" it surveyed.

[25] U.S. Census Bureau, "Annual Demographic Survey, March [2003] Supplement," Current Population Survey, Table 24, http://ferret.bls.census.gov/macro/032002/pov/new24_001.htm and Table HI01, . . .32002/health/h01_001.htm.

[26] This was calculated from Table 24 of the "ferret" 3/2002 CPS poverty/health insurance coverage tables for 2001, which broke the population down by both age and sex. This particular table has not been updated, and more recent data by age by sex is not to be found elsewhere.

[27] D. Misra, ed., *Women's Health Data Book: A Profile of Women's Health in the United States*, 3rd ed., (Washington, DC: Jacobs Institute of Women's Health and The Henry J. Kaiser Family Foundation, 2001), 177.

[28] U.S. Census Bureau, "Annual Demographic Survey, March [2003] Supplement," Current Population Survey, Table HI01, http://ferret.bls.census.gov/macro/032003/health/h01_001.htm.

[29] 2001 is the latest year for which these data are available.

[30] While the Health Insurance Portability and Accountability Act (HIPAA) limits the pre-existing condition period to 12 months or less and requires that people who have been insured for at least 18 months be offered health insurance, it does not regulate or cap insurance premiums for coverage. Since there are, for the most part, no upper limits on insurance premiums or deductibles, many people with costly chronic conditions are labeled "high-risk" and unable to afford the premiums associated with "high-risk" insurance. See Gary Claxton, *How Private Insurance Works: A Primer*, (Washington DC: The Henry J. Kaiser Family Foundation, 2002).

[31] D. Misra, ed., *Women's Health Data Book: A Profile of Women's Health in the United States*, 3rd ed., (Washington, DC: Jacobs Institute of Women's Health and The Henry J. Kaiser Family Foundation, 2001), 177.

[32] U.S. Census Bureau, "Poverty 2002" (table), http://www.census.gov/hhes/poverty/thresh/thresh02.html.

[33] The comparable figures for 2003 were $11,033 and $17,652.

[34] According to the March 2002 CPS, 60.9 percent of noninstitutionalized women 75 and over, and 79 percent of those 85 and over, were widows. No doubt the percentage would be higher if women in nursing homes were counted.

[35] The latest year for which both these age breakdowns are available.

[36] According to the Social Security Administration (Annual Statistical Supplement 2002), as of December 2001, more than seven and one-half million widows over 65 were social security beneficiaries. About 45 percent of them were dually entitled; their average monthly benefit was $993.10 (times 12, this is $11,917.20) The remaining 55 percent were entitled as widows only. Their benefits averaged $846 (times 12, $10,152).

[37] Bureau of Labor Statistics, "Age of reference person: Average annual expenditures and characteristics," Table 3, Consumer Expenditure Survey, 2001-2002, http://www.bls.gov/cex/2002/Standard/age.pdf.

[38] The latest year for which readily available Census Bureau health insurance information is broken down by age and sex.

[39] It is conceivable that part of the difference could be explained by enrollments in Medicare+Choice plans, but breakdowns by sex of Medicare+Choice plan participants are not readily available.

[40] AARP, "Supplemental Plans (Medigap)," www.aarp.org/Articles/a2003-06-03-medigapcharts2.

[41] Institute of Medicine, "Insuring America's Health: Principles and Recommendations," 2004, http://www.iom.edu/Object.File/Master/17/732/0.pdf.

[42] *Ibid*.

[43] Institute of Medicine, "Hidden Costs, Value Lost Uninsurance in America," 2003, http://www.iom.edu/Object.File/Master/12/327/0.pdf.

[44] Steffie Woolhandler, David U. Himmelstein, Marcia Angell, Quentin D. Young, "Proposal of the Physicians' Working Group for Single-Payer National Health Insurance," Journal of the American Medical Assoication 290 (2003): 798 – 805.

[45] Jack Hadley and John Holahan, "Covering the Uninsured: How Much Would It Cost?" *Health Affairs* W3-263, June 2003, http://content.healthaffairs.org/cgi/reprint/hlthaff.w3.250v1.pdf

[46] Richard W. Johnson, Marilyn Moon, Amy J. Davidoff, *A Medicare Buy-In for the Near-Elderly: Design Issues and Potential Effects on Coverage*, (Washington DC: The Henry J. Kaiser Family Foundation, 2002).
John Sheilds, Ying-Jun Chen, *Medicare Buy-In Options: Estimating Coverage and Costs*, (New York: The Commonwealth Fund, 2001).

[47] The passage of the Medicare Prescription Drug and Modernization Act of 2003 added Medicare Part D, which will be fully integrated into the Medicare system in 2006. There is also Medicare Part C, which is Medicare + Choice, or HMO managed Medicare. If an individual is enrolled in Medicare Part C, it takes the place of Medicare Part A and Part B.

[48] National Alliance for Caregiving and AARP, *Caregiving in the U.S.*, (Washington, DC: National Alliance for Caregiving and AARP, 2004) 10.

[49] 9.4 percent of the U.S. population in 1965 was age 65 or over, according to the Census Bureau's Population Division, Information and Research Services Branch (e-mail from Karen D. Thompson to the author, April 19, 2004).

Acknowledgements

Research and Writing:
Anne J. Stone, Women's Research and Education Institute

Additional Research and Writing:
Elizabeth MacLeod Runkle, OWL
Laurie Young, OWL

Editing:
Susan Scanlan, Women's Research and Education Institute
Cynthia Middleton, OWL
Patrick Cody, Cody Communications
Joan B. Bernstein, OWL

Layout:
Monica F. Jacobe, Women's Research and Education Institute

Original cover graphic design by Graves Fowler Associates
Additional graphic designs by Ken Falk

OWL gratefully acknowledges Lisa Maatz, American Association of University Women; Dianna Porter, Alliance for Retired Americans, and Susan Scanlan, Women's Research and Education Institute for serving as readers of this report.

Thanks to Allison Peiser for her assistance.

A thank you to Amy Gotwals, Center for Science in the Public Interest for her guidance in the production of this report.

OWL
THE VOICE OF MIDLIFE AND OLDER WOMEN

Isn't It Time You Joined?

Make a difference in the lives of midlife and older women--Join OWL today.

Enclosed is my membership contribution of:
☐ $25 ☐ $50 ☐ $100 ☐ Other (Annual dues $25)

Name _____
Address _____
City, State, Zip _____
Phone _____
E-mail _____
☐ Sign me up for OWL's E-mail Action Alert Network!

Your contribution to OWL is tax-deductible to the extent allowed by the law.
Make your check payable to OWL, or charge your contribution to your credit card:
☐ VISA ☐ Mastercard ☐ AMEX
☐ OWL has authorization to chrage my credit card.
Name on Card _____
Acct. No. _____
Exp. Date _____
Amount _____
Signature _____

OWL is a 501(c)3 nonprofit organization. It is funded through membership dues, the contributions of its members and other individuals, and through foundation, government, and corporate grants for research and special projects. For more information, contact OWL at 202-783-6686 or 800-825-3695, or visit our website at www.owl-national.org.

☐ Send me information about OWL's planned giving program.
☐ Mail me copies of OWL's previous reports.
- ☐ 2002 Mother's Day Report: Social Security Privatization: A False Promise for Women
- ☐ 2001 State of Older Women in America
- ☐ 2001 Mother's Day Report: Faces of Caregiving
- ☐ 2000 Mother's Day Report: Prescription for Change: Why Women Need a Medicare Drug Benefit
- ☐ 1999 Mother's Day Report"The Face of Medicare is a Woman You Know

Please send this form and membership dues/contribution to:
OWL
1750 New York Avenue, NW, Suite 350
Washington, DC 20006

For Office Use Only: check # _____ Date _____ Amount _____

✂ Cut Here