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Policy matters

A Window of Vulnerability: Health Insurance Coverage Among Women 55 to 64 Years of Age

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A B S T R A C T

Introduction: Largely a consequence of historical gender differences in labor force attachment in the United States, many women rely on their spouse for health insurance coverage, particularly during late middle age. Prior research finds that this creates a window of vulnerability for women during late middle age who may lose their (older) spouse's employment-based coverage when he retires from the labor force and enrolls in Medicare. However, the few studies that have examined this window of vulnerability have been based primarily on white adults.

Methods: We used the 2004 and 2006 Annual Social and Economic Supplements to the Current Population Survey to examine whether the window of vulnerability exists among non-Hispanic Black, Mexican-origin, and non-Hispanic White women 55 to 64 years of age, and whether similar factors contribute to the vulnerability across these race/ethnic groups.

Results: Women 55 to 64 years of age married to men 65 years or older had an elevated risk of lacking coverage at a time of life when health problems are common and expensive. Among non-Hispanic White women, their husband's exit from full-time employment accounted for the higher risk, whereas a more complex and systemic set of social factors contributed to the higher risk among non-Hispanic Black and Mexican-origin women.

Conclusion: Ensuring adequate and affordable health insurance coverage among women during late middle age may require additional health care reforms such as extending Medicare eligibility to younger adults or basing Medicare age eligibility on the age of the older partner within a married couple.

Introduction and Background

In all developed nations, health care represents a core component of the modern welfare state. Basic preventive and curative care is vital for optimal functioning and productivity and has become a basic social right (Institute of Medicine, 2001). Yet, in the United States, substantial gaps in basic health care access exist among a large segment of the population (DeNavas-Walt, Proctor, & Smith, 2007), in part because of our lack of universal health insurance (Quadagno, 2005). Instead, during the twentieth century we developed a complex system of health care financing based largely on employment and marriage such that individuals with good jobs, or married to spouses with good jobs, have access to high-quality and affordable health insurance (Harrington Meyer & Pavalko, 1996; Zimmerman & Legerski, 2010). The system was based on the male breadwinner model of family economic security. That model, which was historically precarious for lower class women, has become increasingly unreliable in ensuring many families' economic security, including health insurance. Indeed, health insurance "is no longer a taken-for-granted benefit" of employment or marriage because of a host of factors, such as industrial restructuring and job insecurity (Moen & Roehling, 2005, p. 193), curtailment of dependent coverage and retiree health benefits (Lambrew, 2008; Patchias & Waxman, 2007), and higher premiums and deductibles (Kaiser Family Foundation [KFF], 2008) which have increased the percent of income spent on health care across income groups (Collins, Kriss, Doty, & Rustgi, 2008).

This system puts women at an additional disadvantage when it comes to securing quality and affordable health insurance coverage, particularly in late middle age (55–64 years), for at least two reasons. First, the link between employment and

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coverage means that women who stay home to raise children or care for aging parents do not have their own coverage. Women who reenter the labor force in mid life may find it difficult to secure employment that offers coverage (Harrington Meyer & Pavalko, 1996). Furthermore, older women often face employment-related age discrimination that makes it difficult to retain their current job or find a new one (Gregory, 2003). Even employed women often lack coverage because they are less likely than men to have full-time jobs that offer fringe benefits (Bird & Rieker, 2008). As a consequence, many married women rely on a spouse for coverage (Short, 1998).

Second, the link between marriage and coverage means that relatively common events such as divorce or a husband's retirement from the labor force mark the end of coverage for many women. Married women are more vulnerable than men to losing coverage owing to divorce (Short, 1998). Although the Consolidated Omnibus Budget Reconciliation Act ensures that women can temporarily retain their former spouse's coverage, the costs can be substantial (U.S. Department of Labor, n.d.). Further, women with an older spouse who retires from the labor force and enrolls in Medicare often lose their spouse's employment-based coverage (Jensen, 1992; Lambrew, 2001, 2008; Mutschler, 2001). Roughly 10% of women aged 50 to 70 who were married to men older than themselves reported that they became uninsured when their husband enrolled in Medicare (Lambrew, 2001). This latter source of vulnerability has received scant attention among social scientists, particularly regarding minority women.

Because age eligibility for Medicare is based on an individual's own age (not the older member of a couple), a woman younger than 65 whose husband is 65 or older may find herself in a health insurance window of vulnerability until she, too, reaches 65 (Schumacher et al., 2009). Moreover, because the period from ages 55 to 64 is one in which medical problems are quite common, this window of vulnerability has potentially deleterious consequences for women's health (Xu, Patel, Vahratian, & Ransom, 2006). As noted, women are at risk of losing coverage during this period of late middle age, and their susceptibility to certain health conditions often makes privately purchased coverage unaffordable (Lambrew, 2001; Rustgi, Doty, & Collins, 2009). Social scientists and policy makers point out that these disparities in coverage for baby boomer women could become more severe in the years ahead (Harrington Meyer & Herd, 2007).

Our employment- and marriage-based system raises a second dimension of vulnerability related to race/ethnicity. Many Hispanic (particularly Mexican-origin) and non-Hispanic Black women lack health insurance coverage: 13% of non-Hispanic White women lack coverage compared with 21% of African-American women, and 42% of Mexican-origin women aged 18 to 64 (Montez, Angel, & Angel, 2009). Minority women tend to have fewer ties to employment or marriage, and they are less likely to gain coverage through these institutions. Among adults aged 18 to 64, Mexican-origin women were less likely to be employed full-time (48%) than non-Hispanic White (58%) and African-American (64%) women, whereas African-American women were less likely to be married (39%) than non-Hispanic White (68%) and Mexican-origin (67%) women (Montez et al., 2009). Employment in low-income jobs lacking coverage among minority women and their spouses also contributes to low levels of coverage (Seccombe, Clarke, & Coward, 1994).

In this paper, we focus on marriage and spousal retirement from the labor force, and indirectly on Medicare age eligibility rules, in contributing to gender gaps in health insurance coverage among women aged 55 to 64. Only a handful of studies have examined this health insurance window of vulnerability among women aged 55 to 64 (e.g., Jensen, 1992; Lambrew, 2001; Mutschler, 2001; Vistnes, Cooper, Bernard, & Banthin, 2009), and those studies were based primarily on white adults. We investigate whether the vulnerability exists among non-Hispanic Black, Mexican-origin, and non-Hispanic White women aged 55 to 64, and whether marriage and spousal retirement similarly contribute to the gap across these race/ethnic groups. We conclude with a discussion of recent health reform and its potential to address this vulnerability.

Methods

Data

We used the Annual Social and Economic (ASEC) Supplements to the March Current Population Survey. Each ASEC provides demographic, economic, and health insurance information for a nationally representative sample of roughly 99,000 households including an oversampling of the Hispanic population. Because the ASEC uses a rolling sample design, approximately one half of households in the same calendar months of consecutive years of the ASEC are duplicated. To ensure sufficient sample sizes of Mexican-origin and non-Hispanic Black adults without duplicating households, we combined the 2004 and 2006 ASEC (U.S. Census Bureau, 2002, 2006). We selected respondents 25 years and older who reported their race/ethnicity as non-Hispanic White (hereafter White), non-Hispanic Black (hereafter Black), or Mexican origin (hereafter Mexican), regardless of nativity.

Variables

Our outcome is a dichotomous indicator of whether the respondent had any health insurance coverage during the previous calendar year, regardless of whether they were the policyholder or dependent on the plan. In the multivariate analysis, we included covariates that prior literature shows are strong predictors of coverage among our sample (e.g., Mutschler, 2001). Age of the female respondent is a continuous measure ranging from 55 to 64 years and the age of her spouse was defined categorically as 54 years or younger, 55 to 64, or 65 and older (reference). Employment statuses for the respondent and her spouse were categorized as not employed, part-time employed, or full-time employed (reference). Educational attainments for the respondent and her spouse were categorized as less than high school, high school, or more than high school (reference). We included dichotomous indicators for foreign birth and self-reported fair/poor health for the respondent and her spouse. We included a family income-to-poverty ratio defined categorically as less than 1.0, 1.0 to 1.99, or 2.0 and higher (reference).

Analyses

We first document age-based patterns of health insurance coverage for men and women across adulthood ($\geq$25 years), regardless of marital status, to illustrate the unique gender gap in coverage among adults aged 55 to 64 compared with other age groups. We then stratify age-based patterns of coverage for men and women by marital status (married, unmarried) to illustrate how marriage shapes the gender gap in coverage among adults aged 55 to 64—owing presumably in part to the tendency for women to marry older men and Medicare eligibility rules as prior research suggests—compared with other age groups.

Because these analyses confirm the vulnerability of married women aged 55 to 64, we then focus on them and examine a) the extent to which being married to a husband 65 years or older contributes to lower odds of coverage, b) the extent to which this is because of his employment and sociodemographic characteristics, and c) whether these results vary by race/ethnicity, using logistic regression models. The two descriptive analyses are weighted but the regression is not because nonweighted analyses are preferred when the weights are a function of the covariates (Winship & Radbill, 1994). All analyses are stratified by own race/ethnicity.

Results

Table 1 documents age-based patterns of coverage for men and women across adulthood, regardless of marital status, for the three race/ethnic groups. The probability of having any form of coverage generally increased with age for all race/ethnic groups, although there were race/ethnic disparities in coverage at all ages. In addition, younger women were more likely to have coverage than their male peers, yet this advantage converged and then reversed with age such that women aged 55 to 64 were less likely than their male peers to have coverage, regardless of race/ethnicity. After age 65, gender differences largely disappeared.

We then examined how these gender differences in coverage corresponded with marital status. Table 2 shows gender differences in having any coverage for married adults in column three and for unmarried adults in column six. The differences illustrate that women's initial health insurance advantage over men declined for both married and unmarried women with age. Furthermore, among married women, the advantage eventually became a disadvantage among women aged 55 to 64 for each race/ethnic group. Among married adults aged 55 to 64, the percent of White, Black, and Mexican-origin women with coverage was 2.4%, 1.5%, and 3.1% less than their male peers. Similar patterns exist for private coverage (data available on request).

Because Tables 1 and 2 revealed a unique vulnerability of married women aged 55 to 64, we then focused on these women. As outlined, we examined how husband's age and retirement from the labor force contributed to this window of vulnerability in the context of current Medicare age eligibility rules. Table 3, Model 1 shows that women aged 55 to 64 who were married to men aged 55 to 64 had a 25%, 125%, and 42% greater odds of coverage than women married to men 65 years or older among White, Black, and Mexican-origin women, respectively, although the difference was not significant for Mexican-origin women. Model 2 indicates that the health insurance disadvantage among women married to men 65 years or older (compared with women married to men aged 55–64) was explained by his exit from full-time employment. In contrast, husband's employment status did not explain the disadvantage among Mexican-origin women, and only slightly among Black women, married to men 65 years or older. For Mexican-origin women married to men 65 years or older, numerous factors accounted for their disadvantage, including family income and husband's human capital (Model 3) and her employment status (Model 4). For Black women married to men 65 years or older, their disadvantage was only slightly accounted for by the characteristics examined.

In summary, Table 3 illustrates that married women aged 55 to 64 had significantly greater odds of lacking coverage if their husband was 65 years or older. The analyses suggest that a large part of the explanation for this vulnerability among White women was her husband's exit from full-time employment. These results, then, indicate that the reversal in the gender gap in coverage for non-Hispanic women aged 55 to 64 was influenced by her (older) husband's retirement from the labor force combined with Medicare age eligibility rules that prevent younger spouses from receiving benefits at the same time as their husbands. In contrast, a husband's retirement from the labor force explained little of the vulnerability among Black or Mexican women married to older men; instead, numerous other systemic factors seem to be responsible.

Discussion

One of the most significant findings of this study was the unique risk of lacking health insurance coverage among women aged 55 to 64 who were married to men aged 65 or older across all three race/ethnic groups. The few studies that have examined this vulnerability were based primarily on White adults and found that married women aged 55 to 64 often lost coverage when their older husband retired from full-time employment and enrolled in Medicare (Lambrew, 2001; Mutschler, 2001), in part because Medicare age eligibility is not based on the age of the older member of a couple. Our study also identified an older husband's retirement as a key risk factor for White women aged 55 to 64. However, by including Black and Mexican-origin, our study adds an important dimension to this literature and to

Table 1
Percent of Adults With Any, Private, or Medicare-Only Health Insurance by Gender and Age

Age (yrs)	Non-Hispanic White			Non-Hispanic Black			Mexican Origin		
	Any	Private	Medicare Only	Any	Private	Medicare Only	Any	Private	Medicare Only
Males									
25–44	82.3	78.0	0.7	70.8	60.8	1.5	49.8	44.4	0.3
45–54	88.6	83.8	1.3	78.6	66.2	2.9	64.1	55.0	1.6
55–64	90.7	84.7	2.9	84.8	68.2	6.5	69.9	55.3	4.8
≥65	99.5	73.2	23.3	97.1	47.5	38.1	92.3	34.8	38.8
n	83,775			11,300			10,392		
Females									
25–44	86.2	79.8	0.6	78.0	61.8	0.8	57.2	46.3	0.3
45–54	89.2	84.5	1.0	81.5	68.1	2.5	66.9	56.4	1.2
55–64	89.1	81.9	2.9	82.9	62.8	6.9	65.9	49.8	4.4
≥65	99.5	67.9	26.2	98.5	38.4	41.5	93.7	27.9	40.4
n	92,099			15,946			10,231		

Note: Percentages are weighted; *n* is not weighted. *Any* includes adults with any source of private or public health insurance. *Private* includes adults with employment-based, privately purchased, or military health insurance, regardless of whether they had additional sources of coverage. *Medicare Only* includes adults whose only source of health insurance is Medicare.

Table 2
Gender Differences in Having Any Health Insurance by Marital Status and Age

Age (years)	Any Insurance Among Married Adults			Any Insurance Among Unmarried Adults		
	Women (%)	Men (%)	Diff (%)	Women (%)	Men (%)	Diff (%)
Non-Hispanic White						
25–44	90.8	90.0	0.8	77.2	70.5	6.7
45–54	91.4	92.6	−1.2	84.2	78.3	5.9
55–64	90.2	92.6	−2.4	86.7	83.5	3.2
≥65	99.6	99.6	0.0	99.4	99.3	0.1
Black						
25–44	85.7	84.8	0.9	73.9	61.8	12.1
45–54	86.2	85.6	0.6	78.1	70.8	7.3
55–64	86.6	88.1	−1.5	80.5	79.7	0.8
≥65	98.0	97.5	0.5	98.6	96.7	1.9
Mexican Origin						
25–44	58.1	54.0	4.1	55.2	43.1	12.1
45–54	66.9	66.0	0.9	66.9	59.5	7.4
55–64	67.5	70.6	−3.1	63.4	67.7	−4.3
≥65	93.3	93.1	0.2	93.9	90.5	3.4

Note: All percentages are weighted. *Diff* is the difference in coverage between women and men.

policy solutions. Although we found that Black and Mexican-origin married women aged 55 to 64 also experienced a window of vulnerability similar to White women, their vulnerability reflected a more complex array of factors. These included low levels of human capital among husbands and wives, low-status employment, and low levels of family income. We expected that husband's retirement from full-time employment would have a smaller consequence for minority women given labor force disadvantages among minority adults, but the negligible association was unanticipated.

Health Insurance Reform and Other Policy Solutions

The recently signed health reform (Patient Protection and Affordable Care Act) will change the health insurance landscape. The law will require most U.S. citizens and legal residents to have coverage, tighten regulations on insurance companies, incentivize employers to offer coverage, and extend coverage to more than 30 million uninsured Americans as a result of Medicaid expansion and the new state-based Health Benefit Exchanges through which individuals can purchase coverage (KFF, 2010). Under the new law, Medicaid expansion will cover all uninsured individuals with incomes up to 133% of the federal poverty level, including adults without dependent children. Individuals with incomes from 133% to 400% of the federal poverty level may receive premium credits and cost-sharing subsidies to purchase coverage through the exchanges (KFF, 2010). However, the new law does not guarantee universal coverage. Some individuals will remain outside the system, including undocumented immigrants, individuals with incomes too high to receive subsidies but too low to afford coverage given other financial obligations, and individuals who choose not to participate and instead pay the tax penalty associated with the individual mandate.

Even in the context of the new health care reform, employment will remain a significant source of coverage for women before Medicare eligibility (Glied, Jack, & Rachlin, 2008). If recent trends continue, future cohorts of women will likely assume even greater responsibility for their own retirement plans and health insurance coverage. The new law could expand access to affordable, employment-based coverage for women across education and occupation categories. For instance, the law

Table 3
Odds Ratios for Having Any Health Insurance Among Married Women 55 to 64 Years of Age

	Non-Hispanic White Women				Non-Hispanic Black Women				Mexican-Origin Women			
	1	2	3	4	1	2	3	4	1	2	3	4
Husband's characteristics												
Age (65+ years)												
≤54	1.136	0.857	0.937	0.798	1.975	1.822	1.876	1.871	0.882	0.917	0.842	0.666
55–64	1.249**	1.025	1.070	0.976	2.245**	2.124**	1.973**	2.065**	1.422	1.471	1.226	1.049
Employment (full time)												
Not employed		0.602**	1.003	1.082		0.819	1.627	1.614		1.042	1.220	1.266
Part time		0.697**	0.835	0.872		1.563	2.071	2.369		1.309	1.317	1.280
Education (more than HS)												
Less than high school			0.512**	0.638**			0.640	0.960			0.351**	0.402**
High school			0.687**	0.791**			1.234	1.475			0.481*	0.496*
Foreign born			0.659**	0.683			0.776	0.484			0.435**	0.550*
Fair or poor health			0.985	0.919			0.933	0.929			1.249	0.982
Household Characteristic												
Income-to-poverty (2.0+)												
<1.0			0.249**	0.285**			0.196**	0.239**			0.264**	0.312**
1.0–1.99			0.345**	0.396**			0.305**	0.369**			0.447**	0.515**
Wife's characteristics												
Age (yrs)				0.980				1.024				0.976
Education (more than HS)												
Less than high school				0.551**				0.424**				0.808
High school				0.714**				0.677				1.007
Employment (full time)												
Not employed				0.659**				0.676				0.533**
Part time				0.646**				0.509*				0.661
Foreign born				0.919				1.844				0.702
Fair or poor health				1.259*				1.115				1.661*
−2LL	5,693	5,655	5,411	5,351	653	650	606	595	676	676	592	580
n	8,782	8,782	8,782	8,782	907	907	907	907	563	563	563	563

Note: The models are not weighted. Omitted references shown in parentheses.
* $p < .05$.
** $p < .01$.

provides tax credits for small businesses to make employee coverage more affordable. However, it remains to be seen whether this induces marginally profitable service sector employers to offer coverage at a price that their low-wage employees (often low-educated or minority women) can afford. The new law also penalizes employers with 50 or more employees if at least one full-time employee receives a federal subsidy to purchase coverage through an exchange, with some exceptions (KFF, 2010). Although these tax credits and penalties may expand access to employment-based coverage, they may not protect against lapses in coverage for women who—more often than men—move in and out of the labor force in response to family circumstances. Thus, achieving maximum employment-based coverage may also require programs, such as the 1993 Family Medical Leave Act and subsidized child care, that make it possible for many women to continue employment after the birth of a child (Harrington Meyer & Herd, 2007).

By imposing tighter regulations on insurance companies, the new law also addresses several sources of the health insurance window of vulnerability experienced by women in late middle age. As discussed, late middle age is a period when chronic health conditions emerge, causing many women to be unable to find and keep affordable coverage (Lambrew, 2001; Rustgi et al., 2009). The new law addresses this source of vulnerability by prohibiting insurance companies from dropping individuals from coverage when they become ill, denying coverage or charging more for preexisting conditions, and charging more because of gender, for example (U.S. Department of Health and Human Services, 2010). Yet, the new law does not explicitly address another source of vulnerability among women in late middle age that we examined here—losing employment-based coverage from an older spouse when he retires from the labor force and enrolls in Medicare. Under the new law, these women must either acquire their own employment-based coverage, purchase a level of coverage that they can afford on the market (including the state-based exchanges), or go without coverage and pay the penalty. Employment-based coverage is unlikely for some fraction of these women, particularly women in poorer health (often low-educated or minority women) and women without long-term employment histories. Reducing this source of vulnerability, then, largely rests on the new law's ability to make market-based coverage available and affordable for everyone. Otherwise, more direct policy solutions should be considered. One option is to reduce Medicare age eligibility to 55 years, perhaps with a buy-in provision. Another option is to base program eligibility for both married partners on the age of the older spouse (Lambrew, 2008; Mutschler, 2001; Schoen, Simantov, Duchon, & Davis, 2000). However, this would increase the cost of Medicare at a time when its cost is already projected to markedly increase as the baby boom cohorts reach 65 years.

In conclusion, this paper has documented a window of vulnerability for health insurance coverage among women aged 55 to 64, particularly if married to men aged 65 or older, across three major race/ethnic groups in the United States. Although the new health care reform package is a significant step toward improving access to coverage for all adults, it may not be enough to guarantee affordable and adequate coverage among women in late middle age for reasons outlined. Researchers should monitor the window of vulnerability for all race/ethnic groups during and after health reform implementation to determine whether additional policy solutions are needed.

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