2016

Older Americans

Key Indicators of Well-Being

FEDERAL INTERAGENCY FORUM ON AGING RELATED STATISTICS

Federal Interagency Forum on Aging-Related Statistics

The Federal Interagency Forum on Aging-Related Statistics (Forum) was founded in 1986 to foster collaboration among Federal agencies that produce or use statistical data on the older population. Forum agencies as of June 2016 are listed below.

Consumer Product Safety Commission
http://www.cpsc.gov

Department of Commerce
U.S. Census Bureau
http://www.census.gov

Department of Health and Human Services
Administration for Community Living
http://www.acl.gov

Agency for Healthcare Research and Quality
http://www.ahrq.gov

Centers for Medicare and Medicaid Services
http://www.cms.gov

National Center for Health Statistics
http://www.cdc.gov/nchs

National Institute on Aging
http://www.nia.nih.gov

Office of the Assistant Secretary for Planning and Evaluation
http://aspe.hhs.gov

Substance Abuse and Mental Health Services Administration
http://www.samhsa.gov

Department of Housing and Urban Development
http://www.hud.gov

Department of Labor
Bureau of Labor Statistics
http://www.bls.gov

Employee Benefits Security Administration
http://www.dol.gov/ebsa

Department of Veterans Affairs
http://www.va.gov

Environmental Protection Agency
http://www3.epa.gov/

Office of Management and Budget
Office of Statistical and Science Policy
http://www.whitehouse.gov/omb/inforeg_statpolicy

Social Security Administration
Office of Research, Evaluation, and Statistics
http://www.ssa.gov

Copyright information: All material appearing in this report is in the public domain and may be reproduced or copied without permission; citation as to source, however, is appreciated. Recommended citation: Federal Interagency Forum on Aging-Related Statistics. *Older Americans 2016: Key Indicators of Well-Being.* Federal Interagency Forum on Aging-Related Statistics. Washington, DC: U.S. Government Printing Office. August 2016.
Report availability: Single copies of this report are available at no charge through the National Center for Health Statistics while supplies last. Requests may be sent to the Information Dissemination Staff, National Center for Health Statistics, 3311 Toledo Road, Room 5412, Hyattsville, MD 20782. Copies may also be ordered by calling 1-866-441-NCHS (6247) or by e-mailing nchsquery@cdc.gov. This report is also available on the World Wide Web at http://www.agingstats.gov.

Older Americans 2016

Key Indicators of Well-Being

Foreword

Older Americans (those age 65 and over) are a vibrant and growing part of our Nation. They also experience unique challenges to their economic well-being, health, and independence. To inform decisions regarding the support and well-being of older Americans, robust statistics reflecting these experiences are needed. Although many Federal agencies provide statistics on aspects of older Americans' lives, it can be difficult to fit the pieces together into a comprehensive representation. Thus, it has become increasingly important for policymakers and the general public to have an accessible, easy-to-understand portrait of how older Americans fare.

Older Americans 2016: Key Indicators of Well-Being (Older Americans 2016) provides a comprehensive, easy-to-understand picture of our older population. It is the seventh such chartbook prepared by the Federal Interagency Forum on Aging-Related Statistics (Forum). Readers will find here an accessible compendium of indicators drawn from the most reliable official statistics. Indicators are categorized into six broad groups: Population, Economics, Health Status, Health Risks and Behaviors, Health Care, and Environment.

The Forum's recent review of the *Older Americans* chartbook resulted in the addition of several new indicators particularly relevant to many of the challenges currently facing older Americans. Among these additions are an indicator describing the changing demographics of Social Security beneficiaries and an indicator describing transportation access for older Americans. Indicators have also been added to describe dementia rates (including Alzheimer's disease rates, among the non-nursing home population) as well as to examine the number of older Americans receiving long-term care by different types of providers. Finally, the Supplemental Poverty Measure (SPM) for Americans age 65 and over has been added.

The SPM extends the official poverty measure by taking into account many government programs designed to assist low-income families that are not included in the official poverty measure.

Although Federal agencies currently collect and report substantial information on the population age 65 and over, other important gaps in our knowledge remain. In *Older Americans 2012,* the Forum identified six such areas where more data are needed: informal caregiving, residential care, elder abuse, functioning and disability, mental health and cognitive functioning, pension measures, and end-of-life issues. In *Older Americans 2016,* we provide updated information on the data availability for these specific areas, in addition to a special feature on informal caregiving.

We continue to appreciate users' requests for greater detail for many existing indicators. We also extend an invitation to all of our readers and partners to let us know what else we can do to make our reports more accessible and useful. Please send any comments to agingforum@cdc.gov.

The *Older Americans* reports reflect the Forum's commitment to advancing our understanding of where older Americans stand today and what challenges they may face tomorrow. I congratulate the Forum agencies for joining together to present the American people with such valuable tools for understanding the well-being of the older population. Last, but not least, none of this work would be possible without the continued cooperation of millions of American citizens who willingly provide the data that are summarized and analyzed by staff in the Federal agencies for the American people.

Katherine K. Wallman
Chief Statistician
Office of Management and Budget

Acknowledgments

Older Americans 2016: Key Indicators of Well-Being is a report of the Federal Interagency Forum on Aging-Related Statistics (Forum). This report was prepared by the Forum's planning committee and reviewed by the Forum's principal members, which include Vicki Gottlich and Robert Hornyak (retired), Administration for Community Living (ACL); Steven B. Cohen, Agency for Healthcare Research and Quality (AHRQ); Dorinda Allard, Bureau of Labor Statistics (BLS); Karen Humes and Roberto Ramirez, U.S. Census Bureau; Debra Reed-Gillette, Centers for Medicare & Medicaid Services (CMS); Kathleen Stralka, U.S. Consumer Product Safety Commission (CPSC); Lynn Ross, Department of Housing and Urban Development (HUD); Joseph Piacentini and Anja Decressin, Employee Benefits Security Administration (EBSA); Kathy Sykes, Environmental Protection Agency (EPA); Charles Rothwell and Jennifer Madans, National Center for Health Statistics (NCHS); John Haaga and John Phillips, National Institute on Aging (NIA); Ruth Katz and William Marton, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services; Katherine K. Wallman, Office of Management and Budget (OMB); Daryl Kade, Substance Abuse and Mental Health Services Administration (SAMHSA); Howard Iams, Social Security Administration (SSA); and Dat Tran and Richard Allman, Department of Veterans Affairs (VA).

The Forum's planning committee and contributing staff members include Forum Staff Director, Traci Cook; Susan Jenkins and Kristen Robinson, ACL; David Kashihara AHRQ; Emy Sok, BLS; Amy Symens Smith and Wan He, U.S. Census Bureau; Kathleen Stralka, CPSC; Katherine Giuriceo and Lisa Mirel, CMS; Meena Bavan, HUD; Allan Beckmann and Lynn Shniper, EBSA; Kathy Sykes, EPA; Julie Dawson Weeks and Ellen Kramarow, NCHS; John Phillips, and Prisca Fall, NIA; Helen Zayac Lamont, ASPE; Jennifer Park, OMB; Beth Han, and Jennifer Solomon, SAMHSA; Howard Iams and Brad Trenkamp, SSA; Hazel Hiza, USDA; and Carolyn Stoesen,VA.

In addition to the 16 agencies of the Forum, the Department of Agriculture (USDA) was invited to contribute to this report. The Forum greatly appreciates the efforts of Hazel Hiza and TusaRebecca Schap, Center for Nutrition Policy and Promotion, USDA, in providing valuable information from their agency. Other staff members of Federal agencies who provided data and assistance include Jennifer Klocinski, ACL; Rachel Krantz-Kent and Geoffrey Paulin, BLS; William Dean, Maria Diacogiannis, Deborah Kidd, Chris McCormick, Maggie Murgolo, Joseph Regan, and Laura Saffron, CMS; Ellen Baldridge, David Mintz, and Rhonda Thompson, EPA; Carolyn Lynch, HUD; Elizabeth Arias, Robin Cohen, Nazik Elgaddal, Ginny Freid, Lauren Harris-Kojetin, Cynthia L. Ogden, Eunice Park-Lee, and Manisha Sengupta, NCHS; Vicky Cahan, NIA; Lynn Fisher, SSA; and Peter Ahn and Tom Garin, VA.

The Forum is also indebted to the people outside the Federal government who contributed to this chartbook: Gwen Fisher, Cathy Liebowitz, and David Weir, University of Michigan; and Xianfen Li, Harris Corporation.

Member agencies of the Forum provided funds and valuable staff time to produce this report. NCHS and its contractor, American Institutes for Research (AIR), facilitated the production, printing, and dissemination of this report. Melissa Diliberti, Ashley Roberts, Katie Mallory, Susan Armstrong, and Kathryn Low managed the report's production process and designed the layout; Richard Devens, First XV Communications, provided consultation and editing services.

About This Report

Introduction

Older Americans 2016: Key Indicators of Well-Being (*Older Americans 2016*) is the seventh in a series of reports by the Federal Interagency Forum on Aging-Related Statistics (Forum) describing the overall condition of the U.S. population age 65 and over. The reports use data from over a dozen national data sources to construct broad indicators of well-being for the older population and to monitor changes over time. By following these data trends, the reports make more information available targeted toward efforts to improving the lives of older Americans.

The Forum periodically conducts a conceptual and methodological review of report indicators and format according to an established indicator selection criteria (see "Selection Criteria for Indicators"). This review ensures that the report features the most current topics and the most reliable, accurate, and accessible statistics.

After conducting a conceptual framework and literature review in preparation for this report, the Forum modified several existing indicators and added four new indicators: Social Security Beneficiaries, Dementia, Long-Term Care Providers, and Transportation. The 2016 report also contains a newly established Environment domain.

This report is intended to stimulate relevant and timely public discussions, encourage exchanges between the data and policy communities, and foster improvements in Federal data collection on older Americans. By examining a broad range of indicators, researchers, policymakers, and service providers can better understand the areas of well-being that are improving for older Americans as well as the areas that require more attention.

Structure of the Report

By presenting data in a nontechnical, user-friendly format, *Older Americans 2016* complements other more technical and comprehensive reports from the individual Forum agencies. The report includes 41 indicators grouped in six sections: Population, Economics, Health Status, Health Risks and Behaviors, Health Care, and Environment. There is also a special feature this year on Informal Caregiving.

Each indicator includes

- A paragraph describing the relevance of the indicator to the well-being of the older population.
- One or more charts that illustrate important aspects of the data.
- Bulleted data highlights.

The data used in the indicators are presented in tables in the back of the report. Data source descriptions and a Glossary are also provided in the back matter.

Selection Criteria for Indicators

The Forum chose these indicators because they meet the following criteria:

- Easy to understand by a wide range of audiences.
- Based on reliable, nationwide data sponsored, collected, or disseminated by the Federal government.
- Objectively based on substantial research that connects the indicator to the well-being of older Americans.
- Balanced so that no single section dominates the report.
- Measured periodically (but not necessarily annually) so that they can be updated, making possible, description of trends over time.
- Representative of large segments of the aging population, rather than one particular group.

Considerations When Examining the Indicators

The data in *Older Americans 2016* usually describe the U.S. population age 65 and over. More specific age groups (e.g., ages 65–74, 75–84, and 85 and over) are reported whenever possible.

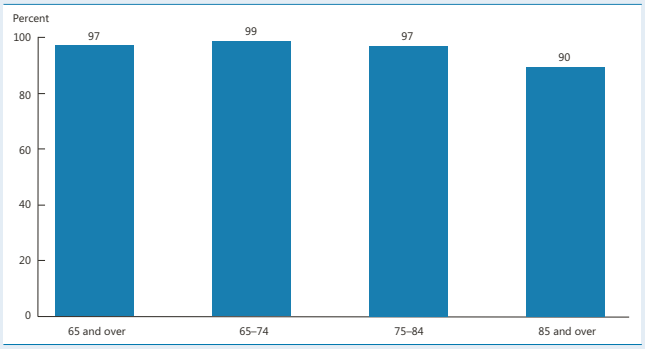
Data availability and analytical relevance may factor into the determination of the age groups presented in an indicator. For example, data for the age range 85 and over may not appear in an indicator because small survey sample sizes have resulted in statistically reliable data for that age range not being available. On the other hand, data for the population younger than age 65 are sometimes included in an indicator if the inclusion allows for a more comprehensive interpretation of the indicator's content. For example, in "Indicator 12: Participation in Labor Force," a comparison with a younger population provided an opportunity for an enhanced interpretation of labor force trends among people age 65 and over. In order to show trends in the amount of savings reserved

for retirement by the entire population, data on public and private retirement assets are included for the total population in "Indicator 11: Net Worth."

To standardize the age distribution of the population age 65 and over across years, some estimates have been age adjusted by multiplying age-specific rates by time-constant weights. If an indicator has been age adjusted, this will be stated in the note under the chart(s) as well as under the corresponding table(s).

The reference population (the base population sampled at the time of data collection) for each indicator is labeled under each chart and table and is defined in the Glossary. Whenever possible, the indicators include data on the U.S. resident population (both people living in the community and people living in institutions). However, many indicators show data only for the civilian noninstitutionalized population. Because the older population residing in nursing homes (and other long-term care institutional settings) is not included in samples based on the noninstitutionalized population, use caution when attempting to generalize the findings from these data sources to the entire population age 65 and over. This is especially true for the older age groups. For example, in 2014, 10 percent of the population age 85 and over was not included in the civilian noninstitutionalized population as defined by the U.S. Census Bureau.

Civilian noninstitutionalized population as a percentage of the total resident population, by age: July 1, 2014.



SOURCE: U.S. Census Bureau, Population Estimates, July 1, 2014.

Survey Years

The reader should be aware that the range of years presented in each chart varies because data availability is not uniform across the data sources.

Accuracy of the Estimates

Most estimates in this report are based on a sample of the population and are therefore subject to sampling error. Standard tests of statistical significance have been used to determine whether differences between populations exist at generally accepted levels of confidence or whether they occurred by chance. Unless otherwise noted, only differences that are statistically significant at the 0.05 level are discussed in the text. To indicate the reliability of the estimates, standard errors for selected estimates in the chartbook can be found on the Forum's website at http://www.agingstats.gov.

Where possible, data estimates have been obtained from the true unrounded value of the original data. Data are rounded to one decimal place in the data tables and are shown as whole numbers in the report text unless a finer breakdown is needed to show a significant difference between two estimates that would otherwise round to the same number. While figures display rounded numbers, the figures are created using unrounded estimates.

Finally, the data in some indicators may not sum to totals because of rounding.

Sources of Data

The data used to create the charts are provided in the tables in the back of the chartbook along with data that are described in the bullets below each chart. The source of the data for each indicator is noted below the chart.

Descriptions of the data sources can be found in the back matter. Additional information about these data sources and contact information for the agency providing the data are available on the Forum's website at http://www.agingstats.gov.

Data Needs

In *Older Americans 2012,* the Forum identified six areas where better data were needed to support research and policy efforts related to older Americans: informal caregiving, residential care, elder abuse, functioning and disability, mental health and cognitive functioning, pension measures, and end-of-life issues.

Since then, the Federal statistical community and the Forum have made significant improvements to enhance data availability related to these data needs, many of which are reflected in *Older Americans 2016.* This report includes a new indicator on dementia using data from the 2011 National Health and Aging Trends Study (NHATS) as well as a special feature on informal caregiving based on data from the 2011 National Study of Caregiving (NSOC). Data from the 2015 NHATS and NSOC will be available in late 2016. A new indicator on long-term care providers, with data from the new 2014 National

Study of Long-Term Care Providers, addresses residential care data needs. The indicator on functional limitations presents disability prevalence among those 65 and over, using questions developed by the United Nations-sponsored Washington Group on Disability Statistics and collected as part of the National Health Interview Survey.

The report also includes a new indicator on social security beneficiaries. This indicator is based on data from the Master Beneficiary Record (MBR) which are published annually in the Statistical Supplement to the Social Security Bulletin.

Other key indicators were identified by the Forum for inclusion in this year's report, such as new measures on oral health, cancer screenings, and transportation. Data on other topics of continued interest, like end-of-life, have been covered in other Federal reports.

With continued discussion on measurement issues and the effect of survey technique on estimates of the incidence of elder abuse[1] as well as with the number of older adults with substance use disorders in the U.S. projected to double by 2020,[2] the Forum continues to identify elder abuse and substance use disorder as ongoing areas of data need and will follow up with forthcoming survey findings.

Mission

The Forum's mission is to encourage cooperation and collaboration among Federal agencies in order to improve the quality and utility of data on the aging population.

The specific goals of the Forum are

- Widening access to information on the aging population through periodic publications and other means.
- Promoting communication among data producers, researchers, and public policymakers.
- Coordinating the development and use of statistical databases among Federal agencies.
- Identifying information gaps and data inconsistencies.
- Investigating questions of data quality.
- Encouraging cross-national research and data collection on the aging population.
- Addressing concerns regarding collection, access, and dissemination of data.

More Information

For more information about *Older Americans 2016* or other Forum activities, contact

Traci Cook
Staff Director
Federal Interagency Forum on Aging-Related Statistics
3311 Toledo Road
Hyattsville, MD 20782
Phone: (301) 458-4082
Fax: (301) 458-4021
E-mail: agingforum@cdc.gov
Website: http://www.agingstats.gov

Older Americans on the Internet

Additional material can be found at http://www.agingstats.gov. The website contains

- Data for all of the indicators in Excel spreadsheets (with standard errors, when available).
- Data source descriptions.
- PowerPoint slides of the charts.

The Forum's website also provides other Forum publications, workshop documents, agency contacts, subject area contact lists for Federal statistics, and information about the Forum.

Additional Online Resources

Administration for Community Living

A Profile of Older Americans
http://www.aoa.acl.gov/Aging_Statistics/Profile/index.aspx

Aging Integrated Database
http://www.agid.acl.gov/

ACL Program Evaulations and Related Reports
http://www.aoa.acl.gov/program_results/program_evaluation.aspx

Agency for Healthcare Research and Quality

Research Tools and Data
http://www.ahrq.gov/research/index.html

Bureau of Labor Statistics

Bureau of Labor Statistics Data
http://www.bls.gov/data

U.S. Census Bureau

Age Data
http://www.census.gov/topics/population/age-and-sex.html

Statistical Abstract of the United States
http://www.census.gov/library/publications/time-series/statistical_abstracts.html

Longitudinal Employer-Household Dynamics
http://lehd.did.census.gov/led/

Centers for Medicare & Medicaid Services

CMS Research, Statistics, Data, and Systems
http://www.cms.gov/research-statistics-data-and-systems/research-statistics-data-and-systems.html

Department of Housing and Urban Development

Policy Development and Research Information Services
http://www.huduser.gov

Department of Veterans Affairs

Veteran Data and Information
http://www1.va.gov/vetdata

Employee Benefits Security Administration

EBSA's Research
http://www.dol.gov/ebsa/publications/research.html

Environmental Protection Agency

Information Resources
http://www.epa.gov/healthresearch/aging-and-sustainability-listserve

National Center for Health Statistics

Longitudinal Studies of Aging
http://www.cdc.gov/nchs/lsoa.htm

Health, United States
http://www.cdc.gov/nchs/hus.htm

Health Indicators Warehouse
http://www.healthindicators.gov/

National Institute on Aging

NIA Centers on the Demography of Aging
http://www.agingcenters.org/

National Archive of Computerized Data on Aging
http://www.icpsr.umich.edu/NACDA

Publicly Available Datasets for Aging-Related Secondary Analysis
http://www.nia.nih.gov/research/dbsr/publicly-available-databases-aging-related-secondary-analyses-behavioral-and-social

Office of the Assistant Secretary for Planning and Evaluation, HHS

Office of Disability, Aging, and Long-Term Care Policy
http://www.aspe.hhs.gov/_/office_specific/daltcp.cfm

Office of Management and Budget

Federal Committee on Statistical Methodology
https://fcsm.sites.usa.gov

Social Security Administration

Social Security Administration Statistical Information
http://www.ssa.gov/policy

Substance Abuse and Mental Health Services Administration

Center for Behavioral Health Statistics and Quality
http://www.samhsa.gov/data

Center for Mental Health Services
http://www.samhsa.gov/about-us/who-we-are/offices-centers/cmhs

Other Resources

FedStats.gov
https://fedstats.sites.usa.gov

Table of Contents

Foreword iii
Acknowledgements iv
About This Report v
List of Tables xi
Highlights xvii

POPULATION

Indicator 1: Number of Older Americans 2
Indicator 2: Racial and Ethnic Composition 4
Indicator 3: Marital Status 5
Indicator 4: Educational Attainment 6
Indicator 5: Living Arrangements 8
Indicator 6: Older Veterans 9

ECONOMICS

Indicator 7: Poverty 12
Indicator 8: Income 13
Indicator 9: Sources of Income 14
Indicator 10: Social Security Beneficiaries 16
Indicator 11: Net Worth 18
Indicator 12: Participation in Labor Force 20
Indicator 13: Housing Problems 22
Indicator 14: Total Expenditures 24

HEALTH STATUS

Indicator 15: Life Expectancy 26
Indicator 16: Mortality 27
Indicator 17: Chronic Health Conditions 28
Indicator 18: Oral Health 29
Indicator 19: Respondent-Assessed Health Status 30
Indicator 20: Dementia 31
Indicator 21: Depressive Symptoms 32
Indicator 22: Functional Limitations 34

HEALTH RISKS AND BEHAVIORS

Indicator 23: Vaccinations 38
Indicator 24: Cancer Screenings 39
Indicator 25: Diet Quality 40
Indicator 26: Physical Activity 41
Indicator 27: Obesity 42
Indicator 28: Cigarette Smoking 43

HEALTH CARE

Indicator 29: Use of Health Care Services 46
Indicator 30: Health Care Expenditures 48
Indicator 31: Prescription Drugs 50
Indicator 32: Sources of Health Insurance 52
Indicator 33: Out-of-Pocket Health Care Expenditures 53
Indicator 34: Sources of Payment for Health Care Services 54
Indicator 35: Veterans' Health Care 55
Indicator 36: Residential Services 56
Indicator 37: Personal Assistance and Equipment 58
Indicator 38: Long-Term Care Providers 60

ENVIRONMENT

Indicator 39: Use of Time 64
Indicator 40: Air Quality 66
Indicator 41: Transportation 68

SPECIAL FEATURE

Informal Caregiving 69

References 75
Tables 81
Data Sources 159
Glossary 171

List of Tables

Indicator 1: Number of Older Americans
Table 1a. Number of people (in millions) age 65 and over and age 85 and over, selected years, 1900–2014, and projected years, 2020–2060 82
Table 1b. Percentage of people age 65 and over and age 85 and over, selected years, 1900–2014, and projected years, 2020–2060 83
Table 1c. Population of countries or areas with at least 10 percent of their population age 65 and over, 2015 84
Table 1d. Percentage of the population age 65 and over, by state, 2014 86
Table 1e. Percentage of the population age 65 and over, by county, 2014 87
Table 1f. Number and percentage of people age 65 and over and age 85 and over, by sex, 2014 87

Indicator 2: Racial and Ethnic Composition
Table 2. Population age 65 and over, by race and Hispanic origin, 2014 and projected 2060 88

Indicator 3: Marital Status
Table 3. Marital status of the population age 65 and over, by age group and sex, 2015 88

Indicator 4: Educational Attainment
Table 4a. Educational attainment of the population age 65 and over, selected years 1965–2015 89
Table 4b. Educational attainment of the population age 65 and over, by sex and race and Hispanic origin, 2015 89

Indicator 5: Living Arrangements
Table 5a. Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2015 90
Table 5b. Percentage of population age 65 and over living alone, by sex and age group, selected years, 1970–2015 90

Indicator 6: Older Veterans
Table 6a. Percentage of population age 65 and over who are veterans, by age group and sex, 2000, 2010, and 2015, and projected 2020 and 2025 91
Table 6b. Number of veterans age 65 and over, by age group and sex, 2000, 2010, and 2015, and projected 2020 and 2025 91

Indicator 7: Poverty
Table 7a. Poverty rate by age, by official poverty measure and Supplemental Poverty Measure, 1966–2014 92
Table 7b. Percentage of the population age 65 and over living in poverty, by selected characteristics, 2014 93

Indicator 8: Income
Table 8a. Income distribution of the population age 65 and over, 1974–2014 94
Table 8b. Median income of householders age 65 and over, in current and in 2014 dollars, 1974–2014 95

Indicator 9: Sources of Income
Table 9a. Percentage distribution of per capita family income for persons age 65 and over, by income quintile and source of income, 2014 96
Table 9b. Percentage of people age 55 and over with family income from specified sources, by age group, 2014 97
Table 9c. Number of participants (in thousands) in private pension plans, by type of plan, 1975–2013 98
Table 9d. Number of participants (in thousands) in private defined benefit pension plans and percent of participants retired or separated from employer, 1975–2013 99

Table 9e. Number of participants (in thousands) in defined benefit and defined contribution retirement plans, by selected type of plan, 1999–2013 100
Table 9f. Percentage of workers in private sector and state and local government with access to retirement benefits, by type of retirement plan, 2015 100

Indicator 10: Social Security Beneficiaries
Table 10a. Percentage distribution of people who began receiving Social Security benefits in 2014, by age and sex 101
Table 10b. Percentage distribution of female Social Security beneficiaries age 62 and over, by type of benefit received, selected years 1960–2014 101

Indicator 11: Net Worth
Table 11a. Median household net worth, in 2013 dollars, by selected characteristics of head of household, selected years 1983–2013 102
Table 11b. Value of household financial assets held in retirement investment accounts, by selected characteristics of head of household, 2007 and 2013 103
Table 11c. Amount of funds (in millions of dollars) held in retirement assets, by sector and type of plan, 1975–2014 104

Indicator 12: Participation in Labor Force
Table 12. Labor force participation rates (annual averages) of persons age 55 and over, by sex and age group, 1963–2015 105

Indicator 13: Housing Problems
Table 13a. Prevalence of housing problems among older-owner/renter households, by type of problem, selected years, 2009–2013 107
Table 13b. Prevalence of housing problems among older-member households, by type of problem, selected years, 2009–2013 107
Table 13c. Prevalence of housing problems among all U.S. households except those households with one or more persons age 65 and over, by type of problem, selected years, 2009–2013 108
Table 13d. Prevalence of housing problems among older-owner/renter intergenerational households, by type of problem, selected years, 2009–2013 108
Table 13e. Prevalence of housing problems among older-member intergenerational households, by type of problem, selected years, 2009–2013 109
Table 13f. Prevalence of housing problems among all older households: householder, spouse, or member(s) age 65 and over, by type of problem, selected years, 2009–2013 109

Indicator 14: Total Expenditures
Table 14. Percentage distribution of total household annual expenditures, by age of reference person, 2014 110

Indicator 15: Life Expectancy
Table 15a. Life expectancy at ages 65 and 85, by race and sex, 1981–2014 111
Table 15b. Life expectancy at birth, age 65, and age 85, by race and Hispanic origin and sex, 2014 113

Indicator 16: Mortality
Table 16a. Death rates among people age 65 and over, by selected leading causes of death, 1981–2014 114
Table 16b. Death rates among people age 65 and over, by selected leading causes of death, sex, and race and Hispanic origin, 2014 115

Indicator 17: Chronic Health Conditions
Table 17a. Percentage of people age 65 and over who reported having selected chronic health conditions, by sex and race and Hispanic origin, 2013–2014 116
Table 17b. Percentage of people age 65 and over who reported having selected chronic health conditions, 1997–1998 through 2013–2014 116

Indicator 18: Oral Health
Table 18a. Percentage of people age 65 and over who had dental insurance, had a dental visit in the past year, or had no natural teeth, by age group, 2014 117
Table 18b. Percentage of people age 65 and over who had dental insurance, had a dental visit in the past year, or had no natural teeth, by sex and race and Hispanic origin, 2014 117

Indicator 19: Respondent-Assessed Health Status
Table 19. Percentage of people age 65 and over with respondent-assessed good to excellent health status, by race and Hispanic origin, sex, and age group, 2012–2014 118

Indicator 20: Dementia
Table 20a. Number and percentage of the non-nursing home population age 65 and over with dementia, by age group, 2011 119
Table 20b. Percentage of the non-nursing home population age 65 and over with dementia, by sex and age group, 2011 119
Table 20c. Percentage of the non-nursing home population age 65 and over with dementia, by sex and educational attainment, 2011 119
Table 20d. Percentage of the non-nursing home population age 65 and over with dementia, by age group and educational attainment, 2011 119

Indicator 21: Depressive Symptoms
Table 21a. Percentage of people age 51 and over with clinically relevant depressive symptoms, by age group and sex, selected years 1998–2014 120
Table 21b. Percentage of people age 51 and over with clinically relevant depressive symptoms, by age group and sex, 2014 120

Indicator 22: Functional Limitations
Table 22a. Percentage of people age 65 and over with a disability, by sex and functional domain, 2010 and 2014 121
Table 22b. Percentage of people age 65 and over with a disability, by age group and functional domain, 2014 122
Table 22c. Percentage of people age 65 and over with a disability, by race and Hispanic origin and functional domain, 2014 122
Table 22d. Percentage of Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, 1992–2013 123
Table 22e. Percentage of Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, by sex and age group, 2013 123

Indicator 23: Vaccinations
Table 23a. Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, selected years, 1989–2014 124

Table 23b. Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by selected characteristics, 2014 124

Indicator 24: Cancer Screenings
Table 24. Percentage of women ages 50–74 who had breast cancer screening and percentage of people ages 50–75 who had colorectal cancer screening, by sex and age group, selected years, 2000–2013 125

Indicator 25: Diet Quality
Table 25. Healthy Eating Index-2010 average total scores and component scores expressed as a percentage of the HEI maximum score for the population age 65 and over, by age group, 2011–2012 126

Indicator 26: Physical Activity
Table 26a. Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the 2008 Federal physical activity guidelines, by age group, 1998–2014 127
Table 26b. Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the 2008 Federal physical activity guidelines, by sex and race and Hispanic origin, 2014 128

Indicator 27: Obesity
Table 27. Percentage of people age 65 and over overweight and with obesity, by sex and age group, selected years, 1976–2014 129

Indicator 28: Cigarette Smoking
Table 28a. Percentage of people age 65 and over who are current cigarette smokers, by sex and race, selected years, 1965–2014 130
Table 28b. Percentage distribution of people age 18 and over, by cigarette smoking status, sex, and age group, 2014 131
Table 28c. Percentage of people age 65 and over who are current cigarette smokers, by sex and poverty status, 2014 131

Indicator 29: Use of Health Care Services
Table 29a. Use of Medicare-covered health care services per 1,000 Medicare beneficiaries age 65 and over, 1992–2013 132
Table 29b. Use of Medicare-covered home health care and skilled nursing facility services per 1,000 Medicare beneficiaries age 65 and over, by age group, 2013 132

Indicator 30: Health Care Expenditures
Table 30a. Average annual health care costs, in 2012 dollars, for Medicare beneficiaries age 65 and over, by age group, 1992–2012 133
Table 30b. Total amount and percentage distribution of annual health care costs among Medicare beneficiaries age 65 and over, by major cost component, 2008 and 2012 133
Table 30c. Average annual health care costs among Medicare beneficiaries age 65 and over, by selected characteristics, 2012 134
Table 30d. Average annual health care costs among Medicare beneficiaries age 65 and over, by age group and major cost component, 2012 135
Table 30e. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who reported problems with access to health care, 1992–2012 135

Indicator 31: Prescription Drugs
Table 31a. Average prescription drug costs, in 2012 dollars, among noninstitutionalized Medicare beneficiaries age 65 and over, by sources of payment, 1992–2012 136

Table 31b. Percentage distribution of annual prescription drug costs among noninstitutionalized Medicare beneficiaries age 65 and over, 2012 136
Table 31c. Number of Medicare beneficiaries age 65 and over who enrolled in Part D prescription drug plans or who were covered by retiree drug subsidy payments, 2006 and 2014 137
Table 31d. Average prescription drug costs among noninstitutionalized Medicare beneficiaries age 65 and over, by selected characteristics, selected years 2000–2012 137

Indicator 32: Sources of Health Insurance
Table 32a. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over with supplemental health insurance, by type of insurance, 1991–2013 138
Table 32b. Percentage of people ages 55–64 with health insurance coverage, by poverty status and type of insurance, 2014 139
Table 32c. Percentage of people ages 55–64 with health insurance coverage, by type of insurance, 2010–2014 139

Indicator 33: Out-of-Pocket Health Care Expenditures
Table 33a. Percentage of people age 55 and over with out-of-pocket expenditures for health care service use, by age group, 1977, 1987, 1996, and 2000–2013 140
Table 33b. Ratio of out-of-pocket expenditures to household income per person among people age 55 and over, by selected characteristics, 1977, 1987, 1996, and 2000–2013 140
Table 33c. Percentage distribution of total out-of-pocket health care expenditures among people age 55 and over, by age group and type of health care service, 2000–2013 141

Indicator 34: Sources of Payment for Health Care Services
Table 34a. Average cost per beneficiary and percentage distribution of sources of payment for health care services for Medicare beneficiaries age 65 and over, by type of service, 2012 144
Table 34b. Average cost per beneficiary and percentage distribution of sources of payment for health care services for Medicare beneficiaries age 65 and over, by income, 2012 144

Indicator 35: Veterans' Health Care
Table 35a. Total number of veterans age 65 and over who are enrolled in the Veterans Health Administration, by age group, 1999–2014 and projected 2019–2034 145
Table 35b. Percentage of enrolled veterans age 65 and over with service-connected disabilities, by service-connected disability rating, 2004–2014 and projected 2019–2034 145

Indicator 36: Residential Services
Table 36a. Percentage distribution of Medicare beneficiaries age 65 and over residing in selected residential settings, by age group, 2013 146
Table 36b. Percentage distribution of Medicare beneficiaries age 65 and over with limitations in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs), by residential setting, 2013 146
Table 36c. Percent availability of specific services among Medicare beneficiaries age 65 and over residing in community housing with services, 2013 146
Table 36d. Percentage distribution of annual income of Medicare beneficiaries age 65 and over, by residential setting, 2013 147
Table 36e. Characteristics of services available to Medicare beneficiaries age 65 and over residing in community housing with services, 2013 147

Indicator 37: Personal Assistance and Equipment
Table 37a. Percentage distribution of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs), by type of assistance, 1992–2013 148

Table 37b. Percentage distribution of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs), by type of assistance, age group, and sex, 2013..... 148
Table 37c. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing instrumental activities of daily living (IADLs) and who receive personal assistance, by age group, 1992–2013 149
Table 37d. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing instrumental activities of daily living (IADLs) and who receive personal assistance, by sex and age group, 2013..... 149

Indicator 38: Long-Term Care Providers
Table 38a. Number of users of long-term care services, by sector and age group, 2013 and 2014 150
Table 38b. Percentage of users of long-term care services needing any assistance with activities of daily living (ADLs), by sector and activity, 2013 and 2014..... 150

Indicator 39: Use of Time
Table 39a. Average number of hours per day and percentage of day that people age 55 and over spent doing selected activities on an average day, by age group, 2014 151
Table 39b. Average number of hours and percentage of total leisure time that people age 55 and over spent doing selected leisure activities on an average day, by age group, 2014..... 151

Indicator 40: Air Quality
Table 40a. Percentage of people age 65 and over living in counties with "poor air quality," by selected pollutant measures, 2000–2014..... 152
Table 40b. Counties with "poor air quality" for any standard in 2014 152

Indicator 41: Transportation
Table 41. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who made a change in transportation mode due to a health or physical problem, by age group and type of change, 2013 155

Special Feature: Informal Caregiving
Table CG1. Number of informal caregivers, by age group and sex, 2011..... 156
Table CG2. Number of informal caregivers and percentage distribution of caregiving hours provided, by relationship to care recipient, 2011..... 156
Table CG3. Percentage of caregivers providing assistance, by sex of caregiver and type of assistance, 2011 157
Table CG4. Percentage of caregiver recipients, caregivers, and hours of help provided, by level of assistance needed by care recipients, 2011 157
Table CG5. Percentage of informal caregivers reporting positive and negative aspects of caregiving, by level of impact, 2011..... 157

Highlights

Older Americans 2016: Key Indicators of Well-Being is one in a series of periodic reports to the Nation on the condition of older adults in the United States. In this report, 41 indicators depict the well-being of older Americans in the areas of Population, Economics, Health Status, Health Risks and Behaviors, Health Care, and Environment. This year's report also includes a special feature on informal caregiving. Selected highlights from each section of the report follow.

Population

- In 2014, 46 million people age 65 and over lived in the United States, accounting for 15 percent of the total population. The older population in 2030 is projected to be more than twice as large as in 2000, growing from 35 million to 74 million and representing 21 percent of the total U.S. population (Indicator 1: Number of Older Americans).
- In 2014, non-Hispanic single-race Whites, Blacks, and Asians accounted for 78 percent, 9 percent, and 4 percent of the U.S. older population, respectively. Hispanics (of any race) were 8 percent of the older population (Indicator 2: Racial and Ethnic Composition).
- In 2015, older men were much more likely than older women to be married. About 74 percent of men ages 65–74 were married, compared with over one-half (58 percent) of women in the same age group. The proportion who were married was lower at older ages: 42 percent of women ages 75–84 and 17 percent of women age 85 and over were married in 2015. For men, the proportion who were married was also lower at older ages, but not as low as for older women. Even among men age 85 and over, the majority (59 percent) were married in 2015 (Indicator 3: Marital Status).
- In 2015, 84 percent of the population age 65 and over were high school graduates or more, and 27 percent had a Bachelor's degree or more (Indicator 4: Educational Attainment).
- In 2015, older men were more likely to live with their spouse than were older women. About 70 percent of older men lived with their spouse while less than half (45 percent) of older women did. In contrast, older women were more likely than older men to live alone (36 percent versus 20 percent) (Indicator 5: Living Arrangements).
- In 2010, there were 9.2 million veterans age 65 and over in the United States. This number is expected to drop to 8.9 million by 2025, an expected decrease of about 2.7 percent (Indicator 6: Older Veterans).

Economics

- In 1966, 29 percent of people age 65 and over lived below the poverty threshold. By 2014, the proportion of the older population living in poverty had decreased dramatically to 10 percent (Indicator 7: Poverty).
- Between 1974 and 2014, there was a decrease in the proportion of older people with an income below poverty (from 15 percent to 10 percent) and with low income (from 35 percent to 23 percent), and there was an increase in the proportion of people with high income (from 18 percent to 36 percent) (Indicator 8: Income).
- For persons age 65 and over, two-thirds of income in 2014 was from retirement benefits including Social Security which accounted for about half of average total family income (Indicator 9: Sources of Income).
- The type of Social Security benefits received by women age 62 and over dramatically changed between 1960 and 2014. The percentage who received spouse-only benefits decreased from 33 percent to 9 percent, and the percentage who received widow-only benefits decreased from 23 percent to 14 percent. In contrast, the percentage who received earned worker benefits increased from 43 percent in 1960 to 77 percent in 2014 (Indicator 10: Social Security Beneficiaries).
- In 2013, the median net worth of households headed by White people age 65 and over ($255,000) was almost five times that of the median net worth of households headed by older Black people ($56,700). This difference was less than in 1998, when the median net worth of households headed by older White people was about six times higher than that of households headed by older Black people (Indicator 11: Net Worth).
- In 2015, labor force participation rates for women age 55 and over remained high after rising over the past four decades. This trend continued through the recent recession, but leveled off since the beginning of the recovery. Among men age 55 and over, labor participation rates increased in the mid-1990s,

following declines in the rates in the previous decades. Since the recent recession, participation rates among men have been fairly flat (Indicator 12: Participation in Labor Force).

- While housing cost burden has generally increased over time, between 2009 and 2013 the prevalence of cost burden decreased from 40 to 36 percent for older owner/renter households and from 39 to 34 percent for older-member households. For households headed by older Americans with children in their homes, housing cost burden remained relatively the same at approximately 40 percent. (Indicator 13: Housing Problems).
- As a share of total expenditures, health care increased dramatically with age in 2014. For the group age 75 and over, the share (16 percent) was more than double the share for the age 45–54 group (7 percent) and larger than the share the oldest group allocated to transportation (14 percent) or the share allocated to food (12 percent) (Indicator 14: Total Expenditures).

Health Status

- Life expectancy varies by race, but the difference decreases with age. In 2014, life expectancy at birth was 3.4 years higher for White people than for Black people. At age 65, White people can expect to live an average of 1.1 years longer than Black people. Among those who survive to age 85, however, the life expectancy among Black people is slightly higher (6.9 years) than White people (6.5 years) (Indicator 15: Life Expectancy).
- Between 1999 and 2014, age-adjusted death rates for all causes of death among people age 65 and over declined by 20 percent. Death rates declined for heart disease, cancer, chronic lower respiratory disease, stroke, diabetes, and influenza and pneumonia. Death rates for Alzheimer's disease and unintentional injuries increased over the same period (Indicator 16: Mortality).
- The prevalence of certain chronic health conditions differed by sex in 2013–2014. Women reported higher levels of asthma and arthritis than men. Men reported higher levels of heart disease, cancer, and diabetes (Indicator 17: Chronic Health Conditions).
- In 2014, about 62 percent of people age 65 and over had a dental visit in the past year. The percentage visiting a dentist was higher among people ages 65–74 than among people age 85 and over (66 percent versus 56 percent) (Indicator 18: Oral Health).
- In 2012–2014, older non-Hispanic White people were more likely to report good to excellent health than their non-Hispanic Black and Hispanic counterparts (80 percent versus 65 and 66 percent, respectively) (Indicator 19: Respondent-Assessed Health Status).
- In 2011, among people ages 65–74, men were more likely to have dementia than women, but among adults age 85 and over, women were more likely to have dementia than men (Indicator 20: Dementia).
- The prevalence of clinically meaningful depressive symptoms for the U.S. population over age 50 remained fairly stable between 1998 and 2014. Although women over 50 have consistently higher prevalence of depressive symptoms than men, in 2014 both men and women had higher prevalence of depressive symptoms in middle adulthood and after age 80, with the lowest prevalence occurring among those ages 65 to 79 (Indicator 21: Depressive Symptoms).
- In 2014, 22 percent of the population age 65 and over reported having a disability as defined by limitations in vision, hearing, mobility, communication, cognition, and self-care. Women were more likely to report any disability than men (24 percent versus 19 percent) (Indicator 22: Functional Limitations).

Health Risks and Behaviors

- In 2014, 70 percent of people age 65 and over reported receiving a flu shot in the past 12 months; however, there were differences by race and ethnicity. About 72 percent of non-Hispanic Whites reported receiving a flu shot, compared with 57 percent of non-Hispanic Blacks and 61 percent of Hispanics (Indicator 23: Vaccinations).
- A higher proportion of women in 2013 received a mammogram in the past 2 years than met colorectal cancer screening guidelines. For example, 71 percent of women ages 50–64 received a mammogram compared with 54 percent who met colorectal cancer screening guidelines (Indicator 24: Cancer Screenings).
- During 2011–2012, people age 75 and over met the dietary recommendations for whole fruits, while people age 65 and over met the dietary recommendations for total protein foods. Overall diet quality, as measured by the Total Healthy Eating Index-2010 score, was 68 out

of 100 for people age 65 and over (Indicator 25: Diet Quality).

- In 2014, about 12 percent of people age 65 and over reported participating in leisure-time aerobic and muscle-strengthening activities that met the 2008 Federal physical activity guidelines. The percentage of older people meeting the physical activity guidelines decreased with age, ranging from 15 percent among people ages 65–74 to 5 percent among people age 85 and over (Indicator 26: Physical Activity).
- As with other age groups, the percentage of people age 65 and over with obesity has increased since 1988–1994. In 2011–2014, about 35 percent of people age 65 and over had obesity, compared with 22 percent in 1988–1994 (Indicator 27: Obesity).
- The percentage of people age 65 and over who were current cigarette smokers declined between 1965 and 2014, with larger declines occuring among men than among women. Levels of cigarette smoking have been stable in the past decade. In 2014, 10 percent of men and 8 percent of women age 65 and over were current smokers (Indicator 28: Cigarette Smoking).

Health Care

- While the number of hospital stays remained fairly stable from 1992 to 2013, the average length of stay in the hospital decreased steadily over time. In 1992, the average length of stay in the hospital for a Medicare beneficiary was 8.4 days; by 2013 the average length of stay had decreased to 5.3 days (Indicator 29: Use of Health Care Services).
- After adjusting for inflation, health care costs per capita increased slightly among those ages 65–74 between 1992 and 2012. In all years, average costs were substantially higher for those age 85 and over compared with those in the younger age groups (Indicator 30: Health Care Expenditures).
- Average prescription drug costs for noninstitutionalized Americans age 65 and over increased rapidly for many years but were relatively stable from 2005 to 2012. Medicare coverage of prescription drugs, which includes a low-income subsidy for beneficiaries with low income and assets, began in January 2006 (Indicator 31: Prescription Drug Costs).
- Enrollment in Medicare Advantage (MA)/Capitated Payment Plans has grown rapidly in recent years. In 2005, 16 percent of Medicare beneficiaries age 65 and over were enrolled in an MA plan, compared with 34 percent in 2013 (Indicator 32: Sources of Health Insurance).
- From 1977 to 2013, the percentage of household income that people age 65 and over allocated to out-of-pocket spending for health care services increased among those in the poor/near poor income category from 12 percent to 17 percent (Indicator 33: Out-of-Pocket Health Care Expenditures).
- Medicare paid for almost 60 percent of all health care costs of enrollees age 65 and over in 2012. Medicare financed all hospice costs and most hospital, physician, home health care, and short-term institution costs (Indicator 34: Sources of Payment for Health Care Services).
- The number of veterans age 65 and over enrolled with the Veterans Health Administration has been steadily increasing since 1999, when eligibility for this benefit was reformed, and the number of veterans age 85 and over enrolled is projected to exceed 1 million by 2034 (Indicator 35: Veterans' Health Care).
- In 2013, about 3 percent of the Medicare population age 65 and over resided in community housing with at least one service available. About 4 percent resided in long-term care facilities. Among those age 85 and over, 8 percent resided in community housing with services, and 15 percent resided in long-term care facilities. Among those ages 65–74, about 98 percent resided in traditional community settings (Indicator 36: Residential Services).
- In 2013, about two-thirds of people who had difficulty with one or more activities of daily living (ADLs) received personal assistance or used special equipment: 7 percent received personal assistance only, 35 percent used equipment only, and 25 percent used both personal assistance and equipment (Indicator 37: Personal Assistance and Equipment).
- In 2014, about 1.2 million people age 65 and over were residents of nursing homes. Nearly 780,000 people of that age lived in residential care communities such as assisted living facilities. In both settings, people age 85 and over were the largest age group among residents (Indicator 38: Long-Term Care Providers).

Environment

- The proportion of leisure time that older Americans spent socializing and communicating—such as visiting

friends or attending or hosting social events—declined with age. In 2014, the percentage of leisure time spent socializing and communicating was about 11 percent for those ages 55–64 and 9 percent for those age 75 and over (Indicator 39: Use of Time).

- The percentage of people age 65 and over living in counties that experienced poor air quality decreased from 66 percent in 2000 to 16 percent in 2014 (Indicator 40: Air Quality).
- In 2013, about 33 percent of the noninstitutionalized Medicare population age 65 and over limited their driving to daytime because of a health or physical problem. The percentage of people who limited their driving to daytime was greater for those age 85 and over (55 percent) than for those age 65–74 (25 percent) (Indicator 41: Transportation).

Special Feature

"Informal caregivers" are family members or friends who are not paid and assist older adults who have functional limitations with everyday tasks such as bathing, dressing, preparing a meal, or managing money. Informal caregivers are a diverse population that includes spouses, children, and other relatives such as daughters-in-law, grandchildren, and friends.

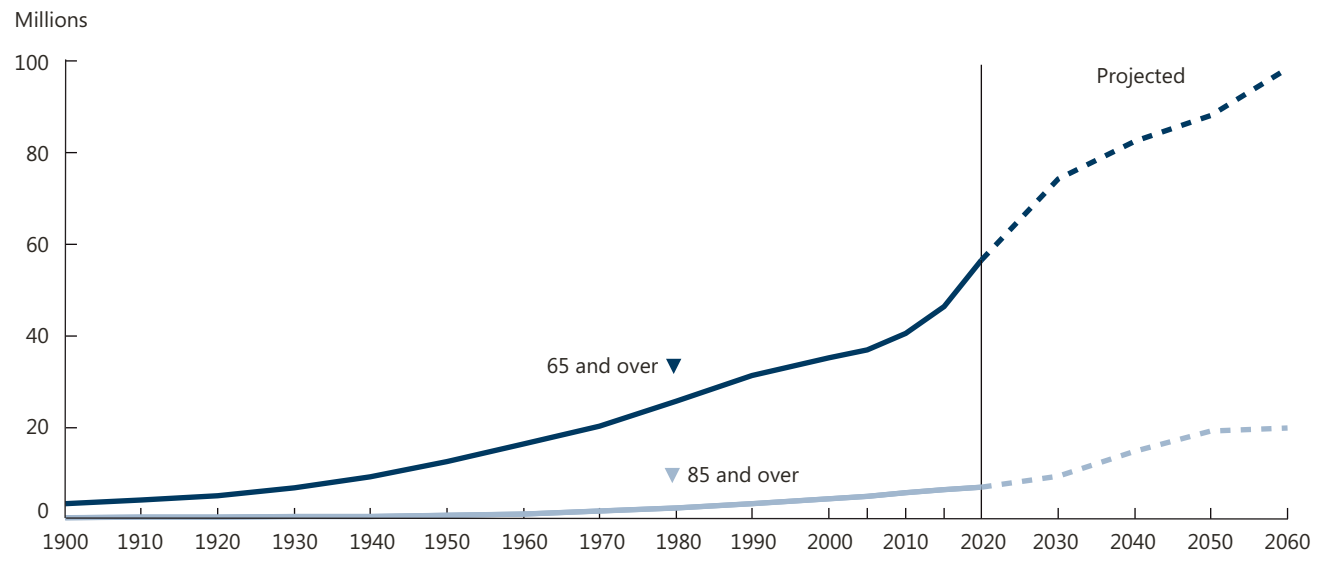
- In 2011, an estimated 18 million informal caregivers provided 1.3 billion hours of care on a monthly basis.
- More informal caregivers were women (11.1 million) than men (6.9 million), and about half of informal caregivers were middle-aged (ages 45–64).
- Almost half of informal caregivers were a child of the care recipient. Although spouses made up only 21 percent of informal caregivers, they accounted for more than 31 percent of the total hours of informal care provided.
- Some types of care provided differ by caregiver gender. For example, men were more likely to provide assistance with mobility, whereas women were more likely to assist with self-care and medical care.
- Most informal caregivers reported positive impacts of caregiving; however, almost half said they have things they cannot handle or do not have enough time for themselves.

Population

INDICATOR 1: **Number of Older Americans**

The growth of the population age 65 and over affects many aspects of our society, presenting challenges to families, businesses, health care providers, and policymakers, among others, to meet the needs of aging individuals.

Population age 65 and over and age 85 and over, selected years, 1900–2014, and projected years, 2020–2060

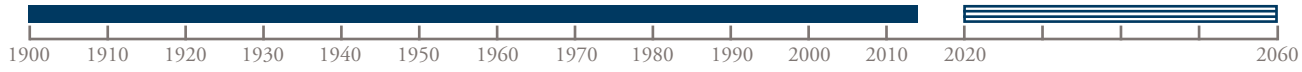


NOTE: Some data for 2020–2050 have been revised and differ from previous editions of *Older Americans*.

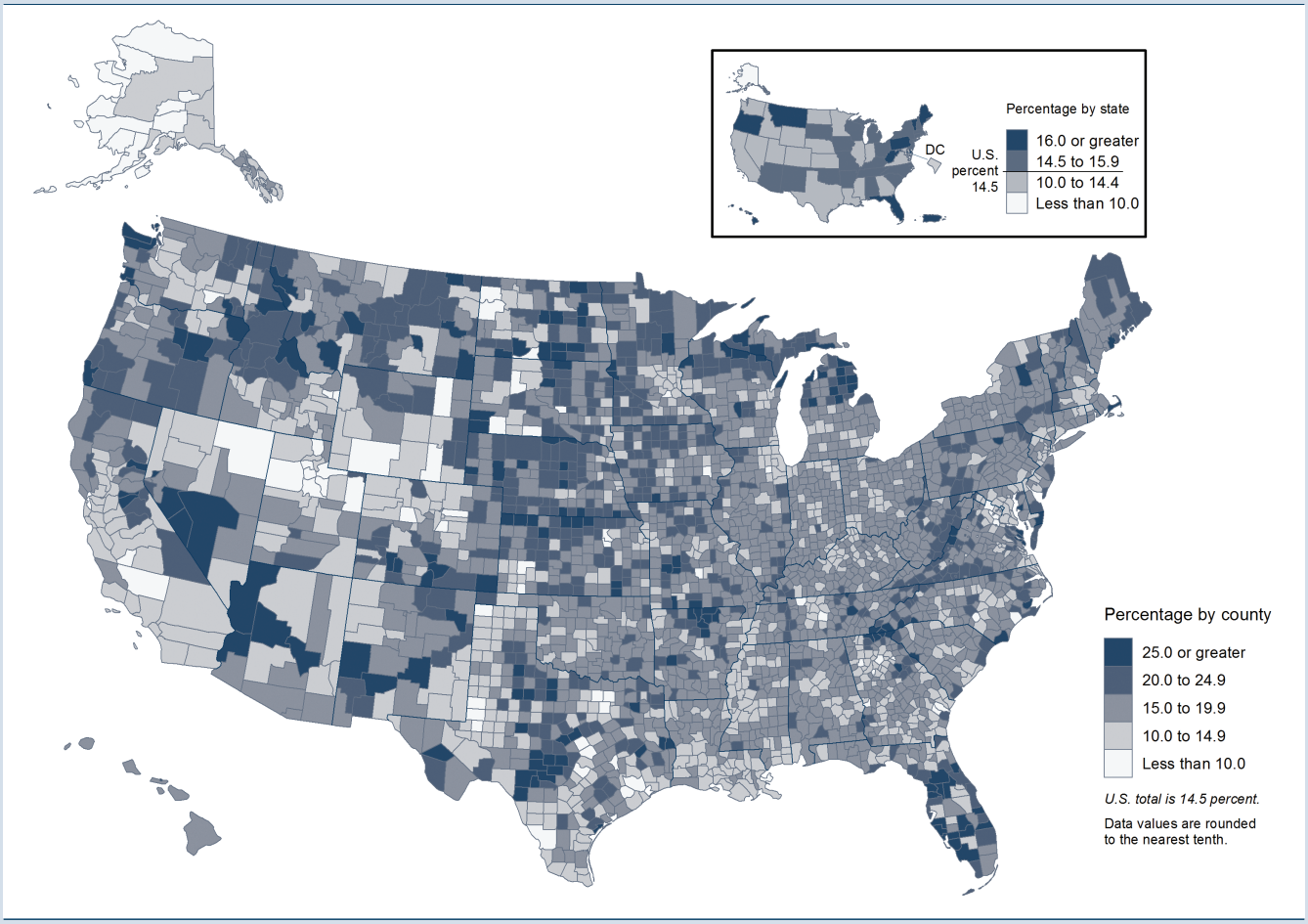
Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File; 2000, U.S. Census Bureau, 2001, *Census 2000 Summary File 1;* U.S. Census Bureau, Table 1: Intercensal Estimates of the Resident Population by Sex and Age for the U.S.: April 1, 2000, to July 1, 2010 (US-EST00INT-01); U.S. Census Bureau, 2011. *2010 Census Summary File 1;* U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010, to July 1, 2014 (PEPAGESEX); U.S. Census Bureau, Table 3: Projections of the Population by Sex and Selected Age Groups for the United States: 2015 to 2060 (NP2014-T3).

- In 2014, 46 million people age 65 and over lived in the United States, accounting for 15 percent of the total population. The older population grew from 3 million in 1900 to 46 million in 2014. The oldest-old population (those age 85 and over) grew from just over 100,000 in 1900 to 6 million in 2014.
- The "Baby Boomers" (those born between 1946 and 1964) started turning 65 in 2011, and the number of older people will increase dramatically during the 2014–2030 period. The older population in 2030 is projected to be twice as large as their counterparts in 2000, growing from 35 million to 74 million and representing nearly 21 percent of the total U.S. population.
- The growth rate of the older population is projected to slow after 2030, when the last Baby Boomers enter the ranks of the older population. From 2030 onward, the proportion of those who are age 65 and over will be relatively stable, ranging from 21 percent to 24 percent, even though the absolute number of people age 65 and over is projected to continue to grow. The oldest-old population is projected to grow rapidly after 2030, when the Baby Boomers move into this age group.
- The U.S. Census Bureau projects that the population age 85 and over could grow from 6 million in 2014 to 20 million by 2060. Some researchers predict that death rates at older ages will decline more rapidly than is reflected in the U.S. Census Bureau's projections, which could lead to faster growth of this population.[3–5]



Percentage of population age 65 and over, by county and state, 2014



Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010, to July 1, 2014 (PEPAGESEX).

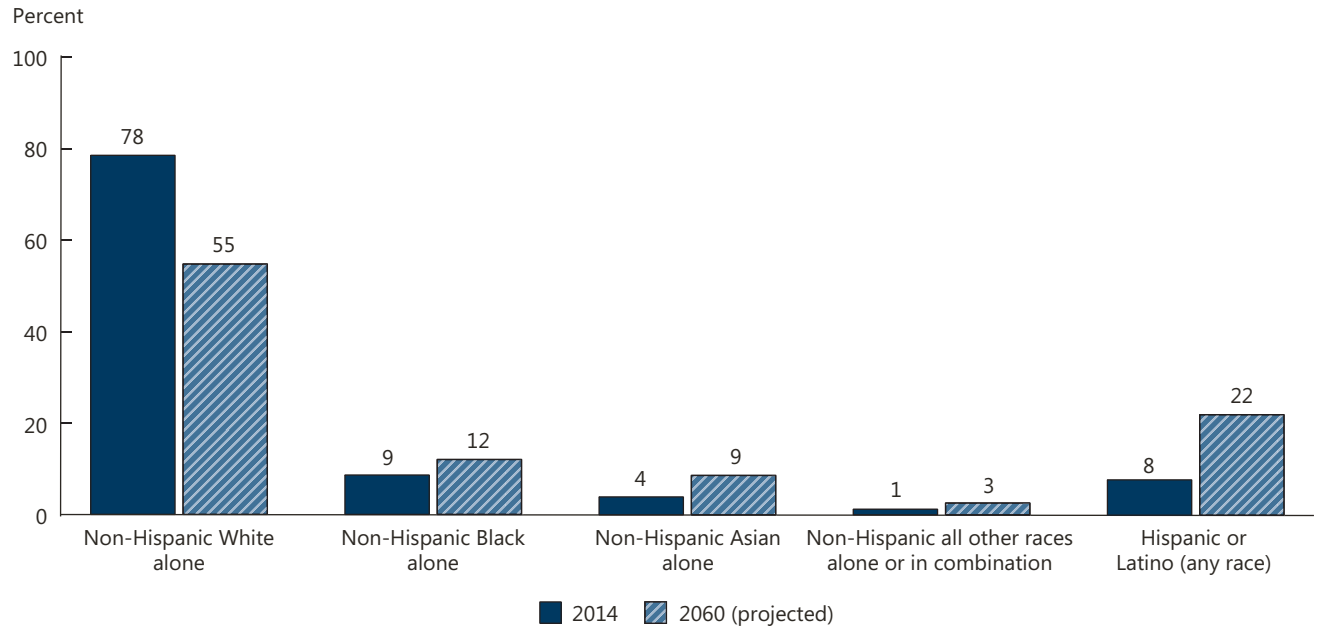
- The proportion of the population age 65 and over varies by state and is partly affected by the state fertility and mortality levels and partly by the number of older and younger people who migrate to and from the state. In 2014, Florida was the state with the highest proportion of people age 65 and over (19 percent). Maine, West Virginia, Vermont, Montana, Pennsylvania, Delaware, Hawaii, and Oregon also had high proportions (16 percent or over).
- The proportion of the population age 65 and over varies even more by county. In 2014, 53 percent of Sumter County, Florida, was age 65 and over, the highest proportion in the country. In several Florida counties, the proportion was over 30 percent. At the other end of the spectrum was Chattahoochee County, Georgia, with only 4.1 percent of its population age 65 and over.
- Older women outnumbered older men in the United States, and the proportion who are female increased with age. In 2014, women accounted for 56 percent of the population age 65 and over and for 66 percent of the population age 85 and over.
- The United States is fairly young for a developed country, with 15 percent of its population age 65 and over in 2015. Japan had the highest percentage of persons age 65 and over (27 percent) among countries with a population of at least 1 million. The older population made up more than 15 percent of the population in most European countries and above 20 percent in Germany, Italy, Greece, and Finland.

Data for this indicator's charts and bullets can be found in Tables 1a through 1f on pages 82–87.

INDICATOR 2: **Racial and Ethnic Composition**

As the older population grows larger, it will also grow more diverse, reflecting the demographic changes in the U.S. population as a whole over the last several decades. By 2060, programs and services for older people will require greater flexibility to meet the needs of a more diverse population.

Population age 65 and over, by race and Hispanic origin, 2014 and projected 2060



NOTE: The presentation of racial and ethnic composition data in this table has changed from previous editions of *Older Americans.* Unlike in previous editions, Hispanics are not counted in any race group. The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "non-Hispanic Black alone" is used to refer to people who reported being Black or African American and no other race and who are not Hispanic, and the term "non-Hispanic Asian alone" is used to refer to people who reported only Asian as their race and who are not Hispanic. The use of single-race populations in this chart does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. The race group "non-Hispanic All other races alone or in combination" includes people who reported American Indian and Alaska Native alone who are not Hispanic; people who reported Native Hawaiian and Other Pacific Islander alone who are not Hispanic; and all people who reported two or more races who are not Hispanic. "Hispanic" refers to an ethnic category; Hispanics may be of any race.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States and States: April 1, 2010, to July 1, 2014 (PEPASR6H); U.S. Census Bureau, Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060 (NP2014_D1).

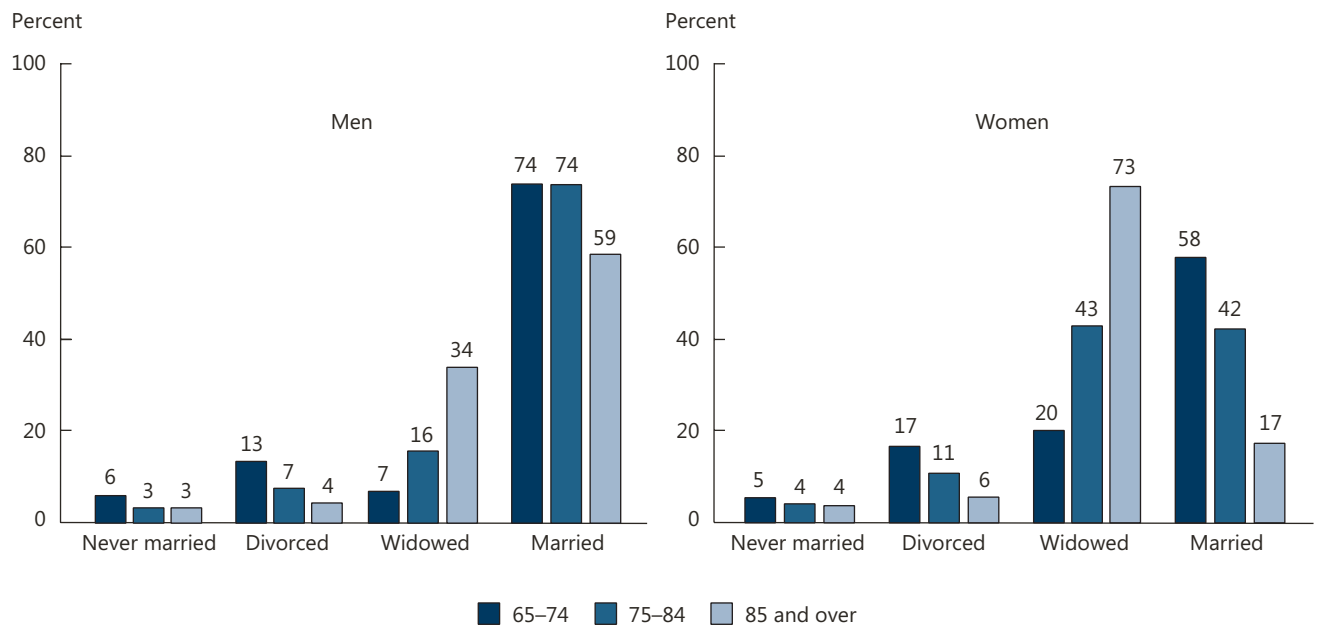
- In 2014, non-Hispanic single-race Whites, Blacks, and Asians accounted for 78 percent, 9 percent, and 4 percent of the U.S. older population, respectively. Hispanics (of any race) were 8 percent of the older population.
- Projections indicate that by 2060 the composition of the older population will be 55 percent non-Hispanic White alone, 12 percent non-Hispanic Black alone, and 9 percent non-Hispanic Asian alone. Hispanics will be 22 percent of the older population in 2060.While the older population will increase among all racial and ethnic groups, the older Hispanic population is projected to grow the fastest, from 3.6 million in 2014 to 21.5 million in 2060. The older Hispanic population is expected to be larger than the older non-Hispanic Black alone population in 2060. The older non-Hispanic Asian alone population is also projected to experience rapid growth. In 2014, nearly 2 million older single-race non-Hispanic Asians lived in the United States; by 2060, this population is projected to be about 8.5 million.

Data for this indicator's charts and bullets can be found in Table 2 on page 88.

INDICATOR 3: **Marital Status**

Marital status can strongly affect one's emotional and economic well-being. Among other factors, it influences living arrangements and the availability of caregivers for older Americans with an illness or disability.

Marital status of the population age 65 and over, by sex and age group, 2015



NOTE: Married includes married, spouse present; married, spouse absent; and separated.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

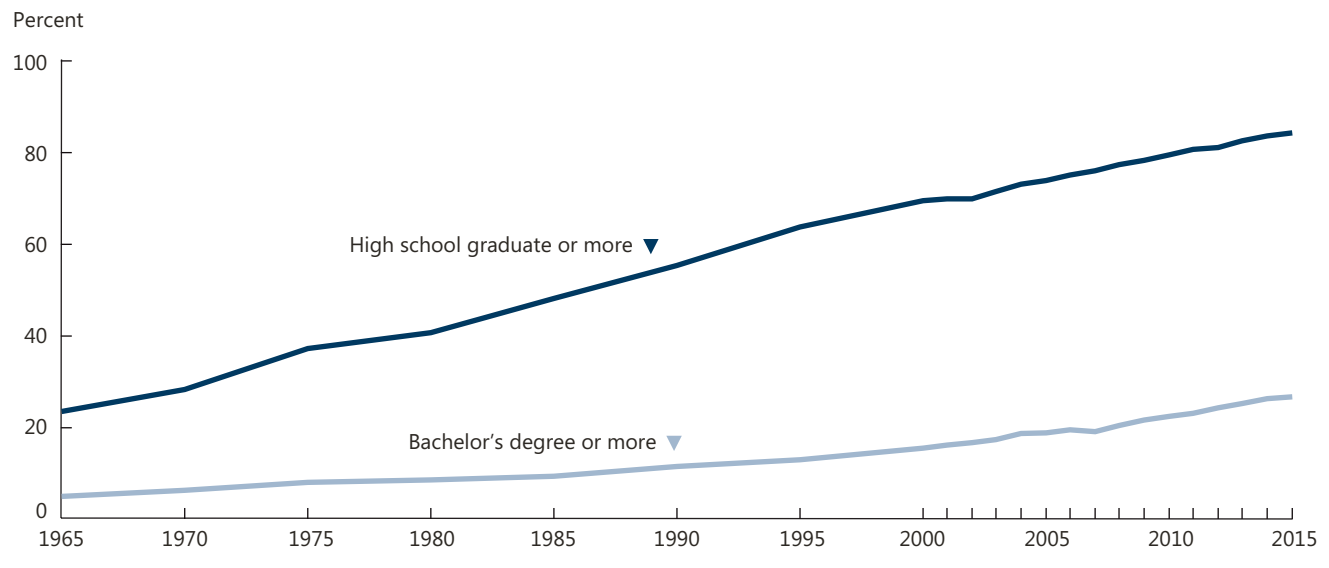
- In 2015, older men were much more likely than older women to be married. About 74 percent of men ages 65–74 were married, compared with over one-half (58 percent) of women in the same age group. The proportion who were married was lower at older ages: 42 percent of women ages 75–84 and 17 percent of women age 85 and over were married in 2015. For men, the proportion who were married was also lower at older ages, but not as low as for older women. Even among the oldest old (those age 85 and over), the majority of men (59 percent) were married in 2015.
- Widowhood was more common among older women than among older men in 2015. Women age 65 and over were more likely than men of the same age to be widowed (34 percent compared with 12 percent). Nearly three-quarters (73 percent) of women age 85 and over were widowed, compared with 34 percent of men.
- Relatively small proportions of older men (11 percent) and women (13 percent) were divorced in 2015. A small proportion (5 percent) of the older population had never married.

All comparisons presented for this indicator are significant at the 0.10 confidence level. Data for this indicator's charts and bullets can be found in Table 3 on page 88.

INDICATOR 4: **Educational Attainment**

Educational attainment has effects throughout the life course, which in turn plays a role in well-being at older ages. Higher levels of education are usually associated with higher incomes, higher standards of living, and above-average health.

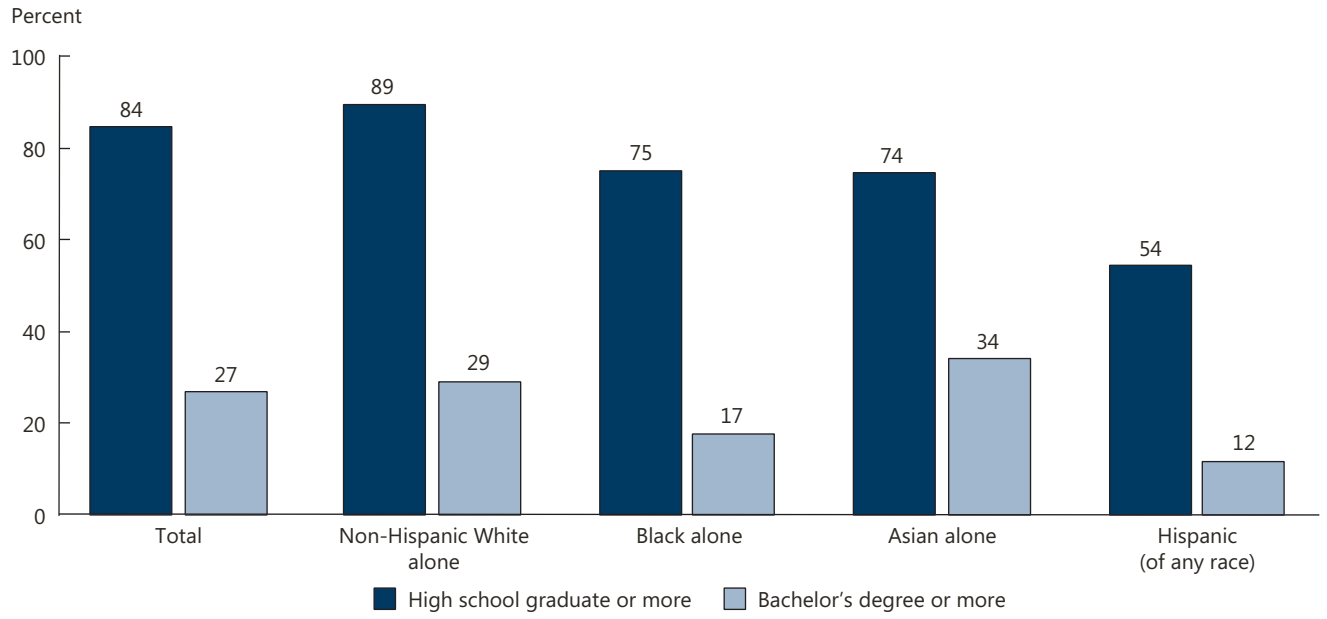
Educational attainment of the population age 65 and over, selected years, 1965–2015



NOTE: A single question that asks for the highest grade or degree completed is used to determine educational attainment. Prior to 1995, educational attainment was measured using data on years of school completed.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

- In 1965, 24 percent of the older population had graduated from high school and only 5 percent had at least a Bachelor's degree. By 2015, 84 percent were high school graduates or more and 27 percent had a Bachelor's degree or more.
- In 2015, 85 percent of older men and 83 percent of older women had at least a high school diploma. Older men attained at least a Bachelor's degree more often than older women (32 percent compared with 23 percent, respectively).

Educational attainment of the population age 65 and over, by race and Hispanic origin, 2015



NOTE: The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "Black alone" is used to refer to people who reported being Black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this chart does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

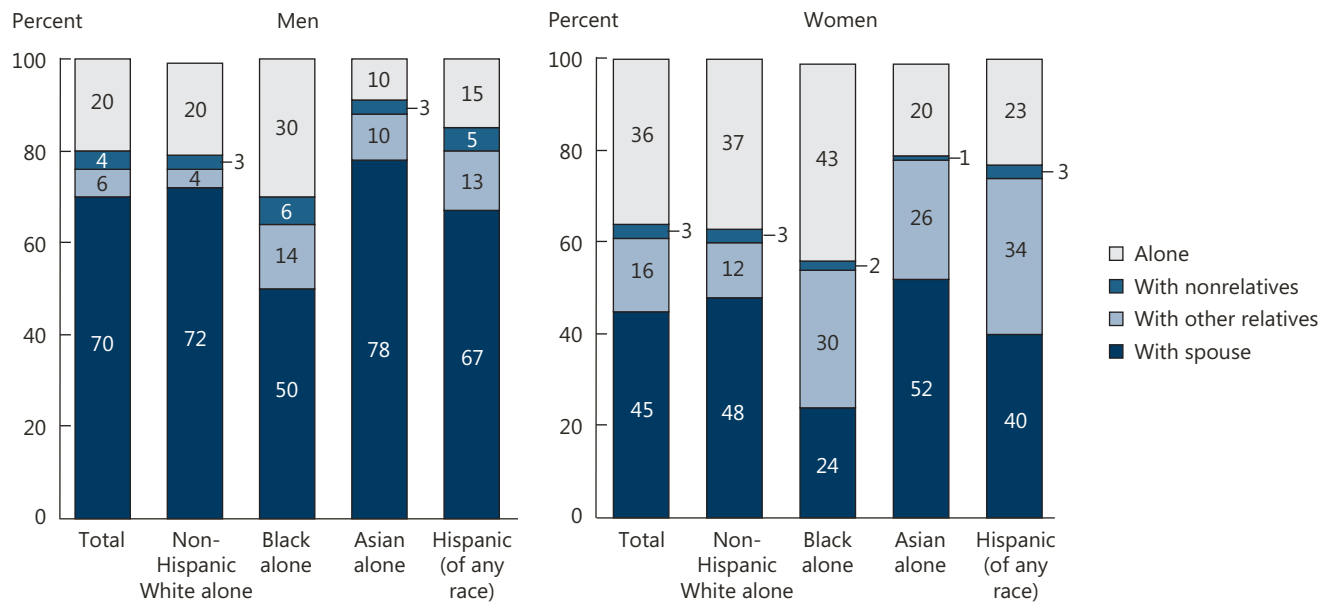
- Despite the overall increase in educational attainment among older Americans, substantial educational differences exist among racial and ethnic groups. In 2015, 89 percent of non-Hispanic Whites age 65 and over had completed high school. The percentages of older Asians and Blacks who had completed high school (74 percent and 75 percent, respectively) were not statistically different. In contrast, 54 percent of older Hispanics had completed high school.
- In 2015, older Asians had the highest proportion with at least a Bachelor's degree (34 percent). About 29 percent of older non-Hispanic Whites had this level of education. The proportions were 17 percent and 12 percent, respectively, for older Blacks and Hispanics.

All comparisons presented for this indicator are significant at the 0.10 confidence level. Data for this indicator's charts and bullets can be found in Tables 4a and 4b on page 89.

INDICATOR 5: **Living Arrangements**

The living arrangements of America's older population are linked to income, health status, and the availability of caregivers.

Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2015



NOTE: Living with other relatives indicates no spouse present. Living with nonrelatives indicates no spouse or other relatives present. The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "Black alone" is used to refer to people who reported being Black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this chart does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

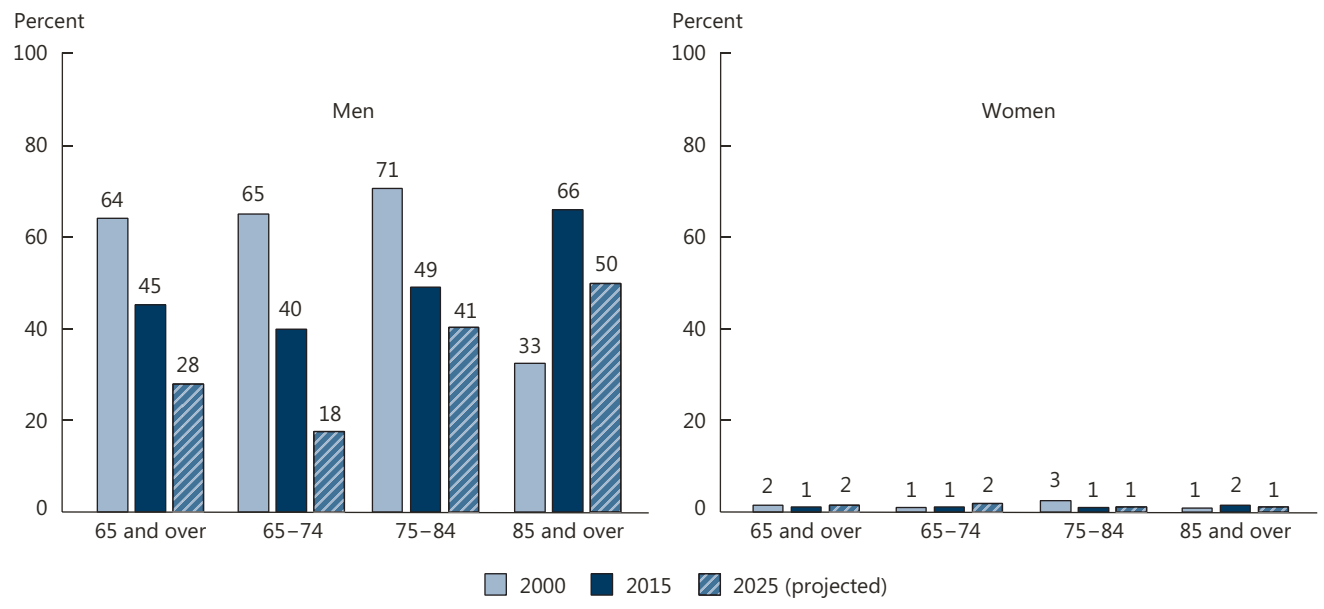
- In 2015, older men were more likely to live with their spouse than were older women. About 70 percent of older men lived with their spouse, while less than half (45 percent) of older women did. In contrast, older women were more likely than older men to live alone (36 percent versus 20 percent).
- Living arrangements of older people differed by race and Hispanic origin. Older Black, Asian, and Hispanic women were more likely than non-Hispanic White women to live with relatives other than a spouse. For example, in 2015, 26 percent of older Asian women, 30 percent of older Black women, and 34 percent of older Hispanic women lived with other relatives, compared with only 12 percent of older non-Hispanic White women. The percentages of Asian and Black women were not different.
- Older non-Hispanic White women and Black women were more likely than women of other races to live alone. In 2015, 37 percent of non-Hispanic White and 43 percent of Black women lived alone, compared with about 20 percent for older Asian women and 23 percent for older Hispanic women. The percentages of older Asian and older Hispanic women living alone were not different.
- The percentage of older Black men living alone was about three times as high as the percentage of older Asian men (30 percent versus 10 percent). The percentage of older Black men living alone was also higher than that of older non-Hispanic White men (20 percent).
- Older Hispanic and Black men were more likely (13 and 14 percent, respectively, which did not differ) than non-Hispanic White men (4 percent) to live with relatives other than a spouse. The percentage of Asian men living with relatives other than a spouse (10 percent) was lower than the percentages for Hispanic and Black men and higher than the percentages for non-Hispanic White men.

All comparisons presented for this indicator are significant at the 0.10 confidence level. Data for this indicator's charts and bullets can be found in Tables 5a and 5b on page 90.

INDICATOR 6: **Older Veterans**

Veteran status among America's older population is associated with higher median family income, lower percentages of individuals who are uninsured or covered by Medicaid, higher percentages of functional limitations in activities of daily living or instrumental activities of daily living, greater likelihood of having any disability, and less likelihood of rating their general health status as good or better.[6] The oldest segment of the veteran population will continue to have significant ramifications with regard to the demand for health care services, particularly in the area of long-term care.[7]

Percentage of population age 65 and over who are veterans, by sex and age group, 2000, 2015, and projected 2025



Reference population: These data refer to the resident population of the United States and Puerto Rico.
SOURCE: U.S. Census Bureau, Population Projections 2014, and *2010 Census Summary File 1;* Department of Veterans Affairs, VetPop2014.

- In 2015, there were 9.9 million veterans age 65 and over in the United States and Pueto Rico. Approximately one out of every two men age 65 and over in 2015 were veterans.
- More than 95 percent of veterans age 65 and over are male. Over time, the number of male veterans age 65 and over will go from 9.4 million in 2000 to a projected 9.0 million in 2020.
- The number of men age 85 and over who are veterans increased from 400,000 in 2000 to over 1.4 million in 2015. The proportion of men age 85 and over who are veterans increased from 33 percent in 2000 to 66 percent in 2015.
- Between 2000 and 2010, the number of female veterans age 85 and over increased from about 30,000 to 97,000 but is projected to decrease to 56,000 by 2025.

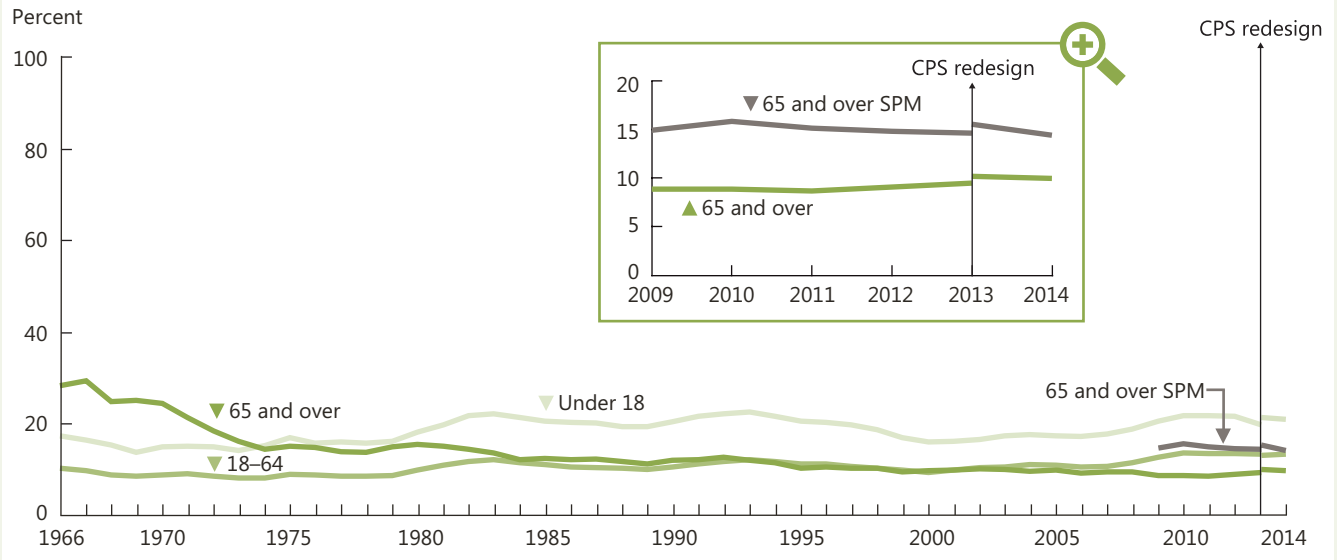
Data for this indicator's charts and bullets can be found in Tables 6a and 6b on page 91.

Economics

INDICATOR 7: **Poverty**

Poverty rates are one way to evaluate economic well-being. People identified as living in poverty are at risk of having inadequate resources for food, housing, health care, and other needs.

Poverty rate by age, by official poverty measure and Supplemental Poverty Measure, 1966–2014



NOTE: Poverty status in the Current Population Survey (CPS) is based on prior year income. The source of the 2013 estimates shown in this figure is the portion of the CPS Annual Social and Economic Supplement (ASEC) sample which received the redesigned income questions. The 2013 estimates from the traditional ASEC can be found in Table 7a. For further information on the redesigned income questions and the Supplemental Poverty Measure (SPM), see NOTE for Table 7a. The official poverty measure is based on money income and does not include noncash benefits such as food stamps. Poverty thresholds reflect family size and composition and are adjusted each year using the annual average Consumer Price Index. For more detail, see U.S. Census Bureau Series P-60, No. 252. The SPM extends the official poverty measure by taking account of many of the government programs designed to assist low income families and individuals that are not included in the current official poverty measure and by using thresholds derived from the Consumer Expenditure Survey by the Bureau of Labor Statistics.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

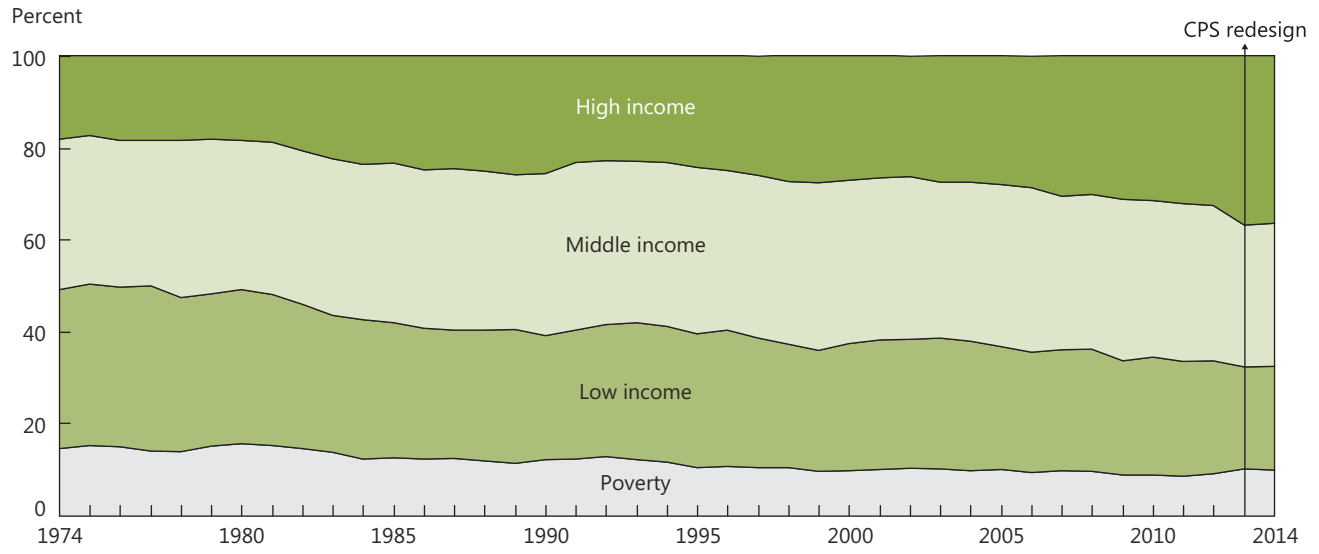
- In 1966, 29 percent of people age 65 and over lived below the poverty threshold. By 2014, the proportion of the older population living in poverty had decreased dramatically to 10 percent.
- Relative levels of poverty among the different age groups have changed over time. In 1966, older people had the highest poverty rate (29 percent), followed by children (18 percent) and those in the working ages (11 percent). By 2014, the proportions of the older population and of those of working age living in poverty were about 10 percent and 14 percent, respectively, while 21 percent of children lived in poverty. The poverty rate for older people in 2014 was not different from the poverty rate for people of working age in 1966.
- Poverty rates differed by age and sex among the older population. Older women (12 percent) were more likely than older men (7 percent) to live in poverty in 2014. People ages 65–74 had a poverty rate of 9 percent, compared with 12 percent of those age 75 and over.
- Race and ethnicity are related to poverty among older men. In 2014, older non-Hispanic White men were less likely than older Black men, older Hispanic men, and older Asian men to live in poverty; 5 percent compared with 17 percent for older Black men, 16 percent for older Hispanic men, and 13 percent for older Asian men. The poverty rates for older Black men, older Hispanic men, and older Asian men were not statistically different from each other.
- Older non-Hispanic White women (10 percent) were less likely than older Black women (21 percent), older Hispanic women (20 percent), and older Asian women (16 percent) to live in poverty. The poverty rates for older Black women, older Hispanic women, and older Asian women were not statistically different from each other.
- In 2014, poverty rates for those 65 years and over were higher under the Supplemental Poverty Measure (14 percent) compared with the official measure (10 percent).

All comparisons presented for this indicator are significant at the 0.10 confidence level. Data for this indicator's charts and bullets can be found in Tables 7a and 7b on pages 92–93.

INDICATOR 8: **Income**

The percentage of people living below the poverty line does not give a complete picture of the economic situation of older Americans. Examining the income distribution of the population age 65 and over and their median income provides additional insights into their economic well-being.

Income distribution of the population age 65 and over, 1974–2014



NOTE: Income distribution in the Current Population Survey (CPS) is based on prior year income. The source of the 2013 estimates shown in this figure is the portion of the CPS Annual Social and Economic Supplement (ASEC) sample that received the redesigned income questions. The 2013 estimates for the portion of the sample that received the traditional ASEC income questions can be found in Table 8a. For further information on the redesigned income questions see the NOTE for Table 8a. The income categories are derived from the ratio of the family's income (or an unrelated individual's income) to the corresponding official poverty threshold. Being in poverty is measured as income less than 100 percent of the poverty threshold. Low income is between 100 and 199 percent of the poverty threshold. Middle income is between 200 percent and 399 percent of the poverty threshold. High income is 400 percent or more of the poverty threshold. Some data have been revised and differ from previous versions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

- Since 1974, the proportion of older people living in poverty and in the low income group has generally declined; as a consequence, by 2014, 10 percent of the older population lived in poverty and 23 percent of the older population was in the low income group.
- In 2014, people in the high income group made up the largest share of older people by income category (36 percent). The proportion with a high income has increased over time. The proportion of the older population in the middle income group decreased from 33 percent in 1974 to 31 percent in 2014.
- The trend in median household income of the older population also has been positive. In 1974, the median household income for householders age 65 and over was $22,921, when expressed in 2014 dollars. By 2014, the median household income of the older population had increased to $36,895.

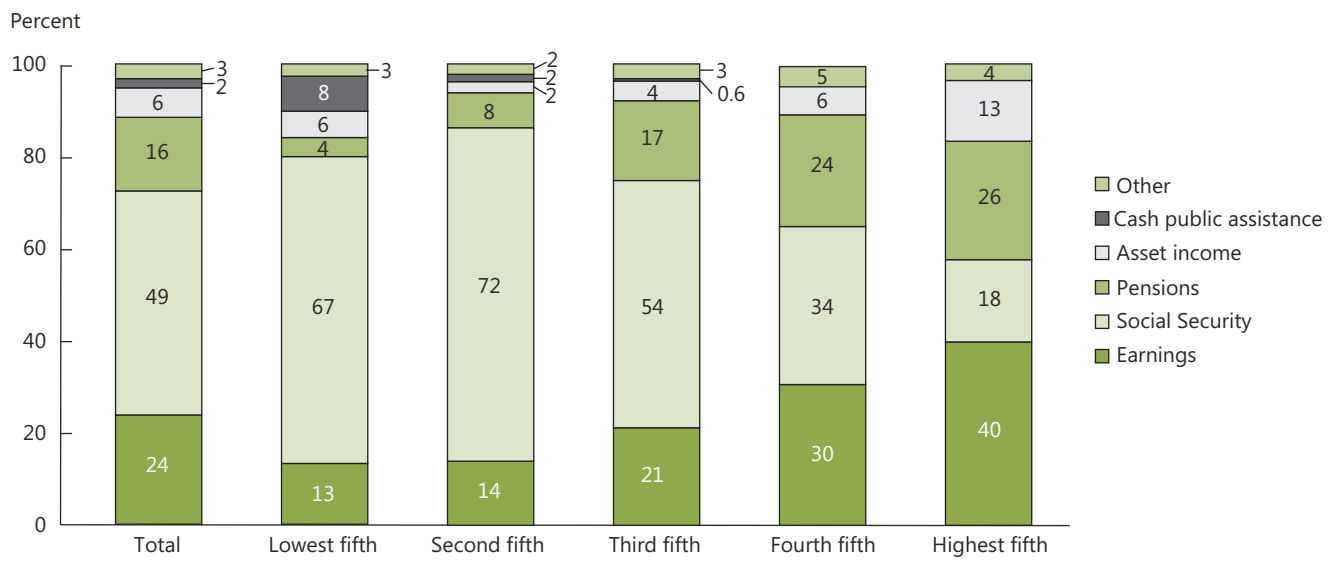
Data for this indicator's charts and bullets can be found in Tables 8a and 8b on pages 94–95.

INDICATOR 9: **Sources of Income**

Most older Americans are retired from full-time work. Social Security was developed as a floor of protection for their incomes, to be supplemented by other pension income, income from assets, and, to some extent, continued earnings. Over time, Social Security has taken on greater importance to older Americans.

Since the early 1960s, Social Security has provided the largest share of aggregate income for older Americans.[8] The share of income from pensions increased rapidly in the 1960s and 1970s, peaked in 1992, and has fluctuated since then at around one-fifth of aggregate income.[8] Asset income generally decreased while earnings generally increased after the mid-1980s.[8]

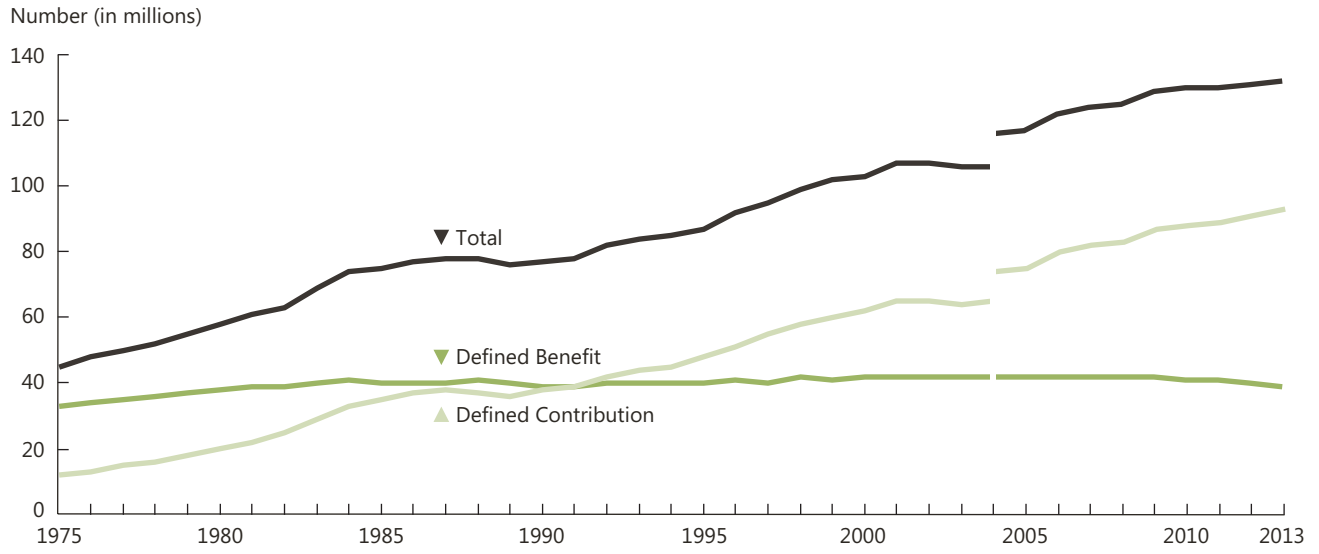
Percentage distribution of per capita family income for persons age 65 and over, by income quintile and source of income, 2014



NOTE: The definition of "other" includes, but is not limited to, unemployment compensation, workers' compensation, veterans' payments, and personal contributions. Quintile limits are $12,492, $19,245, $29,027, and $47,129. Estimates may not sum to the totals because of rounding.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

- In 2014, most persons (86 percent) age 65 and over lived in families with Social Security income. About two-fifths (41 percent) lived in families with private pensions or annuities, while almost a fifth (18 percent) lived in families with other public pensions. Two-thirds (67 percent) lived in families with income from assets. Two-fifths (40 percent) lived in families with earnings, and about one-tenth (13 percent) were in families receiving public assistance (cash and noncash) with other income sources. One-tenth (13 percent) were in families receiving income from other sources.
- The proportion of per capita family income of persons age 65 and over from specified sources varied across major sources and levels of income. Overall, Social Security accounted for 49 percent of per capita family income. For those in the lowest quintile of income, Social Security accounted for two-thirds and earnings accounted for about one-tenth (13 percent) of per capita family income. For those in the highest income quintile, Social Security accounted for one-fifth (18 percent) of per capita family income, pension income accounted for one-quarter, and earnings accounted for about two-fifths.
- For those age 80 and over, a larger percentage lived in families with Social Security income (90 percent, including families of one) and a smaller percentage (23 percent) had earnings than did the population age 65–69.

Number of participants in private pension plans, by type of plan, 1975–2013



NOTE: The methodology for calculating participants was changed beginning with the 2005 Form 5500 series in response to the discontinuance of the IRS Form 5500 Schedule T. For 2004, the revision increases counts of participants by 9 million. Under the current methodology, participant counts include all workers eligible to participate in a plan. The term "participants" refers to active, retired, and separated vested participants not yet in pay status. Workers participating in more than one plan are counted separately for each plan in which they participate.

Reference population: These data refer to counts of participants reported by private pension plans on the Form 5500.

SOURCE: U.S. Department of Labor, Employee Benefits Security Administration, Form 5500 filings.

- Retirement savings held in private sector employer-sponsored retirement plans are an important source of income for older Americans. Over time, the number of participants in such plans has grown along with the rising number of participants in defined contribution plans such as 401(k) plans. However, the number of participants in traditional defined benefit plans in the private sector has remained steady, while the proportion of these participants that are either retired or separated from their employer has been increasing.
- A growing share of the participants in defined benefit plans participate in hybrid defined benefit plans, like cash balance plans, that have some characteristics that are similar to defined contribution plans. Among defined benefit plan participants, the share in plans that are cash balance plans has risen from less than 15 percent in 1999 to over 30 percent in 2013.
- Out of the 93 million participants in private sector employer-sponsored defined contribution plans in 2013, about 77 million were in 401(k)-type plans. Among participants in 401(k)-type plans, the share in plans that allow participants to direct all or a portion of their investments has risen from 85 percent in 1999 to 97 percent in 2013.
- Private sector workers most commonly have access to only a defined contribution plan, while state and local government workers most commonly have access to only a defined benefit plan. Among private sector workers in 2015, 47 percent had access to only a defined contribution plan, 14 percent had access to both a defined benefit and a defined contribution plan, and 4 percent had access to only a defined benefit plan. The rates for state and local government workers were 6 percent, 27 percent, and 57 percent, respectively.

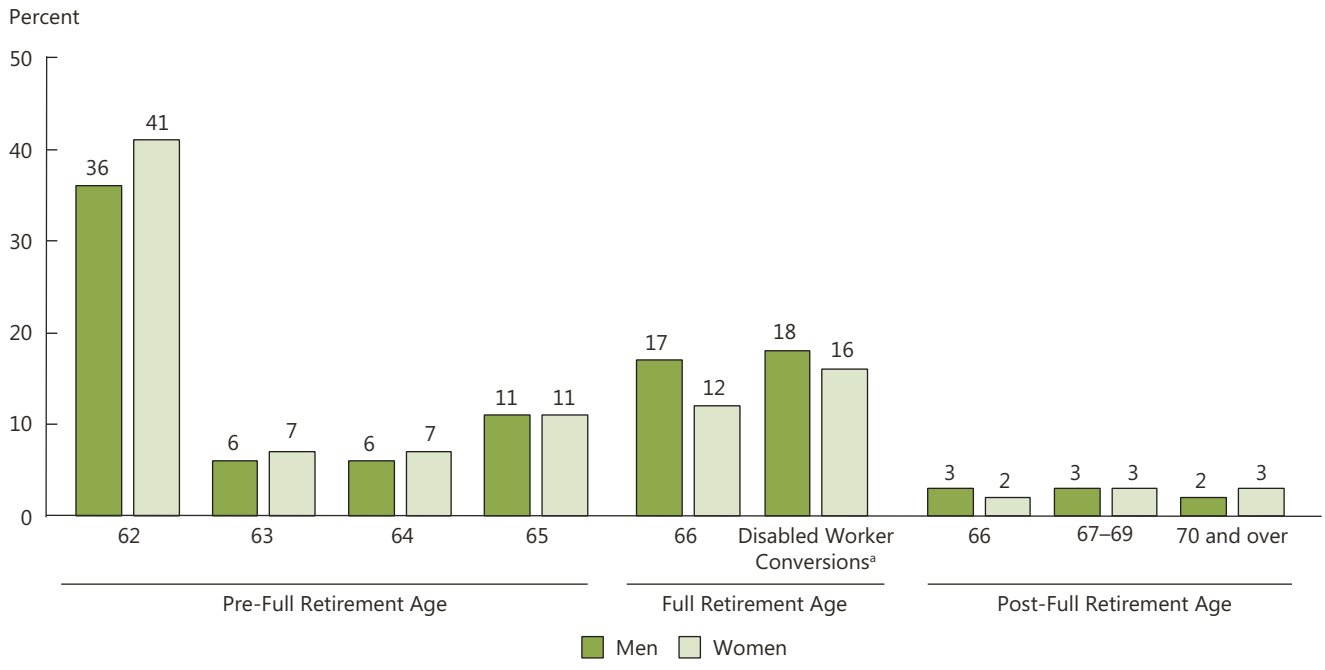
Data for this indicator's charts and bullets can be found in Tables 9a through 9f on pages 96–100.

INDICATOR 10: **Social Security Beneficiaries**

Social Security benefits provide a baseline for retirement income for the majority of older Americans and are the most important income source for the aged. In December 2014, 47 million adults age 62 and over received Social Security benefits.[9] About 5.1 million adults ages 62–64 received an average of $1,134 per month in benefits and 42 million adults age 65 and over received an average of $1,309 per month.

In December 2014, most aged beneficiaries received retired worker benefits (about 60 percent of those ages 62–64 and 86 percent of those 65 and over). Social Security provides retired worker benefits to workers with full insurance from work covered by Social Security over a lifetime. Full insurance of the aged usually requires a minimum of 10 years of covered earnings. About 1.9 million disabled workers ages 62–65 also received benefits in 2014, an increase from the number receiving benefits in 2000.

Percentage distribution of people who began receiving Social Security benefits in 2014, by age and sex



[a] At Full Retirement Age (FRA), persons formerly receiving disabled worker benefits are reclassified and begin receiving retired worker benefits.

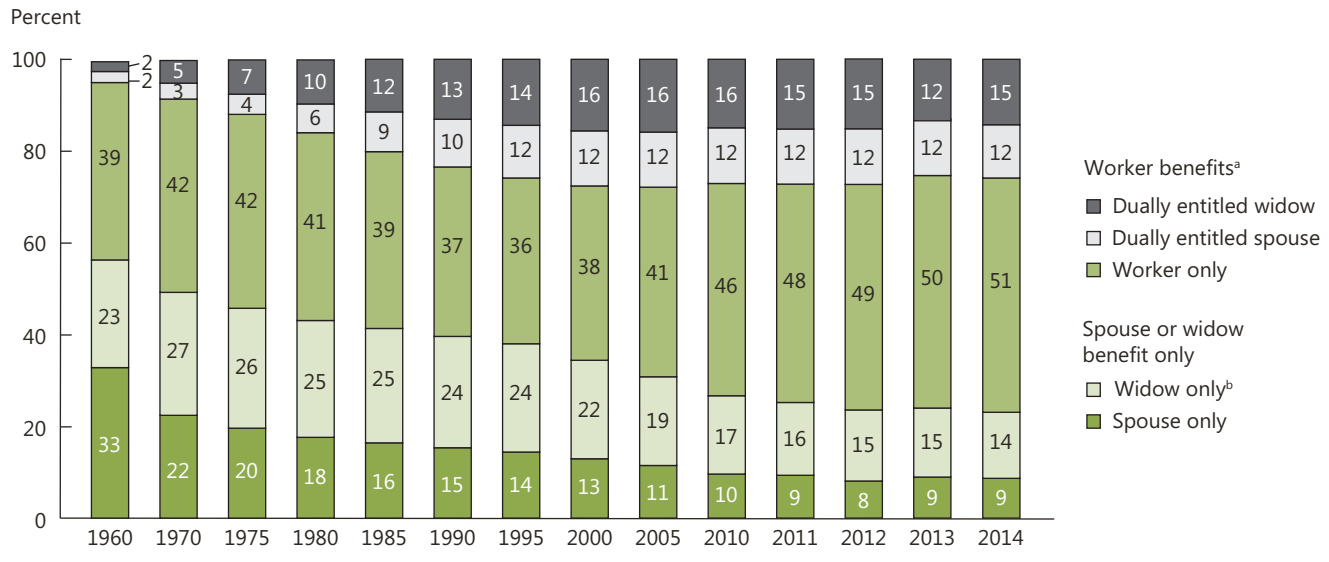
NOTE: FRA is defined as age 66 for those born between 1943 and 1955. The percentages are not probabilities of a birth cohort claiming at a particular age. A person begins receiving Social Security benefits the month after he or she becomes entitled. Totals may not sum to 100 percent because of rounding.

Reference population: Persons fully insured for Social Security retired worker benefits who became entitled to benefits in 2014.

SOURCE: Social Security Administration, Master Beneficiary Record.

- In 2014, the majority (59 percent) of new Social Security retired worker beneficiaries became entitled to benefits prior to Full Retirement Age (FRA) at age 66 and, thus, started receiving reduced monthly Social Security benefits. Few received a greater amount of benefits by waiting to claim benefits until after reaching FRA. Persons begin receiving benefits the month after entitlement.
- Of new Social Security retired worker beneficiaries in 2014, over one-third of men and two-fifths of women became entitled at age 62 and about one-quarter of men and women became entitled at ages 63–65. In contrast, 17 percent of men and 12 percent of women became entitled at FRA, and few (8 percent of both men and women) became entitled post-FRA.
- Of new Social Security retired worker beneficiaries in 2014, 18 percent of men and 16 percent of women converted from receiving disabled worker benefits to receiving retired worker benefits.

Percentage distribution of female Social Security beneficiaries age 62 and over, by type of benefit received, selected years 1960–2014



[a] Worker benefits include retired and disabled worker benefits.

[b] Widow-only beneficiaries include disabled workers and mothers of surviving children under age 19.

NOTE: All data for 2005 and dual-entitlement data for 1995 and 2000 are based on a 10 percent sample of administrative records. All other estimates are based on 100 percent of available data. Benefits exclude special age-72 beneficiaries and disabled adult children and include disabled workers. Totals may not sum to 100 percent because of rounding.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Social Security Administration, Master Beneficiary Record.

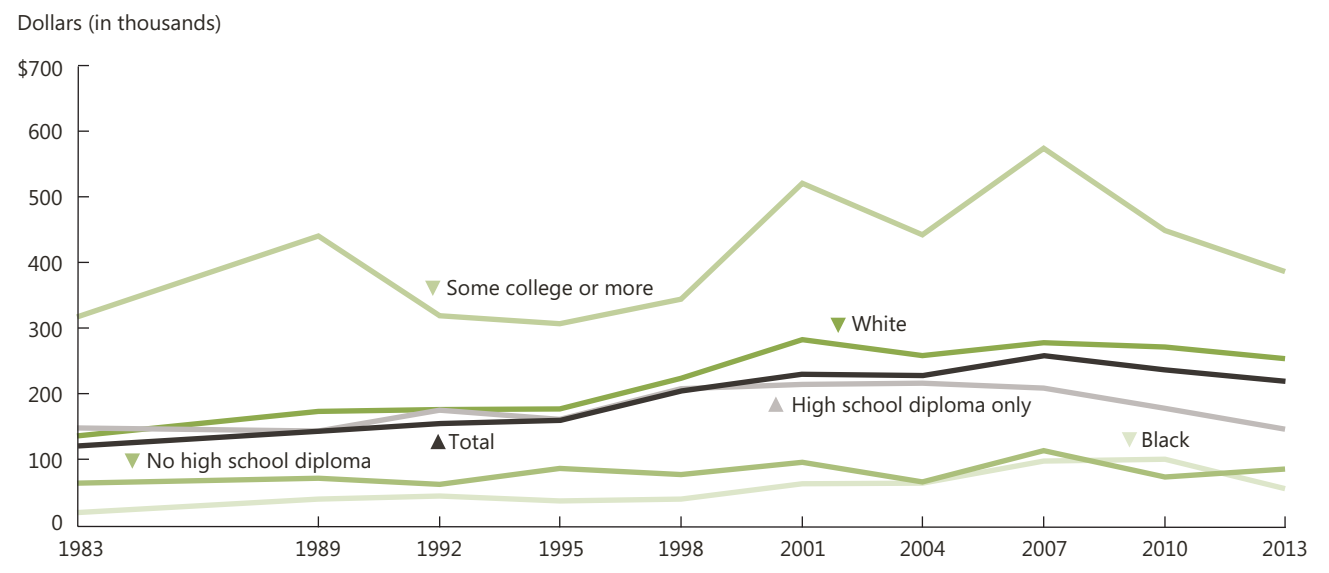
- In 2014, 77 percent of women beneficiaries age 62 and over received earned worker benefits.
- The remaining portion of women (23 percent) received benefits only as the spouse or surviving widow of an entitled worker. In 2014, about 9 percent of women received spouse-only benefits and 14 percent received widow-only benefits.
- Women entitled to their own earned worker benefits and to higher auxiliary benefits, such as spouse or widow benefits, are considered dually entitled. Of female Social Security beneficiaries age 62 and over in 2014, about 51 percent received only earned worker benefits, 12 percent received both earned worker and spouse benefits, and 15 percent received both earned worker and widow benefits.
- The type of benefits received by women age 62 and over dramatically changed between 1960 and 2014. The percentage of female Social Security beneficiaries who received spouse-only benefits decreased from 33 percent to 9 percent, and the percentage receiving widow-only benefits decreased from 23 percent to 14 percent. In contrast, the percentage of female Social Security beneficiaries who received earned worker benefits increased from 43 percent in 1960 to 77 percent in 2014.

Data for this indicator's charts and bullets can be found in Tables 10a and 10b on page 101.

INDICATOR 11: **Net Worth**

Net worth (the value of real estate, stocks, bonds, retirement investment accounts, and other assets minus debts) is an important indicator of economic security and well-being. Greater net worth allows a family to maintain its standard of living when income falls due to job loss, health problems, or family changes such as divorce.

Median household net worth, in 2013 dollars, by race and educational attainment of head of household age 65 and over, selected years, 1983–2013



NOTE: Median net worth is measured in constant 2013 dollars. Net worth includes assets held in investment retirement accounts such as individual retirement accounts, Keoghs, and 401(k)-type plans. All observations are weighted for analysis. The term "household" in this indicator is from the codebook of the 2013 Survey of Consumer Finance (www.federalreserve.gov/econresdata/). The data are for the "primary economic unit" (PEU). The PEU consists of an economically dominant single individual or couple (married or living partners) in a household and all other members of the household who are financially interdependent with the individual or couple. In the majority of cases, the PEU and household are identical.

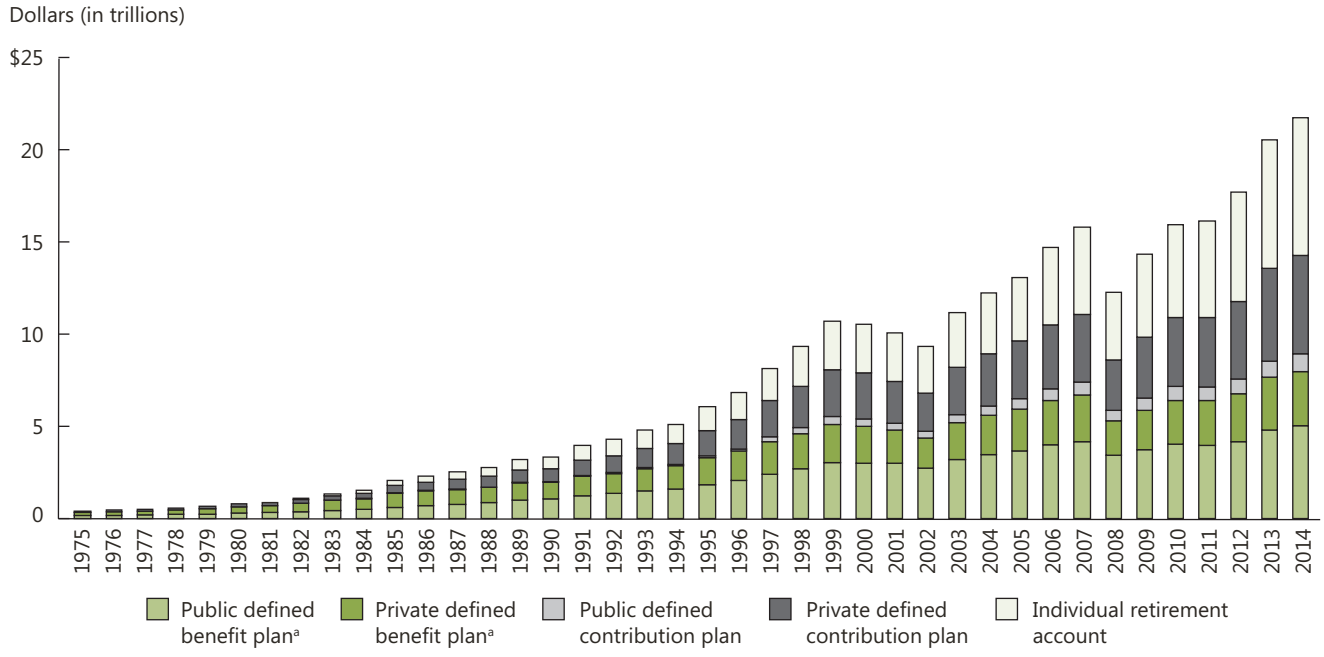
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Survey of Consumer Finances.

- Overall between 1983 and 2013, the median net worth, in 2013 dollars (including the value of retirement investment accounts), of households headed by people age 65 and over almost doubled, from $116,500 to $210,500. The rate of change was quite variable over this time period. The largest increase was between 1995 and 1998. In addition, there was a decrease between 2001 and 2004 and between 2007 and 2013.
- Between 1983 and 2013, the median net worth of households headed by White people age 65 and over almost doubled, from $137,300 to $255,000. The median net worth of households headed by Black people age 65 and over almost tripled over the same period, increasing from $20,200 to $56,700.
- In 1983, the median net worth of households headed by White people age 65 and over was almost seven times that of households headed by Black people age 65 and over. In 2013, the median net worth of households headed by older White people was about four and a half times that of households headed by older Black people.
- In 2013, the median net worth of households headed by married people age 65 and over ($319,800) was more than twice as high as that of households headed by unmarried people in the same age group ($119,300).
- Between 1983 and 2013, the median net worth of people age 65 and over either without a high school diploma or with some college had similar increases (33 percent and 22 percent, respectively). In 2013, households headed by persons age 65 and over who attended college had a median net worth almost four and a half times greater than persons without a high school diploma.

- With the shift from traditional defined benefit pension plans to investment retirement accounts such as 401(k)-type Individual Retirement Accounts (IRAs), financial assets held in individual retirement accounts have become prevalent among older Americans. Data from the Survey of Consumer Finances show public and private retirement assets for all ages, broken out by age group. The proportion of American families headed by people age 65 and over with retirement accounts to all households headed by people age 65 and over remained about two-fifths in 2007 and 2013.
- The median retirement account value for households headed by a person age 65 and over almost doubled between 2007 and 2013, increasing from $68,000 to $118,000. (These retirement accounts are more likely to be held by later birth cohorts.) People seldom withdraw account money as annuity payments or regular payments; rather, most are taken as ad hoc distributions. Tax laws require that the account funds be distributed based on life expectancy beginning in the year after 70 and a half years of age.

Amount of funds held in retirement assets, by sector and type of plan, 1975–2014



[a] Public and private defined benefit plans do not include claims of pension funds on sponsor.
Reference population: Public and private retirement assets for total population.
SOURCE: Federal Reserve Board Z.1 Statistical Release for Dec. 10, 2015.

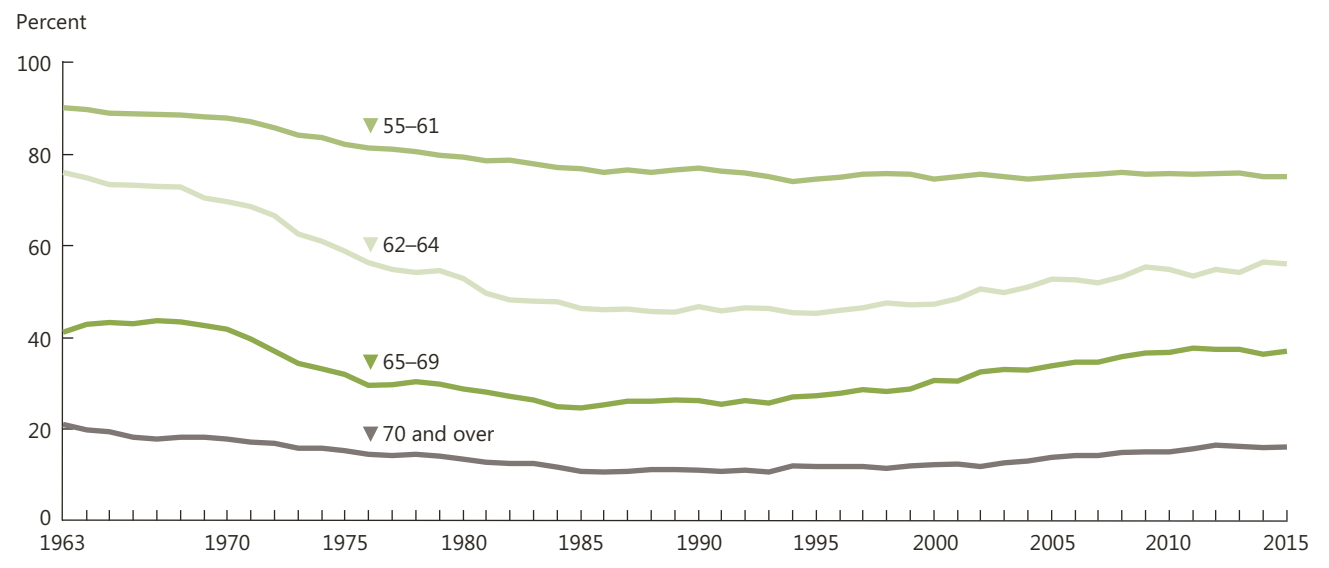
- Retirement savings held in public and private pension plans or IRAs play a large role in the net worth of older Americans. In 2014, IRAs held about $7.4 trillion in assets, public and private defined contribution plans held about $6.3 trillion in assets, and public and private defined benefit plans held about $8.0 trillion in assets.
- Over time, an increasing proportion of retirement assets has shifted from traditional defined benefit plans to individual account-based retirement vehicles such as defined contribution plans and IRAs.
- While defined contribution plans are more commonly provided in the private sector, defined benefit plans have been largely dominant in the public sector.

Data for this indicator's charts and bullets can be found in Tables 11a through 11c on pages 102–104.

INDICATOR 12: **Participation in Labor Force**

The labor force participation rate is the percentage of a population that is in the labor force—that is, either working (employed) or actively looking for work (unemployed). Some older Americans work out of economic necessity. Others may be attracted by the social contact, intellectual challenges, or sense of value that work often provides.

Labor force participation rates (annual averages) of men age 55 and over, by age group, 1963–2015



NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey.

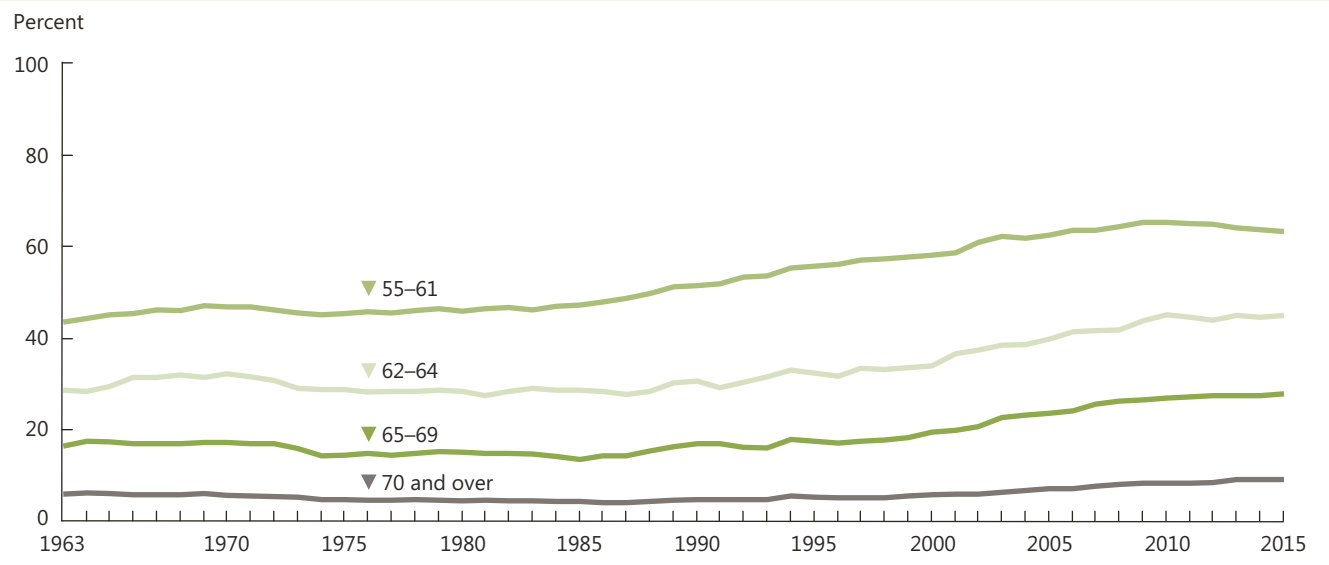
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, Current Population Survey.

- In 2015, the labor force participation rate for men ages 55–61 was 75 percent, far below the rate in 1963 (90 percent). The participation rate for men ages 62–64 declined from 76 percent in 1963 to a low of 45 percent in 1995. In 2015, the participation rate for men ages 62–64 increased to 56 percent.
- Men ages 65–69 also experienced a gradual rise in labor force participation following a period of decline in the late 1960s and 1970s. The labor force participation rate for men ages 65–69 declined from a high of 43 percent in 1967 to 24 percent in 1985. Their participation rate from the mid-1980s to the early 1990s remained in the range of 24 to 26 percent. In the mid-1990s, the labor force participation rate for men in this age group began to increase and reached 37 percent in 2011; it has remained mostly unchanged since then.
- From 1963 to 2015, the participation rate for men age 70 and over showed a somewhat similar pattern as men ages 65–69. In 1993, the labor force participation rate for men age 70 and over reached a low of 10 percent after declining from 21 percent in 1963. Since the mid-1990s, the participation rate for men ages 70 and over has trended higher but has leveled off in recent years. The rate was 16 percent in 2015.

The labor force participation rate for older women reflects changes in the work experience of successive generations of women. Many women now in their 60s and 70s did not work outside the home when they were younger, or they moved in and out of the labor force. As new cohorts of women Baby Boomers approach older ages, they are participating in the labor force at higher rates than in previous generations.

Labor force participation rates (annual averages) of women age 55 and over, by age group, annual averages, 1963–2015



NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, Current Population Survey.

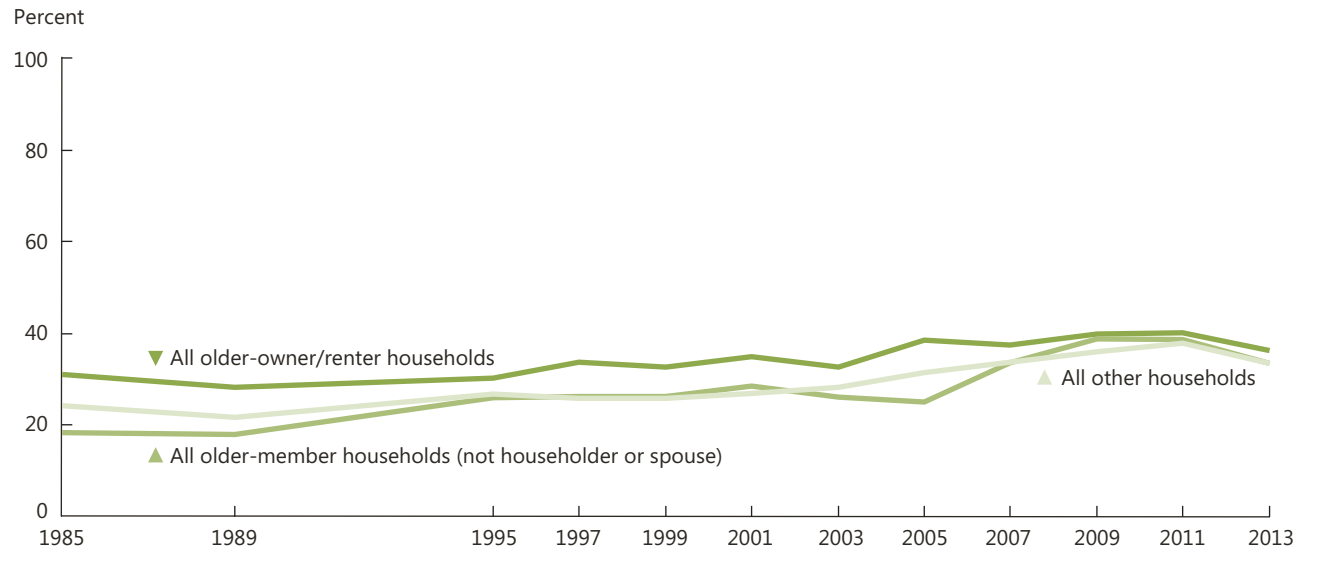
- Among women age 55 and over, the labor force participation rate rose over the past four decades. The increase has been largest among women ages 55–61, rising from 44 percent in 1963 to 66 percent in 2010, with a majority of the increase occurring after 1985. For women ages 62–64, 65–69, and 70 and over, labor force participation rates began increasing in the mid-1980s but have leveled off in recent years.
- In 2015, 64 percent of women ages 55–61 were in the labor force, compared with 44 percent in 1963. Over the same period, the labor force participation rate for women ages 62–64 increased from 29 percent to 45 percent, and the rate for women ages 65–69 increased from 17 percent to 28 percent.
- The difference between labor force participation rates for men and women has narrowed over time. Among those ages 55–61, for example, the gap between men's and women's rates in 2015 was 11 percentage points, compared with 46 percentage points in 1963.

Data for this indicator's charts and bullets can be found in Table 12 on pages 105–106.

INDICATOR 13: **Housing Problems**

Most older Americans live in adequate, affordable housing. Some, however, live in costly, physically inadequate, and crowded housing, which can pose serious problems for an older person's physical or psychological well-being. While housing cost burden has remained the most prevalent housing problem for all older American households over the years, some older American households and intergenerational households continue to face physically inadequate housing problems, such as housing that lacks complete plumbing or has multiple and major upkeep problems. These households also have crowded housing situations, which are households that have more than one person per room.

Percentage of older American households and all other U.S. households that report housing cost burden, selected years 1985–2013



NOTE: Housing cost burden refers to expenditures on housing and utilities that exceed 30 percent of household income. All older-owner/renter households are households with a householder or spouse age 65 and over; all older-member households are households with a member age 65 and over who is not the householder or spouse; and all other households are households without one or more persons age 65 and over. Some data for 2009 have been revised and differ slightly from previous editions of *Older Americans.*

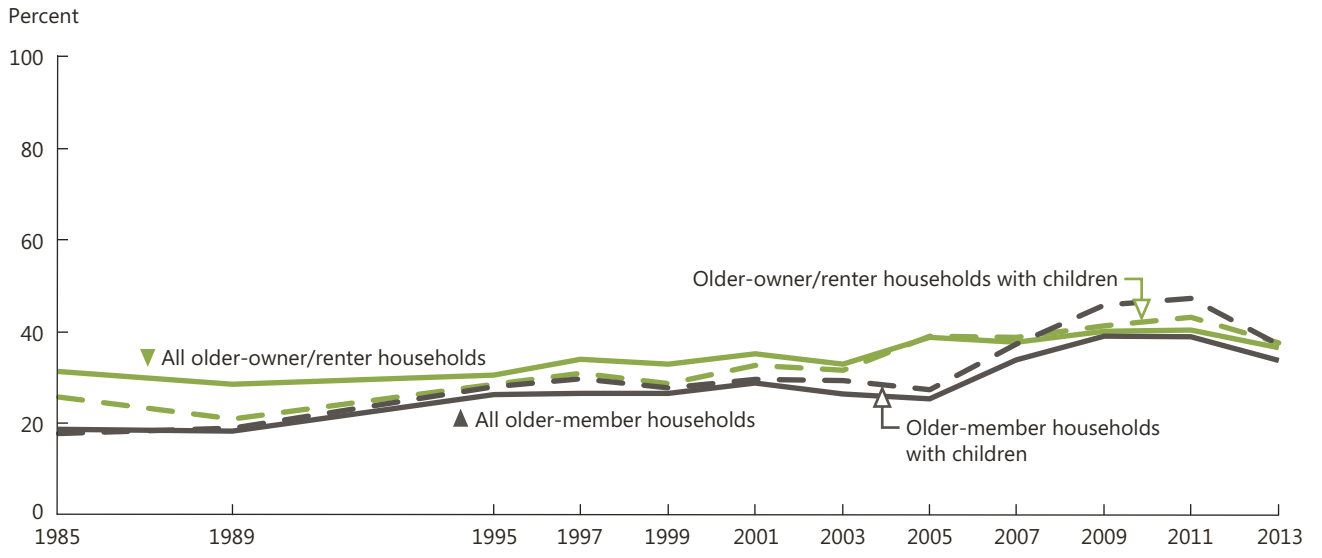
Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

SOURCE: U.S. Department of Housing and Urban Development, American Housing Survey.

- Approximately 39 percent of both older-owner/renter households (households with a householder or spouse age 65 and over) and older-member households (households with a member age 65 and over who is not the householder or spouse) have housing problems. The most prevalent housing problem remains cost burden (expenditures on housing and utilities that exceed 30 percent of household income).
- While cost burden has generally increased over time, between 2009 and 2013 the prevalence of cost burden decreased from 40 to 36 percent for older-owner/renter households and from 39 to 34 percent for older-member households. In comparison, the prevalence of housing cost burden for all other U.S. households (households without one or more persons age 65 and over) decreased from 36 to 34 percent over the same time period.

Cost burden is also the most dominant housing problem for intergenerational households, or households with older people (age 65 and over) and children (age 19 or younger) living in the household. For some intergenerational households, crowded housing continues to be fairly prevalent.

Percentage of older American households and intergenerational households that report housing cost burden, selected years 1985–2013



NOTE: Housing cost burden refers to expenditures on housing and utilities that exceed 30 percent of household income. All older-owner/renter households are households with a householder or spouse age 65 and over; all older-member households are households with a member age 65 and over who is not the householder or spouse; older-owner/renter households with children are households with a householder or spouse age 65 and over and children (age 19 or younger); and older-member households with children are households with a member age 65 and over and children (age 19 or younger). Some data for 2009 have been revised and differ slightly from previous editions of *Older Americans.*

Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

SOURCE: U.S. Department of Housing and Urban Development, American Housing Survey.

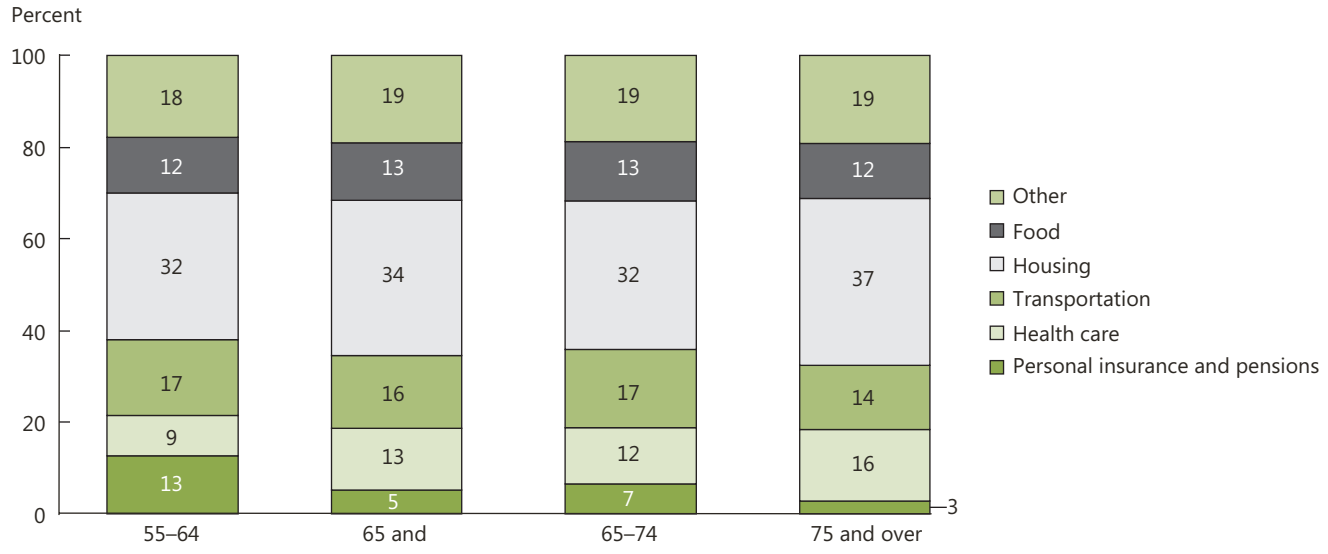
- Older-owner/renter and older-member intergenerational households are likely to represent households where grandparents are helping to raise their grandchildren or where three generations are living within the same household. From 2009 to 2013, housing cost burden remained relatively the same at approximately 40 percent for older-owner/renter intergenerational households. For older-member intergenerational households, housing problems overall decreased, largely as a result of housing cost burden decreasing from 46 to 37 percent between 2009 and 2013.

Data for this indicator's charts and bullets can be found in Tables 13a through 13f on pages 107–109.

INDICATOR 14: **Total Expenditures**

Household expenditures are another indicator of economic well-being and show how the older population allocates resources to food, housing, health care, and other needs. Expenditures may vary with changes in work status, health status, or income.

Percentage distribution of total household annual expenditures, by expenditure category and age group of reference person, 2014



NOTE: Other expenditures include apparel, personal care, entertainment, reading, education, alcohol, tobacco, cash contributions, and miscellaneous expenditures. Data from the Consumer Expenditure Survey by age group represent average annual expenditures for consumer units by the age of the reference person, that is the person listed as the owner or renter of the home. For example, the data on people age 65 and over reflect consumer units with a reference person age 65 and over. The Consumer Expenditure Survey collects and publishes information from consumer units, which are generally defined as a person or group of people who live in the same household and are related by blood, marriage, or other legal arrangement (i.e., a family) or people who live in the same household who are unrelated but make financial decisions together. A household usually refers to a physical dwelling and may contain more than one consumer unit (e.g., roommates who are sharing an apartment but who are financially independent from each other). However, for convenience, the term "household" is substituted for "consumer unit" in this text.

Reference population: These data refer to the resident noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, Consumer Expenditure Survey.

- Housing accounted for the largest share (nearly one-third or more on average) of total expenditures for all groups of households with a reference person (i.e., a selected household owner or renter) age 55 and over. In 2014, the share was 37 percent for households with a reference person age 75 and over.
- As a share of total expenditures, health care expenditures increased dramatically with age. For the group age 75 and over, the share (16 percent) was nearly twice as high as it was for the group age 55–64 (9 percent); in addition, the share that those age 75 and over allocated to health care was slightly higher than this group allocated to transportation (4 percent).
- Among the age groups studied, the share of total expenditures allocated to food ranged between 12 and 13 percent.

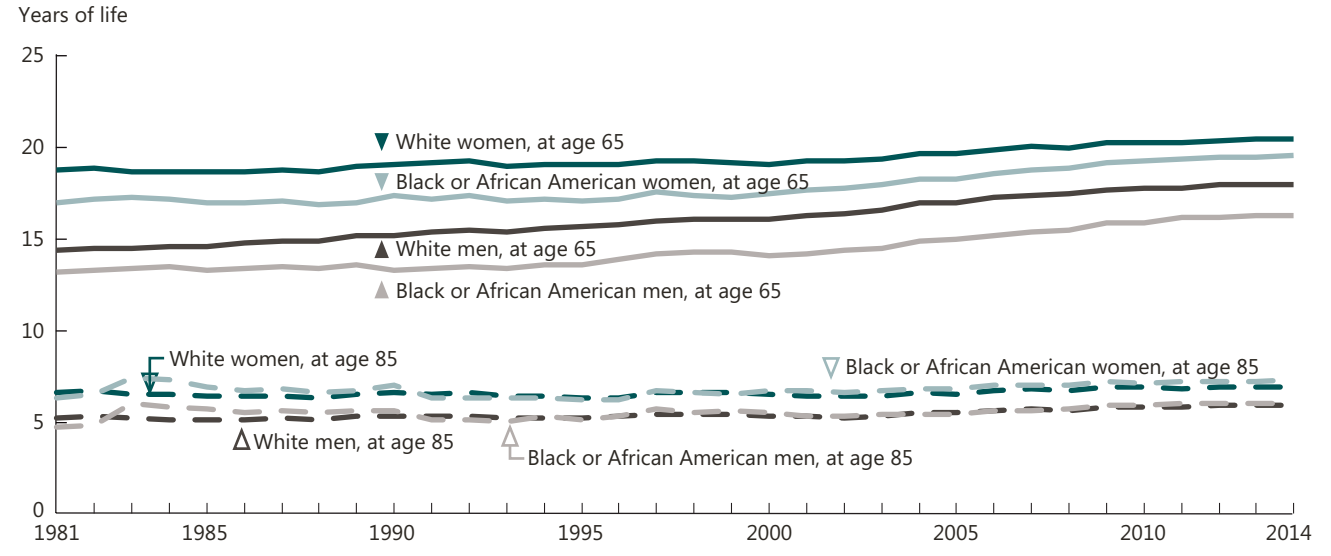
Data for this indicator's charts and bullets can be found in Table 14 on page 110.

Health Status

INDICATOR 15: **Life Expectancy**

Life expectancy is a summary measure of the overall health of a population. It represents the average number of years of life remaining to a person at a given age if death rates remain constant. Improvements in health have resulted in increased life expectancy. However, there are differences in life expectancy by socioeconomic status, and these differences have been increasing over time.[10] Life expectancy in the United States is lower than in many other industrialized countries.[11]

Life expectancy at ages 65 and 85, by race and sex 1981–2014



NOTE: Life expectancy estimates are from annual life tables produced by the National Center for Health Statistics found at http://www.cdc.gov/nchs/products/life_tables.htm. Some estimates have been revised and may differ from previous editions of *Older Americans* due to changes in methodology and to the use of intercensal population estimates for 2001–2009. See Appendix II, Life Expectancy, of *Health, United States, 2015* for a description of the changes in life table methodology.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

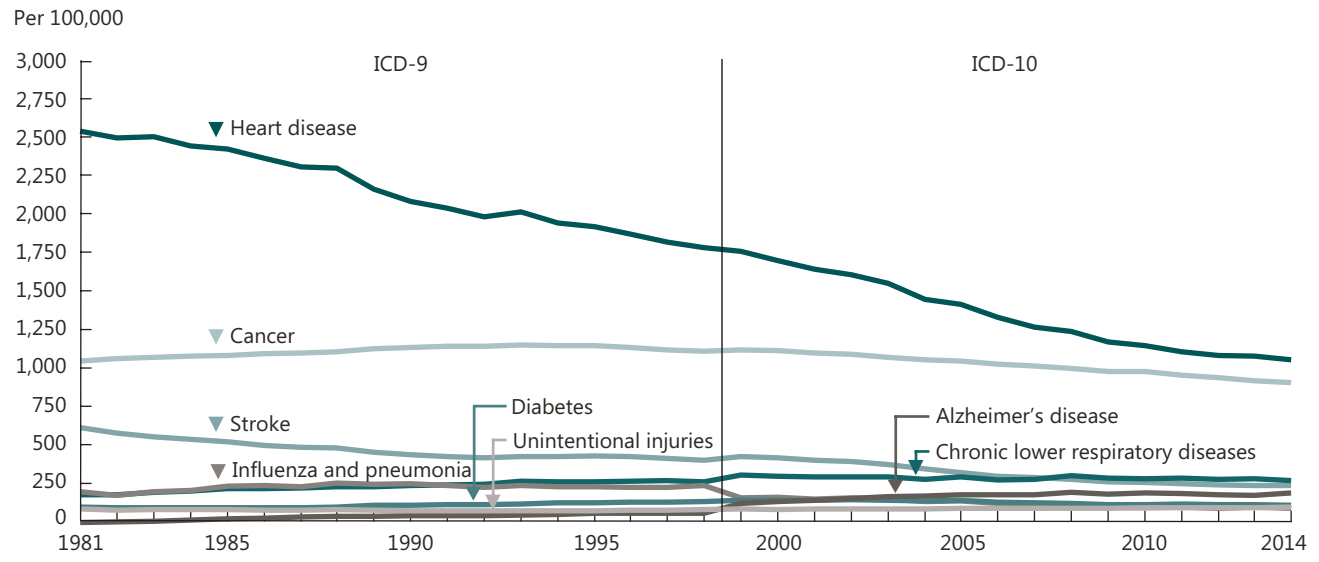
- Americans are living longer than ever before. Life expectancies at both age 65 and age 85 have increased. Under current mortality conditions, people who survive to age 65 can expect to live an average of 19.3 more years. In 2014, the life expectancy of people who survive to age 85 was 7.0 years for women and 5.9 years for men.
- Life expectancy varies by race, but the difference decreases with age. In 2014, life expectancy at birth was 3.4 years higher for White people than for Black people. At age 65, White people can expect to live an average of 1.1 years longer than Black people. Among those who survive to age 85, however, the life expectancy for Black people is slightly higher (6.9 years) than White people (6.5 years).
- In 2014, women had higher life expectancy than men. At age 65, women can expect to live 2.5 years longer. At age 85, women can expect to live 1.1 years longer. Differences by sex are seen among the White, Black, and Hispanic populations.
- Life expectancy in 2014 among the Hispanic population was higher than among non-Hispanic Whites or non-Hispanic Blacks. Hispanic people who survive to age 65 can expect to live 1.8 years longer than non-Hispanic Whites and 3.0 years longer than non-Hispanic Blacks.

Data for this indicator's charts and bullets can be found in Tables 15a and 15b on pages 111–113.

INDICATOR 16: **Mortality**

Overall, death rates for the population age 65 and over have declined in recent decades. However, for some causes of death, rates among older Americans have increased in recent years. There are differences in death rates by sex and race and Hispanic origin for many causes of death.

Death rates among people age 65 and over, by selected leading causes of death, 1981–2014



NOTE: Death rates for 1981–1998 are based on the 9th revision of the International Classification of Diseases (ICD-9). Starting in 1999, death rates are based on ICD-10. For the period 1981–1998, causes were coded using ICD-9 codes that are more comparable with codes for corresponding ICD-10 categories and may differ from other published estimates. See http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_02.pdf for information on the comparability of death rates between ICD-9 and ICD-10. Some data from 2000–2009 have been revised and differ from previous versions of *Older Americans.* Rates are age adjusted using the 2000 standard population.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

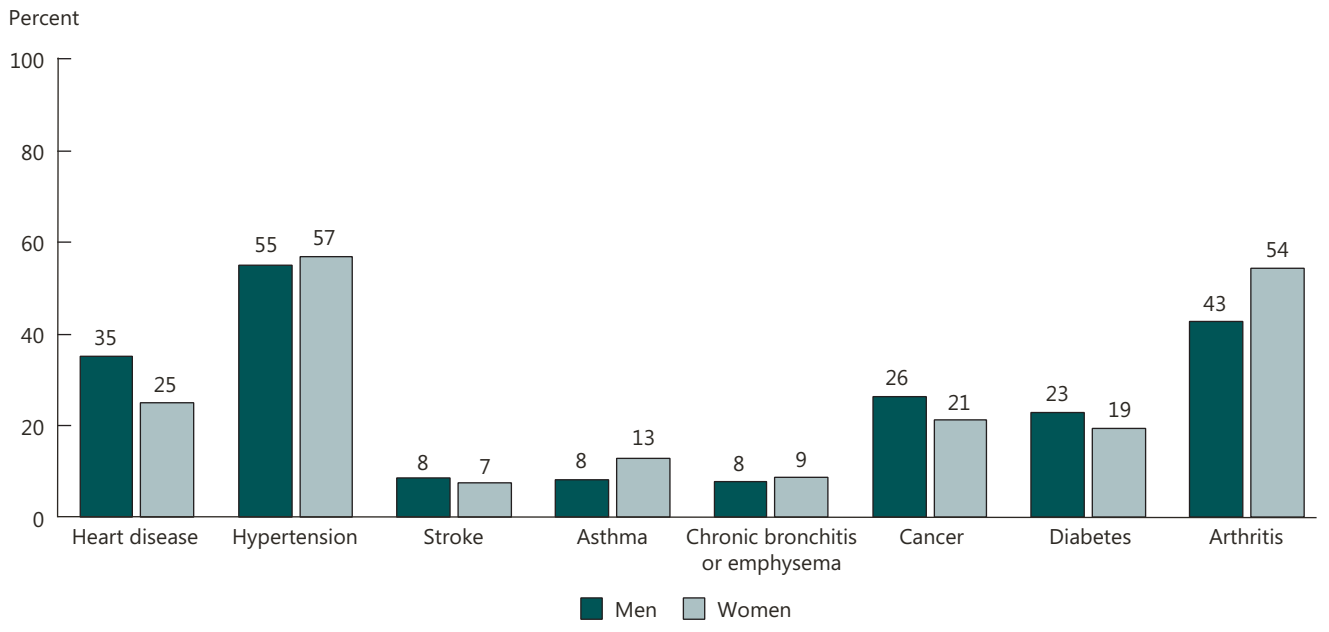
- In 2014, the leading cause of death among people age 65 and over was heart disease (1,062 deaths per 100,000 people), followed by cancer (915 per 100,000), chronic lower respiratory diseases (277 per 100,000), stroke (247 per 100,000), Alzheimer's disease (200 per 100,000), diabetes (119 per 100,000), unintentional injuries (105 per 100,000), and influenza and pneumonia (97 per 100,000).
- Between 1999 and 2014, age-adjusted death rates for all causes of death among people age 65 and over declined by 20 percent. Death rates declined for heart disease, cancer, chronic lower respiratory disease, stroke, diabetes, and influenza and pneumonia. Death rates for Alzheimer's disease and unintentional injuries increased over the same period.
- Heart disease and cancer were the top two leading causes of death in 2014 among all people age 65 and over. They were also the top two leading causes of death for both men and women as well as for non-Hispanic Whites, non-Hispanic Blacks, and Hispanics. Diabetes was the seventh leading cause of death among non-Hispanic Whites, but the fourth leading cause among non-Hispanic Blacks and Hispanics.
- Other causes of death varied among older Americans by sex and race and Hispanic origin. For example, in 2014 women had higher death rates from Alzheimer's disease than men (222 per 100,000 compared with 161 per 100,000), while men had higher rates of death from unintentional injuries (131 per 100,000 compared with 86 per 100,000). Rates of death for heart disease and stroke were higher among non-Hispanic Blacks than among non-Hispanic Whites and Hispanics.

Data for this indicator's charts and bullets can be found in Tables 16a and 16b on pages 114–115.

INDICATOR 17: **Chronic Health Conditions**

Chronic diseases and conditions such as heart disease, stroke, cancer, diabetes, and arthritis are among the most common and costly health conditions.[12] The majority of older adults have multiple chronic conditions, which contribute to frailty and disability.[13] Many of the negative effects of chronic conditions are caused by health risk behaviors that can be changed.[12] The six leading causes of death among older Americans in 2014 were chronic diseases (see "Indicator 16: Mortality").

Percentage of people age 65 and over who reported having selected chronic health conditions, by sex, 2013–2014



NOTE: Data are based on a 2-year average from 2013–2014.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

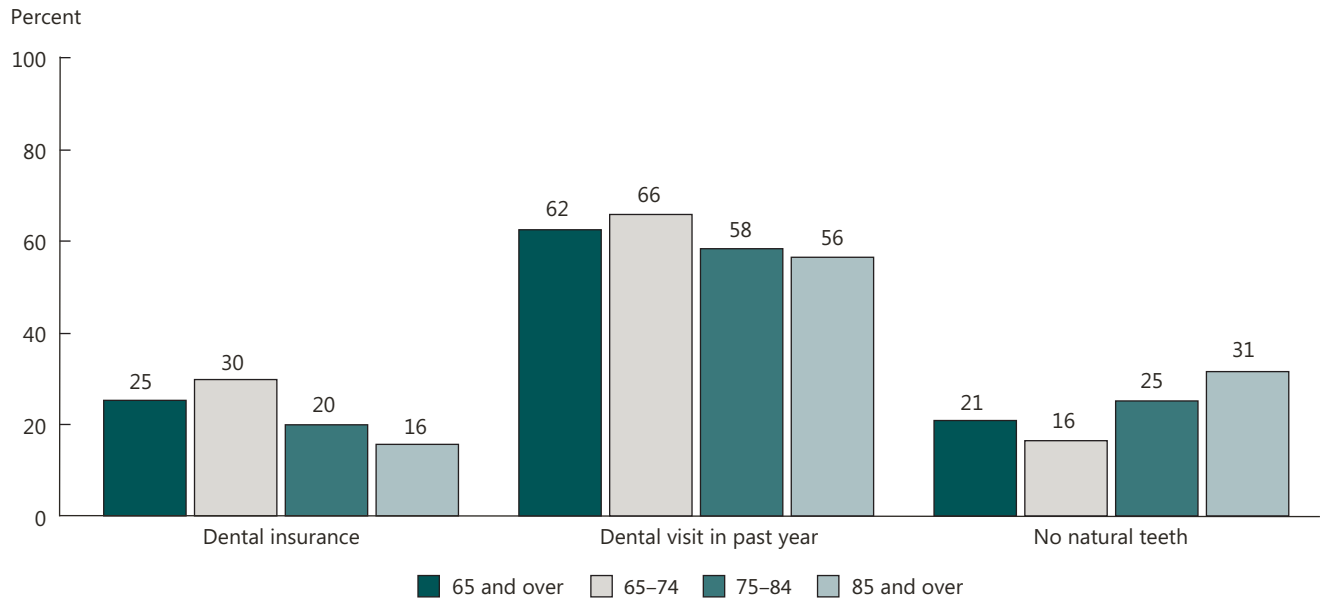
- The prevalence of certain chronic health conditions differed by sex. Women reported higher levels of asthma and arthritis than men. Men reported higher levels of heart disease, cancer, and diabetes than women.
- There were differences by race and ethnicity in the prevalence of certain chronic health conditions. In 2013–2014, among people age 65 and over, non-Hispanic Blacks reported higher levels of hypertension and diabetes than non-Hispanic Whites (71 percent compared with 54 percent for hypertension, and 32 percent compared with 18 percent for diabetes). Hispanics also reported higher levels of diabetes (32 percent) than non-Hispanic Whites, but lower levels of arthritis than non-Hispanic Whites (44 percent compared with 50 percent).
- The prevalence of some chronic health conditions among people age 65 and over has increased over time. The percentage of people who reported hypertension, asthma, cancer, and diabetes was higher in 2013–2014 compared with 1997–1998.

Data for this indicator's charts and bullets can be found in Tables 17a and 17b on page 116.

INDICATOR 18: **Oral Health**

Oral health is an important component of an older person's general health and well-being. Oral health reflects overall health status and is related to the risk and treatment of various chronic conditions.[14] Regular dental care is not covered under Medicare.

Percentage of people age 65 and over who had dental insurance, had a dental visit in the past year, and had no natural teeth, by age group, 2014



NOTE: Dental insurance is estimated from questions on whether the respondent's private health insurance plan covers dental care and whether the respondent has a single service plan covering dental care. Dental visits in the past year were estimated from responses to the question, "About how long has it been since you last saw or talked to a dentist?" The percentage with no natural teeth was estimated from responses to the question, "Have you lost all of your upper and lower natural (permanent) teeth?" All estimates were calculated from the sample adult component of the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

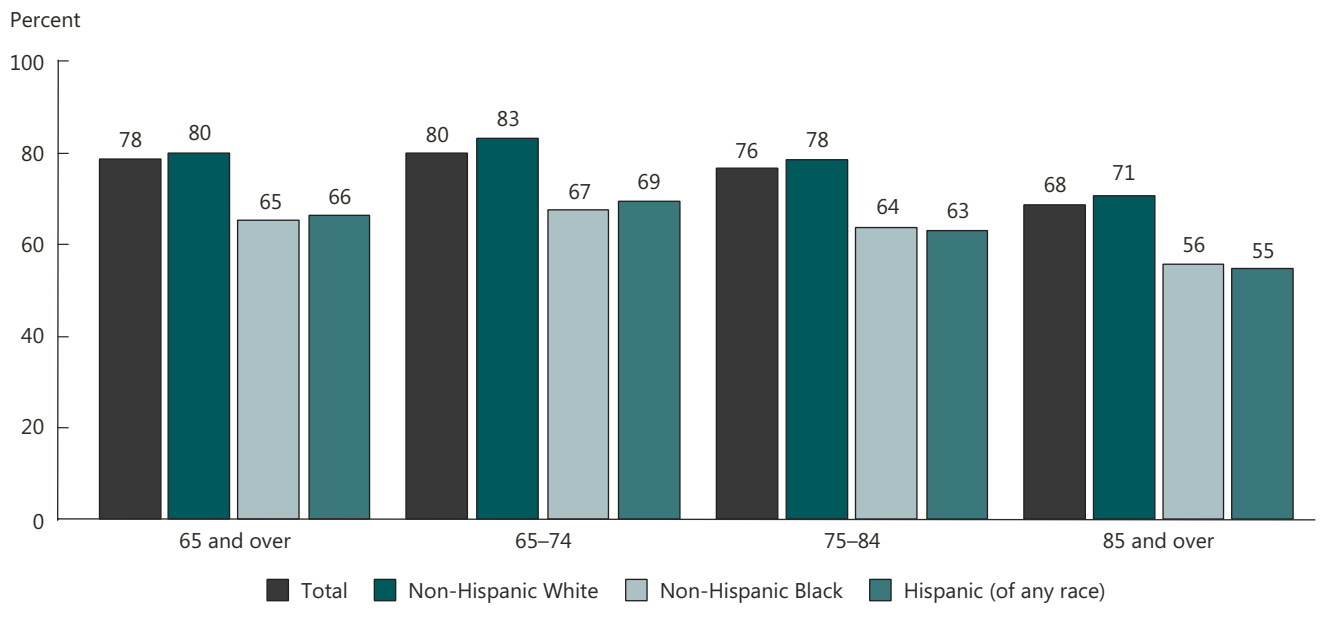
- About 25 percent of people age 65 and over reported having dental insurance in 2014. The percentage with dental insurance declines with age, from 30 percent among people ages 65–74 to 16 percent among people age 85 and over.
- In 2014, about 62 percent of people age 65 and over had a dental visit in the past year. The percentage visiting a dentist was higher among people ages 65–74 than among people age 85 and over (66 percent versus 56 percent).
- The prevalence of edentulism, having no natural teeth, was nearly twice as high among people age 85 and over (31 percent) as among people ages 65–74 (16 percent).
- The percentage of older women with dental insurance was lower than the percentage of older men with dental insurance. Similar percentages of men and women age 65 and over had a dental visit in the past year and had no natural teeth.
- Non-Hispanic Black people age 65 and over had higher levels of edentulism and lower levels of dental visits than non-Hispanic Whites and Hispanics.

Data for this indicator's charts and bullets can be found in Tables 18a and 18b on page 117.

INDICATOR 19: **Respondent-Assessed Health Status**

Asking people to rate their health as excellent, very good, good, fair, or poor provides an indicator of health status easily measured in surveys. It represents physical, emotional, and social aspects of health and well-being. Self-rated health has been shown to predict mortality and health care expenditures.[15,16]

Percentage of people age 65 and over with respondent-assessed good to excellent health status, by age group and race and Hispanic origin, 2012–2014



NOTE: Data are based on a 3-year average from 2012–2014. Total includes all other races not shown separately. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

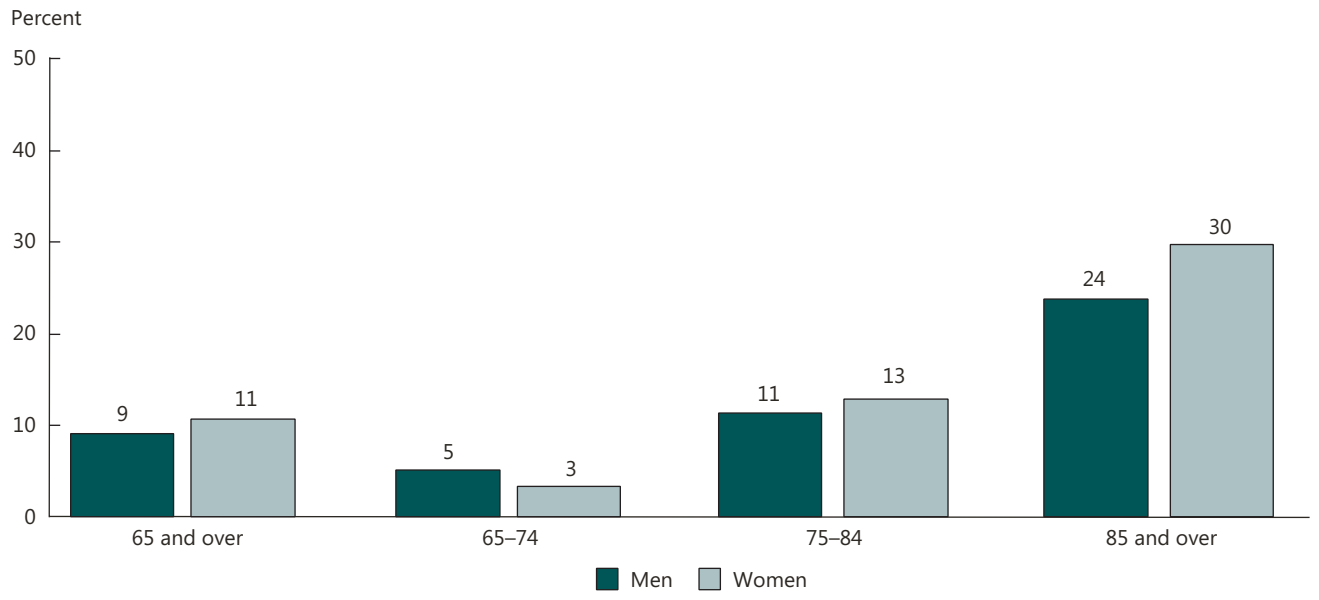
- During the period 2012–2014, 78 percent of people age 65 and over rated their health as good, very good, or excellent. The levels of health reported by older men and older women were similar.
- The proportion of people reporting good to excellent health was lower among the oldest age groups. About 80 percent of those age 65–74 reported good or better health. At age 85 and over, 68 percent of people reported good or better health. This pattern was also evident within racial and ethnic groups.
- Regardless of age, older non-Hispanic White men and women were more likely to report good to excellent health than their non-Hispanic Black and Hispanic counterparts. Non-Hispanic Blacks and Hispanics were similar to one another in the percentages of positive health evaluations that they reported.

Data for this indicator's charts and bullets can be found in Table 19 on page 118.

INDICATOR 20: **Dementia**

Dementias, including Alzheimer's disease and other related disorders that cause memory impairment and cognitive decline, affect the health and well-being of the U.S. population (see "Indicator 16: Mortality").[17] Dementia is a condition overwhelmingly faced by older adults, although there are some conditions in which the onset is seen in people under age 65. Increasing age is one of the strongest risk factors for dementia.

Percentage of the non-nursing home population age 65 and over with dementia, by age group and sex, 2011



NOTE: The estimate of dementia presented here includes Alzheimer's disease and other related dementias such as frontotemporal, Lewy body, mixed, and vascular dementia, which are often indistinguishable from Alzheimer's disease in their presentation and outcomes. Dementia status in the National Health and Aging Trends Study (NHATS) was determined using three types of information: (1) a report (by the respondent or proxy) that a doctor told the sample person that he or she had dementia or Alzheimer's disease; (2) a score indicating probable dementia on a screening instrument administered to proxy respondents during the interview; and (3) cognitive tests that evaluate memory, orientation, and executive function administered to the respondent during the interview. See http://nhats.org/scripts/documents/DementiaTechnicalPaperJuly_2_4_2013_10_23_15.pdf for details on dementia measurements in NHATS.

Reference population: These data refer to Medicare beneficiaries not living in nursing homes.

SOURCE: National Health and Aging Trends Study.

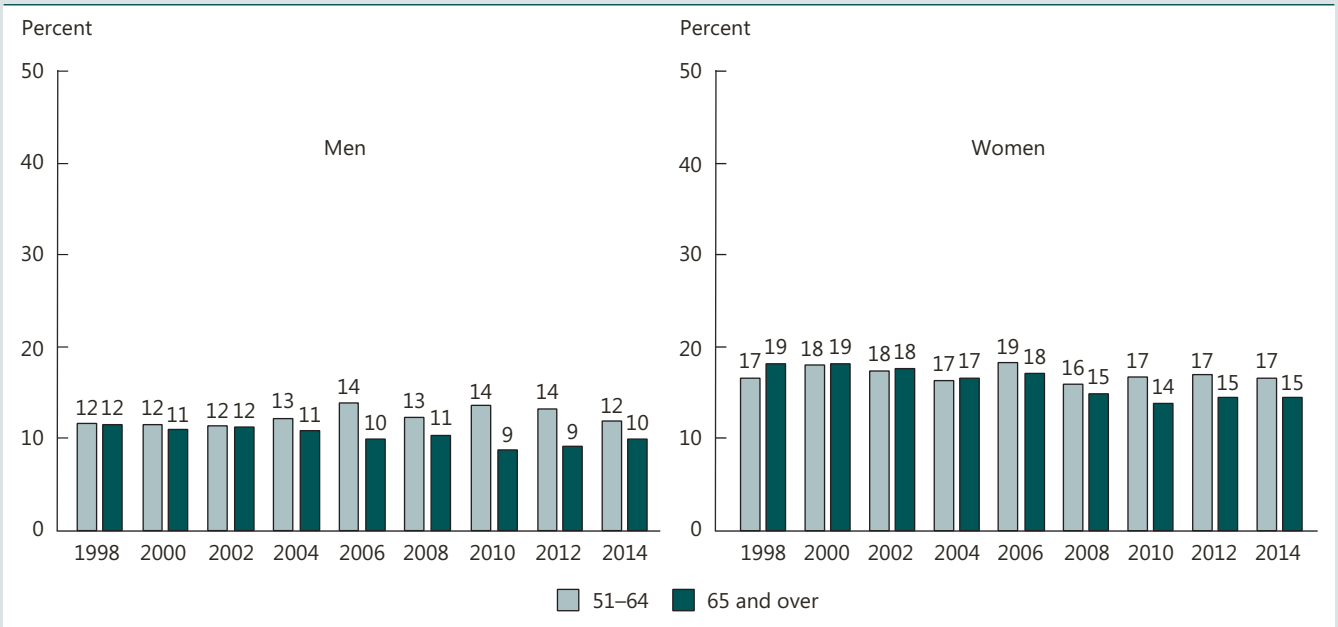
- There are sex differences in the prevalence of dementia. Although women overall are more likely than men to have dementia, this pattern is not consistent at all age groups. In 2011, for those people ages 65–74, men were more likely to have dementia than women (5 percent versus 3 percent, respectively). For those adults age 85 and over, women were more likely to have dementia than men (30 percent versus 24 percent).
- In addition to the higher prevalence of dementia among women age 85 and over, the size of the population of women in this age group is larger than that of men. As a result, far more women than men age 85 and over have dementia. Over 900,000 women in this age group have dementia, compared with just under 400,000 men.
- Most people with dementia live in the community. However, the prevalence of dementia among nursing home residents is higher than among the non-nursing home population. It is estimated that in 2011, between 41 percent and 68 percent of nursing home residents had moderate or severe cognitive impairment.[18]
- The prevalence of dementia decreased with educational level. In 2011, among people age 65 and over, 21 percent with less than a high school education had dementia, compared with 5 percent of people who had a bachelor's degree or more. These differences by educational level are seen for both men and women and in all age groups.

Data for this indicator's charts and bullets can be found in Tables 20a through 20d on page 119.

INDICATOR 21: **Depressive Symptoms**

Depressive symptoms are an important indicator of general well-being and mental health among older adults. People who report many depressive symptoms often experience higher rates of physical illness, greater functional disability, higher health care resource utilization,[19] and dementia.[20]

Percentage of people age 51 and over with clinically relevant depressive symptoms, by sex and age group, selected years, 1998–2014



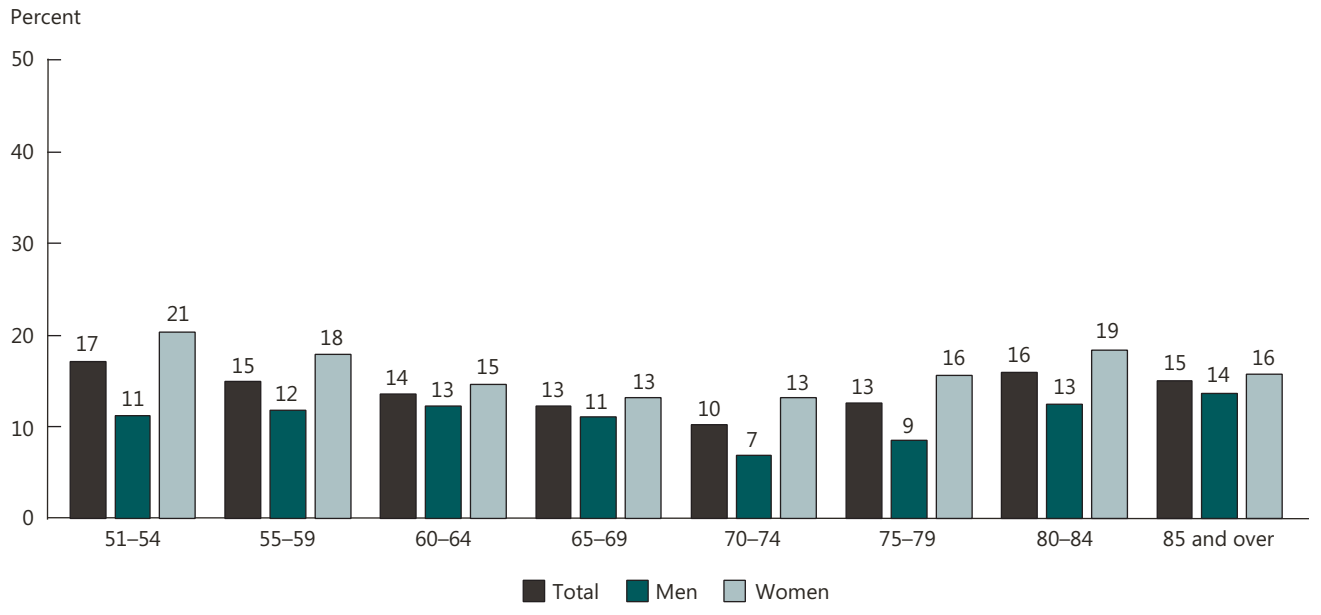
NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D), adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "four or more symptoms" cut-off can be found in the following documentation: http://hrsonline.isr.umich.edu/sitedocs/userg/dr_005.pdf. Percentages are based on weighted data using the preliminary respondent weights from the 2014 Early Release HRS Tracker File. Some data for 1998–2008 have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Health and Retirement Study.

- Older women were more likely to report clinically relevant depressive symptoms than were older men. In 2014, 15 percent of women age 65 and over reported depressive symptoms, compared with 10 percent of men. There was no significant change in this difference between the sexes from 1998 to 2014.
- The percentage of people age 51 and over reporting clinically relevant symptoms has remained relatively stable over the past few years. Between 1998 and 2014, the percentage of men in this age group who reported depressive symptoms ranged between 11 and 12 percent. For women in this age group, the percentage reporting these symptoms ranged between 16 and 19 percent.

Percentage of people age 51 and over with clinically relevant depressive symptoms, by age group and sex, 2014



NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D), adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "four or more symptoms" cut-off can be found in the following documentation: http://hrsonline.isr.umich.edu/sitedocs/userg/dr_005.pdf. Percentages are based on weighted data using the preliminary respondent weight from HRS 2014.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Health and Retirement Study.

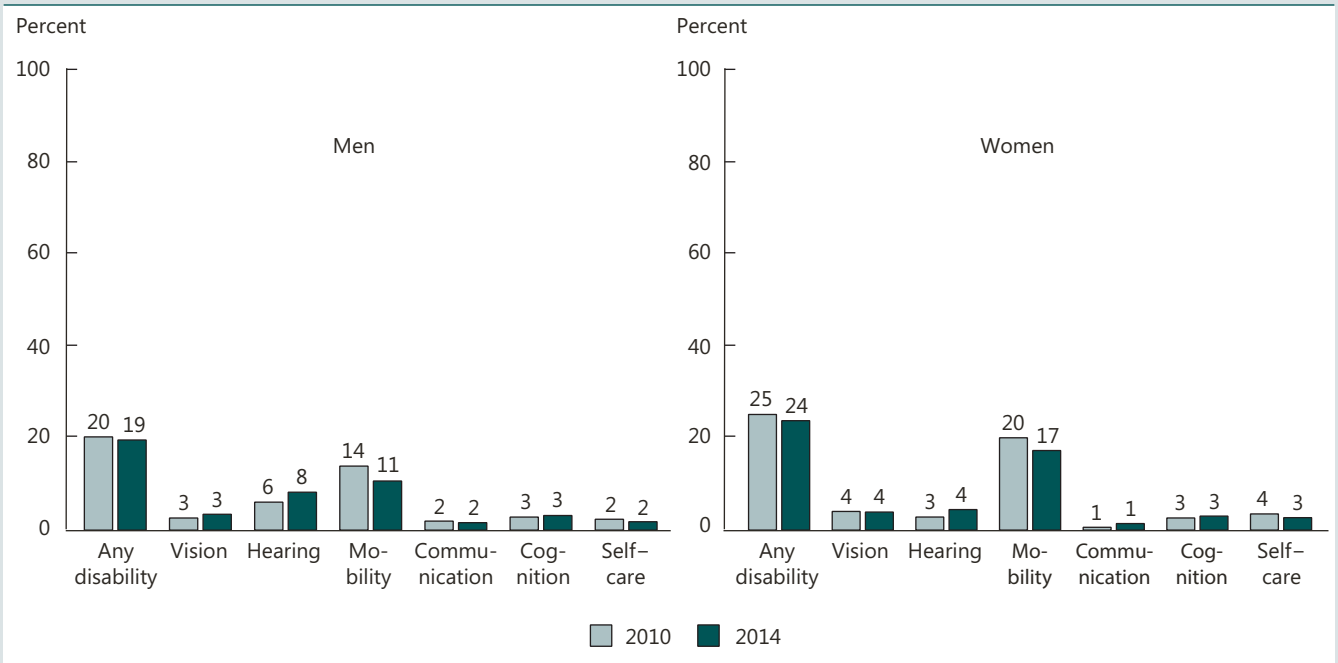
- The prevalence of depressive symptoms varies by age. In 2014, the proportion of people age 51 and over with clinically relevant symptoms was higher for the younger age group (17 percent among those ages 51–54) and the older age group (15 to 16 percent among those age 80 and over) than for people ages 65–79 (10 to 13 percent).
- In 2014, the percentage of men 85 and over (14 percent) reporting clinically relevant depressive symptoms was almost twice that of men in their 70s (about 8 percent), and was slightly higher than those in their 50s and 60s (roughly 12 percent). Prevalence of clinically relevant depressive symptoms among women age 51 and over shows a clear U-shaped pattern, with the highest rates among those ages 51–54 (21 percent) and those ages 80–84 (19 percent).

Data for this indicator's charts and bullets can be found in Tables 21a and 21b on page 120.

INDICATOR 22: **Functional Limitations**

As people age, illness or injury may result in disability, including limitations in vision, hearing, mobility, communication, cognition, or self-care. These changes may have important implications for work and retirement policies, health and long-term care needs, and policies affecting the built environment, all of which affect the well-being of the older population and the ability to fully and independently participate in society.

Percentage of people age 65 and over with a disability, by sex and functional domain, 2010 and 2014



NOTE: Disability is defined as "a lot" or "cannot do/unable to do" when asked about difficulty with seeing, even if wearing glasses (vision); hearing, even if wearing hearing aids (hearing); walking or climbing steps (mobility); communicating, for example, understanding or being understood by others (communication); remembering or concentrating (cognition); and self-care, such as washing all over or dressing (self-care). Any disability is defined as having difficulty with at least one of these activities. The data source and measures presented have changed from previous editions of *Older Americans.* Data labels in this chart are based on rounded values.

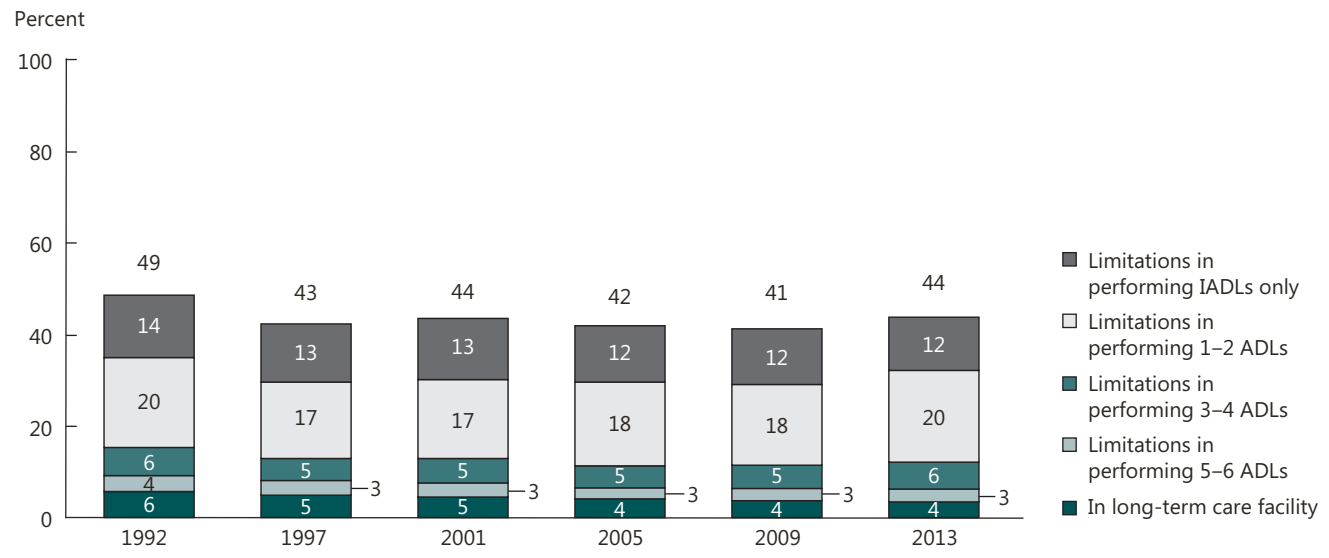
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- In 2014, 22 percent of the population age 65 and over reported having a disability as defined by limitations in vision, hearing, mobility, communication. cognition, and self-care. Women were more likely to report any disability than men (24 percent versus 19 percent).
- Difficulties with mobility (walking or climbing stairs) were the most commonly reported disability for those age 65 and over in 2014 (17 percent of women and 11 percent of men).
- Between 2010 and 2014, the percentage of the total population age 65 and over with hearing difficulties increased, while the percentage with mobility difficulties decreased.
- Disability increases with age. In 2014, 42 percent of people age 85 and over reported any disability, compared with 17 percent of people ages 65–74. People age 85 and over also had higher levels of disability than people ages 65–74 in all the individual domains of functioning.
- Non-Hispanic Blacks age 65 and over were more likely to report having any disability than non-Hispanic Whites (26 percent compared with 21 percent). The percentage of those age 65 and over reporting difficulties with cognition and self-care was higher among Hispanics compared with non-Hispanic Whites (6 percent versus 3 percent, and 5 percent versus 2 percent, respectively).

Difficulties performing activities of daily living (ADLs), such as bathing, dressing, and toileting, and instrumental activities of daily living (IADLs), such as housework, shopping, and managing money, affect the ability to live independently. Tracking these changes over time is helpful to planning for the care needs of the older population.

Percentage of Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, selected years 1992–2013



NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has three or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. Limitations in performing activities of daily living (ADL) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Limitations in performing instrumental activities of daily living (IADL) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Percentages are age adjusted using the 2000 standard population. Estimates may not sum to the totals because of rounding.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

- In 2013, 44 percent of people age 65 and over enrolled in Medicare reported limitations in activities of daily living, instrumental activities of daily living, or were living in a long-term care facility. Roughly 12 percent had difficulty performing one or more IADLs but had no ADL limitations. Approximately 29 percent had difficulty performing at least one ADL, and 4 percent were in a facility.
- The age-adjusted proportion of people age 65 and over with limitations in activities of daily living, instrumental activities of daily living, or who were living in a long-term care facility was lower in 2013 than in 1997 (44 percent compared with 49 percent). There was a decrease in the percentage with limitations from 1992 to 1996. From 1996 to 2013, the overall percentages did not significantly change, although a smaller proportion of this population was in a facility than in earlier years.
- Women reported higher levels of limitations than men. In 2013, about 49 percent of female Medicare beneficiaries age 65 and over had difficulty performing ADLs or IADLs, or were in a long-term care facility, compared with 37 percent of male Medicare beneficiaries in this age group.
- Levels of limitation varied by age. Among Medicare beneficiaries age 85 and over, 74 percent had difficulty performing ADLs or IADLs or were in a long-term care facility, compared with 48 percent of people ages 75–84 and 34 percent of people ages 65–74.

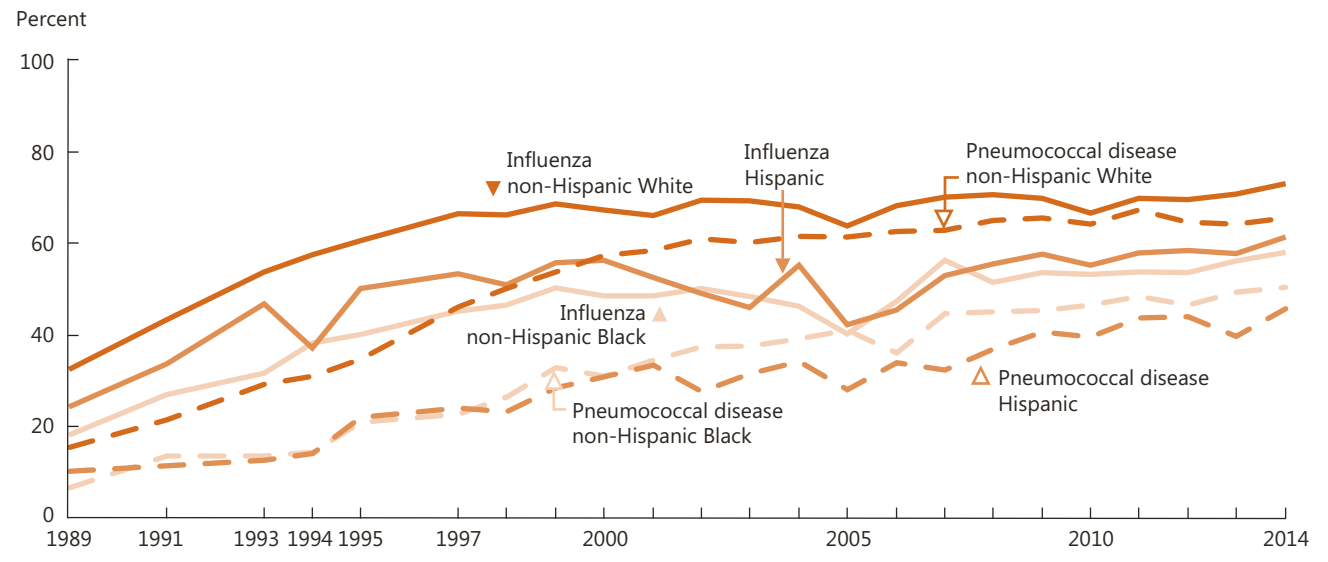
Data for this indicator's charts and bullets can be found in Tables 22a through 22e on pages 121–123.

Health Risks and Behaviors

INDICATOR 23: **Vaccinations**

Vaccinations against influenza and pneumococcal disease are recommended for older Americans, who are at increased risk for these diseases and their complications as they age.[21,22,23] Influenza (flu) vaccinations are given annually, and pneumococcal (pneumonia) vaccinations are usually given once or twice in a lifetime.

Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, selected years 1989–2014



NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months. Beginning with data from 2005, receipt of nasal spray flu vaccine is included in the estimate of flu vaccinations. For pneumococcal disease, the percentage refers to people who reported ever having a pneumonia vaccination. Questions concerning the use of influenza and pneumonia vaccinations differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States, 2015* Appendix II. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey. Some data for 2005–2010 have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

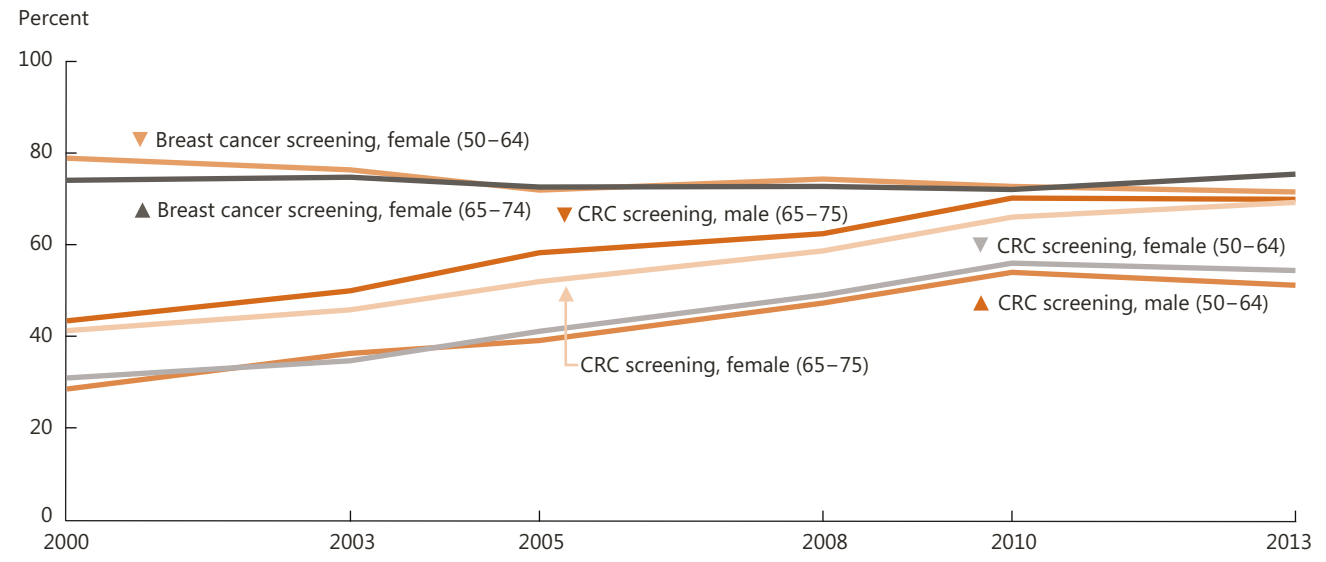
- In 2014, 70 percent of people age 65 and over reported receiving a flu shot in the past 12 months; however, there were differences by race and ethnicity. About 72 percent of non-Hispanic Whites reported receiving a flu shot, compared with 57 percent of non-Hispanic Blacks and 61 percent of Hispanics.
- In 2014, about 61 percent of people age 65 and over had ever received a pneumonia vaccination. Despite increases in the rates for all groups over time, non-Hispanic Whites (65 percent) were more likely to have received a pneumonia vaccination in 2014 than non-Hispanic Blacks (50 percent) or Hispanics (45 percent).
- The percentage of older people receiving vaccinations increased with age. In 2014, about 78 percent of persons age 85 and over had received a flu shot, compared with 73 percent of persons age 75–84 and 67 percent of persons age 65–74. In that same year, 69 percent of persons 85 and over had ever received a pneumonia vaccination compared with 56 percent of persons age 65–74.
- In 2014, people age 65 and over who had not graduated from high school were less likely to be vaccinated against both flu and pneumonia than were people who had more education (64 percent versus 72 percent for the flu vaccination and 55 percent versus 63 percent for the pneumonia vaccination).

Data for this indicator's charts and bullets can be found in Tables 23a and 23b on page 124.

INDICATOR 24: **Cancer Screenings**

Health care services and screenings can help prevent disease or detect it at an early, treatable stage. The U.S. Preventive Services Task Force recommends colorectal cancer screenings for people ages 50–75 and breast cancer screenings (i.e., mammography) for women ages 50–74.[24,25]

Percentage of women ages 50–74 who had breast cancer screening and percentage of people age 50–75 who had colorectal cancer (CRC) screening, by sex and age group, selected years, 2000–2013



NOTE: Breast cancer screening is defined as reporting having had a mammogram in the last 2 years. Colorectal cancer screening (CRC) is defined as reporting a fecal occult blood test (FOBT) in the past year, a sigmoidoscopy procedure in the past 5 years with FOBT in the past 3 years, or a colonoscopy in the past 10 years. Questions concerning use of CRC screening and mammography differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States, 2015,* Appendix II. Breast cancer screening is reported for women ages 50–74, and CRC screening is reported for men and women ages 50–75.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- The percentage of people ages 50–75 who received colorectal cancer screening increased from 2000 to 2013. The percentage increased for both men and women.
- In 2013, the percentage receiving colorectal cancer screening was higher among people ages 65–75 than among people ages 50–64 (70 percent versus 51 percent for men and 69 percent versus 54 percent for women).
- Women ages 50–64 were slightly more likely than men of the same age to have received colorectal cancer screening in 2013 (54 percent versus 51 percent). There were no differences by sex among people ages 65–75.
- The percentage of women ages 50–64 who received a mammogram in the past 2 years declined from 2000 to 2013 (79 percent versus 71 percent). There were no significant changes in the percentage of women ages 65–74 receiving a mammogram.
- A higher proportion of women in 2013 received a mammogram in the past 2 years than met colorectal cancer screening guidelines. For example, 71 percent of women ages 50–64 received a mammogram compared with 54 percent who met colorectal cancer screening guidelines.

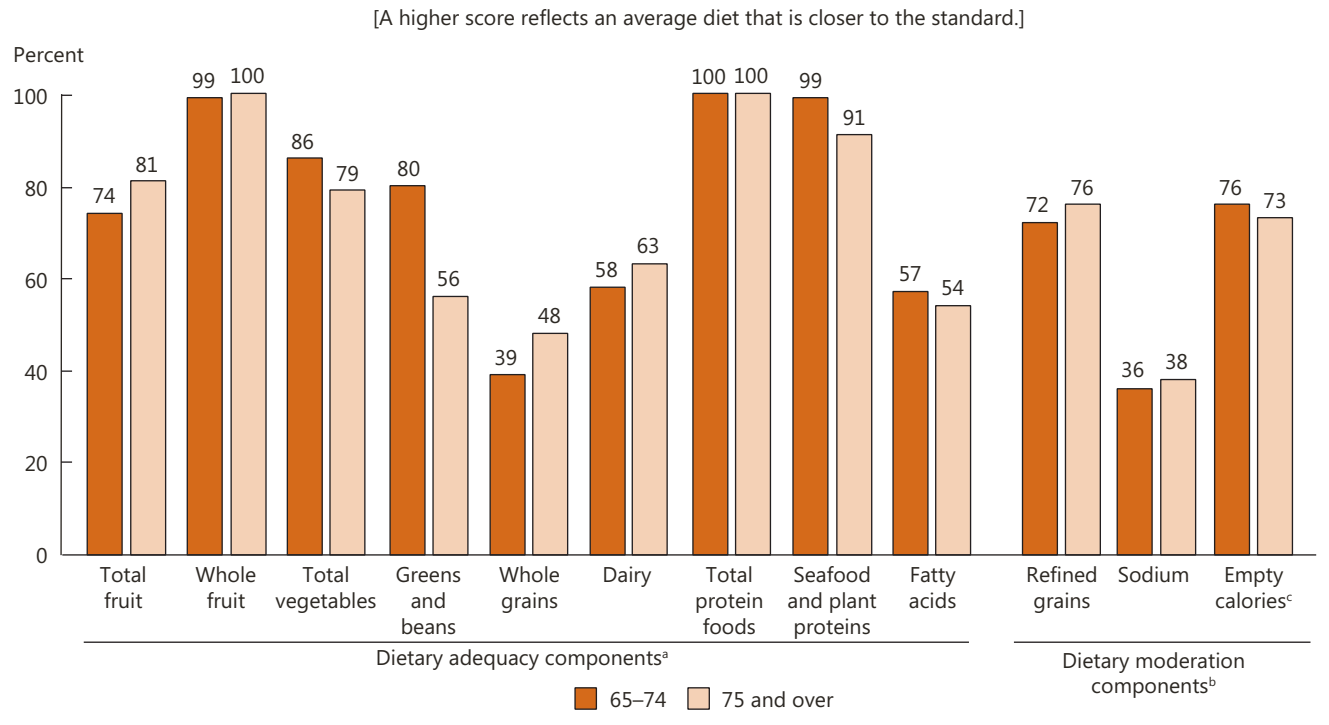
Data for this indicator's charts and bullets can be found in Table 24 on page 125.

INDICATOR 25: **Diet Quality**

The majority of older Americans report a variety of chronic health conditions,[26] many of which are related to poor quality diet. Healthy eating helps to prevent and reduce risk for many of the most common chronic conditions including hypertension, heart disease, diabetes, osteoporosis, some cancers and obesity.[27,28] Among older adults, healthy eating is also associated with a sense of well-being and improved quality of life.[27,28,29,30] The Healthy Eating Index (HEI) provides a comprehensive analytic approach to characterizing complex diets and allows researchers to make associations between total diet and health outcomes.

The HEI-2010[31] has 12 components, nine of which are adequacy components and three are moderation components. Intakes of the various components of a healthy diet that are equal to or better than the standards set for each component are assigned a maximum score. A higher score indicates a higher quality diet that aligns with the *2010 Dietary Guidelines for Americans.* Scores are averaged across all adults based on usual dietary intakes.

Healthy Eating Index-2010 average component scores expressed as a percentage of the HEI maximum score for the population age 65 and over, by age group, 2011–2012



[a] Higher scores reflect higher intakes.
[b] Higher scores reflect lower intakes.
[c] Empty calories are calories from solid fats (i.e., sources of saturated fats and trans fats) and added sugars (i.e., sugars not naturally occurring).
Reference population: These data refer to the resident noninstitutionalized population.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, and U.S. Department of Agriculture, Center for Nutrition Policy and Promotion, and National Cancer Institute. Healthy Eating Index-2010.

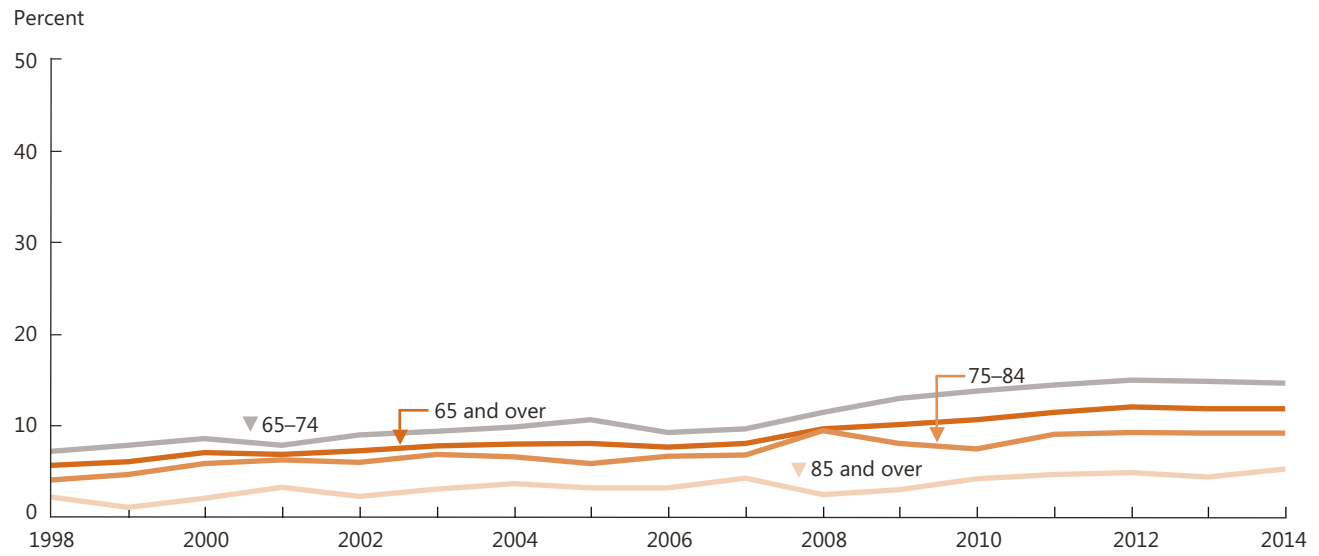
- During 2011–2012, total HEI-2010 scores for age groups age 65 and over, 65–74, and 75 and over were 68.3, 68.4, and 67.8, respectively.
- Older Americans age 75 and over, met the dietary recommendations for whole fruits, while Americans from the age groups 65 and over, 65–74, and 75 and over met the dietary recommendations for total protein foods.
- The diet quality of older Americans can better align with the *2010 Dietary Guidelines for Americans* by increasing dietary intakes of whole grains, vegetables and legumes, fat-free or low-fat milk products, and foods and beverages that are lower in sodium and have fewer calories from solid fats and added sugars.

Data for this indicator's charts and bullets can be found in Table 25 on page 126.

INDICATOR 26: **Physical Activity**

Physical activity is important for people of all ages. It improves overall health and reduces the risk of many health problems.[32] For older adults, exercise can reduce the risk of certain chronic diseases and may offer psychological and cognitive benefits.[33] Physical activity can reduce pain and improve functioning.[34] Exercise is recommended as an intervention to prevent falls in older adults.[35]

Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the 2008 Federal physical activity guidelines, by age group, 1998–2014



NOTE: This measure of physical activity reflects the 2008 Federal physical activity guidelines for Americans (available from: http://www.health.gov/PAGuidelines/). The 2008 Federal guidelines recommend that adults age 65 and over who are fit and have no limiting chronic conditions perform at least 150 minutes (2 hours and 30 minutes) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) a week of vigorous-intensity aerobic physical activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. Aerobic activity should be performed in episodes of at least 10 minutes, and preferably, it should be spread throughout the week. In addition, they should perform muscle-strengthening activities that are moderate or high intensity and involve all major muscle groups on two or more days a week, because these activities provide additional health benefits. The measure shown here presents the percentage of people who fully met both the aerobic activity and muscle-strengthening guidelines, irrespective of their chronic condition status.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

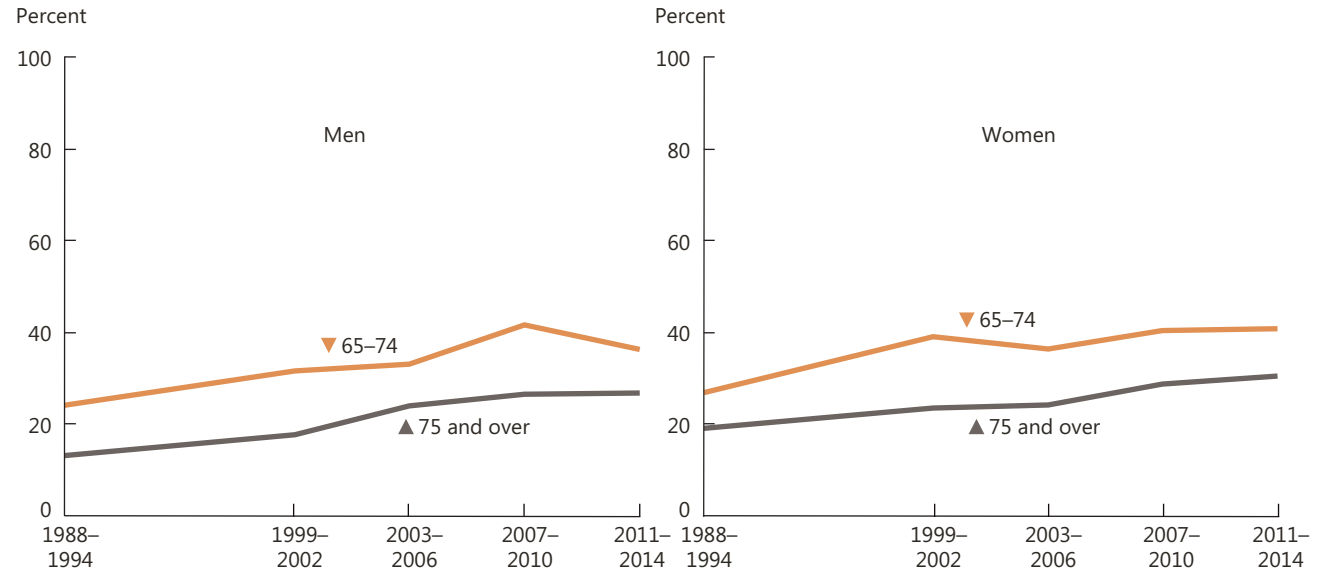
- In 2014, about 12 percent of people age 65 and over reported participating in leisure-time aerobic and muscle-strengthening activities that met the 2008 Federal physical activity guidelines. The percentage of older people meeting the physical activity guidelines decreased with age, ranging from 15 percent among people ages 65–74 to 5 percent among people age 85 and over.
- Men age 65 and over were more likely than women in the same age group to meet the physical activity guidelines in 2014 (15 percent versus 9 percent). Non-Hispanic Whites age 65 and over reported higher levels of physical activity than their non-Hispanic Black and Hispanic counterparts (13 percent compared with 9 percent and 7 percent, respectively).
- The percentage of older Americans meeting the 2008 Federal physical activity guidelines increased over time. In 1998, about 6 percent of people age 65 and over met the guidelines, compared with 12 percent in 2014.
- Although only 12 percent of people age 65 and over met the guidelines for both aerobic and muscle-strengthening activities in 2014, 37 percent met the guidelines for aerobic activity and 17 percent met the guidelines for muscle-strengthening activities that year.

Data for this indicator's charts and bullets can be found in Tables 26a and 26b on pages 127–128.

INDICATOR 27: **Obesity**

Obesity is a major cause of preventable disease and premature death.[36] It is associated with increased risk of coronary heart disease; Type 2 diabetes; endometrial, colon, postmenopausal breast, and other cancers; asthma and other respiratory problems; osteoarthritis; and disability.[37,38]

Percentage of people age 65 and over with obesity, by sex and age group, selected years, 1988–2014



NOTE: Data are based on measured height and weight. Height was measured without shoes. Obese is defined by a BMI of 30 kilograms/meter^2 or greater. The percentage of people with obesity is a subset of the percentage of those who are overweight. See glossary for the definition of BMI. Beginning in 1999, the National Health and Nutrition Examination Survey has been in the field continuously with data released every 2 years. Two survey cycles are often combined to create increased sample size, especially for subgroup estimates. Some data have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey.

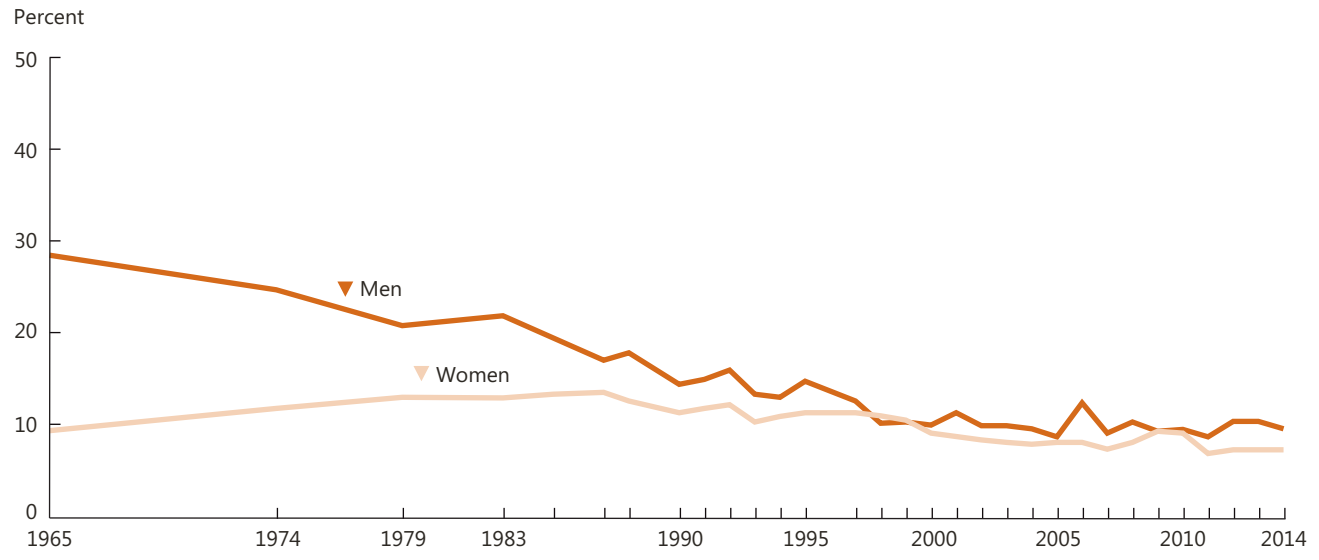
- As with other age groups, the percentage of people age 65 and over with obesity increased since 1988–1994. In 2011–2014, about 35 percent of people age 65 and over had obesity, compared with 22 percent in 1988–1994.
- In 2011–2014, approximately 41 percent of women ages 65–74 and 31 percent of women age 75 and over had obesity. This is an increase from 1988–1994, when 27 percent of women ages 65–74 and 19 percent of women age 75 and over had obesity.
- Older men followed similar trends. About 24 percent of men ages 65–74 and 13 percent of men age 75 and over had obesity in 1988–1994, compared with 36 percent of men ages 65–74 and 27 percent of men age 75 and over in 2011–2014.
- Over the past 15 years between 1999–2002 and 2011–2014, there has been an increase in the prevalence of obesity for both men and women.

Data for this indicator's charts and bullets can be found in Table 27 on page 129.

INDICATOR 28: **Cigarette Smoking**

Smoking affects nearly every organ of the body; it causes diminished health status and diseases such as cancer, cardiovascular disease, and chronic obstructive lung diseases.[39]

Percentage of people age 65 and over who are current cigarette smokers, by sex, selected years, 1965–2014



NOTE: Questions concerning cigarette smoking differed slightly on the National Health Interview Survey across the years for which data are shown. Data starting in 1997 are not strictly comparable with data for earlier years due to the 1997 National Health Interview Survey (NHIS) questionnaire redesign. For details, see *Health, United States, 2015,* Appendix II.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

- The percentage of people age 65 and over who were current cigarette smokers declined between 1965 and 2014, with larger declines among men than women. Levels of cigarette smoking have been stable in the past decade. In 2014, 10 percent of men and 8 percent of women age 65 and over were current smokers.
- In 2014, the percentage of older men who were current smokers was higher among Blacks than Whites (14 percent versus 9 percent). The percentages for older women were similar for Whites and Blacks (both were 8 percent).
- A large percentage of both men and women age 65 and over were former smokers. In 2014, about 50 percent of older men previously smoked cigarettes, while 30 percent of women age 65 and over were former smokers.
- The percentage of people age 65 and over who were current smokers was higher among those that lived below the poverty threshold than among those with incomes above the poverty threshold. In 2014, 14 percent of people age 65 and over with incomes less than 100 percent of the poverty threshold were current smokers, compared with 7 percent of people in the 200 percent or more of poverty threshold income category.

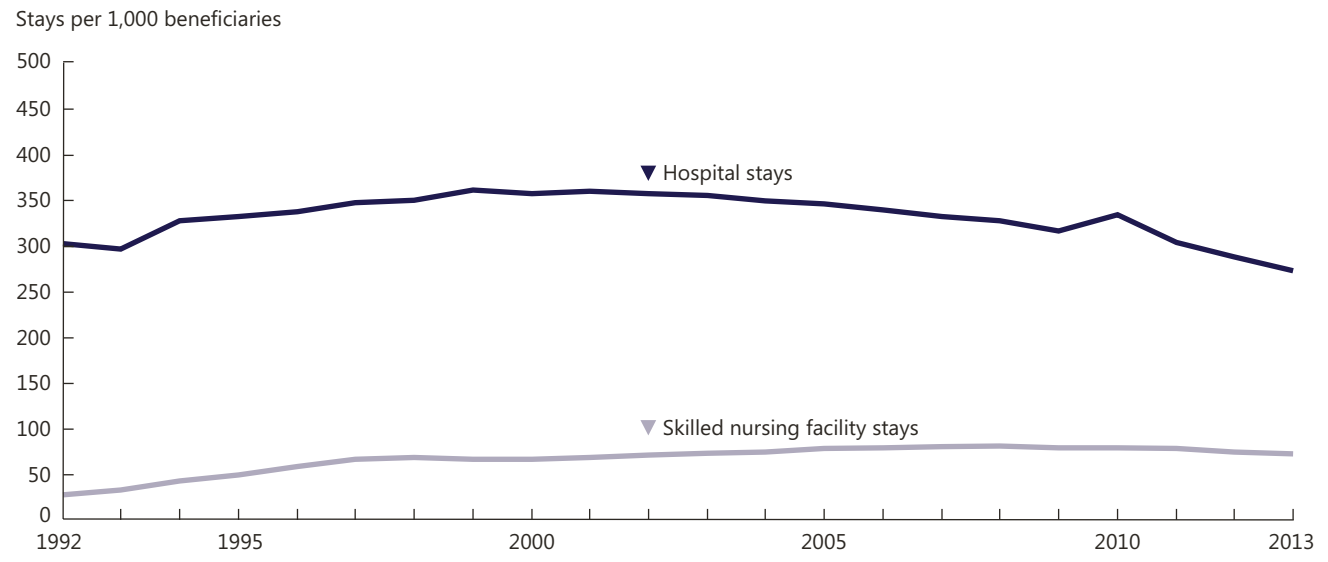
Data for this indicator's charts and bullets can be found in Tables 28a through 28c on pages 130–131.

Health Care

INDICATOR 29: **Use of Health Care Services**

Most older Americans have health insurance through Medicare. Medicare covers a variety of services, including inpatient hospital care, physician services, hospital outpatient care, home health care, skilled nursing facility care, hospice services, and (beginning in January 2006) prescription drugs. Utilization rates for many services change over time because of changes in physician practice patterns, medical technology, Medicare payment amounts, and patient demographics.

Medicare-covered hospital and skilled nursing facility stays per 1,000 Medicare beneficiaries age 65 and over in fee-for-service, 1992–2013



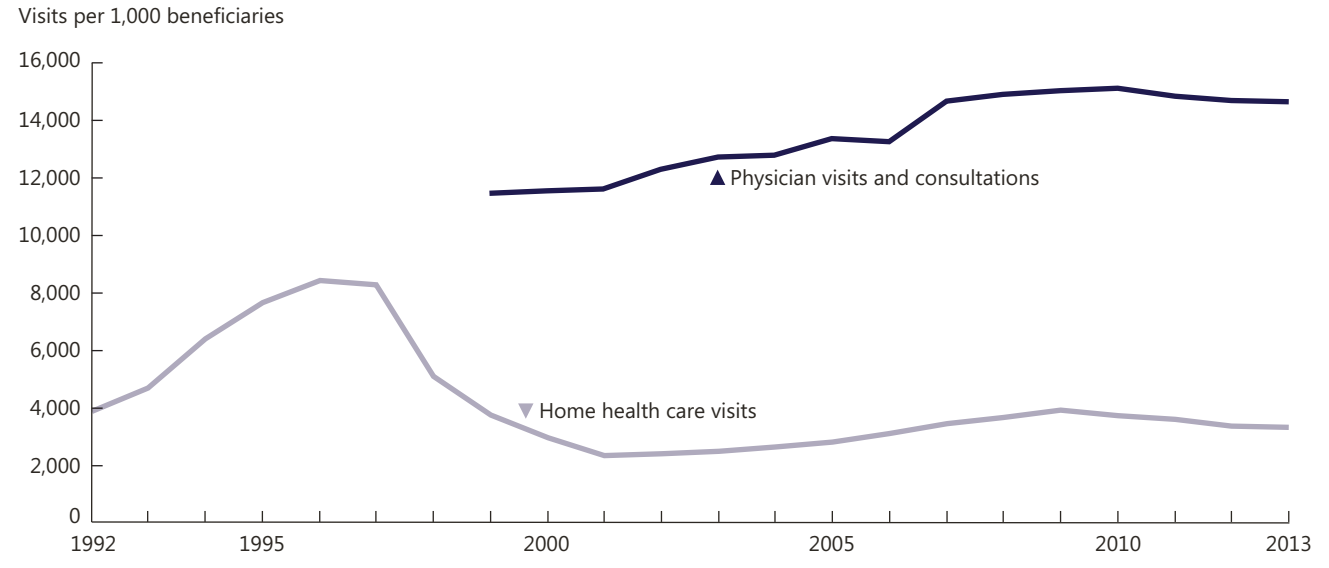
NOTE: Data are for Medicare beneficiaries in fee-for-service only. Beginning in 1994, managed care beneficiaries were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care beneficiaries were included in the denominators; they made up 7 percent or less of the Medicare population. See glossary for definition of fee-for-service.

Reference population: These data refer to the Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

- Between 1992 and 1999, the hospitalization rate increased from 306 hospital stays per 1,000 Medicare beneficiaries to 365 per 1,000. After 1999, the rate decreased until 2009 and then increased slightly to 338 per 1,000 beneficiaries in 2010. Since 2010, the rate has continued to decrease, reaching 276 per 1,000 beneficiaries in 2013. The average length of a hospital stay decreased from 8.4 days in 1992 to 5.3 days in 2013.
- Skilled nursing facility stays increased from 28 per 1,000 Medicare beneficiaries in 1992 to 80 per 1,000 in 2010. Much of the increase occurred from 1992 to 1997. The number of skilled nursing facility stays has dropped slightly after 2011, decreasing to 73 per 1,000 beneficiaries in 2013.

Medicare-covered physician and home health care visits per 1,000 Medicare beneficiaries age 65 and over in fee-for-service, 1992–2013



NOTE: Data are for Medicare beneficiaries in fee-for-service only. Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. The database used to generate rates of physician visits and consultations in previous *Older Americans* reports is no longer available. This chart uses two different databases based on the availability of data to estimate rates of physician visits and consultations. The first database provides data that begins with 1999 data through 2006 and the second database provides data beginning with 2007. As a result, some data for 2007–2009 have been revised and differ from previous editions of *Older Americans.* Beginning in 1994, managed care beneficiaries were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care beneficiaries were included in the denominators; they made up 7 percent or less of the Medicare population. See glossary for definition of fee-for-service.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

- The number of physician visits and consultations increased from 11,395 per 1,000 Medicare beneficiaries in 1999 to 14,587 per 1,000 Medicare beneficiaries in 2013.
- The number of home health care visits increased from 3,822 per 1,000 Medicare beneficiaries in 1992 to 8,376 per 1,000 Medicare beneficiaries in 1996. Home health care use increased during this period in part because of an expansion in the coverage criteria for the Medicare home health care benefit.[40] Home health care visits declined after 1997 to 2,295 per 1,000 beneficiaries in 2001. The decline coincided with changes in Medicare payment policies for home health care resulting from implementation of the Balanced Budget Act of 1997. Since 2001, the visit rate increased to 3,864 per 1,000 beneficiaries in 2009 and has declined since that time to 3,276 per 1,000 beneficiaries in 2013.
- Use of skilled nursing facility and home health care increased with age. In 2013, there were about 67 skilled nursing facility stays per 1,000 Medicare beneficiaries ages 65–74, compared with about 204 per 1,000 beneficiaries age 85 and over. Home health care agencies made 1,475 visits per 1,000 beneficiaries ages 65–74, compared with 8,604 visits per 1,000 beneficiaries for those age 85 and over.

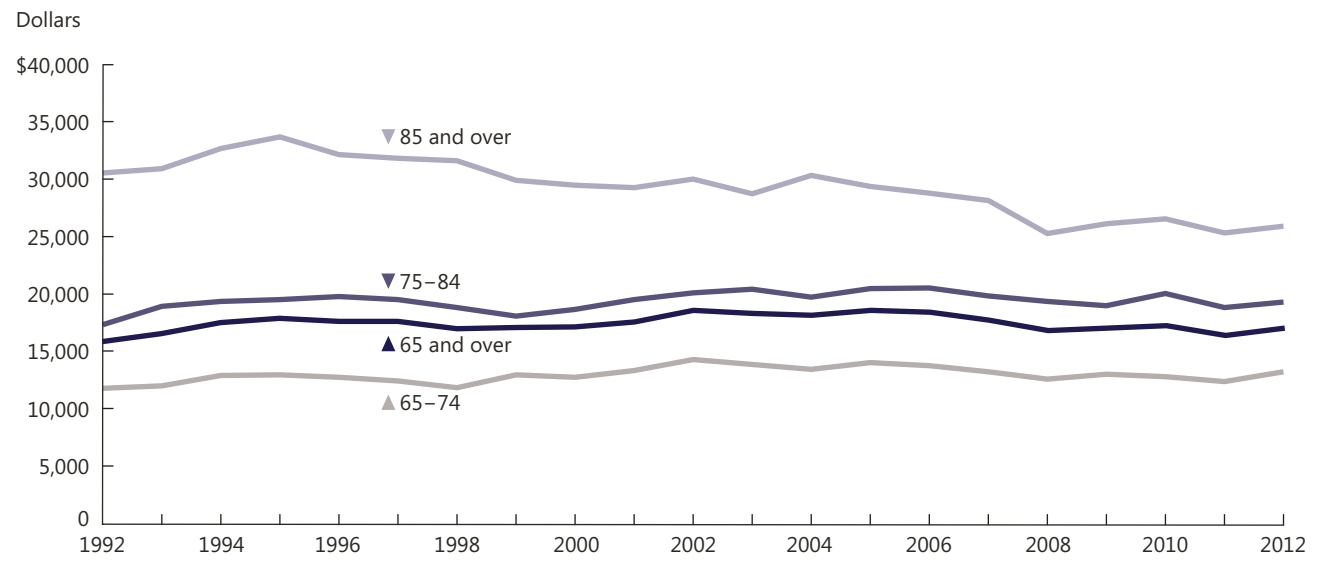
Data for this indicator's charts and bullets can be found in Tables 29a and 29b on page 132.

INDICATOR 30: **Health Care Expenditures**

Health care costs per capita for the oldest Medicare beneficiaries (age 85 and over) are higher than for any other age group but have remained relatively stable over time. Health care costs per capita, however, for those ages 65–74 did increase between 1992 and 2012.

Health care costs post a major concern for older Americans. Among Medicare beneficiaries age 65 and over, these costs vary by demographic characteristics such as income, health status, and access to health care. On average, individuals with no chronic health conditions incur lower health care costs. The percentage of Medicare beneficiaries reporting difficulty obtaining health care remains low.

Average annual health care costs, in 2012 dollars, for Medicare beneficiaries age 65 and over by age group, 1992–2012



NOTE: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation adjusted to 2012 using the Consumer Price Index (Series CPI-U-RS). Some data have been revised from previously published figures as a result of a CPI adjustment.
Reference population: These data refer to Medicare beneficiaries.
SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

- After adjusting for inflation, annual health care costs per capita increased slightly among those ages 65–74 between 1992 and 2012.
- Average annual costs were substantially higher for Medicare beneficiaries age 85 and over compared with those in other age groups.
- Average annual health care costs for Medicare beneficiaries varied by demographic characteristics. In 2012, low-income individuals incurred higher health care costs; those with less than $10,000 in income averaged $24,596 in health care costs, whereas those with more than $30,000 in income averaged only $14,687.
- Access to health care is determined by a variety of factors related to the cost, quality, and availability of health care services. The percentage of older Americans who reported they delayed getting care because of cost declined from about 10 percent in 1992 to about 5 percent in 1997 and remained relatively constant thereafter, fluctuating between 4 and 6 percent. The percentage of Medicare beneficiaries who reported difficulty obtaining health care fluctuated between 2 and 3 percent.

Health care costs can be broken down among different types of goods and services. The amount of money older Americans spend on health care and the type of health care that they receive provide an indication of the health status and needs of older Americans in different age and income groups.

Percentage distribution of annual health care costs among Medicare beneficiaries age 65 and over, by major cost component, 2008 and 2012

NOTE: Data include both out-of-pocket costs and costs covered by insurance. Dollars are not inflation adjusted. Estimates may not sum to the totals because of rounding.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

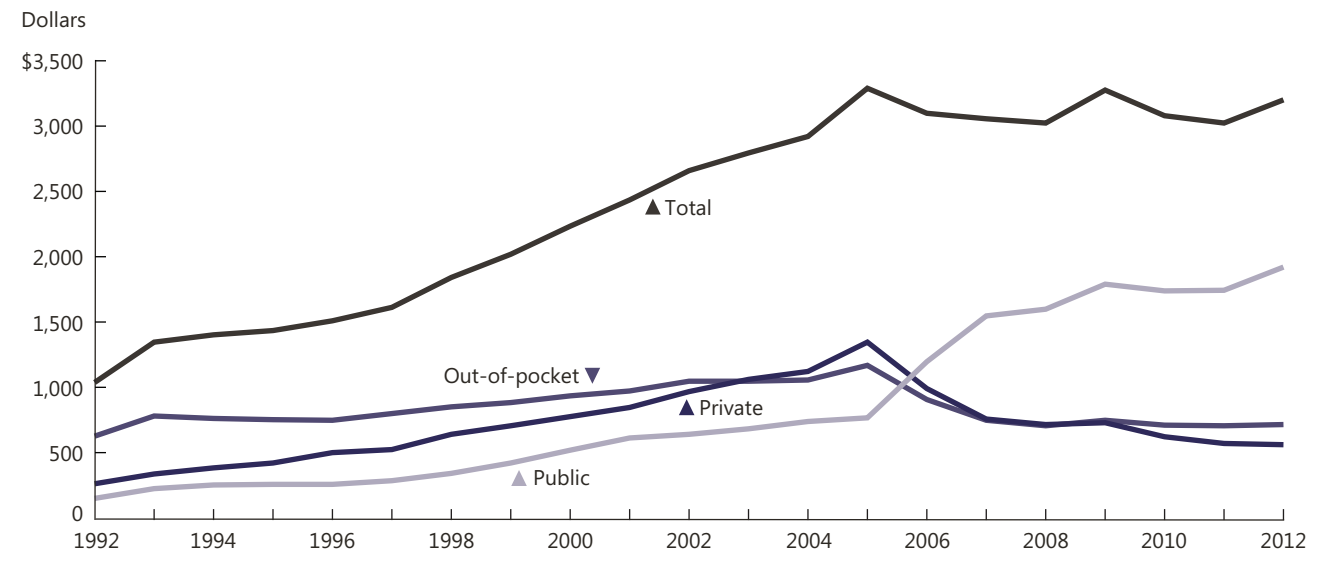
- The percentage distribution of health care services remained relatively constant between 2008 and 2012.
- Outpatient hospital and physician services were the largest components of health care costs, accounting for 35 percent of total health care costs in 2012. In the same year, long-term care facilities accounted for 12 percent of total costs, and prescription drugs accounted for 17 percent of health care costs.
- Inpatient hospital care accounted for 22 percent of total costs in 2012. "Other" costs (short-term institutions, hospice, and dental care) constituted 10 percent of total costs.
- The mix of services varied with age. In 2012, the biggest difference occurred for long-term care facility services: average costs were $7,175 among Medicare beneficiaries age 85 and over, compared with just $718 among Medicare beneficiaries ages 65–74. Costs of home health care and "other" services were also higher at older ages.

Data for this indicator's charts and bullets can be found in Tables 30a through 30e on pages 133–135.

INDICATOR 31: **Prescription Drugs**

Prescription drug costs have increased rapidly in recent years as more new drugs become available. Lack of prescription drug coverage has created a financial hardship for many older Americans. Medicare coverage of prescription drugs began in January 2006—including a low-income subsidy for beneficiaries with low incomes and assets.

Average prescription drug costs, in 2012 dollars, among noninstitutionalized Medicare beneficiaries age 65 and over, by sources of payment, 1992–2012



NOTE: Dollars have been inflation adjusted to 2012 using the Consumer Price Index (Series CPI-U-RS). Some data have been revised from previously published figures as a result of a CPI adjustment. Reported costs have been adjusted to account for underreporting of prescription drug use. The adjustment factor changed in 2006 with the initiation of the Medicare Part D prescription drug program. Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other State and Federal programs.

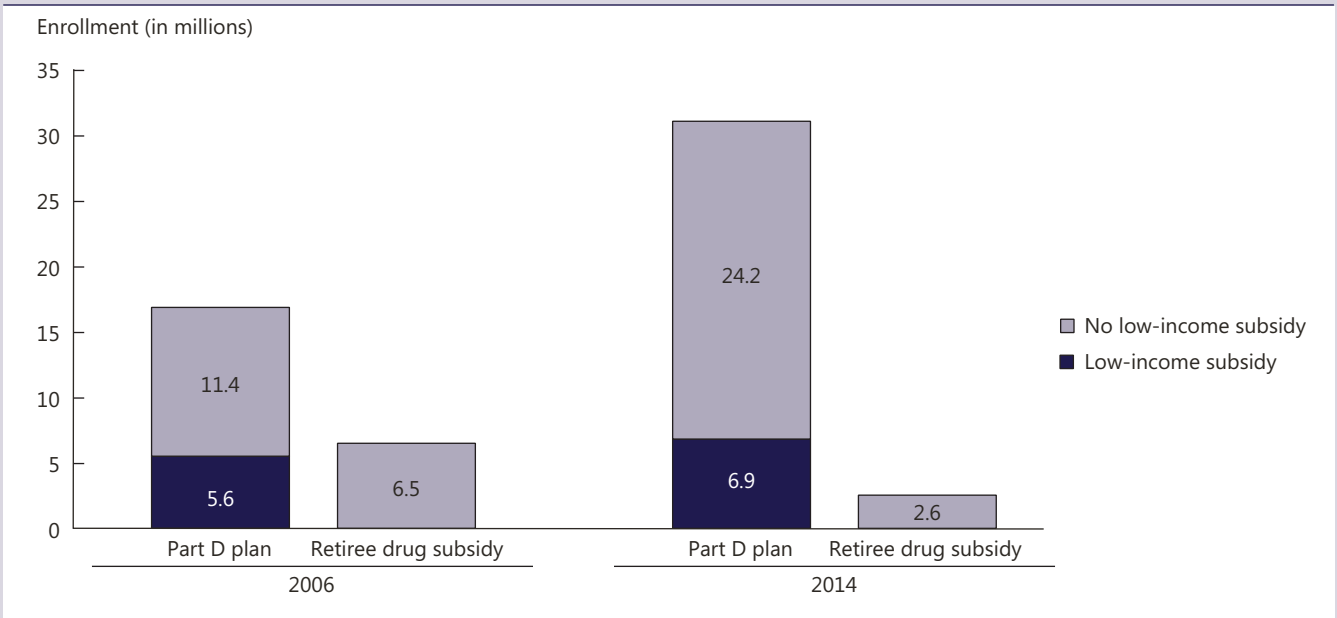
Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

- Average prescription drug costs for noninstitutionalized Americans age 65 and over increased rapidly for many years but were relatively stable from 2005 to 2012. The average costs per person were $3,201 in 2012.
- Average out-of-pocket spending and costs covered by private insurance decreased after the introduction of the Medicare Part D prescription drug program in 2006. There was a corresponding increase in drug costs covered by public insurance. Older Americans paid about 60 percent of prescription drug costs out of pocket in 1992, compared with about 22 percent in 2012. Private insurance covered 18 percent of prescription drug costs for noninstitutionalized older Americans in 2012 and public programs covered about 60 percent.
- Prescription drug costs varied significantly among individuals. In 2012, approximately 5 percent of noninstitutionalized older Americans incurred no prescription drug costs compared with about 18 percent who incurred costs of $5,000 or more.
- Chronic conditions are associated with higher prescription drug costs. In 2012, older Americans with no chronic conditions incurred average prescription drug costs of $1,389. Those with five or more chronic conditions incurred $8,263 in prescription drug costs, on average.

Under Medicare Part D, beneficiaries may join a stand-alone prescription drug plan or a Medicare Advantage plan that provides prescription drug coverage in addition to other Medicare-covered services. In situations where beneficiaries receive drug coverage from a former employer, the former employer may be eligible to receive a retiree drug subsidy from Medicare to help cover the cost of the drug benefit.

Number of Medicare beneficiaries age 65 and over who enrolled in Part D prescription drug plans or who were covered by retiree drug subsidy payments, 2006 and 2014



NOTE: Some data for 2006 have been revised and differ from previous editions of *Older Americans.*
Reference population: These data refer to Medicare beneficiaries.
SOURCE: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

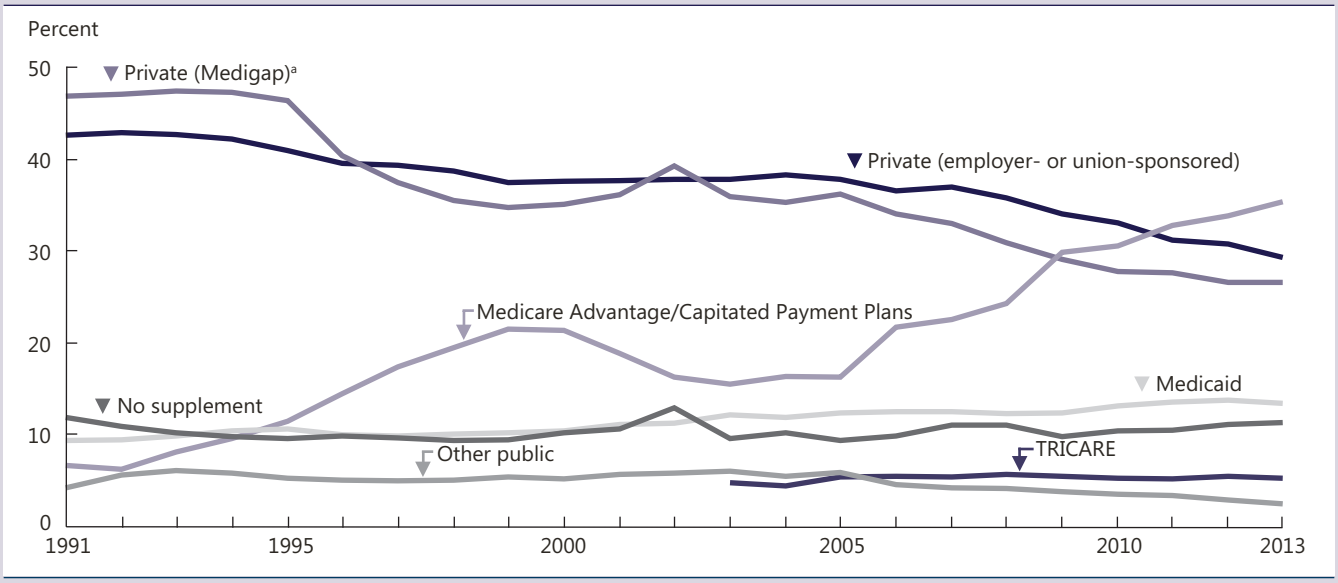
- The number of Medicare beneficiaries age 65 and over enrolled in Part D prescription drug plans increased from 16.9 million (46 percent of beneficiaries) in 2006 to 31.1 million (69 percent of beneficiaries) in 2014. In 2014, 61 percent of Part D beneficiaries were enrolled in stand-alone plans and 39 percent were in Medicare Advantage plans. Approximately 2.6 million beneficiaries age 65 and over were covered by the retiree drug subsidy in 2014. About 11.7 million beneficiaries who were not in Part D plans and were not covered by the retiree drug subsidy in 2014 either had drug coverage through another source (e.g., TRICARE, Federal Employees Health Benefits plan, Department of Veterans' Affairs, current employer) or did not have drug coverage.
- In 2014, 6.9 million Part D beneficiaries were receiving low-income subsidies. Many of these beneficiaries had drug coverage through the Medicaid program prior to enrollment in Part D.

Data for this indicator's charts and bullets can be found in Tables 31a through 31d on pages 136–137.

INDICATOR 32: **Sources of Health Insurance**

Medicare is the primary insurance provider for all eligible beneficiaries over age 65. Medicare covers mostly acute care services and requires beneficiaries to pay part of the cost, leaving about half of health spending to be covered by other sources. Many beneficiaries have supplemental insurance to fill these gaps and to pay for services not covered by Medicare. Prior to 2006, many beneficiaries received prescription drug coverage through supplemental insurance. Since January 2006, beneficiaries have had the option of receiving prescription drug coverage under Medicare through stand-alone prescription drug plans or through some Medicare Advantage health plans.

Percentage of noninstitutionalized Medicare beneficiaries age 65 and over with supplemental health insurance, by type of insurance, 1991–2013



[a] Includes people with private supplement of unknown sponsorship.

NOTE: Medicare Advantage/Capitated Payment Plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and private fee-for-service (PFFS) plans. Not all types of plans were available in all years. Since 2003, these types of plans have been known collectively as Medicare Advantage and/or Medicare Part C. Estimates are based on beneficiaries' insurance status in the fall of each year. Categories are not mutually exclusive (i.e., individuals may have more than one supplemental policy). Chart excludes beneficiaries whose primary insurance is not Medicare (approximately 1 to 3 percent of beneficiaries). Medicaid coverage was determined from both survey responses and Medicare administrative records. TRICARE coverage was added to Medicare Current Beneficiary Survey Access to Care files beginning in 2003. Previous versions of *Older Americans* did not include data on TRICARE coverage. Adding TRICARE coverage changes the percentage of beneficiaries in the "No supplement" group. Some data for 2009 have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

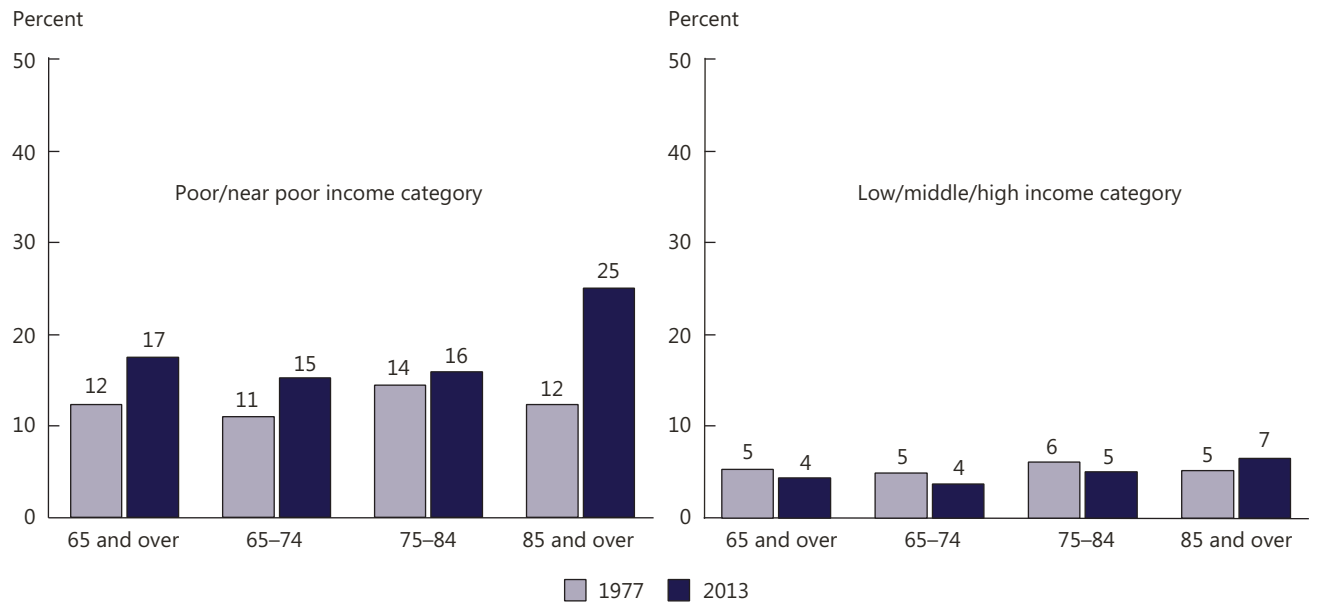
- Most Medicare beneficiaries have a private insurance supplement, either provided by a former employer or purchased as a Medigap policy.
- The percentage of Medicare beneficiaries with Medicaid coverage has increased from 10 percent in 2000 to 13 percent in 2013.
- Between 1991 and 2013, enrollment in Medicare Advantage/Capitated Payment Plans and other public health plans, which are usually equivalent to Medicare supplements because they offer extra benefits, varied between 6 percent and 34 percent.
- About 11 percent of Medicare beneficiaries reported having no health insurance supplement in 2013.
- While almost all older Americans have health insurance via Medicare, many people younger than age 65 have no health insurance. In 2014, about 10 percent of people ages 55–64 were uninsured. The percentage of people not covered by health insurance varied by poverty status. In 2014, 25 percent of people ages 55–64 who lived below the poverty line had no health insurance, compared with 5 percent for people who had incomes greater than or equal to 200 percent of the poverty threshold. The percent of people ages 55–64 without health insurance declined significantly from 14 percent in 2013 to 10 percent in 2014.

Data for this indicator's charts and bullets can be found in Tables 32a through 32c on pages 138–139.

INDICATOR 33: **Out-of-Pocket Health Care Expenditures**

Large out-of-pocket expenditures for use of health care services have been shown to encumber access to care, affect health status and quality of life, and leave insufficient resources for other necessities.[41,42] The percentage of household income that is allocated to health care expenditures is a measure of health care expense burden placed on older people.

Ratio of out-of-pocket expenditures to household income per person among people age 65 and over, by income category and age group, 1977 and 2013



NOTE: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care. People are classified into the "poor/near poor" income category if their household income is below 125 percent of the poverty level; otherwise, people are classified into the "low/middle/high" income category. The poverty level is calculated according to the U.S. Census Bureau guidelines for the corresponding year. The ratio of a person's out-of-pocket expenditures to their household income was calculated based on the person's per capita household income. For people whose ratio of out-of-pocket expenditures to income exceeded 100 percent, the ratio was capped at 100 percent. For people with out-of-pocket expenditures and with zero income (or negative income), the ratio was set at 100 percent. For people with no out-of-pocket expenditures the ratio was set to zero.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) and MEPS predecessor surveys.

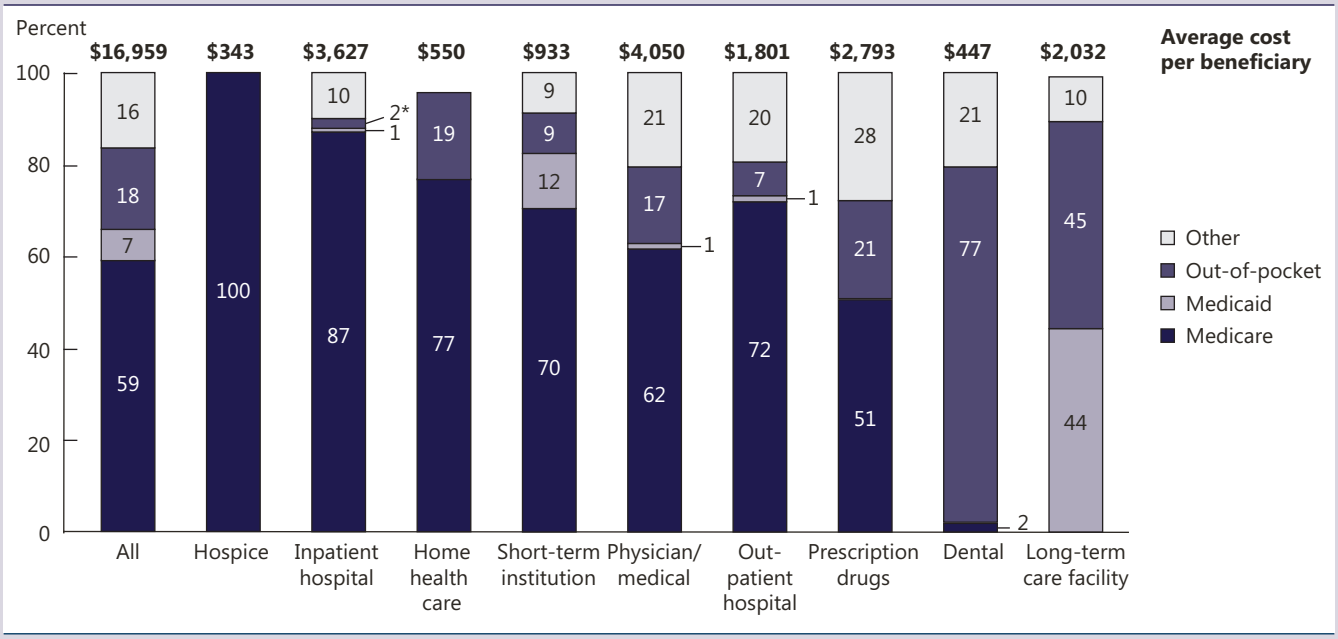
- In 1977, the average per-person percentage of household income attributable to out-of-pocket spending for health care services for poor/near-poor persons age 65 and over was 12 percent. This average increased to 17 percent in 2013. The average percentage for the low/middle/high income category was lower, at 5 percent in 1977 and 4 percent in 2013.
- The percentage of people age 65 and over with out-of-pocket spending for health care services increased between 1977 and 2013, from 83 percent to 93 percent.
- From 2000 to 2006, more than half of out-of-pocket health care spending by people age 65 and over was for prescription drugs. By 2013, only about one-third of out-of-pocket spending for this group was for prescription drugs.
- In 2013, nearly half (47 percent) of out-of-pocket expenses for people age 85 and over were for home health care and other miscellaneous health expenses. This proportion is substantially higher than for persons ages 65–74 (12 percent) or ages 75–84 (14 percent).

Data for this indicator's charts and bullets can be found in Tables 33a through 33c on pages 140–143.

INDICATOR 34: **Sources of Payment for Health Care Services**

Medicare's payments are focused on acute care services such as hospitals and physicians. Historically, long-term care facilities, prescription drugs, and dental care have been primarily financed out of pocket or by other payers. Medicare coverage of prescription drugs, including a low-income subsidy, began in January 2006.

Average cost per beneficiary and percentage distribution of sources of payment for health care services for Medicare beneficiaries age 65 and over, by type of service, 2012



* Estimates are considered unreliable. Data with an asterisk have a relative standard error of 20 to 30 percent.

NOTE: "Other" refers to private insurance, Department of Veterans Affairs, uncollected liability, and other public programs. Estimates may not sum to 100 percent because of rounding or suppression due to high relative standard errors.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

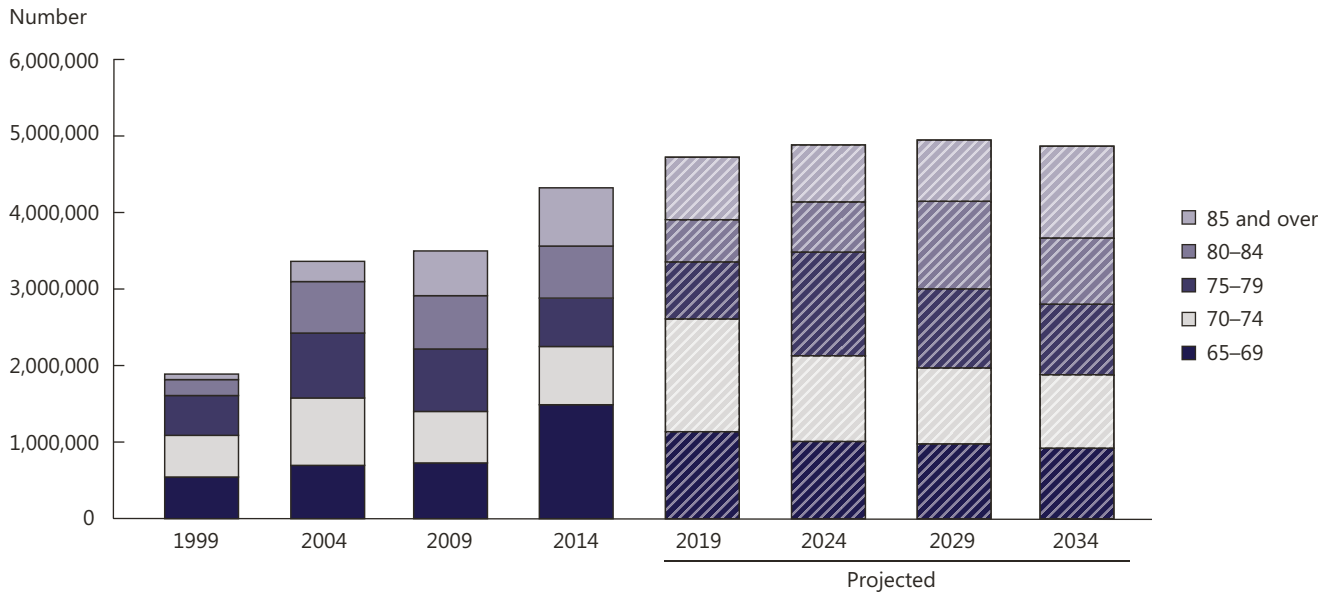
- Medicare paid for almost 60 percent of all health care costs of Medicare beneficiaries age 65 and over in 2012. Medicare financed all hospice costs and most hospital, physician, home health care, and short-term institution costs.
- Medicaid covered 7 percent of all health care costs of Medicare beneficiaries age 65 and over, and other payers (primarily private insurers) covered another 16 percent. Medicare beneficiaries age 65 and over paid 18 percent of their health care costs out of pocket (not including insurance premiums).
- In 2012, about 44 percent of long-term care facility costs for Medicare beneficiaries age 65 and over were covered by Medicaid; another 45 percent of these costs were paid out of pocket. About 51 percent of prescription drug costs for Medicare beneficiaries age 65 and over were covered by Medicare, 28 percent were covered by third-party payers other than Medicare and Medicaid (consisting mostly of private insurers), and 21 percent were paid out of pocket. About 77 percent of dental care received by older Americans was paid out of pocket.
- Sources of payment for health care other than Medicare varied by income. In general, individuals with lower incomes relied heavily on Medicaid, while those with higher incomes relied more on private insurance. As shown in Indicator 33 (Out-of-Pocket Health Care Expenditures), people in the poor/near poor income category spent a higher percentage of their household income on health care services than did people in the low/middle/high income category.

Data for this indicator's charts and bullets can be found in Tables 34a and 34b on page 144.

INDICATOR 35: **Veterans' Health Care**

The number of veterans age 65 and over who are enrolled in and receive health care from the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), has been steadily increasing since eligibility for this benefit was reformed in 1999. Older veterans continue to turn to VHA for their health care needs, despite their eligibility for other sources of health care. VHA fills important gaps in older veterans' health care needs not currently covered or fully covered by Medicare, such as long-term services and supports (nursing home care for eligible veterans and community-based care for all enrolled veterans) and specialized services for the disabled, including acute mental health services. In addition, VHA provides access to these important services in rural and highly rural communities.

Number of veterans age 65 and over who are enrolled in the Veterans Health Administration, by age group, selected years 1999–2014 and projected 2019–2034



NOTE: Department of Veterans Affairs (VA) enrollees are veterans who have signed up to receive health care from the Veterans Health Administration (VHA). Counts for 2019, 2024, 2029, and 2034 are projections from the 2015 VA Enrollee Health Care Projection Model.

Reference population: These data refer to the count of unique VHA enrollees per fiscal year.

SOURCE: Department of Veterans Affairs, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, 2015 VA Enrollee Health Care Projection Model.

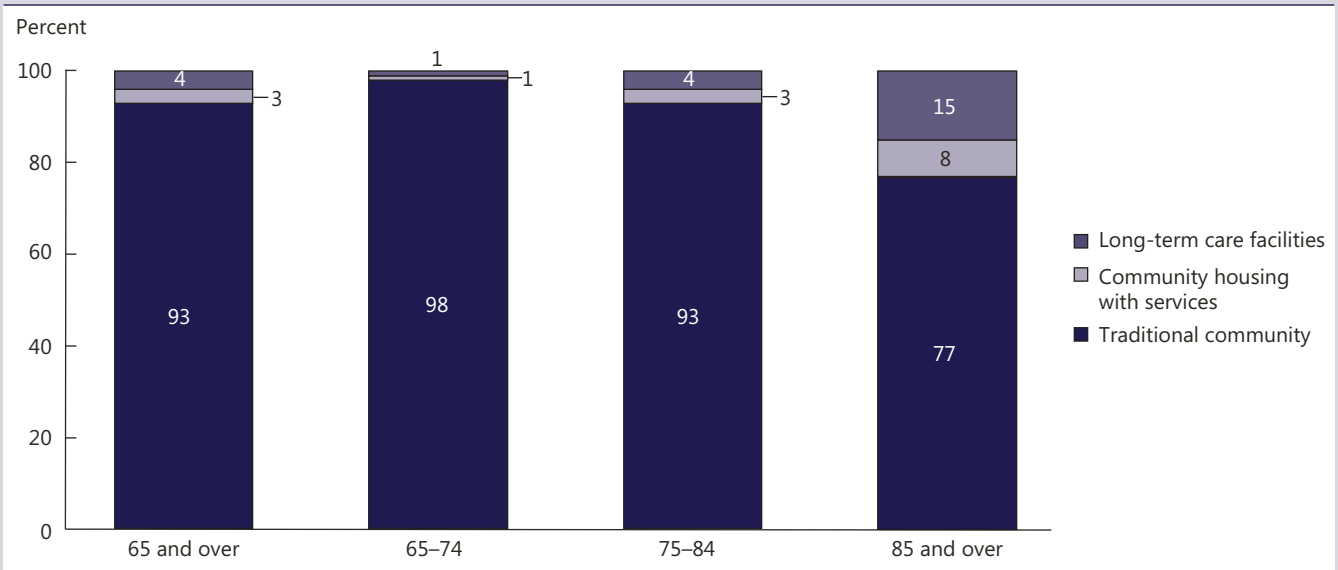
- In 2014, approximately 4.3 million veterans age 65 and over were enrolled with VHA, out of a total of 9.1 million enrolled veterans (48 percent).
- The percentages of older veterans among the enrollee population are expected to increase as the Vietnam-era enrollee cohort gets older. In 2014, approximately 23 percent of enrollees were age 75 and over; by 2034, approximately 32 percent of enrollees are projected to be age 75 and over.
- Among enrollees age 65 and over, 36 percent had been disabled by an injury or illness that was incurred or aggravated during active military service. In 2014, about 13 percent of enrollees with service-connected disabilities had a disability rating of 70 percent or more. Among enrollees of all ages, approximately 42 percent had been adjudicated for service-connected conditions in 2014, since service-connected disability ratings are more prevalent among younger enrollees. As a result, service-connected disability ratings are projected to increase as younger enrollees age into the 65 and over age groups.

Data for this indicator's charts and bullets can be found in Tables 35a and 35b on page 145.

INDICATOR 36: **Residential Services**

Most older Americans live independently in traditional communities. Others live in licensed long-term care facilities, and still others live in communities with access to various services through their place of residence. Such services may include meal preparation, laundry and cleaning services, and help with medications. Availability of such services through the place of residence may help older Americans maintain their independence and avoid institutionalization.

Percentage distribution of Medicare beneficiaries age 65 and over residing in selected residential settings, by age group, 2013



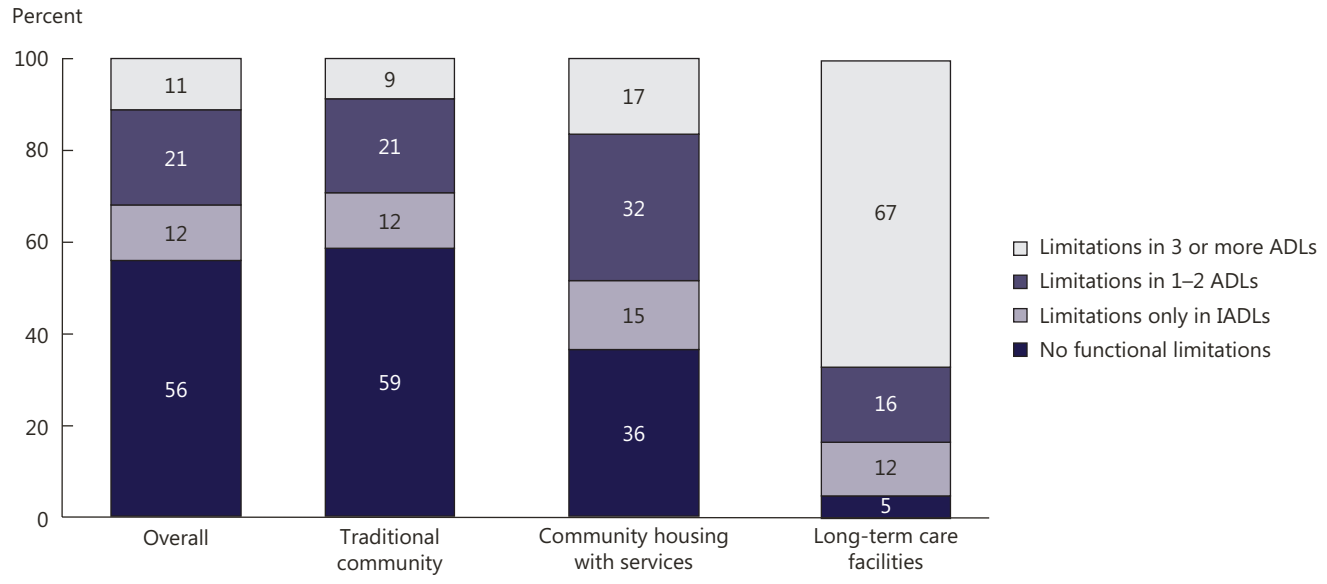
NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, or help with medications. Respondents were asked about access to these services, but not whether they actually used the services. A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a non-family, paid caregiver.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

- In 2013, about 3 percent of the Medicare population age 65 and over resided in community housing with at least one service available. About 4 percent resided in long-term care facilities, and 93 percent resided in traditional community.
- The percentage of people residing in community housing with services and in long-term care facilities was higher for the older age groups than for the 65–74 age group. Among individuals age 85 and over, 8 percent resided in community housing with services, 15 percent resided in long-term care facilities. Among individuals ages 65–74, about 98 percent resided in traditional community settings.
- Among residents of community housing with services, 86 percent reported access to meal preparation services; 79 percent reported access to cleaning or housekeeping services; 69 percent reported access to laundry services; and 49 percent reported access to help with medications. These numbers reflect percentages reporting availability of specific services, not necessarily the number that actually used these services.
- About 53 percent of residents in community housing with services reported that there were separate charges for at least some services.

Percentage distribution of Medicare beneficiaries age 65 and over with limitations performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs), by residential setting, 2013



NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations, AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, or help with medications. Respondents were asked about access to these services, but not whether they actually used the services. A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a non-family, paid caregiver. Long-term care facility residents with no limitations may include individuals with limitations in performing certain IADLs, such as doing light or heavy housework or meal preparation. These questions were not asked of facility residents.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

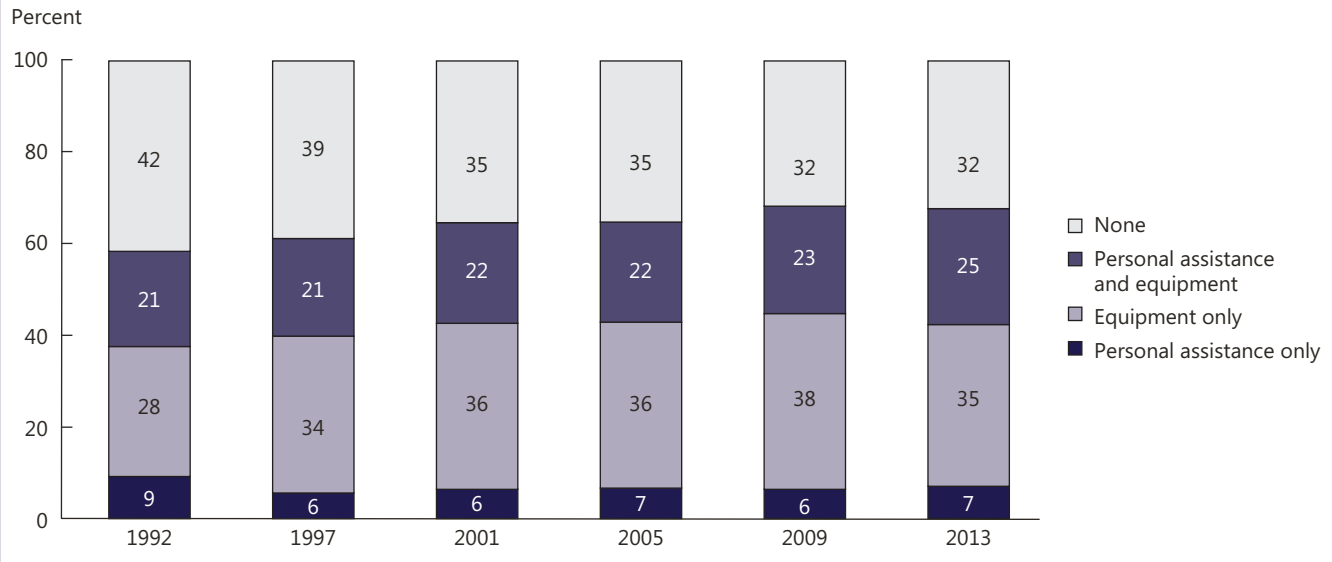
- People living in community housing with services had more limitations in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs) than traditional community residents, but not as many as those living in long-term care facilities. About 49 percent of individuals living in community housing with services had at least one ADL limitation, compared with 29 percent of traditional community residents and 83 percent of long-term care facility residents in 2013. Approximately 36 percent of individuals living in community housing with services had no ADL or IADL limitations.
- Residents of community housing with services tended to have somewhat lower incomes than traditional community residents and higher incomes than long-term care facility residents. About 70 percent of long-term care facility residents had incomes of $20,000 or less in 2013, compared with 28 percent of traditional community residents and 41 percent of residents of community housing with services.
- About 61 percent of people living in community housing with services reported they could continue living there if they needed substantial care.

Data for this indicator's charts and bullets can be found in Tables 36a through 36e on pages 146–147.

INDICATOR 37: **Personal Assistance and Equipment**

As the proportion of the older population residing in long-term care facilities has declined, the use of personal assistance and/or special equipment among those with limitations has increased. This assistance helps older people living in the community maintain their independence.

Percentage distribution of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs), by type of assistance, selected years 1992–2013



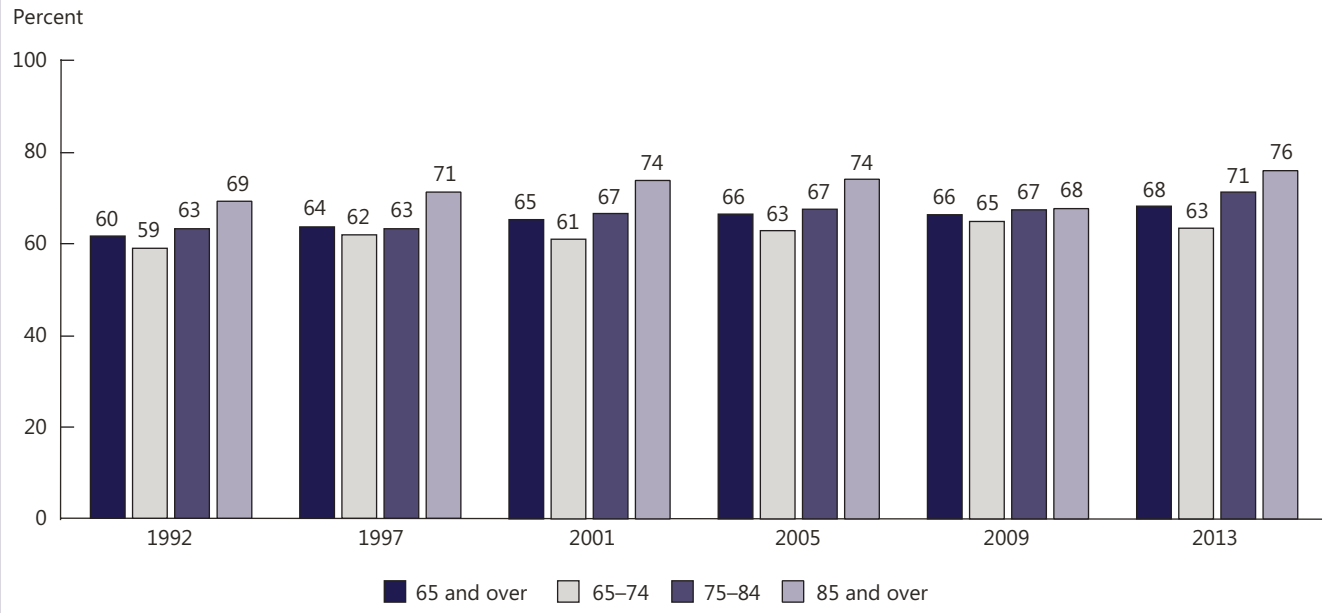
NOTE: Limitations in performing activities of daily living (ADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Respondents who report difficulty with an activity are subsequently asked about receiving help or supervision from another person with the activity and about using special equipment or aids. In this chart, personal assistance does not include supervision. Percentages are age adjusted using the 2000 standard population. Estimates may not sum to the totals because of rounding.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more ADLs.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

- Between 1992 and 2013, the age-adjusted proportion of people age 65 and over who had difficulty with one or more activities of daily living (ADLs) and who did not receive personal assistance or use special equipment for these activities decreased from 42 percent to 32 percent. Over the same period, the percentage of people using equipment only increased from 28 percent to 35 percent, while the percentage of people who used personal assistance only decreased from 9 percent to 7 percent.
- In 2013, about two-thirds of people who had difficulty with one or more ADLs received personal assistance or used special equipment: 7 percent received personal assistance only, 35 percent used equipment only, and 25 percent used both personal assistance and equipment.
- In 2013, men age 65 and over were more likely than women to have received no assistance with their limitations (36 percent compared with 30 percent), but women were more likely than men to have received personal assistance and used equipment (27 percent compared with 23 percent). There were no differences in the percentages of women and men with limitations in performing ADLs who received personal assistance only or used equipment only.
- In 2013, only 13 percent of people age 85 and over with limitations in performing ADLs did not receive assistance or use equipment compared with 41 percent of people ages 65–74. In addition, people age 85 and over were more likely to receive personal assistance and use equipment compared with younger age groups. There were no differences by age group in the percentage of people with limitations in performing ADLs who received personal assistance only.

Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing instrumental activities of daily living (IADLs) and who receive personal assistance, by age group, selected years 1992–2013



NOTE: Limitations in performing instrumental activities of daily living (IADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Respondents who report difficulty with an activity are subsequently asked about receiving help from another person with the activity. In this chart, personal assistance does not include supervision or special equipment.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more IADLs.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

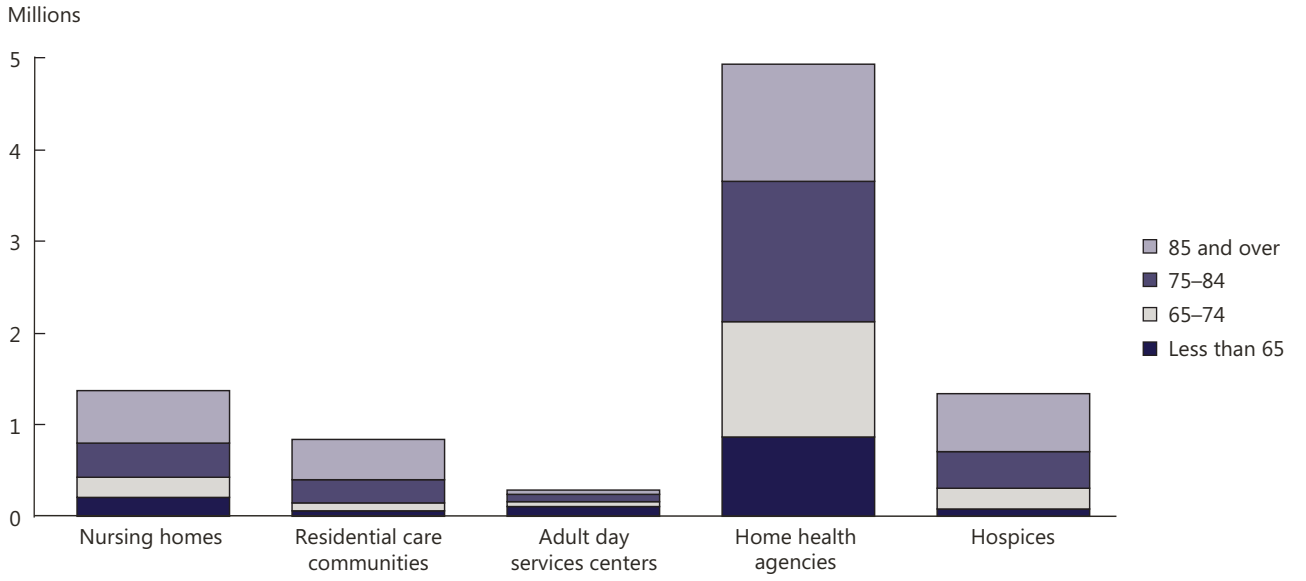
- In 2013, slightly more than two-thirds of people age 65 and over who had difficulty with one or more instrumental activities of daily living (IADLs) received personal assistance.
- In 2013, people ages 65–74 were less likely to receive assistance with IADLs than people ages 75–84 and 85 and over.
- Between 1992 and 2013, there were increases in the percentages of people ages 65–74 and 75–84 who received assistance with IADLs. Among people 85 and over, there was no significant increase.
- Men age 85 and over were more likely than women of the same age group to receive personal assistance with their IADLs in 2013.

Data for this indicator's charts and bullets can be found in Tables 37a through 37d on page 148–149.

INDICATOR 38: **Long-Term Care Providers**

Long-term care refers to a broad range services and supports to meet the needs of frail older adults and other people who are limited in their abilities for self-care because of chronic illness or a disability. Long-term care services include health care-related services and services that are not health-care related; they include assistance with activities of daily living (ADLs), assistance with instrumental activities of daily living (IADLs), and health maintenance tasks. Care can be provided in the home or in a variety of other settings.[43,44]

Number of users of long-term care services, by sector and age group, 2013 and 2014



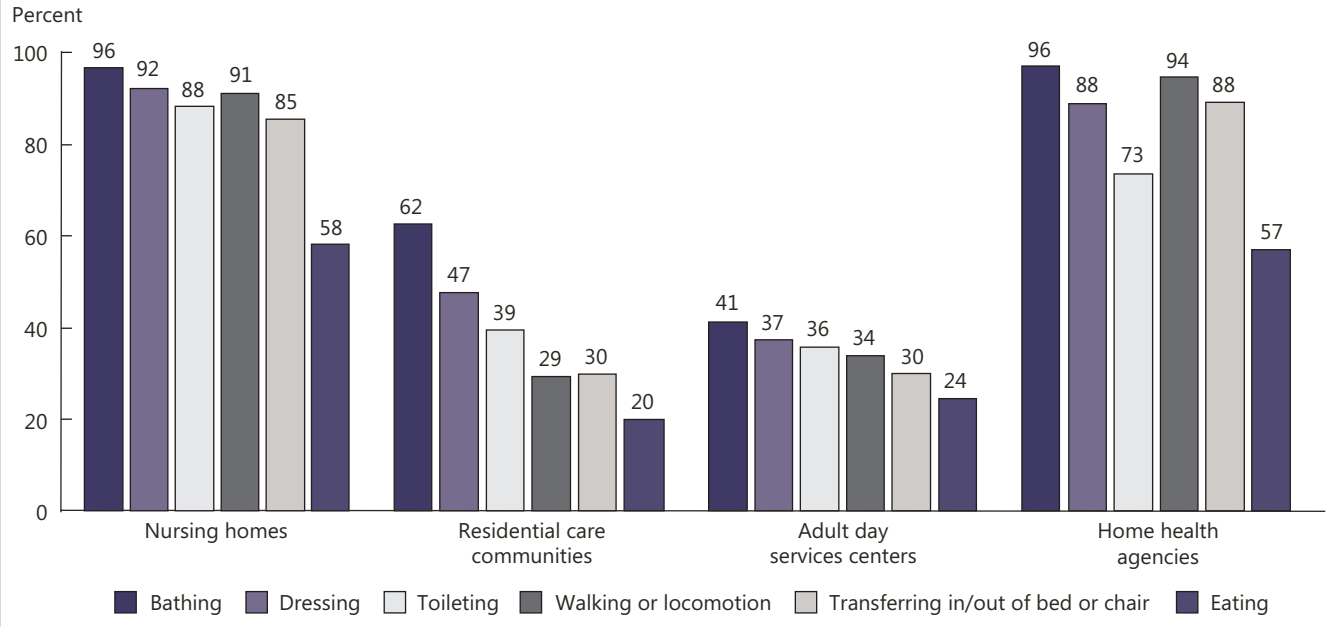
NOTE: Long-term care services are provided by paid, regulated providers. They comprise both health care-related and non-health care-related services, including post-acute care and rehabilitation. People can receive more than one type of service. The estimated number of users of nursing homes, residential care communities, and adult day services centers represents participants or residents enrolled on the day of data collection in 2014. The estimated number of users of home health agencies represents patients who ended care (i.e., were discharged) in 2013. The estimated number of users of hospice represents patients who received care at any time in 2013. The number in each age group is calculated by applying the percentage distribution by age to the estimated total number of users. See http://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf for definitions.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Study of Long-Term Care Providers.

- In 2014, about 1.2 million people age 65 and over were residents of nursing homes. In the same year, nearly 780,000 people age 65 and over lived in residential care communities such as assisted living facilities. In both settings, people age 85 and over were the largest share by age group among residents.
- In 2014, approximately 280,000 participants received care in adult day services centers. About two-thirds of the participants (180,000) were age 65 and over.
- Nearly 5 million people received care from a home health agency in 2013. People ages 75–84 (about 1.5 million) made up the largest share by age group of people receiving care from a home health agency. Nearly equal numbers (about 1.3 million) of people ages 65–74 and age 85 and over received home health care.
- In 2013, 1.3 million people received hospice care. Nearly 50 percent (630,000) of the hospice patients were age 85 and over.

Percentage of users of long-term care services needing any assistance with activities of daily living (ADLs), by sector and activity, 2013 and 2014



NOTE: Long-term care services are provided by paid, regulated providers. They comprise both health care-related and non-health care-related services, including post-acute care and rehabilitation. People can receive more than one type of service. Users of formal long term care include persons of all ages. In nursing homes, 85 percent of residents were age 65 and over. In residential care communities, 93 percent of residents were age 65 and over. In adult day services centers, 64 percent of participants were age 65 and over. Among home health care patients, 83 percent were age 65 and over. Data were not available for hospice patients. Participants, patients, or residents were considered needing any assistance with a given activity if they needed help or supervision from another person or used special equipment to perform the activity. See http://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf for definitions.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Study of Long-Term Care Providers.

- In 2014, most residents of nursing homes needed help with activities of daily living (ADLs). Nearly all (96 percent) needed help with bathing, and most needed help with dressing, toileting, and walking (92 percent, 88 percent, and 91 percent, respectively).
- In 2014, 62 percent of residents of residential care communities needed assistance with bathing. About 29 percent needed help with walking, and 30 percent needed assistance transferring in or out of beds or chairs.
- In 2014, less than half of adult day center participants needed assistance with ADLs. About 41 percent needed help with bathing and 34 percent needed help with walking.
- The majority of home health care patients in 2013 needed assistance with all six ADLs. Nearly all (96 percent) needed help with bathing.
- Assistance with bathing was the most common need across all sectors, while assistance with eating was the least common.

Data for this indicator's charts and bullets can be found in Tables 38a and 38b on page 150.

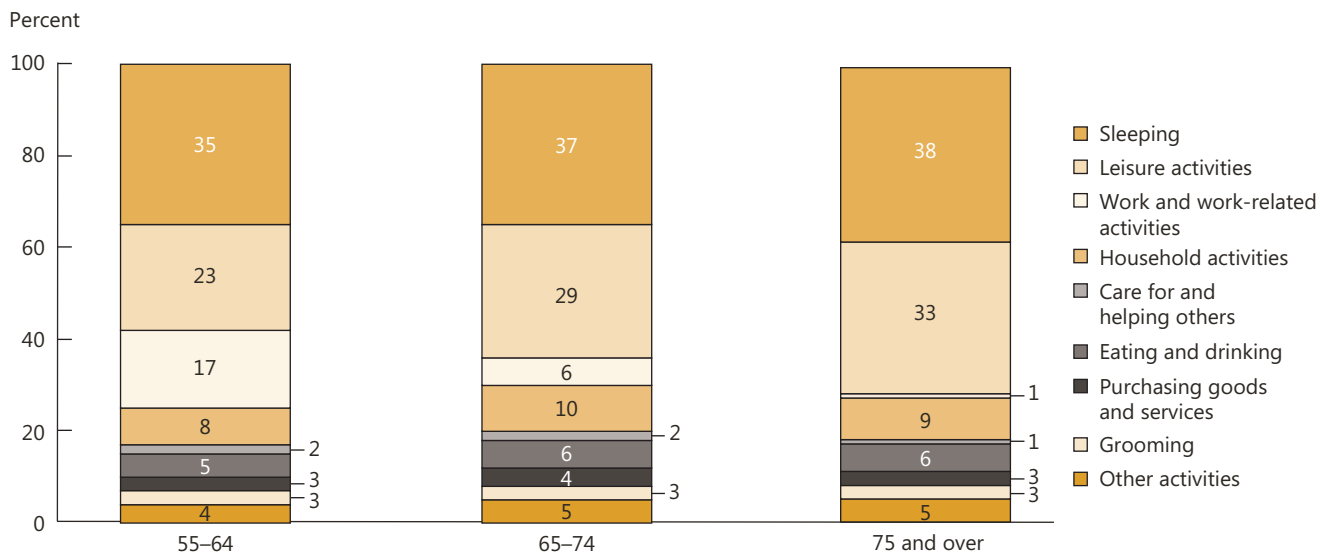
Environment

INDICATOR 39: **Use of Time**

How individuals spend their time reflects their financial, health and personal situations, employment status, needs, and desires. Time-use data show that as Americans get older, they spend more of their time in leisure activities.

As people age, they are less likely to be employed. In 2014, a majority (61 percent) of people ages 55–64 were employed compared with 25 percent of those ages 65–74 and 8 percent of those age 75 and over.[45] This change in employment status is reflected in how older Americans spent their time.

Percentage of day that people age 55 and over spent doing selected activities on an average day, by age group, 2014



NOTE: "Other activities" includes activities such as educational activities; organizational, civic, and religious activities; and telephone calls. Chart includes people who did not work at all.

Reference population: These data refer to the civilian noninstitutionalized population.

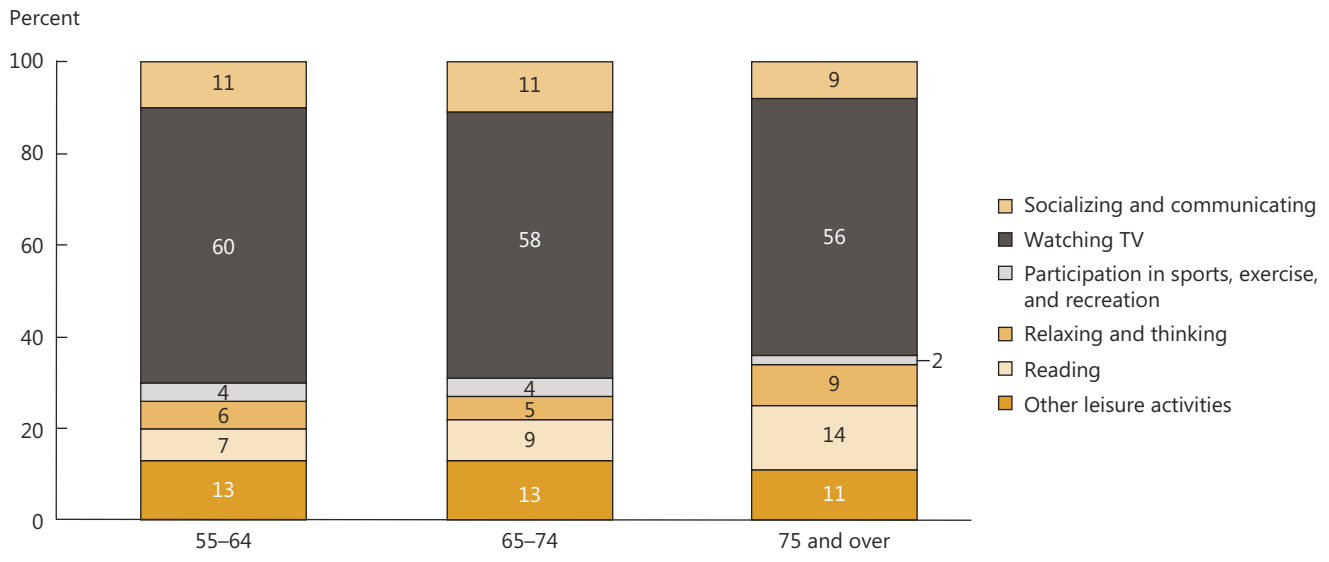
SOURCE: Bureau of Labor Statistics, American Time Use Survey.

- On an average day, people ages 55–64 spent 17 percent of their time (4 hours) working or doing work-related activities, compared with 6 percent (about 1 hour and 20 minutes) for people ages 65–74 and 1 percent (20 minutes) for people age 75 and over.

In 2014, older Americans spent, on average, more than one-quarter of their time in leisure activities. This proportion increased with age: Americans age 75 and over spent 33 percent of their time in leisure activities, compared with 23 percent for those age 55–64.

Leisure activities are those done when free from duties such as working, shopping, doing household chores, or caring for others. During these times, individuals have flexibility in choosing what to do.

Percentage of total leisure time that people age 55 and over spent doing selected leisure activities on an average day, by age group, 2014



NOTE: "Other leisure activities" includes activities such as playing games, using the computer for leisure, doing arts and crafts as a hobby, experiencing arts and entertainment (other than sports), and engaging in related travel.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, American Time Use Survey.

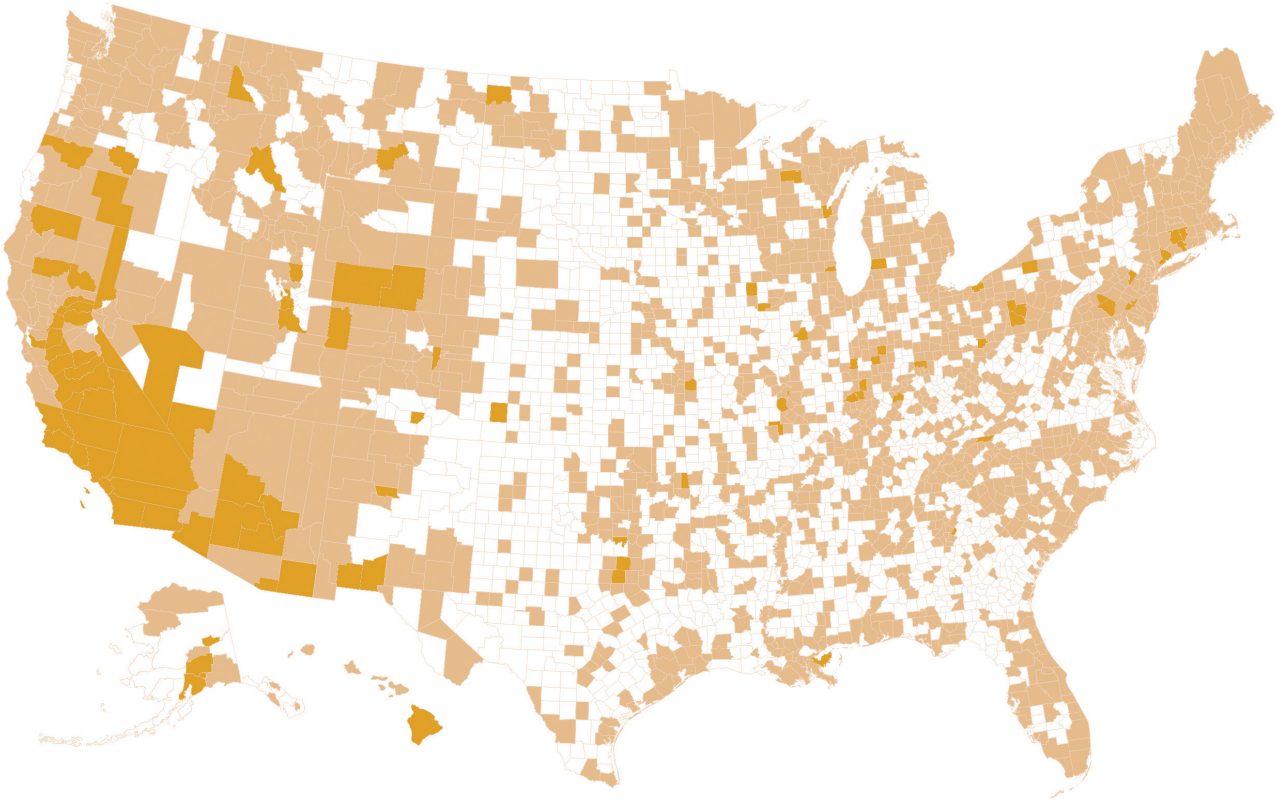
- Watching TV was the activity that occupied the most leisure activity time—more than one-half of the total—for Americans age 55 and over.
- Americans age 75 and over spent a higher percentage of their leisure time reading than did Americans ages 55–64 (14 percent versus 7 percent) and relaxing and thinking (9 percent versus 6 percent). Americans age 75 and over spent just over an hour per day reading, compared with 22 minutes per day for Americans ages 55–64.
- In general, older Americans spend more time reading for leisure than do those under age 65. In 2014, Americans age 65 and over spent 49 minutes per day reading for leisure.
- The proportion of leisure time that older Americans spent socializing and communicating—such as visiting friends or attending or hosting social events—declined with age. For Americans ages 55–64, about 11 percent of leisure time was spent socializing and communicating, compared with 9 percent for those age 75 and over.

Data for this indicator's charts and bullets can be found in Tables 39a and 39b on page 151.

INDICATOR 40: **Air Quality**

As people age, their bodies are less able to compensate for the effects of environmental hazards. Air pollution can aggravate chronic heart and lung diseases, leading to increased medication use, more visits to health care providers, admissions to additional emergency rooms and hospitals, and even death. An important indicator for environmental health is the percentage of older adults living in areas that have measured air pollutant concentrations above the level of the national standards of the Environmental Protection Agency (EPA).

Counties with instances of "poor air quality" for any standard in 2014



NOTE: The term "poor air quality" is defined as air quality concentrations above the level of the National Ambient Air Quality Standards (NAAQS). The term "any standard" refers to any NAAQS for ozone, particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide, or lead. Measuring concentrations above the level of a standard is not equivalent to violating the standard. The level of a standard may be exceeded on multiple days before the exceedance is considered a violation of the standard.

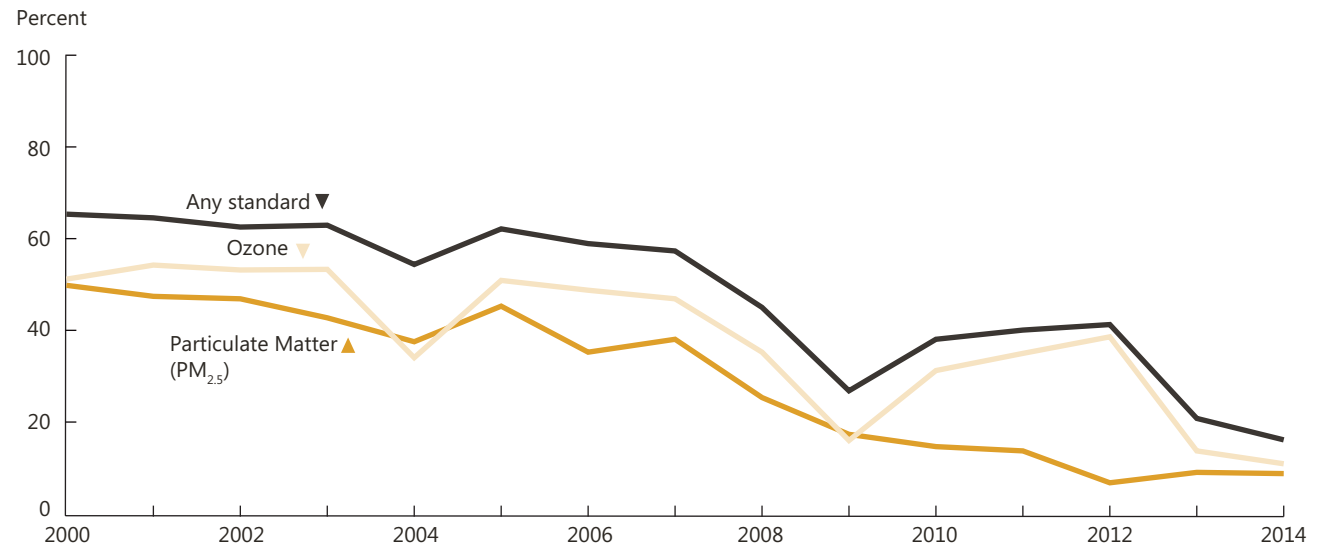
Reference population: These data refer to the resident population.

SOURCE: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Air Quality System; U.S. Census Bureau, 2010 Population.

- In 2014, approximately 57 million people lived in counties where monitored air was unhealthy at times because of high levels of at least one of the six principal air pollutants: ozone, PM, nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead. About 12 percent, or nearly 7 million people, of those living in counties where monitored air quality was unhealthy at times were age 65 and over. The vast majority of areas that experienced unhealthy air did so because of one or both of two pollutants—ozone and $PM_{2.5}$.

Ozone and particulate matter (PM), especially the smaller, fine particle pollution called $PM_{2.5}$, have the greatest potential to affect the health of older adults. Fine particle pollution has been linked to premature death, cardiac arrhythmias and heart attacks, asthma attacks, and the development of chronic bronchitis. Ozone, even at low levels, can exacerbate respiratory diseases such as chronic obstructive pulmonary disease or asthma.[46–50]

Percentage of people age 65 and over living in counties with instances of "poor air quality," by selected pollutant measures, 2000–2014



NOTE: The term "poor air quality" is defined as air quality concentrations above the level of the National Ambient Air Quality Standards (NAAQS). The term "any standard" refers to any NAAQS for ozone, particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide, or lead. Data for previous years have been computed using the standards in effect as of August 2015 to enable comparisons over time. This results in percentages that are not comparable to those in previous publications of *Older Americans.* Measuring concentrations above the level of a standard is not equivalent to violating the standard. The level of a standard may be exceeded on multiple days before the exceedance is considered a violation of the standard.

Reference population: These data refer to the resident population.

SOURCE: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Air Quality System; U.S. Census Bureau, 2010 Population.

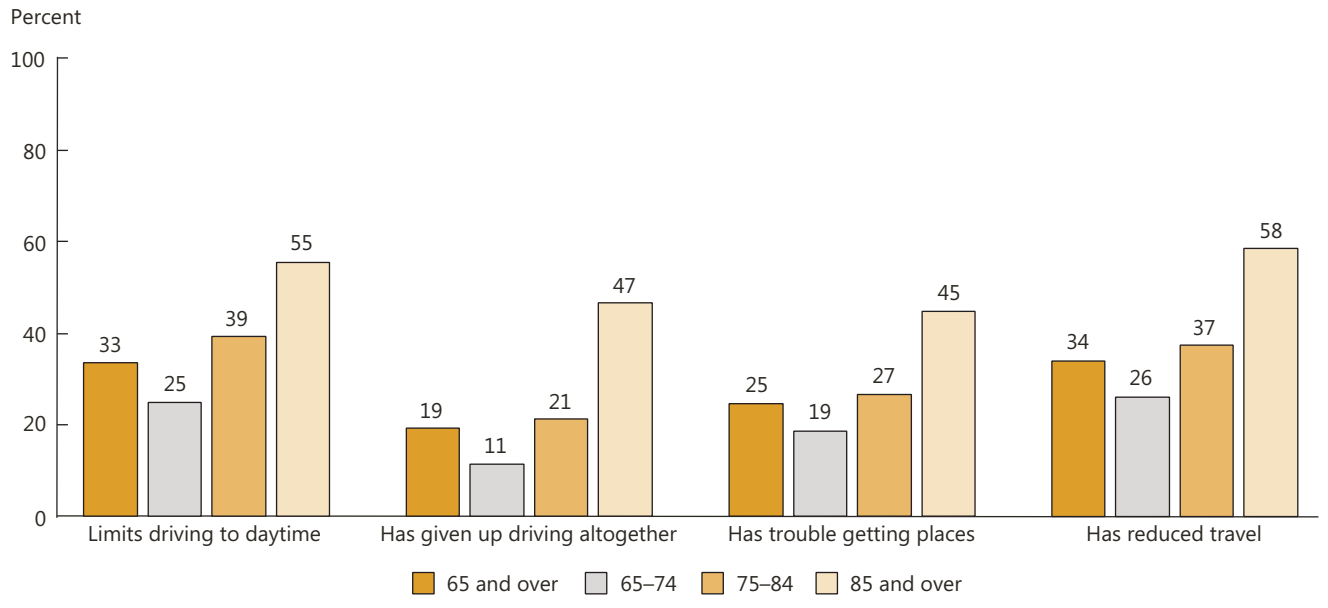
- The percentage of people age 65 and over living in counties that experienced poor air quality for any standard decreased from 66 percent in 2000 to 16 percent in 2014.
- In 2014, about 11 percent of people age 65 and over lived in counties with poor air quality for ozone, compared with 51 percent in 2000.
- A comparison of 2000 and 2014 showed a reduction in exposure to $PM_{2.5}$ pollution. In 2000, about 50 percent of people age 65 and over lived in a county where $PM_{2.5}$ concentrations were at times above the EPA standard, compared with 9 percent of people age 65 and over in 2014.

Data for this indicator's charts and bullets can be found in Tables 40a and 40b on pages 152–154.

INDICATOR 41: **Transportation**

The ability to travel independently to appointments, to the grocery store, and to visit friends plays an important role in the daily lives of older adults. For many older adults, the ability to travel independently may change due to health or physical problems. However, access to modes of transportation such as riding with a friend or using public transit may help older adults continue to get the services they need.

Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who made a change in transportation mode due to a health or physical problem, by type of change and age group, 2013



Reference population: These data refer to noninstitutionalized Medicare beneficiaries.
SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

- In 2013, 33 percent of the noninstitutionalized Medicare population age 65 and over had limited their driving to daytime because of a health or physical problem. The percentage of people who had limited their driving to daytime was greater for those age 85 and over (55 percent) than for those ages 65–74 (25 percent).
- Furthermore, 19 percent of the noninstitutionalized Medicare population age 65 and over had given up driving altogether, about 24 percent had trouble getting places, and 34 percent had reduced their travel because of a health or physical problem.

Data for this indicator's charts and bullets can be found in Table 41 on page 155.

Special Feature

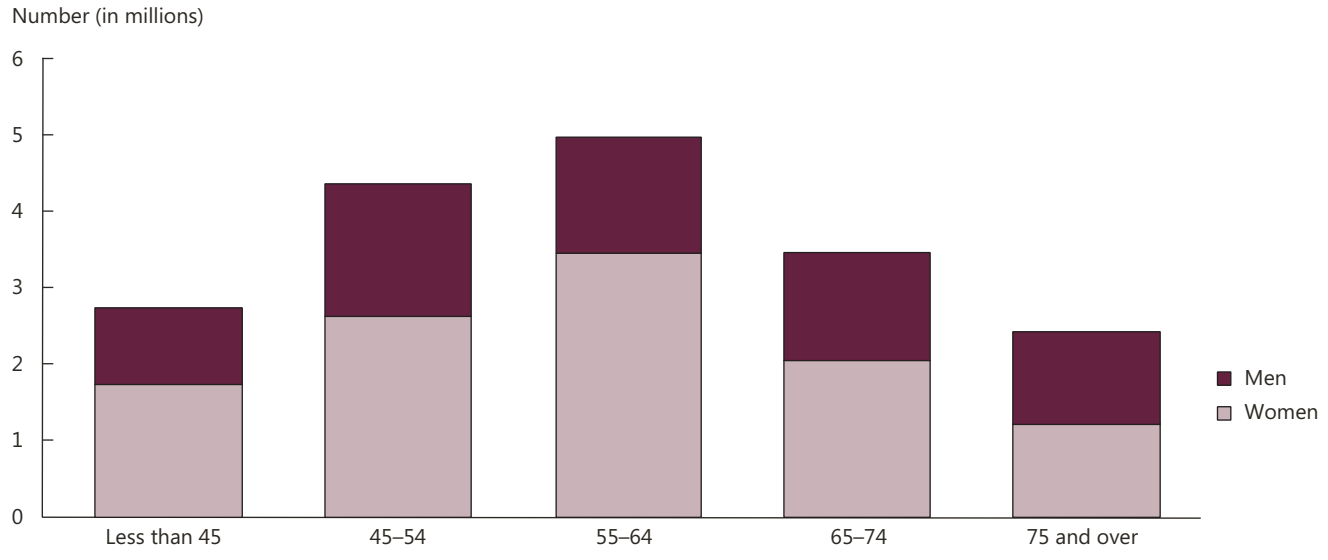
SPECIAL FEATURE: **Informal Caregiving**

Despite efforts to stay healthy and avoid disease, many older adults will eventually develop some degree of limitations and need paid or unpaid help with basic daily living activities. Family members or friends provide the majority of this assistance, without pay, as informal caregivers, including help with everyday tasks such as bathing, dressing, preparing a meal, or managing money. At least 90 percent of older adults receiving help with daily activities receive some informal care, and about two-thirds receive only informal care.[51,52,53,54]

In 2011, an estimated 18 million informal caregivers provided 1.3 billion hours of care on a monthly basis to Medicare beneficiaries age 65 and over. Informal caregivers are a diverse population that includes spouses, children, and other relatives such as daughters-in-law, grandchildren, and friends. Caregivers range in age from teenagers to older adults. About half are employed. Research has shown that the financial, emotional, and physical demands of caregiving can be high and that the resulting stress or burden can threaten the ability of caregivers to maintain their efforts.[55]

This special feature provides some information about the population of informal caregivers of older adults with functional limitations.

Number of informal caregivers, by age group and sex, 2011

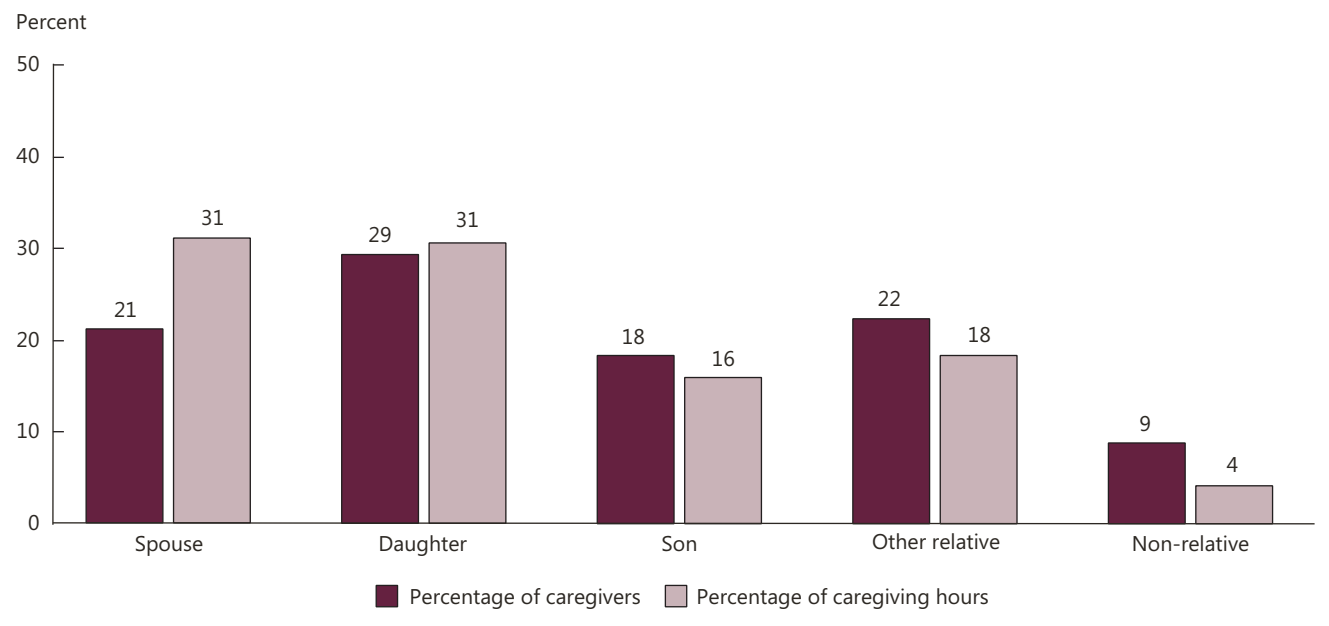


Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.

- In 2011, many more caregivers were women (11.1 million) than men (6.9 million), and most informal caregivers were middle-aged (ages 45–64).
- Of the approximately 2.7 million caregivers in the youngest group (those less than 45), most were adult children or grandchildren.

Percentage distribution of informal caregivers and number of caregiving hours provided, by relationship to care recipient, 2011

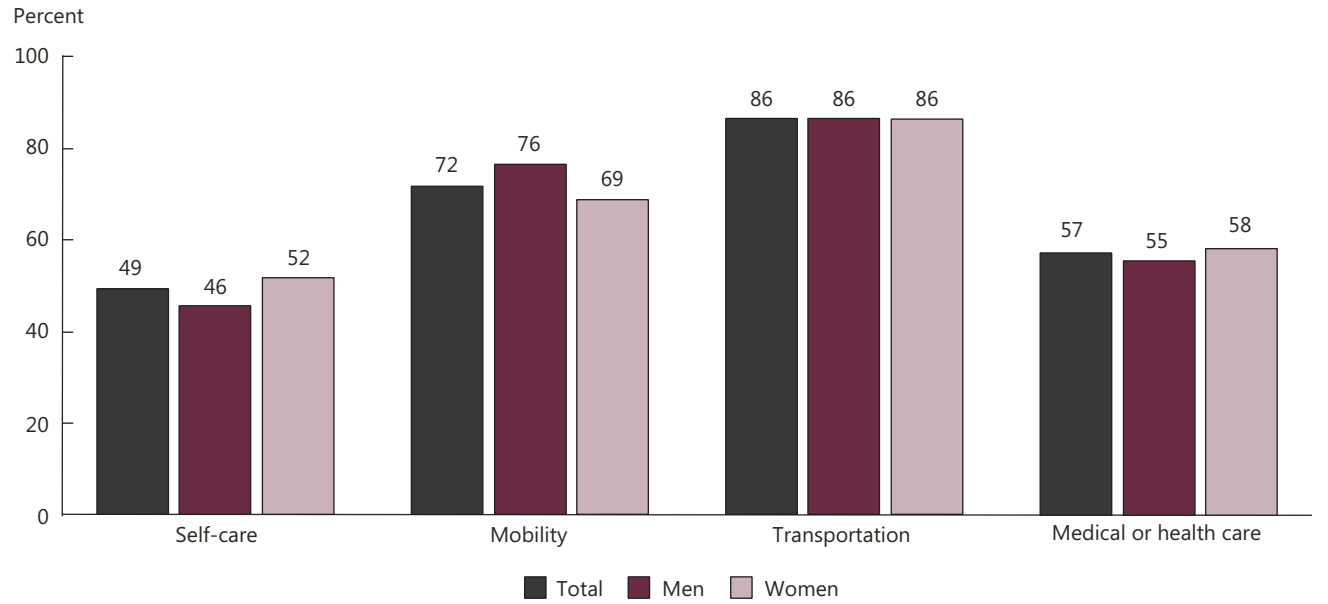


Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.

- In 2011, almost half of informal caregivers were a child of the care recipient, more frequently a daughter (29 percent) than a son (18 percent).
- Although spouses were only 21 percent of informal caregivers, they provided more than 31 percent of the total hours of care in 2011.
- Other relatives providing informal care included granddaughters (5 percent) and daughters-in-law (3 percent).

Percentage of caregivers providing assistance, by type of assistance and sex, 2011



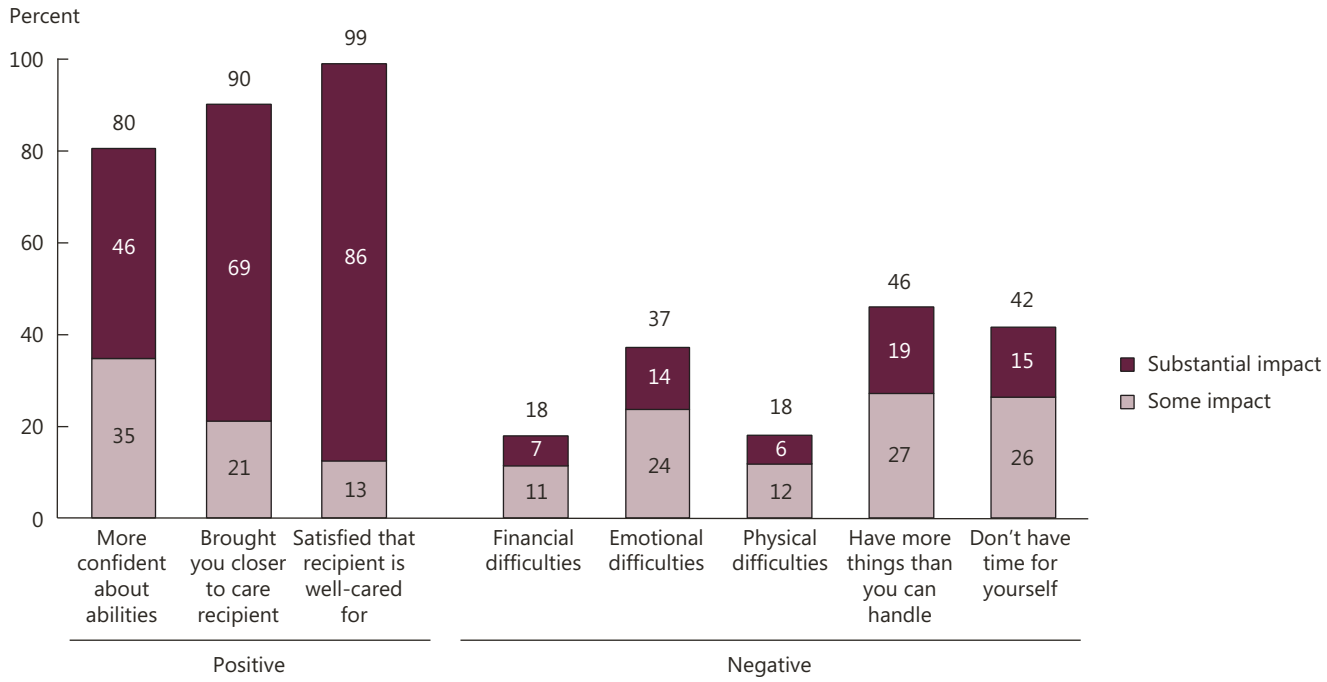
NOTE: Respondents reported whether they helped with different types of activities. Self-care activities include bathing, dressing, eating, and toileting. Mobility-related activities include getting out of bed, getting around inside one's home or building, and leaving one's home or building. Health or medical care tasks were assistance with diet, foot care, giving injections, and managing medical tasks, such as ostomy care, IV therapy assistance, or blood tests.

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.

- There were small gender differences in the type of care provided by informal caregivers.
- Almost half of all caregivers assisted with self-care activities, but a slightly larger proportion of women caregivers (52 percent) than male caregivers (46 percent) provided such care.
- There were larger gender differences in mobility assistance: 76 percent of men provided mobility assistance, compared with 69 percent of women.
- The vast majority of caregivers assisted with transportation, and there were no gender differences in providing this type of help.
- Men were less likely (55 percent) than women (58 percent) to assist with medical or health care.

Percentage of informal caregivers reporting positive and negative aspects of caregiving, by level of impact, 2011



Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability. Estimates may not sum to the totals because of rounding.

SOURCE: National Study on Caregiving.

- In 2011, most caregivers reported substantial positive impacts of caregiving. For example, 69 percent identified substantial positive impacts of being closer to the care recipient.
- About 86 percent reported that informal caregiving gives them satisfaction that the care recipient is well cared for.
- Caregivers also reported negative aspects of caregiving; almost half said they have more things than they can handle or don't have time for themselves. Less than one in five caregivers reported that these negative impacts were a substantial problem.

Data for this indicator's charts and bullets can be found in Tables CG1 through CG6 on pages 156–157.

References

References

[1] Retrieved May 19, 2016 from http://www.nationalacademies.org/hmd/activities/global/violenceforum/2013-apr-17.aspx. For the PowerPoint presentation on survey methodology, see http://www.nationalacademies.org/hmd/~/media/Files/Activity%20Files/Global/ViolenceForum/2013-APR-17/Presentations/02-09-Beach.pdf.

[2] United Nations Statistics Division. (2012). Washington Group on Disability Statistics and UNECE Task Force on Measuring Health Status (Budapest Initiative) Retrieved June 7, 2012 from http://unstats.un.org/unsd/methods/citygroup/washington.htm and http://www.unece.org/statistics/statsexperts/task-force-on-measuring-health-status-budapest-initiative.html.

[3] Horiuchi, S. (2000). Greater lifetime expectation. Nature, 405(6788), 744–745.

[4] Oeppen, J., & Vaupel, J. W. (2002). Broken limits to life expectancy. *Science, 296*(5570), 1029–1031.

[5] Tuljapurkar, S., Li, N., & Boe, C. (2000). A universal pattern of mortality decline in the G7 countries. *Nature, 405*(6788), 789–792.

[6] Department of Veterans Affairs. Unpublished analyses: *American Community Survey 2005, Current Population Survey 2004, National Health Interview Survey 2005, National Long Term Care Survey 2004, and National Survey of Veterans 2001.*

[7] Department of Veterans Affairs, Office of the Secretary (2006, October). *Strategic Plan FY 2006–2011.*

[8] Social Security Administration. (2016). *Income of the Aged Chartbook, 2014* (SSA Publication No. 13-11727). Washington, DC: Author.

[9] Social Security Administration. Statistical Supplement to the Social Security Bulletin 2015, Table 5.A.14, Table 5.A.a6, and Table 6 B.5.1.

[10] National Academies of Sciences, Engineering, and Medicine. (2015). *The Growing Gap in Life Expectancy by Income: Implications for Federal Programs and Policy Responses.* Committee on the Long-Run Macroeconomic Effects of the Aging U.S. Population-Phase II. Committee on Population, Division of Behavioral and Social Sciences and Education. Board on Mathematical Sciences and Their Applications, Division on Engineering and Physical Sciences. Washington, DC: The National Academies Press.

[11] OECD (2015). *Health at a Glance 2015: OECD Indicators,* OECD Publishing, Paris. http://dx.doi.org/10.1787/health_glance-2015-en

[12] Centers for Disease Control and Prevention. (2016, January). Chronic disease overview. Retrieved December 11, 2015, from http://www.cdc.gov/chronicdisease/overview/index.htm

[13] U.S. Department of Health and Human Services. (2010, December). *Multiple chronic conditions—a strategic framework: Optimum health and quality of life for individuals with multiple chronic conditions.* Retrieved from http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf

[14] U.S. Department of Health and Human Services, National Institute of Dental and Craniofacial Research, National Institutes of Health. (2000). *Oral health in America: A report of the Surgeon General.* Retrieved from http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral/Documents/hck1ocv.@www.surgeon.fullrpt.pdf

[15] Schnittker, J., & Bacak, V. (2014). The increasing predictive validity of self-rated health. *PLoS ONE 9*(1): e84933.

[16] DeSalvo, K. B., Jones, T. M., Peabody, J., McDonald, J., Fihn, S., Fan, V., ... Muntner, P. (2009). Health care expenditure prediction with a single item, self-rated health measure. *Medical Care 47*(4): 440–447.

[17] Kasper, J. D., Freedman, V. A., & Spillman, B. (2014). Disability and care needs of older Americans by dementia status: An analysis of the 2011 National Health and Aging Trends Study. Washington DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging, and Long-Term Care Policy. Retrieved from http://aspe.hhs.gov/daltcp/reports/2014/NHATS-DS.pdf

[18] U.S. Department of Health & Human Services, Centers for Medicare & Medicaid Services. (2013). *Nursing home data compendium 2013 edition.* Retrieved from: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/downloads/nursinghomedatacompendium_508.pdf

[19] Emptage, N. P., Sturm, R., & Robinson, R. L. (2005). Depression and comorbid pain as predictors of disability, employment, insurance status, and health care costs. *Psychiatric Services, 56*(4): 468–74.

[20] Saczynski, J. S., Beiser, A., Seshadri, S., Auerbach, S., Wolf, P. A., & Au, R. (2010). Depressive symptoms and risk of dementia: The Framingham Heart Study. *Neurology, 75*(1): 35–41.

[21] Kim, D. K., Bridges, C. B., & Harriman, K. H., on behalf of the Advisory Committee on Immunization Practices. (2015). Advisory committee on immunization practices recommended immunization schedule for adults aged 19 years or older—United States, 2015. *Annals of Internal Medicine 162*(3): 214–223.

[22] Centers for Disease Control and Prevention. (2015, August). What you should know and do this flu season if you are 65 years and older. Retrieved December 14, 2015, from http://www.cdc.gov/flu/about/disease/65over.htm

[23] Centers for Disease Control and Prevention. (2014, September). What vaccines are recommended for you. Retrieved December 14, 2015, from http://www.cdc.gov/vaccines/adults/rec-vac/index.html

[24] U.S. Preventive Services Task Force. (2016, June). *Final Update Summary: Colorectal Cancer: Screening.* Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/colorectal-cancer-screening2

[25] U.S. Preventive Services Task Force. (2016, January). *Breast cancer: Screening.* Retrieved from http://www.uspreventiveservicestaskforce.org/Page/Document/UpdateSummaryFinal/breast-cancer-screening1?ds=1&s=breast%20cancer

[26] Federal Interagency Forum on Aging-Related Statistics (2012, June). *Older Americans 2012: Key indicators of well-being.* Washington, DC: U.S. Government Printing Office. Retrieved from http://www.agingstats.gov/main_site/data/2012_documents/docs/entirechartbook.pdf

[27] Reedy, J., Krebs-Smith, S. M., Miller, P. E., Liese, A. D., Kahle, L. L., Park, Y., & Subar, A. F. (2014, June). Higher diet quality is associated with decreased risk of all-cause, cardiovascular disease, and cancer mortality among older adults. *Journal of Nutrition, 144*(6): 881–889.

[28] Schwingshackl, L., & Hoffmann, G. (2015, May). Diet quality as assessed by the Healthy Eating Index, the Alternate Healthy Eating Index, the Dietary Approaches to Stop Hypertension score, and health outcomes: A systematic review and meta-analysis of cohort studies. *Journal of the Academy of Nutrition and Dietetics, 115*(5): 780–800.

[29] Bernstein, M., & Munoz, N. (2012). Position of the Academy of Nutrition and Dietetics: Food and nutrition for older adults: Promoting health and wellness. *Journal of the Academy of Nutrition and Dietetics, 112*(8): 1255–1277.

[30] Anderson, A. L., Harris, T. B., Tylavsky, F. A., Perry, S. E., Houston, D. K., Hue, T. F., ... Sahyoun, N. R. (2011). Dietary patterns and survival in older adults. *Journal of the American Dietetic Association, 111*(1): 84–91.

[31] Guenther, P. M., Casavale, K. D., Reedy, J., Kirkpatrick, S. I., Hiza, H. A., Kuczynski, K. J., ... Krebs-Smith, S. M. (2013). Update of the Healthy Eating Index: HEI-2010. *Journal of the Academy of Nutrition and Dietetics, 113*(4): 569–580. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23415502

[32] U.S. Department of Health and Human Services. (2008). *Physical activity guidelines for Americans.* Washington, DC: U.S. Department of Health and Human Services. Retrieved from http://health.gov/paguidelines/guidelines/

[33] American College of Sports Medicine, Chodzko-Zajko, W. J., Proctor, D. N., Fiatarone Singh, M. A., Minson, C. T., Nigg, C. R., Salem, G. J., & Skinner, J. S. (2009). American College of Sports Medicine position stand. Exercise and physical activity for older adults. *Medicine & Science in Sports & Exercise 41*(7): 1510–1530.

[34] Tse, M. M., Wan, V. T., & Ho, S. S. (2011). Physical exercise: Does it help in relieving pain and increasing mobility among older adults with chronic pain? *Journal of Clinical Nursing 20:* 635–644.

[35] Panel on Prevention of Falls in Older Persons, American Geriatrics Society and British Geriatrics Society. (2011). Summary of the updated American Geriatrics Society/British Geriatrics Society clinical practice guideline for prevention of falls in older persons. *Journal of the American Geriatrics Society 59*(1): 148–157.

[36] U.S. Department of Health and Human Services, Public Health Service, Office of the Surgeon General. (2001). *The Surgeon General's call to action to prevent and decrease overweight and obesity.* Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK44206

[37] U.S. Preventive Services Task Force. (2003, November). Screening for obesity in adults: Recommendations and rationale. *Annals of Internal Medicine 139*(11): 930–932. Retrieved from http://annals.org/article.aspx?articleid=1355696

[38] Must, A., Spadano, J., Coakley, E. H., Field, A. E., Colditz, G., & Dietz, W. H. (1999, October). The disease burden associated with overweight and obesity. *The Journal of the American Medical Association 282*(16): 1530–1538. Retrieved from http://jama.jamanetwork.com/article.aspx?articleid=192030

[39] Tobacco use. (2010, September). *CDC Vital Signs.* Retrieved from http://www.cdc.gov/vitalsigns/pdf/2010-09-vitalsigns.pdf

[40] Health Care Financing Administration. (1999). *A profile of Medicare home health: Chartbook* (Publication No. 1999-771-472). Washington, DC: U.S. Government Printing Office.

[41] Altman, A., Cooper, P. F., & Cunningham, P. J. (1999). The case of disability in the family: Impact on health care utilization and expenditures for nondisabled members. *The Milbank Quarterly, 77*(1), 39–75.

[42] Rasell, E., Bernstein, J., & Tang, K. (1994). The impact of health care financing on family budgets. *International Journal of Health Services, 24*(4), 691–714.

[43] U.S. Department of Health and Human Services. (n.d.). What is long-term care? Retrieved from http://longtermcare.gov/the-basics/what-is-long-term-care

[44] Harris-Kojetin, L., Sengupta, M., Park-Lee, E., Valverde, R., Caffrey, C., Rome, V., & Lendon, J. (2016). Long-term care providers and services users in the United States: Data from the National Study of Long-Term Care Providers, 2013–2014. *Vital and Health Statistics 3*(38). Retrieved from http://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf

[45] Bureau of Labor Statistics, Current Population Survey. (2014). *Employment and earnings online*.

[46] U.S. Environmental Protection Agency, Office of Research and Development, National Center for Environmental Assessment. (1996, July). *Air quality criteria for ozone and related photochemical oxidants* (EPA Report No. 600/P-93/004aF). Retrieved from http://nepis.epa.gov/

[47] U.S. Environmental Protection Agency, Office of Research and Development, Environmental Criteria and Assessment Office. (1993, August). *Air quality criteria for oxides of nitrogen* (EPA Report No. 600/8-91/049aF). Retrieved from http://nepis.epa.gov/

[48] U.S. Environmental Protection Agency, Office Research and Development, National Center for Environmental Assessment. (2000, July). *Air quality criteria for carbon monoxide* (EPA Report No. 600/P-99/001F). Retrieved from http://cfpub.epa.gov/ncea/risk/recordisplay.cfm?deid=18163

[49] U.S. Environmental Protection Agency, Office of Research and Development, National Center for Environmental Assessment. (2002, April). *Air quality criteria for particulate matter, third external review draft, volume II* (EPA Report No. 600/P-99/002aC). Retrieved from http://cfpub.epa.gov/ncea/risk/recordisplay.cfm?deid=29503&CFID=58108299&CFTOKEN=39147464

[50] Pope, C. A., III, Burnett, R. T., Thun, M. J., Calle, E. E., Krewski, D., Ito, K., & Thurston, G. D. (2002). Lung cancer, cardiopulmonary mortality, and long-term exposure to fine particulate air pollution. *The Journal of the American Medical Association 287*(9):1132–41.

[51] Freedman, V. A., Spillman, B. C., Andreski, P. M., Cornman, J. C., Crimmins, E. M., Kramarow, E., ... Waidmann, T.A. (2013). Trends in late-life activity limitations in the United States: An update from five national surveys. *Demography 50*(2): 661–671.

[52] Kaye, H., Harrington, C., & LaPlante, M. (2010). Long-term care: Who gets it, who provides it, who pays, and how much? *Health Affairs 29*(1): 11–21.

[53] Spillman, B. C. (2009). *Analyses of informal caregiving 2004.* Washington DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Office of Disability, Aging and Long-Term Care Policy. Retrieved from https://aspe.hhs.gov/sites/default/files/pdf/77146/NHATS-IC.pdf

[54] Spillman, B. C., & Black, K. (2005). *Staying the course: Trends in family caregiving* (Paper #2005-17). Retrieved from AARP website: http://assets.aarp.org/rgcenter/il/2005_17_caregiving.pdf

[55] Spillman, B. C. (2014). *Why do elders receiving informal home care transition to long stay nursing home residency?* Retrieved from U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation website: http://aspe.hhs.gov/basic-report/why-do-elders-receiving-informal-home-care-transition-long-stay-nursing-home-residency

[56] U.S. Department of Agriculture and U.S. Department of Health and Human Services. (2010). *Dietary guidelines for Americans* (7th ed.). Washington, DC: U.S. Government Printing Office. Retrieved from http://www.cnpp.usda.gov/dietaryguidelines.htm

[57] Freedman, L. S., Guenther, P. M., Krebs-Smith, S. M., & Kott, P. S. (2008). A population's mean Healthy Eating Index-2005 scores are best estimated by the score of the population ratio when one 24-hour recall is available. *Journal of Nutrition, 138*(9): 1725–1729.

[58] Zuvekas, S., & Cohen, J. W. (2002). A guide to comparing health care expenditures in the 1996 MEPS to the 1987 NMES. *Inquiry 39*(1): 76–86. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12067078

[59] Explanatory notes and estimates of error. *Employment and Earnings 51*(1):269–86. U.S. Department of Labor, Bureau of Labor Statistics. January 2004.

[60] Cohen, J. W., & Taylor, A. K. (1999). The provider system and the changing locus of expenditure data: Survey strategies from fee-for-service to managed care. In: A. C. Monheit, R. Wilson, R.H. Arnett III (Eds.), *Informing American health care policy: The dynamics of medical expenditures and insurance surveys, 1977–1996* (pp.43–66). San Francisco, CA: Jossey-Bass Publishers.

[61] Population estimates for cities and towns and estimates of housing units are covered in a separate document.

[62] For more information on the accuracy of the population estimates, see http://www.census.gov/population/www/documentation/twps0100/E2%20County%20Totals_FINAL.pdf.

[63] Domestic migration sums to 0 at the national level and therefore has no effect on the estimates.

[64] Citro, C. F., & Michael, R. T. (Eds.). (1995). *Measuring poverty: A new approach.* Washington DC: National Academy Press.

[65] Interagency Technical Working Group. (2010, March). *Observations From the Interagency Technical Working Group on developing a Supplemental Poverty Measure.* Retrieved from https://www.census.gov/hhes/povmeas/methodology/supplementalresearch/SPM_TWGObservations.pdf.

[66] Short, K. (2015, September). *The Supplemental Poverty Measure: 2014* (Current Population Report P60-254). Retrieved from U.S. Census Bureau website: http://www.census.gov/content/dam/Census/library/publications/2015/demo/p60-254.pdf.

[67] Data files can be downloaded from http://www.census.gov/hhes/povmeas/data/supplemental/public-use.html.

[68] Cagetti, M., & DeNardi, M. (2008). Wealth inequality: data and models. *Macroeconomic Dynamics, 12,* 285–313.

[69] Meijer, E., Karoly, L., & Michaud, P. C. (2010). Using Matched Survey and Administrative Data to Estimate Eligibility for the Medicare Part D Low-Income Subsidy Program. *Social Security Bulletin, 70*(2), 63–82.

[70] Bucks, B. K., Kennickell, A. B., March, T. L., & Moore, K.B. (2009, February). Changes in U.S. Family Finances from 2004 to 2007: Evidence from the Survey of Consumer Finances. *Federal Reserve Bulletin,* pp. A1–A56.

[71] U.S. Department of Health and Human Services, National Heart, Lung, and Blood Institute. (1998). *Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults* (NIH Publication No. 98-4083). Retrieved from http://www.ncbi.nlm.nih.gov/books/NBK2003/pdf/Bookshelf_NBK2003.pdf

[72] WHO. International statistical classification of diseases and related health problems, tenth revision (ICD-10). 2008 ed. Geneva, Switzerland. 2009.

[73] U.S. Census Bureau. Poverty definition, thresholds and guidelines. Retrieved from http://www.census.gov/hhes/www/poverty/methods/definitions.html.

Tables

INDICATOR 1: **Number of Older Americans**

Table 1a. Number of people (in millions) age 65 and over and age 85 and over, selected years, 1900–2014, and projected years, 2020–2060

Year	65 and over	85 and over
Estimates		
1900	3.1	0.1
1910	3.9	0.2
1920	4.9	0.2
1930	6.6	0.3
1940	9.0	0.4
1950	12.3	0.6
1960	16.2	0.9
1970	20.1	1.5
1980	25.5	2.2
1990	31.2	3.1
2000	35.0	4.2
2005	36.7	4.7
2010	40.3	5.5
2014	46.2	6.2
Projections		
2020	56.4	6.7
2030	74.1	9.1
2040	82.3	14.6
2050	88.0	19.0
2060	98.2	19.7

NOTE: Some data for 2020–2050 have been revised and differ from previous editions of *Older Americans*.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File; 2000, U.S. Census Bureau, 2001, *Census 2000 Summary File 1;* U.S. Census Bureau, Table 1: Intercensal Estimates of the Resident Population by Sex and Age for the U.S.: April 1, 2000, to July 1, 2010 (US-EST00INT-01); U.S. Census Bureau, 2011. *2010 Census Summary File 1;* U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010, to July 1, 2014 (PEPAGESEX); U.S. Census Bureau, Table 3: Projections of the Population by Sex and Selected Age Groups for the United States: 2015 to 2060 (NP2014-T3).

INDICATOR 1: **Number of Older Americans**

Table 1b. Percentage of people age 65 and over and age 85 and over, selected years, 1900–2014, and projected years, 2020–2060

Year	65 and over	85 and over
Estimates		
1900	4.1	0.2
1910	4.3	0.2
1920	4.7	0.2
1930	5.4	0.2
1940	6.8	0.3
1950	8.1	0.4
1960	9.0	0.5
1970	9.9	0.7
1980	11.3	1.0
1990	12.6	1.2
2000	12.4	1.5
2005	12.4	1.6
2010	13.0	1.8
2014	14.5	1.9
Projections		
2020	16.9	2.0
2030	20.6	2.5
2040	21.7	3.9
2050	22.1	4.8
2060	23.6	4.7

NOTE: Some data for 2020–2050 have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, 1900 to 1940, 1970, and 1980, U.S. Census Bureau, 1983, Table 42; 1950, U.S. Census Bureau, 1953, Table 38; 1960, U.S. Census Bureau, 1964, Table 155; 1990, U.S. Census Bureau, 1991, 1990 Summary Table File; 2000, U.S. Census Bureau, 2001, *Census 2000 Summary File 1;* U.S. Census Bureau, Table 1: Intercensal Estimates of the Resident Population by Sex and Age for the U.S.: April 1, 2000, to July 1, 2010 (US-EST00INT-01); U.S. Census Bureau, 2011. *2010 Census Summary File 1;* U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010, to July 1, 2014 (PEPAGESEX); U.S. Census Bureau, Table 3: Projections of the Population by Sex and Selected Age Groups for the United States: 2015 to 2060 (NP2014-T3).

INDICATOR 1: **Number of Older Americans**

Table 1c. Population of countries or areas with at least 10 percent of their population age 65 and over, 2015

	Population (number in thousands)		Percent
Country or area	Total	65 and over	65 and over
Japan	126,920	33,750	26.6
Germany	80,854	17,346	21.5
Italy	61,855	13,110	21.2
Greece	10,776	2,204	20.5
Finland	5,477	1,107	20.2
Sweden	9,802	1,959	20.0
Lithuania	2,884	552	19.1
Estonia	1,265	242	19.1
Latvia	1,987	377	19.0
Austria	8,666	1,639	18.9
Portugal	10,825	2,045	18.9
France	66,554	12,472	18.7
Bulgaria	7,187	1,345	18.7
Denmark	5,582	1,043	18.7
Slovenia	1,983	365	18.4
Hungary	9,898	1,805	18.2
Belgium	11,324	2,065	18.2
Croatia	4,465	814	18.2
Czech Republic	10,645	1,917	18.0
Netherlands	16,948	3,046	18.0
Switzerland	8,122	1,443	17.8
Spain	48,146	8,546	17.7
United Kingdom	64,088	11,366	17.7
Canada	35,100	6,223	17.7
Serbia	7,177	1,264	17.6
Puerto Rico	3,598	630	17.5
Norway	5,208	850	16.3
Ukraine	44,429	7,019	15.8
Romania	21,666	3,408	15.7
Poland	38,562	6,044	15.7
Georgia	4,931	766	15.5
Australia	22,751	3,520	15.5
Hong Kong	7,141	1,096	15.3
United States	321,369	47,830	14.9
New Zealand	4,438	649	14.6
Belarus	9,590	1,385	14.4
Slovakia	5,445	782	14.4
Uruguay	3,342	469	14.0
Bosnia and Herzegovina	3,867	528	13.7
Russia	142,424	19,384	13.6
Korea, South	49,115	6,395	13.0
Cuba	11,031	1,428	12.9
Macedonia	2,096	267	12.7
Ireland	4,892	617	12.6
Taiwan	23,415	2,922	12.5
Moldova	3,547	414	11.7
Argentina	43,432	5,018	11.6
Cyprus	1,189	137	11.5

See notes at end of table.

INDICATOR 1: **Number of Older Americans**

Table 1c. Population of countries or areas with at least 10 percent of their population age 65 and over, 2015—continued

	Population (number in thousands)		Percent
Country or area	Total	65 and over	65 and over
Albania	3,029	342	11.3
Israel	8,049	873	10.8
Armenia	3,056	327	10.7
Chile	17,508	1,789	10.2
China	1,367,485	136,890	10.0

NOTE: Table excludes countries and areas with less than 1,000,000 total population.

SOURCE: U.S. Census Bureau, International Data Base, accessed on October 1, 2015.

INDICATOR 1: **Number of Older Americans**

Table 1d. Percentage of the population age 65 and over, by state, 2014

State (listed alphabetically)	Percent	State (ranked by percentage)	Percent
United States	**14.5**	**United States**	**14.5**
Alabama	15.3	Florida	19.1
Alaska	9.4	Maine	18.3
Arizona	15.9	West Virginia	17.8
Arkansas	15.7	Vermont	16.9
California	12.9	Montana	16.7
Colorado	12.7	Pennsylvania	16.7
Connecticut	15.5	Delaware	16.4
Delaware	16.4	Hawaii	16.1
District of Columbia	11.3	Oregon	16.0
Florida	19.1	New Hampshire	15.9
Georgia	12.4	Arizona	15.9
Hawaii	16.1	Iowa	15.8
Idaho	14.3	South Carolina	15.8
Illinois	13.9	Rhode Island	15.7
Indiana	14.3	Arkansas	15.7
Iowa	15.8	Ohio	15.5
Kansas	14.3	Connecticut	15.5
Kentucky	14.8	Michigan	15.4
Louisiana	13.6	Missouri	15.4
Maine	18.3	Alabama	15.3
Maryland	13.8	New Mexico	15.3
Massachusetts	15.1	South Dakota	15.3
Michigan	15.4	Wisconsin	15.2
Minnesota	14.3	Massachusetts	15.1
Mississippi	14.3	Tennessee	15.1
Missouri	15.4	Kentucky	14.8
Montana	16.7	North Carolina	14.7
Nebraska	14.4	New Jersey	14.7
Nevada	14.2	New York	14.7
New Hampshire	15.9	Oklahoma	14.5
New Jersey	14.7	Nebraska	14.4
New Mexico	15.3	Mississippi	14.3
New York	14.7	Kansas	14.3
North Carolina	14.7	Minnesota	14.3
North Dakota	14.2	Idaho	14.3
Ohio	15.5	Indiana	14.3
Oklahoma	14.5	North Dakota	14.2
Oregon	16.0	Nevada	14.2

See notes at end of table.

INDICATOR 1: **Number of Older Americans**

Table 1d. Percentage of the population age 65 and over, by state, 2014—continued

State (listed alphabetically)	Percent	State (ranked by percentage)	Percent
Pennsylvania	16.7	Washington	14.1
Rhode Island	15.7	Wyoming	14.0
South Carolina	15.8	Illinois	13.9
South Dakota	15.3	Virginia	13.8
Tennessee	15.1	Maryland	13.8
Texas	11.5	Louisiana	13.6
Utah	10.0	California	12.9
Vermont	16.9	Colorado	12.7
Virginia	13.8	Georgia	12.4
Washington	14.1	Texas	11.5
West Virginia	17.8	District of Columbia	11.3
Wisconsin	15.2	Utah	10.0
Wyoming	14.0	Alaska	9.4
Puerto Rico	17.4	Puerto Rico	17.4

NOTE: Puerto Rico is not included in the U.S. average.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010, to July 1, 2014 (PEPAGESEX).

Table 1e. Percentage of the population age 65 and over, by county, 2014

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010, to July 1, 2014 (PEPAGESEX).

Data for this table can be found at http://www.agingstats.gov.

Table 1f. Number and percentage of people age 65 and over and age 85 and over, by sex, 2014

Age and sex	Number (in thousands)	Percent
65 and over	46,243	100.0
Men	20,351	44.0
Women	25,892	56.0
85 and over	6,162	100.0
Men	2,109	34.2
Women	4,053	65.8

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States, States, Counties, and Puerto Rico Commonwealth and Municipios: April 1, 2010 to July 1, 2014 (PEPAGESEX).

INDICATOR 2: **Racial and Ethnic Composition**

Table 2. Population age 65 and over, by race and Hispanic origin, 2014 and projected 2060

	2014		2060 projections	
Race and Hispanic or Latino origin	Number (in thousands)	Percent	Number (in thousands)	Percent
Total	46,243	100.0	98,164	100.0
Non-Hispanic or Latino				
White alone	36,208	78.3	53,566	54.6
Black alone	4,017	8.7	11,954	12.2
Asian alone	1,869	4.0	8,491	8.7
All other races alone or in combination	598	1.3	2,644	2.7
Hispanic or Latino (any race)	3,551	7.7	21,508	21.9

NOTE: The presentation of racial and ethnic composition data in this table has changed from previous editions of *Older Americans*. Unlike in previous editions, Hispanics are not counted in any race group. The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "non-Hispanic Black alone" is used to refer to people who reported being Black or African American and no other race and who are not Hispanic, and the term "non-Hispanic Asian alone" is used to refer to people who reported only Asian as their race and who are not Hispanic. The use of single-race populations in this table does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. The race group "non-Hispanic All other races alone or in combination" includes people who reported American Indian and Alaska Native alone who are not Hispanic; people who reported Native Hawaiian and Other Pacific Islander alone who are not Hispanic; and all people who reported two or more races who are not Hispanic. "Hispanic" refers to an ethnic category; Hispanics may be of any race.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Annual Estimates of the Resident Population by Sex, Age, Race, and Hispanic Origin for the United States and States: April 1, 2010, to July 1, 2014 (PEPASR6H); U.S. Census Bureau, Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2014 to 2060 (NP2014_D1).

INDICATOR 3: **Marital Status**

Table 3. Marital status of the population age 65 and over, by age group and sex, 2015

Sex and marital status	65 and over	65–74	75–84	85 and over
Total	100.0	100.0	100.0	100.0
Married	58.6	65.4	56.0	32.1
Widowed	24.4	13.9	31.0	59.3
Divorced	12.2	15.1	9.3	5.2
Never married	4.8	5.6	3.7	3.5
Men	100.0	100.0	100.0	100.0
Married	72.4	73.9	73.8	58.6
Widowed	11.9	6.8	15.6	33.9
Divorced	10.8	13.4	7.5	4.3
Never married	4.9	5.9	3.2	3.3
Women	100.0	100.0	100.0	100.0
Married	47.6	57.9	42.2	17.4
Widowed	34.3	20.1	42.9	73.3
Divorced	13.3	16.6	10.8	5.6
Never married	4.8	5.4	4.1	3.7

NOTE: Married includes married, spouse present; married, spouse absent; and separated.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 4: **Educational Attainment**

Table 4a. Educational attainment of the population age 65 and over, selected years 1965–2015

Educational attainment	1965	1970	1975	1980	1985	1990	1995	2000	2001	2002	2003	2004
						Percent						
High school graduate or more	23.5	28.3	37.3	40.7	48.2	55.4	63.8	69.5	70.0	69.9	71.5	73.1
Bachelor's degree or more	5.0	6.3	8.1	8.6	9.4	11.6	13.0	15.6	16.2	16.7	17.4	18.7
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	
High school graduate or more	74.0	75.2	76.1	77.4	78.3	79.5	80.7	81.1	82.6	83.7	84.3	
Bachelor's degree or more	18.9	19.5	19.2	20.5	21.7	22.5	23.2	24.3	25.3	26.3	26.7	

NOTE: A single question that asks for the highest grade or degree completed is used to determine educational attainment. Prior to 1995, educational attainment was measured using data on years of school completed.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Table 4b. Educational attainment of the population age 65 and over, by sex and race and Hispanic origin, 2015

Sex and race and Hispanic origin	High school graduate or more	Bachelor's degree or more
	Percent	
Total	84.3	26.7
Sex		
Men	85.5	31.8
Women	83.4	22.5
Race and Hispanic origin		
Non-Hispanic White alone	89.1	28.9
Black alone	74.8	17.5
Asian alone	74.4	34.0
Hispanic (any race)	54.2	11.5

NOTE: The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "Black alone" is used to refer to people who reported being Black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this table does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 5: **Living Arrangements**

Table 5a. Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2015

Sex and race and Hispanic origin	Total	With spouse	With other relatives	With nonrelatives	Alone
			Percent		
Men	100.0	70.0	6.0	3.7	20.2
Non-Hispanic White alone	100.0	72.0	4.4	3.3	20.3
Black alone	100.0	50.0	13.7	6.3	29.9
Asian alone	100.0	78.2	9.5	2.8	9.5
Hispanic (any race)	100.0	66.6	12.8	5.2	15.4
Women	100.0	45.2	16.4	2.6	35.8
Non-Hispanic White alone	100.0	47.9	12.2	2.6	37.2
Black alone	100.0	24.4	30.2	2.1	43.3
Asian alone	100.0	52.2	26.0	1.4	20.4
Hispanic (any race)	100.0	39.7	34.4	3.2	22.8

NOTE: Living with other relatives indicates no spouse present. Living with nonrelatives indicates no spouse or other relatives present. The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "Black alone" is used to refer to people who reported being Black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this table does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. Totals may not sum to 100 percent because of rounding.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Table 5b. Percentage of population age 65 and over living alone, by sex and age group, selected years, 1970–2015

	Men		Women	
Year	65–74	75 and over	65–74	75 and over
1970	11.3	19.1	31.7	37.0
1980	11.6	21.6	35.6	49.4
1990	13.0	20.9	33.2	54.0
2000	13.8	21.4	30.6	49.5
2003	15.6	22.9	29.6	49.8
2004	15.5	23.2	29.4	49.9
2005	16.1	23.2	28.9	47.8
2006	16.9	22.7	28.5	48.0
2007	16.7	22.0	28.0	48.8
2008	16.3	21.5	29.1	50.1
2009	—	—	—	—
2010	16.4	22.6	27.7	47.4
2011	16.3	22.2	27.7	46.5
2012	16.7	22.2	27.2	46.3
2013	16.3	23.0	27.0	45.0
2014	17.1	22.6	26.9	46.0
2015	18.5	23.0	27.7	46.3

— Not available.

Reference population: These data refer to the civilian noninstitutionalized population.

Source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 6: **Older Veterans**

Table 6a. Percentage of population age 65 and over who are veterans, by age group and sex, 2000, 2010, and 2015, and projected 2020 and 2025

	65 and over		65–74		75–84		85 and over	
Year	Men	Women	Men	Women	Men	Women	Men	Women
Estimates								
2000	64.3	1.7	65.2	1.1	70.9	2.7	32.6	1.0
2010	51.3	1.3	42.8	1.1	60.8	1.1	68.3	2.5
2015	45.4	1.3	40.0	1.3	49.3	1.1	66.2	1.7
Projections								
2020	35.6	1.5	28.5	1.7	42.3	1.1	60.6	1.4
2025	28.1	1.7	17.7	2.0	40.5	1.3	50.0	1.2

NOTE: Some data for 2020 have been revised and differ from previous editions of *Older Americans*.
Reference population: These data refer to the resident population of the United States and Puerto Rico.
SOURCE: U.S. Census Bureau, Population Projections 2014, and *2010 Census Summary File 1;* Department of Veterans Affairs, VetPop2014.

Table 6b. Number of veterans age 65 and over, by age group and sex, 2000, 2010, and 2015, and projected 2020 and 2025

	Estimates			Projections	
Age group and sex	2000	2010	2015	2020	2025
			Number (in thousands)		
65 and over	9,723	9,169	9,934	9,428	8,924
Men	9,374	8,866	9,591	8,976	8,316
Women	349	303	343	452	609
65–74	5,628	4,377	5,360	4,696	3,478
Men	5,516	4,253	5,174	4,405	3,079
Women	112	124	186	291	398
75–84	3,667	3,403	3,060	3,199	3,990
Men	3,460	3,321	2,972	3,097	3,836
Women	207	82	88	102	154
85 and over	427	1,389	1,513	1,533	1,457
Men	398	1,292	1,444	1,474	1,401
Women	30	97	69	59	56

NOTE: Some data for 2020 have been revised and differ from previous editions of *Older Americans*. Estimates may not sum to the totals because of rounding.
Reference population: These data refer to the resident population of the United States and Puerto Rico.
SOURCE: U.S. Census Bureau, Population Projections 2014, and *2010 Census Summary File 1;* Department of Veterans Affairs, VetPop2014.

INDICATOR 7: **Poverty**

Table 7a. Poverty rate by age, by official poverty measure and Supplemental Poverty Measure, 1966–2014

			65 and over			
Year	Under 18	18–64	Total	65–74	75–84	85 and over
1966	17.6	10.5	28.5	—	—	—
1967	16.6	10.0	29.5	—	—	—
1968	15.6	9.0	25.0	—	—	—
1969	14.0	8.7	25.3	—	—	—
1970	15.1	9.0	24.6	—	—	—
1971	15.3	9.3	21.6	—	—	—
1972	15.1	8.8	18.6	—	—	—
1973	14.4	8.3	16.3	—	—	—
1974	15.4	8.3	14.6	—	—	—
1975	17.1	9.2	15.3	—	—	—
1976	16.0	9.0	15.0	—	—	—
1977	16.2	8.8	14.1	—	—	—
1978	15.9	8.7	14.0	—	—	—
1979	16.4	8.9	15.2	—	—	—
1980	18.3	10.1	15.7	—	—	—
1981	20.0	11.1	15.3	—	—	—
1982	21.9	12.0	14.6	12.4	17.4	21.2
1983	22.3	12.4	13.8	11.9	16.7	21.3
1984	21.5	11.7	12.4	10.3	15.2	18.4
1985	20.7	11.3	12.6	10.6	15.3	18.7
1986	20.5	10.8	12.4	10.3	15.3	17.6
1987	20.3	10.6	12.5	9.9	16.0	18.9
1988	19.5	10.5	12.0	10.0	14.6	17.8
1989	19.6	10.2	11.4	8.8	14.6	18.4
1990	20.6	10.7	12.2	9.7	14.9	20.2
1991	21.8	11.4	12.4	10.6	14.0	18.9
1992	22.3	11.9	12.9	10.6	15.2	19.9
1993	22.7	12.4	12.2	10.0	14.1	19.7
1994	21.8	11.9	11.7	10.1	12.8	18.0
1995	20.8	11.4	10.5	8.6	12.3	15.7
1996	20.5	11.4	10.8	8.8	12.5	16.5
1997	19.9	10.9	10.5	9.2	11.3	15.7
1998	18.9	10.5	10.5	9.1	11.6	14.2
1999	17.1	10.1	9.7	8.8	9.8	14.2
2000	16.2	9.6	9.9	8.6	10.6	14.5
2001	16.3	10.1	10.1	9.2	10.4	13.9
2002	16.7	10.6	10.4	9.4	11.1	13.6
2003	17.6	10.8	10.2	9.0	11.0	13.8
2004	17.8	11.3	9.8	9.4	9.7	12.6
2005	17.6	11.1	10.1	8.9	10.9	13.4
2006	17.4	10.8	9.4	8.6	10.0	11.4
2007	18.0	10.9	9.7	8.8	9.8	13.0
2008	19.0	11.7	9.7	8.4	10.7	12.7
2009	20.7	12.9	8.9	8.0	9.4	11.6
2010	22.0	13.8	8.9	8.1	9.2	12.2

See notes at end of table.

INDICATOR 7: **Poverty**

Table 7a. Poverty rate by age, by official poverty measure and Supplemental Poverty Measure, 1966–2014—continued

			65 and over			
Year	Under 18	18–64	Total	65–74	75–84	85 and over
2011	21.9	13.7	8.7	7.4	10.0	11.5
2012	21.8	13.7	9.1	7.9	9.9	12.3
2013 (traditional)	19.9	13.6	9.5	8.3	10.9	11.8
2013 (redesign)	21.5	13.3	10.2	8.8	11.1	14.2
2014	21.1	13.5	10.0	8.7	11.3	12.7
			Supplemental Poverty Peasure			
2009	17.0	14.4	14.9	12.6	17.0	19.1
2010	17.9	15.2	15.8	13.3	17.7	21.8
2011	18.0	15.5	15.1	12.7	17.6	19.2
2012	18.0	15.5	14.8	12.3	17.1	20.9
2013 (traditional)	16.4	15.4	14.6	12.1	17.3	20.1
2013 (redesign)	18.1	14.9	15.5	13.5	17.0	22.0
2014	16.7	15.0	14.4	12.5	16.2	19.6

— Data not available.

NOTE: Poverty status in the Current Population Survey (CPS) is based on prior year income. The 2014 CPS Annual Social and Economic Supplement (ASEC) included redesigned questions for income that were implemented to a subsample of the 98,000 addresses using a probability split panel design. The source for "2013 (traditional)" in this table is the portion of the sample (68,000) which received a set of income questions similar to those used in 2013; the source for "2013 (redesign)" is the portion of the 2014 CPS ASEC sample (30,000) which received the redesigned income questions. The redesigned income questions were used for the entire 2015 CPS ASEC sample. The official poverty measure is based on money income and does not include noncash benefits such as food stamps. Poverty thresholds reflect family size and composition and are adjusted each year using the annual average Consumer Price Index. The Supplemental Poverty Measure (SPM) extends the official poverty measure by taking account of many of the government programs designed to assist low income families and individuals that are not included in the current official poverty measure and by using thresholds derived from the Consumer Expenditure Survey by the Bureau of Labor Statistics. For more detail, see U.S. Census Bureau Series P-60, No. 252. Additional years of data are available at agingstats.gov.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

Table 7b. Percentage of the population age 65 and over living in poverty, by selected characteristics, 2014

	65 and over				
Selected characteristic	Total	Living alone	Married couples	65–74	75 and over
Both Sexes					
Total	10.0	18.0	5.0	8.7	11.7
Non-Hispanic White alone	7.8	14.8	3.8	6.4	9.7
Black alone	19.2	28.4	7.5	19.0	19.6
Asian alone	14.7	34.6	10.5	14.0	15.8
Hispanic (any race)	18.1	32.9	12.7	16.1	21.3
Male					
Total	7.4	13.6	5.1	7.2	7.6
Non-Hispanic White alone	5.3	10.4	3.7	4.9	5.8
Black alone	16.7	25.4	8.5	17.9	14.3
Asian alone	13.1	29.5	11.0	13.0	13.4
Hispanic (any race)	16.2	26.2	13.2	15.8	16.8
Female					
Total	12.1	20.2	4.9	10.1	14.7
Non-Hispanic White alone	9.9	17.0	3.9	7.8	12.6
Black alone	20.9	30.0	6.3	19.8	22.6
Asian alone	16.0	37.0	9.9	14.9	17.7
Hispanic (any race)	19.6	36.8	12.2	16.3	24.5

NOTE: The poverty level is based on money income and does not include noncash benefits such as food stamps. Poverty thresholds reflect family size and composition and are adjusted each year using the annual average Consumer Price Index. For more detail, see U.S. Census Bureau, Series P-60, No. 252. The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "Black alone" is used to refer to people who reported being Black or African American and no other race, and the term "Asian alone" is used to refer to people who reported only Asian as their race. The use of single-race populations in this table does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 8: **Income**

Table 8a. Income distribution of the population age 65 and over, 1974–2014

Year	Poverty	Low income	Middle income	High income
1974	14.6	34.6	32.6	18.2
1975	15.3	35.0	32.3	17.4
1976	15.0	34.7	31.8	18.5
1977	14.1	35.9	31.5	18.5
1978	14.0	33.4	34.2	18.5
1979	15.2	33.0	33.6	18.2
1980	15.7	33.5	32.4	18.4
1981	15.3	32.8	33.1	18.9
1982	14.6	31.4	33.3	20.7
1983	13.8	29.7	34.1	22.4
1984	12.4	30.2	33.8	23.6
1985	12.6	29.4	34.6	23.4
1986	12.4	28.4	34.4	24.8
1987	12.5	27.8	35.1	24.7
1988	12.0	28.4	34.5	25.1
1989	11.4	29.1	33.6	25.9
1990	12.2	27.0	35.2	25.6
1991	12.4	28.0	36.3	23.3
1992	12.9	28.6	35.6	22.9
1993	12.2	29.8	35.0	23.0
1994	11.7	29.5	35.6	23.2
1995	10.5	29.1	36.1	24.3
1996	10.8	29.5	34.7	25.1
1997	10.5	28.1	35.3	26.0
1998	10.5	26.8	35.3	27.5
1999	9.7	26.2	36.4	27.7
2000	9.9	27.5	35.5	27.1
2001	10.1	28.1	35.2	26.7
2002	10.4	28.0	35.3	26.2
2003	10.2	28.5	33.8	27.5
2004	9.8	28.1	34.6	27.5
2005	10.1	26.6	35.2	28.1
2006	9.4	26.2	35.7	28.6
2007	9.8	26.3	33.3	30.6
2008	9.7	26.5	33.7	30.1
2009	8.9	24.8	35.1	31.2
2010	8.9	25.6	34.0	31.5
2011	8.7	24.9	34.2	32.2
2012	9.1	24.6	33.7	32.6
2013 (traditional)	9.5	23.6	33.0	33.8
2013 (redesign)	10.2	22.1	30.9	36.8
2014	10.0	22.5	31.1	36.4

NOTE: Income distribution in the Current Population Survey (CPS) is based on prior year income. The 2014 CPS Annual Social and Economic Supplement (ASEC) included redesigned questions for income that were implemented to a subsample of the 98,000 addresses using a probability split panel design. The source for "2013 (traditional)" in this table is the portion of the sample (68,000 addresses) that received a set of income questions similar to those used in 2013; the source for "2013 (redesign)" is the portion of the 2014 CPS ASEC sample (30,000 addresses) that received the redesigned income questions. The redesigned income questions were used for the entire 2015 CPS ASEC sample. The income categories are derived from the ratio of the family's income (or an unrelated individual's income) to the corresponding official poverty threshold. Being in poverty is measured as income less than 100 percent of the poverty threshold. Low income is between 100 and 199 percent of the poverty threshold. Middle income is between 200 percent and 399 percent of the poverty threshold. High income is 400 percent or more of the poverty threshold. Some data have been revised and differ from previous versions of *Older Americans*.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 8: **Income**

Table 8b. Median income of householders age 65 and over, in current and in 2014 dollars, 1974–2014

Year	Number (in thousands)	Current dollars	2014 dollars
1974	14,263	$5,292	$22,921
1975	14,802	5,585	22,353
1976	14,816	5,962	22,563
1977	15,225	6,347	22,595
1978	15,795	7,081	23,590
1979	16,544	7,879	23,975
1980	16,912	8,781	24,029
1981	17,312	9,903	24,743
1982	17,671	11,041	26,017
1983	17,901	11,718	26,499
1984	18,155	12,799	27,787
1985	18,596	13,254	27,820
1986	18,998	13,845	28,544
1987	19,412	14,443	28,803
1988	19,716	14,923	28,707
1989	20,156	15,771	29,084
1990	20,527	16,855	29,622
1991	20,921	16,975	28,785
1992	20,682	17,135	28,338
1993	20,806	17,751	28,649
1994	21,365	18,095	28,607
1995	21,486	19,096	29,479
1996	21,408	19,448	29,231
1997	21,497	20,761	30,544
1998	21,589	21,729	31,542
1999	22,478	22,797	32,402
2000	22,469	23,083	31,732
2001	22,476	23,118	30,913
2002	22,659	23,152	30,466
2003	23,048	23,787	30,618
2004	23,151	24,516	30,727
2005	23,459	26,036	31,563
2006	23,729	27,798	32,641
2007	24,113	28,305	32,319
2008	24,834	29,744	32,706
2009	25,270	31,354	34,597
2010	25,737	31,461	34,162
2011	26,843	33,118	34,862
2012	27,924	33,848	34,902
2013 (traditional)	28,729	35,611	36,194
2013 (redesign)	29,069	37,297	37,907
2014	29,946	36,895	36,895

NOTE: Income distribution in the Current Population Survey (CPS) is based on prior year income. The 2014 CPS Annual Social and Economic Supplement (ASEC) included redesigned questions for income that were implemented to a subsample of the 98,000 addresses using a probability split panel design. The source for "2013 (traditional)" in this table is the portion of the sample (68,000 addresses) that received a set of income questions similar to those used in 2013; the source for "2013 (redesign)" is the portion of the 2014 CPS ASEC sample (30,000 addresses) that received the redesigned income questions. The redesigned income questions were used for the entire 2015 CPS ASEC sample. Some data have been revised and differ from previous versions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 9: **Sources of Income**

Table 9a. Percentage distribution of per capita family income for persons age 65 and over, by income quintile and source of income, 2014

Source of income	Total	Lowest fifth	Second fifth	Third fifth	Fourth fifth	Highest fifth
Total	100.0	100.0	100.0	100.0	100.0	100.0
Percentage of income from						
Earnings	23.7	13.1	13.8	21.0	30.4	39.6
Retirement benefits	64.7	70.8	79.8	71.0	58.5	43.6
Social Security	48.7	66.7	72.3	53.6	34.2	17.8
Railroad Retirement	0.2	0.1	0.2	0.3	0.3	0.1
Government employee pensions	5.6	1.0	2.1	4.9	8.7	11.2
Private pensions or annuities	10.1	3.0	5.3	12.2	15.3	14.5
Asset income	6.4	5.8	2.4	4.2	6.3	13.1
Cash public assistance	2.0	7.6	1.6	0.6	0.3	0.1
Other	3.3	2.6	2.3	3.3	4.5	3.7
Number (in thousands)	45,079	8,630	9,114	9,120	9,100	9,115

NOTE: The definition of "other" includes, but is not limited to, unemployment compensation, workers' compensation, veterans' payments, and personal contributions. Quintile limits are $12,492, $19,245, $29,027, and $47,129. Estimates may not sum to the totals because of rounding.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 9: **Sources of Income**

Table 9b. Percentage of people age 55 and over with family income from specified sources, by age group, 2014

			65 and over				
Source of family income	55–61	62–64	Total	65–69	70–74	75–79	80 and over
Earnings	83.7	72.9	40.2	57.1	40.4	30.6	22.8
Wages and salaries	80.6	69.2	37.0	53.3	36.6	28.0	20.9
Self-employment	10.8	10.4	6.4	8.6	7.3	4.8	3.4
Retirement benefits	31.4	57.3	89.1	83.2	91.7	92.4	92.2
Social Security	22.2	46.6	86.0	78.7	89.4	90.2	90.0
Benefits other than Social Security	16.1	29.6	47.7	43.0	50.9	51.7	48.0
Other public pensions	7.1	13.4	17.7	17.4	18.5	18.0	17.2
Railroad Retirement	0.1	0.5	0.4	0.3	0.6	0.3	0.4
Government employee pensions	7.0	13.0	17.4	17.1	18.0	17.7	16.8
Military	1.0	1.2	2.0	1.7	2.0	2.0	2.3
Federal	1.9	2.9	4.7	4.2	5.2	5.2	4.6
State or local	4.5	9.5	12.1	12.4	12.6	12.0	11.2
Private pensions or annuities	12.0	23.0	40.9	35.7	44.4	45.7	41.2
Asset income	66.9	68.9	67.1	69.0	68.1	65.6	64.5
Interest	66.0	67.6	65.7	68.1	66.6	64.0	62.6
Other income from assets	25.4	28.0	28.4	29.2	28.1	28.3	27.6
Dividends	21.0	22.7	23.1	23.9	22.4	23.1	22.5
Rent or royalties	9.0	11.2	10.3	10.9	10.6	10.4	9.0
Estates or trusts	0.3	0.4	0.4	0.4	0.2	0.4	0.6
Veterans' benefits	2.7	4.1	5.6	6.8	5.0	4.5	5.4
Unemployment compensation	4.3	3.5	1.4	2.1	1.4	0.9	0.7
Workers' compensation	1.1	0.9	0.5	0.7	0.4	0.4	0.4
Cash public assistance and noncash benefits	15.0	13.8	13.3	12.6	13.0	13.7	14.3
Cash public assistance	7.6	6.9	5.2	5.3	4.9	5.2	5.2
Supplemental Security Income	6.9	6.3	4.8	4.9	4.5	4.9	4.9
Other	1.2	0.7	0.5	0.6	0.5	0.4	0.4
Noncash benefits	11.6	10.7	11.0	10.2	10.8	11.6	12.1
Food	9.5	8.8	7.4	7.3	7.2	7.7	7.6
Energy	2.9	2.6	3.3	2.8	2.9	4.4	3.8
Housing	2.9	3.0	3.9	3.3	3.8	4.5	4.4
Personal contributions	2.4	1.8	1.4	1.3	1.2	1.4	1.7
Number (in thousands)	29,434	10,983	45,994	15,728	11,209	8,002	11,054

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement.

INDICATOR 9: **Sources of Income**

Table 9c. Number of participants (in thousands) in private pension plans, by type of plan, 1975–2013

		Defined	
Year	Total	Benefit	Contribution
1975	44,511	33,004	11,507
1976	47,679	34,207	13,472
1977	50,236	34,997	15,239
1978	52,371	36,103	16,268
1979	55,097	36,810	18,287
1980	57,903	37,979	19,924
1981	60,564	38,903	21,661
1982	63,243	38,633	24,610
1983	69,147	40,025	29,122
1984	73,895	40,980	32,915
1985	74,665	39,692	34,973
1986	76,672	39,989	36,682
1987	78,223	39,958	38,265
1988	77,685	40,722	36,963
1989	76,405	39,958	36,447
1990	76,924	38,832	38,091
1991	77,662	39,027	38,634
1992	81,914	39,531	42,383
1993	83,870	40,267	43,603
1994	85,117	40,338	44,778
1995	87,452	39,736	47,716
1996	91,716	41,111	50,605
1997	94,985	40,392	54,593
1998	99,455	41,552	57,903
1999	101,794	41,427	60,368
2000	103,329	41,613	61,716
2001	106,579	42,067	64,511
2002	107,354	42,078	65,275
2003	106,296	42,179	64,117
2004	106,335	41,707	64,627
2004[a]	115,707	41,918	73,789
2005	117,406	41,925	75,481
2006	121,995	42,146	79,849
2007	123,854	42,280	81,574
2008	124,853	42,344	82,510
2009	129,268	41,820	87,448
2010	129,724	41,423	88,301
2011	129,581	40,876	88,705
2012	130,584	39,809	90,775
2013	131,631	39,084	92,547

[a] The number of participants for 2004 was revised using the new definition summarized in the note below.

NOTE: The methodology for calculating participants was changed beginning with the 2005 Form 5500 series in response to the discontinuance of the IRS Form 5500 Schedule T. For 2004, the revision increases counts of participants by 9 million. Under the current methodology, participant counts include all workers eligible to participate in a plan. The term "participants" refers to active, retired, and separated vested participants not yet in pay status. Workers participating in more than one plan are counted separately for each plan in which they participate.

Reference population: These data refer to counts of participants reported by private pension plans on the Form 5500.

SOURCE: U.S. Department of Labor, Employee Benefits Security Administration, Form 5500 filings.

INDICATOR 9: **Sources of Income**

Table 9d. Number of participants (in thousands) in private defined benefit pension plans and percent of participants retired or separated from employer, 1975–2013

Year	Number of participants	Percent retired or separated from employer
1975	33,004	17.5
1976	34,207	19.5
1977	34,997	19.8
1978	36,103	19.6
1979	36,810	20.0
1980	37,979	20.7
1981	38,903	22.8
1982	38,633	23.2
1983	40,025	25.4
1984	40,980	26.6
1985	39,692	27.2
1986	39,989	28.7
1987	39,958	28.9
1988	40,722	31.3
1989	39,958	32.1
1990	38,832	32.5
1991	39,027	34.4
1992	39,531	36.2
1993	40,267	37.9
1994	40,338	39.3
1995	39,736	41.1
1996	41,111	43.7
1997	40,392	44.0
1998	41,552	45.0
1999	41,427	45.4
2000	41,613	46.6
2001	42,067	47.5
2002	42,078	48.6
2003	42,179	49.5
2004	41,707	50.6
2005	41,925	51.6
2006	42,146	52.7
2007	42,280	54.1
2008	42,344	55.2
2009	41,820	56.7
2010	41,423	58.5
2011	40,876	59.6
2012	39,809	60.4
2013	39,084	61.0

Reference population: These data refer to participants in private defined benefit pension plans who filed a Form 5500.

SOURCE: U.S. Department of Labor, Employee Benefits Security Administration, Form 5500 filings.

INDICATOR 9: **Sources of Income**

Table 9e. Number of participants (in thousands) in defined benefit and defined contribution retirement plans, by selected type of plan, 1999–2013

	Defined benefit			Defined contribution			
		Cash balance			401(k)-type plans		
						401(k)-type plans that allow participants to direct all or portion of investments	
Year	Total	Number	Share of total participants in defined benefit plans	Total	Number	Number	Share of total participants in 401(k)-type plans
1999	41,427	6,175	14.9	60,368	46,203	39,493	85.5
2000	41,613	7,016	16.9	61,716	48,348	43,834	90.7
2001	42,067	7,820	18.6	64,511	51,814	47,530	91.7
2002	42,078	8,244	19.6	65,275	53,296	49,250	92.4
2003	42,179	9,346	22.2	64,117	53,842	50,255	93.3
2004	41,707	9,808	23.5	64,627	54,892	51,250	93.4
2005	41,925	10,135	24.2	75,481	65,652	62,009	94.5
2006	42,146	10,185	24.2	79,849	70,295	66,555	94.7
2007	42,280	10,520	24.9	81,574	72,178	68,642	95.1
2008	42,344	10,812	25.5	82,510	73,156	69,542	95.1
2009	41,820	11,760	28.1	87,448	72,499	69,478	95.8
2010	41,423	12,040	29.1	88,301	72,165	69,627	96.5
2011	40,876	12,150	29.7	88,705	72,968	70,517	96.6
2012	39,809	11,833	29.7	90,775	74,881	72,532	96.9
2013	39,084	11,956	30.6	92,547	76,640	74,354	97.0

Reference population: These data refer to participants in private pension plans who filed a Form 5500.

SOURCE: U.S. Department of Labor, Employee Benefits Security Administration, Form 5500 filings.

Table 9f. Percentage of workers in private sector and state and local government with access to retirement benefits, by type of retirement plan, 2015

Type of employment	Defined contribution only	Defined benefit and defined contribution	Defined benefit only
Private sector, all workers	47	14	4
State and local government, all workers	6	27	57

Reference population: These data refer to civilian workers in establishments covered by unemployment insurance.

SOURCE: National Compensation Survey, March 2015, Bureau of Labor Statistics.

INDICATOR 10: **Social Security Beneficiaries**

Table 10a. Percentage distribution of people who began receiving Social Security benefits in 2014, by age and sex

		Pre-Full Retirement Age				Full Retirement Age		Post-Full Retirement Age		
Sex	Total years	Age 62	Age 63	Age 64	Age 65	Age 66	Disabled Worker Conversions[a]	Age 66	Age 67–69	Age 70 and over
Men	100	36	6	6	11	17	18	3	3	2
Women	100	41	7	7	11	12	16	2	3	3

[a] At Full Retirement Age (FRA), persons formerly receiving disabled worker benefits are reclassified and begin receiving retired worker benefits.

NOTE: FRA is defined as age 66 for those born between 1943 and 1955. The percentages are not probabilities of a birth cohort claiming at a particular age. A person begins receiving Social Security benefits the month after he or she becomes entitled. Totals may not sum to 100 percent because of rounding.

Reference population: Persons fully insured for Social Security retired worker benefits who became entitled to benefits in 2014.

SOURCE: Social Security Administration, Master Beneficiary Record.

Table 10b. Percentage distribution of female Social Security beneficiaries age 62 and over, by type of benefit received, selected years 1960–2014

Type of benefit	1960	1970	1975	1980	1985	1990	1995	2000	2005	2010	2011	2012	2013	2014
Worker benefit only[a]	38.7	42.1	42.3	41.0	38.5	36.9	36.2	38.0	41.4	46.3	47.5	48.7	49.9	51.1
Spouse or widow benefit only														
Spouse only	32.8	22.4	19.6	17.6	16.4	15.3	14.3	12.9	11.4	9.6	9.3	8.0	8.8	8.6
Widow only[b]	23.4	26.8	26.1	25.4	24.9	24.3	23.6	21.5	19.3	17.0	15.9	15.3	14.7	14.4
Dual entitlement														
Worker and spouse	2.4	3.4	4.4	6.2	8.7	10.4	11.5	12.0	12.0	12.1	12.0	11.9	11.8	11.6
Worker and widow	2.1	5.0	7.4	9.6	11.5	13.0	14.4	15.6	16.0	15.5	15.3	15.1	11.6	14.6

[a] Worker benefits include retired and disabled worker benefits.

[b] Widow-only beneficiaries include disabled workers and mothers of surviving children under age 19.

NOTE: All data for 2005 and dual-entitlement data for 1995 and 2000 are based on a 10 percent sample of administrative records. All other estimates are based on 100 percent of available data. Benefits exclude special age-72 beneficiaries and disabled adult children and include disabled workers. Totals may not sum to 100 percent because of rounding.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Social Security Administration, Master Beneficiary Record.

INDICATOR 11: **Net Worth**

Table 11a. Median household net worth, in 2013 dollars, by selected characteristics of head of household, selected years 1983–2013

	In dollars									
Selected characteristic	1983	1989	1992	1995	1998	2001	2004	2007	2010	2013
Age of family head										
45–54	$122,780	$177,320	$127,220	$140,710	$151,000	$176,390	$178,560	$207,720	$125,550	$105,350
55–64	153,690	177,450	184,900	175,330	182,840	243,310	284,850	284,850	191,512	165,660
65 and over	116,480	137,560	149,090	153,290	196,530	221,150	219,380	247,910	227,630	210,500
65–74	135,980	140,270	160,360	168,420	209,430	233,750	234,540	268,800	221,490	232,100
75 and over	79,820	131,140	141,190	141,160	179,830	205,320	201,130	239,380	231,770	195,000
Marital status,[a] family head age 65 and over										
Married	157,050	240,810	246,330	239,230	311,210	368,090	349,350	327,970	347,340	319,800
Unmarried	75,490	74,910	104,150	116,540	125,230	121,700	142,550	180,870	132,840	119,300
Race, family head age 65 and over										
White	137,340	173,890	176,940	177,740	225,010	283,390	259,490	278,680	272,640	255,000
Black	20,160	41,280	45,220	37,950	40,370	64,150	64,740	98,580	101,650	56,700
Education, family head age 65 and over										
No high school diploma	65,160	72,300	63,220	87,130	77,770	96,390	67,180	114,300	74,270	86,650
High school diploma only	149,320	144,610	176,600	161,970	209,140	215,550	216,790	210,190	179,130	147,250
Some college or more	317,980	441,210	319,920	307,830	345,520	521,690	442,700	574,590	450,040	387,000

[a] "Married" includes legally married couples."Unmarried" includes cohabitating couples, separated, divorced, widowed, and never married.

NOTE: Median net worth is measured in constant 2013 dollars. Net worth includes assets held in investment retirement accounts such as individual retirement accounts, Keoghs, and 401(k)-type plans. All observations are weighted for analysis. The term "household" in this indicator is from the codebook of the 2013 Survey of Consumer Finance (www.federalreserve.gov/econresdata/). The data are for the "primary economic unit" (PEU). The PEU consists of an economically dominant single individual or couple (married or living partners) in a household and all other members of the household who are financially interdependent with the individual or couple. In the majority of cases, the PEU and household are identical. All data are for households with positive values.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Survey of Consumer Finances.

INDICATOR 11: **Net Worth**

Table 11b. Value of household financial assets held in retirement investment accounts, by selected characteristics of head of household, 2007 and 2013

	2007				2013			
	In dollars				In dollars			
Selected characteristic	Lowest quartile	Middle quartiles	Highest quartile	Percent holding	Lowest quartile	Middle quartiles	Highest quartile	Percent holding
Age of family head								
45–54	$24,000	$71,000	$199,000	65.0	$20,000	$87,000	$240,000	56.5
55–64	33,000	112,000	301,000	61.0	26,000	104,000	300,000	59.3
65 and over	18,000	68,000	202,000	40.8	40,000	118,000	295,000	39.4
65–74	23,000	87,000	231,000	51.7	50,000	149,000	400,000	48.0
75 and over	15,000	39,000	124,000	30.0	33,000	69,000	174,000	29.0
Marital status,[a] family head age 65 and over								
Married	21,000	83,000	224,000	53.5	60,000	160,000	440,000	51.0
Unmarried	16,000	39,000	139,000	28.9	20,000	68,000	165,000	28.7
Race, family head age 65 and over								
White	18,000	69,000	197,000	45.3	45,000	124,000	330,000	44.9
Other race[b]	19,000	125,000	488,000	12.6	23,000	110,000	300,000	15.8
Education, family head age 65 and over								
No high school diploma[c]	8,000	34,000	91,000	19.1	5,000	22,000	50,000	9.1
High school diploma only	11,000	39,000	84,000	35.1	24,000	62,000	135,000	31.4
Some college or more	31,000	130,000	354,000	59.1	60,000	170,000	491,000	55.5

[a] "Married" includes legally married couples."Unmarried" includes cohabitating couples, separated, divorced, widowed, and never married.

[b] "Other race" includes Black, Hispanic, and Other. The figures for 2007 are based on 28 real observations. This category is dominated by household heads who belong to the "Other" racial category.

[c] The figures for households headed by a person without a high school diploma in 2013 are based on 25 real observations.

NOTE: Median net worth is measured in constant 2013 dollars. Net worth includes assets held in investment retirement accounts such as individual retirement accounts, Keoghs, and 401(k)-type plans. All observations are weighted for analysis. The term "household" in this indicator is from the codebook of the 2013 Survey of Consumer Finance (www.federalreserve.gov/econresdata/). The data are for the "primary economic unit" (PEU). The PEU consists of an economically dominant single individual or couple (married or living partners) in a household and all other members of the household who are financially interdependent with the individual or couple. In the majority of cases, the PEU and household are identical. All data are for households with positive values.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Survey of Consumer Finances.

INDICATOR 11: **Net Worth**

Table 11c. Amount of funds (in millions of dollars) held in retirement assets, by sector and type of plan, 1975–2014

	All sectors			Private only		Public only	
Year	Individual retirement accounts (IRAs)	Defined contribution	Defined benefit[a]	Defined contribution	Defined benefit[a]	Defined contribution	Defined benefit[a]
1975	—	$74,612	$315,782	$74,612	$169,719	—	$146,063
1976	—	84,341	356,824	84,341	190,962	—	165,862
1977	—	92,766	388,647	92,766	204,503	—	184,144
1978	—	110,620	452,980	110,620	240,687	—	212,293
1979	—	133,307	515,723	133,307	279,781	—	235,942
1980	—	163,363	622,636	158,812	349,622	$4,551	273,014
1981	$38,000	174,363	673,378	169,597	364,853	4,766	308,525
1982	68,000	208,297	818,105	202,201	460,731	6,096	357,374
1983	107,000	254,655	974,341	246,783	560,398	7,872	413,943
1984	159,000	287,475	1,067,492	278,883	588,721	8,592	478,771
1985	241,000	431,714	1,368,996	420,382	795,064	11,332	573,932
1986	329,000	469,697	1,494,230	455,466	816,033	14,231	678,197
1987	404,000	551,750	1,567,113	535,617	803,294	16,133	763,819
1988	468,000	597,132	1,674,304	577,118	812,800	20,014	861,504
1989	546,000	715,197	1,918,853	688,709	921,494	26,488	997,359
1990	637,000	737,198	1,962,358	708,546	899,857	28,652	1,062,501
1991	776,000	890,757	2,274,407	853,052	1,051,654	37,705	1,222,753
1992	873,000	974,323	2,427,769	930,324	1,079,860	43,999	1,347,909
1993	993,000	1,111,304	2,684,968	1,057,931	1,195,109	53,373	1,489,859
1994	1,056,000	1,186,477	2,853,227	1,127,009	1,275,964	59,468	1,577,263
1995	1,288,000	1,467,738	3,299,521	1,389,546	1,466,122	78,192	1,833,399
1996	1,467,000	1,679,084	3,660,841	1,582,489	1,590,232	96,595	2,070,609
1997	1,728,000	2,223,790	4,159,755	1,950,745	1,763,538	273,045	2,396,217
1998	2,150,000	2,585,459	4,581,283	2,240,694	1,907,730	344,765	2,673,553
1999	2,651,000	2,955,912	5,084,432	2,531,038	2,074,645	424,874	3,009,787
2000	2,629,000	2,905,379	4,977,000	2,500,499	1,978,987	404,880	2,998,013
2001	2,619,000	2,638,370	4,782,651	2,254,552	1,810,236	383,818	2,972,415
2002	2,532,000	2,402,674	4,369,875	2,054,726	1,639,303	347,948	2,730,572
2003	2,993,000	2,992,979	5,182,865	2,551,316	1,994,538	441,663	3,188,327
2004	3,299,000	3,328,948	5,586,436	2,822,627	2,132,170	506,321	3,454,266
2005	3,425,000	3,706,573	5,922,727	3,146,539	2,281,326	560,034	3,641,401
2006	4,207,000	4,089,707	6,382,102	3,448,388	2,393,189	641,319	3,988,913
2007	4,748,000	4,364,497	6,678,779	3,664,143	2,516,486	700,354	4,162,293
2008	3,681,000	3,268,405	5,303,013	2,733,992	1,897,817	534,413	3,405,196
2009	4,488,000	3,986,583	5,845,781	3,327,103	2,126,880	659,480	3,718,901
2010	5,029,000	4,507,019	6,395,589	3,763,657	2,387,116	743,362	4,008,473
2011	5,241,000	4,493,069	6,388,358	3,766,231	2,429,469	726,838	3,958,889
2012	5,907,000	5,000,368	6,770,005	4,220,842	2,627,787	779,526	4,142,218
2013	6,966,000	5,891,192	7,648,274	5,003,857	2,875,486	887,335	4,772,788
2014	7,443,000	6,298,411	7,964,469	5,342,952	2,932,973	955,459	5,031,496

— Not available.

[a] Public and private defined benefit plans do not include claims of pension funds on sponsor.

Reference population: Public and private retirement assets for total population.

SOURCE: Federal Reserve Board Z.1 Statistical Release for Dec. 10, 2015.

INDICATOR 12: **Participation in Labor Force**

Table 12. Labor force participation rates (annual averages) of persons age 55 and over, by sex and age group, 1963–2015

	Men				Women			
Year	55–61	62–64	65–69	70 and over	55–61	62–64	65–69	70 and over
1963	89.9	75.8	40.9	20.8	43.7	28.8	16.5	5.9
1964	89.5	74.6	42.6	19.5	44.5	28.5	17.5	6.2
1965	88.8	73.2	43.0	19.1	45.3	29.5	17.4	6.1
1966	88.6	73.0	42.7	17.9	45.5	31.6	17.0	5.8
1967	88.5	72.7	43.4	17.6	46.4	31.5	17.0	5.8
1968	88.4	72.6	43.1	17.9	46.2	32.1	17.0	5.8
1969	88.0	70.2	42.3	18.0	47.3	31.6	17.3	6.1
1970	87.7	69.4	41.6	17.6	47.0	32.3	17.3	5.7
1971	86.9	68.4	39.4	16.9	47.0	31.7	17.0	5.6
1972	85.6	66.3	36.8	16.6	46.4	30.9	17.0	5.4
1973	84.0	62.4	34.1	15.6	45.7	29.2	15.9	5.3
1974	83.4	60.8	32.9	15.5	45.3	28.9	14.4	4.8
1975	81.9	58.6	31.7	15.0	45.6	28.9	14.5	4.8
1976	81.1	56.1	29.3	14.2	45.9	28.3	14.9	4.6
1977	80.9	54.6	29.4	13.9	45.7	28.5	14.5	4.6
1978	80.3	54.0	30.1	14.2	46.2	28.5	14.9	4.8
1979	79.5	54.3	29.6	13.8	46.6	28.8	15.3	4.6
1980	79.1	52.6	28.5	13.1	46.1	28.5	15.1	4.5
1981	78.4	49.4	27.8	12.5	46.6	27.6	14.9	4.6
1982	78.5	48.0	26.9	12.2	46.9	28.5	14.9	4.5
1983	77.7	47.7	26.1	12.2	46.4	29.1	14.7	4.5
1984	76.9	47.5	24.6	11.4	47.1	28.8	14.2	4.4
1985	76.6	46.1	24.4	10.5	47.4	28.7	13.5	4.3
1986	75.8	45.8	25.0	10.4	48.1	28.5	14.3	4.1
1987	76.3	46.0	25.8	10.5	48.9	27.8	14.3	4.1
1988	75.8	45.4	25.8	10.9	49.9	28.5	15.4	4.4
1989	76.3	45.3	26.1	10.9	51.4	30.3	16.4	4.6
1990	76.7	46.5	26.0	10.7	51.7	30.7	17.0	4.7
1991	76.1	45.5	25.1	10.5	52.1	29.3	17.0	4.7
1992	75.7	46.2	26.0	10.7	53.6	30.5	16.2	4.8
1993	74.9	46.1	25.4	10.3	53.8	31.7	16.1	4.7
1994	73.8	45.1	26.8	11.7	55.5	33.1	17.9	5.5
1995	74.3	45.0	27.0	11.6	55.9	32.5	17.5	5.3
1996	74.8	45.7	27.5	11.5	56.4	31.8	17.2	5.2
1997	75.4	46.2	28.4	11.6	57.3	33.6	17.6	5.1
1998	75.5	47.3	28.0	11.1	57.6	33.3	17.8	5.2
1999	75.4	46.9	28.5	11.7	57.9	33.7	18.4	5.5
2000	74.3	47.0	30.3	12.0	58.3	34.1	19.5	5.8
2001	74.9	48.2	30.2	12.1	58.9	36.7	20.0	5.9
2002	75.4	50.4	32.2	11.5	61.1	37.6	20.7	6.0
2003	74.9	49.5	32.8	12.3	62.5	38.6	22.7	6.4
2004	74.4	50.8	32.6	12.8	62.1	38.7	23.3	6.7
2005	74.7	52.5	33.6	13.5	62.7	40.0	23.7	7.1

See notes at end of table.

INDICATOR 12: **Participation in Labor Force**

Table 12. Labor force participation rates (annual averages) of persons age 55 and over, by sex and age group, 1963–2015—continued

	Men				Women			
Year	55–61	62–64	65–69	70 and over	55–61	62–64	65–69	70 and over
2006	75.2	52.4	34.4	13.9	63.8	41.5	24.2	7.1
2007	75.4	51.7	34.3	14.0	63.8	41.8	25.7	7.7
2008	75.8	53.0	35.6	14.6	64.6	42.0	26.4	8.1
2009	75.4	55.1	36.3	14.8	65.5	44.0	26.6	8.3
2010	75.6	54.6	36.5	14.7	65.6	45.3	27.0	8.3
2011	75.4	53.2	37.4	15.4	65.3	44.7	27.3	8.4
2012	75.5	54.6	37.1	16.2	65.2	44.1	27.6	8.5
2013	75.7	54.0	37.2	15.9	64.4	45.2	27.6	9.1
2014	74.9	56.2	36.1	15.7	64.0	44.7	27.5	9.2
2015	74.9	55.8	36.8	15.8	63.5	45.2	27.9	9.2

NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, Current Population Survey.

INDICATOR 13: **Housing Problems**

Table 13a. Prevalence of housing problems among older-owner/renter households,[a] by type of problem, selected years, 2009–2013

	2009				2011				2013			
	Households	%	Persons[b]	%	Households	%	Persons[b]	%	Households	%	Persons[b]	%
	Number (in thousands)											
Total	24,115	100.0	32,473	100.0	26,419	100.0	35,799	100.0	28,330	100.0	38,327	100.0
Number and percent with												
One or more housing problems	10,169	42.2	12,629	38.9	11,199	42.4	14,013	39.1	10,905	38.5	13,541	35.3
Housing cost burden (>30%)	9,614	39.9	11,877	36.6	10,621	40.2	13,251	37.0	10,316	36.4	12,809	33.4
Physically inadequate housing	1,003	4.2	1,252	3.9	1,120	4.2	1,380	3.9	1,063	3.8	1,290	3.4
Crowded housing	48	0.2	73	0.2	76	0.3	105	0.3	106	0.4	147	0.4

[a] Older-owner/renter households are defined as households with a householder or spouse age 65 and over.

[b] Number of persons age 65 and over.

NOTE: Some data for 2009 have been revised and differ slightly from previous editions of *Older Americans.* Additional years of data are available at agingstats.gov.

Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

SOURCE: U.S. Department of Housing and Urban Development, American Housing Survey.

Table 13b. Prevalence of housing problems among older-member households,[a] by type of problem, selected years, 2009–2013

	2009				2011				2013			
	Households	%	Persons[b]	%	Households	%	Persons[b]	%	Households	%	Persons[b]	%
	Number (in thousands)											
Total	2,022	100.0	2,225	100.0	2,111	100.0	2,363	100.0	2,115	100.0	2,366	100.0
Number and percent with												
One or more housing problems	902	44.6	1,025	46.1	924	43.8	1,028	43.5	818	38.7	940	39.7
Housing cost burden (>30%)	787	38.9	890	40.0	819	38.8	907	38.4	711	33.6	820	34.7
Physically inadequate housing	98	4.9	107	4.8	101	4.8	111	4.7	81	3.8	92	3.9
Crowded housing	123	6.1	151	6.8	123	5.8	147	6.2	129	6.1	156	6.6

[a] Older-member households are defined as households with one or more members age 65 and over and exclude households with a householder or spouse age 65 and over.

[b] Number of persons (excluding householder and spouse) age 65 and over.

NOTE: Some data for 2009 have been revised and differ slightly from previous editions of *Older Americans.* Additional years of data are available at agingstats.gov.

Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

SOURCE: U.S. Department of Housing and Urban Development, American Housing Survey.

INDICATOR 13: **Housing Problems**

Table 13c. Prevalence of housing problems among all U.S. households except those households[a] with one or more persons age 65 and over, by type of problem, selected years, 2009–2013

	2009				2011				2013			
	Households	%	Persons	%	Households	%	Persons	%	Households	%	Persons	%
	Number (in thousands)											
Total	85,740	100.0	233,778	100.0	86,377	100.0	234,244	100.0	85,406	100.0	230,689	100.0
Number and percent with												
One or more housing problems	34,522	40.3	96,151	41.1	36,483	42.2	100,963	43.1	32,285	37.8	87,835	38.1
Housing cost burden (>30%)	30,976	36.1	83,254	35.6	32,703	37.9	87,475	37.3	28,606	33.5	74,587	32.3
Physically inadequate housing	4,628	5.4	11,725	5.0	5,103	5.9	13,005	5.6	4,744	5.6	11,807	5.1
Crowded housing	2,318	2.7	14,254	6.1	2,609	3.0	15,935	6.8	2,262	2.6	14,101	6.1

[a] Households with no persons age 65 and over.

NOTE: Some data for 2009 have been revised and differ slightly from previous editions of *Older Americans.* Additional years of data are available at agingstats.gov.

Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

SOURCE: U.S. Department of Housing and Urban Development, American Housing Survey.

Table 13d. Prevalence of housing problems among older-owner/renter intergenerational households,[a] by type of problem, selected years, 2009–2013

	2009				2011				2013			
	Households	%	Persons[b]	%	Households	%	Persons[b]	%	Households	%	Persons[b]	%
	Number (in thousands)											
Total	845	100.0	1,049	100.0	1,128	100.0	1,377	100.0	1,220	100.0	1,494	100.0
Number and percent with												
One or more housing problems	383	45.2	453	43.2	536	47.5	623	45.3	532	43.6	630	42.2
Housing cost burden (>30%)	347	41.1	409	39.0	485	43.0	560	40.7	457	37.4	542	36.3
Physically inadequate housing	41	4.9	46	4.4	53	4.7	57	4.2	57	4.7	65	4.4
Crowded housing	37	4.3	51	4.8	63	5.6	83	6.0	89	7.3	121	8.1

[a] Older-owner/renter intergenerational households are defined as households with a householder or spouse age 65 and over with children age 19 or younger.

[b] Number of persons age 65 and over.

NOTE: Some data for 2009 have been revised and differ slightly from previous editions of *Older Americans.* Additional years of data are available at agingstats.gov.

Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

SOURCE: U.S. Department of Housing and Urban Development, American Housing Survey.

INDICATOR 13: **Housing Problems**

Table 13e. Prevalence of housing problems among older-member intergenerational households,[a] by type of problem, selected years, 2009–2013

	2009				2011				2013			
	Households	%	Persons[b]	%	Households	%	Persons[b]	%	Households	%	Persons[b]	%
	Number (in thousands)											
Total	763	100.0	869	100.0	865	100.0	980	100.0	862	100.0	982	100.0
Number and percent with												
One or more housing problems	420	55.1	489	56.3	468	54.0	524	53.5	391	45.3	447	45.5
Housing cost burden (>30%)	348	45.7	405	46.6	408	47.1	453	46.3	319	37.0	364	37.1
Physically inadequate housing	39	5.1	42	4.8	44	5.0	50	5.1	40	4.7	48	4.9
Crowded housing	109	14.3	127	14.7	110	12.7	129	13.2	118	13.7	136	13.9

[a] Older-member intergenerational households are defined as households with one or more members age 65 and over with children age 19 or younger, and exclude households with a householder or spouse age 65 and over.

[b] Number of persons age 65 and over.

NOTE: Some data for 2009 have been revised and differ slightly from previous editions of *Older Americans.* Additional years of data are available at agingstats.gov.

Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

SOURCE: U.S. Department of Housing and Urban Development, American Housing Survey.

Table 13f. Prevalence of housing problems among all older households: householder, spouse, or member(s) age 65 and over,[a] by type of problem, selected years, 2009–2013

	2009				2011				2013			
	Households	%	Persons[a]	%	Households	%	Persons[a]	%	Households	%	Persons[a]	%
	Number (in thousands)											
Total	26,138	100.0	34,698	100.0	28,530	100.0	38,162	100.0	30,446	100.0	40,693	100.0
Number and percent with												
One or more housing problems	11,071	42.4	13,654	39.4	12,123	42.5	15,041	39.4	11,723	38.5	14,481	35.6
Housing cost burden (>30%)	10,400	39.8	12,767	36.8	11,440	40.1	14,158	37.1	11,027	36.2	13,630	33.5
Physically inadequate housing	1,101	4.2	1,359	3.9	1,221	4.3	1,491	3.9	1,145	3.8	1,382	3.4
Crowded housing	170	0.7	223	0.6	198	0.7	252	0.7	235	0.8	303	0.7

[a] Number of persons age 65 and over.

NOTE: Some data for 2009 have been revised and differ slightly from previous editions of *Older Americans.* Additional years of data are available at agingstats.gov.

Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

SOURCE: U.S. Department of Housing and Urban Development, American Housing Survey.

INDICATOR 14: **Total Expenditures**

Table 14. Percentage distribution of total household annual expenditures, by age of reference person, 2014

			65 and over		
Annual expenditure	45–54	55–64	Total	65–74	75 and over
Personal insurance and pensions	12.8	12.6	5.2	6.5	2.8
Health care	6.9	8.8	13.4	12.2	15.6
Transportation	17.1	16.6	15.9	17.1	13.9
Housing	31.7	32.0	33.9	32.4	36.5
Food	12.2	12.1	12.5	12.9	11.9
Food at home	7.1	7.3	7.8	7.6	8.0
Food away from home	5.2	4.8	4.7	5.3	3.8
Other	19.3	17.9	19.1	18.9	19.3

NOTE: Other expenditures include apparel, personal care, entertainment, reading, education, alcohol, tobacco, cash contributions, and miscellaneous expenditures. Data from the Consumer Expenditure Survey by age group represent average annual expenditures for consumer units by the age of the reference person, that is the person listed as the owner or renter of the home. For example, the data on people age 65 and over reflect consumer units with a reference person age 65 and over. The Consumer Expenditure Survey collects and publishes information from consumer units, which are generally defined as a person or group of people who live in the same household and are related by blood, marriage, or other legal arrangement (i.e., a family) or people who live in the same household who are unrelated but make financial decisions together. A household usually refers to a physical dwelling and may contain more than one consumer unit (e.g., roommates who are sharing an apartment but who are financially independent from each other). However, for convenience, the term "household" is substituted for "consumer unit" in this text.

Reference population: These data refer to the resident noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, Consumer Expenditure Survey.

INDICATOR 15: **Life Expectancy**

Table 15a. Life expectancy at ages 65 and 85, by race and sex, 1981–2014

	All races[a]			White			Black or African American		
Age and year	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women
At age 65									
1981	16.7	14.4	18.6	16.8	14.4	18.8	15.2	13.2	17.0
1982	16.8	14.5	18.8	16.9	14.5	18.9	15.4	13.3	17.2
1983	16.7	14.5	18.6	16.8	14.5	18.7	15.5	13.4	17.3
1984	16.8	14.6	18.6	16.9	14.6	18.7	15.5	13.5	17.2
1985	16.7	14.6	18.6	16.8	14.6	18.7	15.3	13.3	17.0
1986	16.8	14.7	18.6	16.9	14.8	18.7	15.4	13.4	17.0
1987	16.9	14.8	18.7	17.0	14.9	18.8	15.4	13.5	17.1
1988	16.9	14.9	18.6	17.0	14.9	18.7	15.4	13.4	16.9
1989	17.2	15.2	18.8	17.3	15.2	19.0	15.5	13.6	17.0
1990	17.3	15.1	18.9	17.4	15.2	19.1	15.6	13.3	17.4
1991	17.4	15.3	19.1	17.5	15.4	19.2	15.5	13.4	17.2
1992	17.5	15.4	19.2	17.6	15.5	19.3	15.7	13.5	17.4
1993	17.3	15.3	18.9	17.4	15.4	19.0	15.5	13.4	17.1
1994	17.4	15.5	19.0	17.5	15.6	19.1	15.7	13.6	17.2
1995	17.4	15.6	18.9	17.6	15.7	19.1	15.6	13.6	17.1
1996	17.5	15.7	19.0	17.6	15.8	19.1	15.8	13.9	17.2
1997	17.7	15.9	19.2	17.8	16.0	19.3	16.1	14.2	17.6
1998	17.8	16.0	19.2	17.8	16.1	19.3	16.1	14.3	17.4
1999	17.7	16.1	19.1	17.8	16.1	19.2	16.0	14.3	17.3
2000	17.6	16.0	19.0	17.7	16.1	19.1	16.1	14.1	17.5
2001	17.9	16.2	19.2	18.0	16.3	19.3	16.2	14.2	17.7
2002	17.9	16.3	19.2	18.0	16.4	19.3	16.3	14.4	17.8
2003	18.1	16.5	19.3	18.2	16.6	19.4	16.5	14.5	18.0
2004	18.4	16.9	19.6	18.5	17.0	19.7	16.8	14.9	18.3
2005	18.4	16.9	19.6	18.5	17.0	19.7	16.9	15.0	18.3
2006	18.7	17.2	19.9	18.7	17.3	19.9	17.2	15.2	18.6
2007	18.8	17.4	20.0	18.9	17.4	20.1	17.3	15.4	18.8
2008	18.8	17.4	20.0	18.9	17.5	20.0	17.5	15.5	18.9
2009	19.1	17.7	20.3	19.2	17.7	20.3	17.8	15.9	19.2
2010	19.1	17.7	20.3	19.2	17.8	20.3	17.8	15.9	19.3
2011	19.2	17.8	20.3	19.2	17.8	20.3	18.0	16.2	19.4
2012	19.3	17.9	20.5	19.3	18.0	20.4	18.1	16.2	19.5
2013	19.3	17.9	20.5	19.3	18.0	20.5	18.1	16.3	19.5
2014	19.3	18.0	20.5	19.3	18.0	20.5	18.2	16.3	19.6

See notes at end of table.

INDICATOR 15: **Life Expectancy**

Table 15a. Life expectancy at ages 65 and 85, by race and sex, 1981–2014—continued

	All races[a]			White			Black or African American		
Age and year	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women
At age 85									
1981	6.1	5.2	6.6	6.1	5.2	6.6	5.7	4.7	6.3
1982	6.3	5.3	6.8	6.2	5.3	6.7	5.8	4.8	6.5
1983	6.1	5.2	6.6	6.1	5.2	6.5	6.9	6.0	7.4
1984	6.1	5.2	6.5	6.0	5.1	6.5	6.8	5.8	7.3
1985	6.0	5.1	6.4	5.9	5.1	6.4	6.5	5.7	6.9
1986	6.0	5.2	6.4	6.0	5.1	6.4	6.3	5.5	6.7
1987	6.1	5.2	6.4	6.0	5.2	6.4	6.4	5.6	6.8
1988	6.0	5.1	6.3	5.9	5.1	6.3	6.3	5.5	6.6
1989	6.2	5.3	6.6	6.1	5.3	6.5	6.3	5.6	6.7
1990	6.2	5.3	6.7	6.2	5.3	6.6	6.5	5.6	7.0
1991	6.2	5.3	6.5	6.1	5.3	6.5	5.9	5.1	6.3
1992	6.2	5.3	6.6	6.2	5.3	6.6	5.9	5.1	6.3
1993	6.0	5.2	6.4	6.0	5.2	6.4	5.9	5.0	6.3
1994	6.1	5.2	6.4	6.1	5.2	6.4	6.0	5.3	6.3
1995	6.0	5.2	6.3	6.0	5.2	6.3	5.9	5.1	6.2
1996	6.1	5.4	6.4	6.0	5.3	6.3	6.0	5.3	6.2
1997	6.3	5.5	6.6	6.2	5.4	6.6	6.4	5.7	6.7
1998	6.3	5.5	6.7	6.3	5.4	6.6	6.3	5.5	6.6
1999	6.3	5.5	6.6	6.2	5.4	6.6	6.2	5.6	6.5
2000	6.1	5.4	6.5	6.1	5.3	6.5	6.3	5.5	6.7
2001	6.1	5.3	6.4	6.0	5.3	6.4	6.3	5.3	6.7
2002	6.0	5.3	6.4	6.0	5.2	6.4	6.2	5.3	6.6
2003	6.1	5.4	6.4	6.1	5.3	6.4	6.3	5.4	6.7
2004	6.3	5.5	6.6	6.2	5.5	6.6	6.4	5.4	6.8
2005	6.2	5.5	6.6	6.2	5.5	6.5	6.4	5.4	6.8
2006	6.3	5.6	6.7	6.3	5.6	6.7	6.5	5.6	7.0
2007	6.4	5.7	6.8	6.4	5.7	6.8	6.6	5.6	7.0
2008	6.4	5.7	6.7	6.3	5.6	6.7	6.6	5.7	7.0
2009	6.6	5.8	7.0	6.5	5.8	6.9	6.8	5.9	7.2
2010	6.5	5.8	6.9	6.5	5.8	6.9	6.8	5.9	7.1
2011	6.5	5.9	6.9	6.5	5.8	6.8	6.8	6.0	7.2
2012	6.6	5.9	7.0	6.5	5.9	6.9	6.8	6.0	7.2
2013	6.6	5.9	7.0	6.5	5.9	6.9	6.8	6.0	7.2
2014	6.6	5.9	7.0	6.5	5.9	6.9	6.9	6.0	7.3

[a] "All races" includes races not shown separately.

NOTE: Life expectancy estimates are from annual life tables produced by the National Center for Health Statistics found at http://www.cdc.gov/nchs/products/life_tables.htm. Some estimates have been revised and may differ from previous editions of *Older Americans* due to changes in methodology and to the use of intercensal population estimates for 2001–2009. See Appendix II, Life Expectancy, of *Health, United States, 2015* for a description of the changes in life table methodology

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

INDICATOR 15: **Life Expectancy**

Table 15b. Life expectancy at birth, age 65, and age 85, by race and Hispanic origin and sex, 2014

	All races[a]			White			Black or African American		
Age	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women
At birth	78.8	76.4	81.2	79.0	76.7	81.4	75.6	72.5	78.4
At age 65	19.3	18.0	20.5	19.3	18.0	20.5	18.2	16.3	19.6
At age 85	6.6	5.9	7.0	6.5	5.9	6.9	6.9	6.0	7.3

	Hispanic			Non-Hispanic White			Non-Hispanic Black or African American		
	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women
At birth	81.8	79.2	84.0	78.8	76.5	81.1	75.2	72.0	78.1
At age 65	21.1	19.6	22.2	19.3	18.0	20.5	18.1	16.2	19.5
At age 85	7.5	6.7	7.8	6.5	5.9	6.9	6.8	6.0	7.2

[a] "All races" includes races not shown separately

NOTE: See data sources for the definition of race and Hispanic origin in the National Vital Statistics System. See http://www.cdc.gov/nchs/data/nvsr/nvsr64/nvsr64_11.pdf for a description of the methodology used to calculate life expectancy for the Hispanic population.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

INDICATOR 16: **Mortality**

Table 16a. Death rates among people age 65 and over, by selected leading causes of death, 1981–2014

Year	Total[a]	Heart disease	Cancer	Stroke	Chronic lower respiratory diseases	Influenza and pneumonia	Diabetes	Alzheimer's disease	Unintentional injuries
				(Number per 100,000 population)					
1981	5,714	2,547	1,056	624	186	207	106	6	94
1982	5,610	2,503	1,069	585	186	181	102	9	88
1983	5,685	2,512	1,078	564	204	207	104	16	89
1984	5,645	2,450	1,087	546	211	214	103	24	89
1985	5,694	2,431	1,091	531	225	243	103	31	89
1986	5,629	2,372	1,101	506	228	245	101	35	87
1987	5,578	2,316	1,106	496	230	237	102	42	87
1988	5,625	2,306	1,114	489	240	263	105	45	90
1989	5,457	2,172	1,133	464	240	253	120	47	88
1990	5,353	2,091	1,142	448	245	258	120	49	84
1991	5,291	2,046	1,150	435	252	245	121	49	83
1992	5,205	1,990	1,151	425	253	233	121	49	82
1993	5,349	2,024	1,159	435	274	248	128	55	84
1994	5,270	1,952	1,155	434	271	238	133	60	84
1995	5,265	1,927	1,153	438	271	237	136	65	84
1996	5,222	1,878	1,141	433	276	234	139	66	87
1997	5,179	1,827	1,127	424	280	236	140	68	87
1998	5,168	1,792	1,119	412	269	247	143	67	90
1999	5,220	1,767	1,126	433	313	167	150	129	94
2000	5,169	1,707	1,124	426	305	169	150	141	89
2001	5,096	1,652	1,105	410	303	157	152	151	93
2002	5,082	1,616	1,098	402	304	165	154	163	94
2003	4,992	1,557	1,080	381	302	159	152	173	95
2004	4,801	1,456	1,061	356	288	144	148	177	96
2005	4,804	1,422	1,053	331	304	148	149	188	99
2006	4,640	1,340	1,036	307	284	129	139	186	97
2007	4,540	1,275	1,024	298	286	117	135	187	99
2008	4,555	1,246	1,008	288	310	121	130	202	100
2009	4,373	1,180	988	270	295	107	123	190	97
2010	4,389	1,156	987	267	292	103	122	197	101
2011	4,342	1,116	962	258	294	106	126	194	102
2012	4,279	1,091	946	250	287	99	123	187	103
2013	4,267	1,085	927	245	290	106	122	184	103
2014	4,198	1,062	915	247	277	97	119	200	105

[a] Includes other causes of death not shown separately.

NOTE: Death rates for 1981–1998 are based on the 9th revision of the International Classification of Diseases (ICD-9). Starting in 1999, death rates are based on ICD-10. For the period 1981–1998, causes were coded using ICD-9 codes that are more comparable with codes for corresponding ICD-10 categories and may differ from other published estimates. See http://www.cdc.gov/nchs/data/nvsr/nvsr49/nvsr49_02.pdf for information on the comparability of death rates between ICD-9 and ICD-10. Some data from 2000–2009 have been revised and differ from previous versions of *Older Americans*. Rates are age adjusted using the 2000 standard population. Ranking of causes of death are based on crude rates of death, not the age-adjusted rates shown here.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

INDICATOR 16: **Mortality**

Table 16b. Death rates among people age 65 and over, by selected leading causes of death, sex, and race and Hispanic origin, 2014

	Total[a]	Heart disease	Cancer	Stroke	Chronic lower respiratory diseases	Influenza and pneumonia	Diabetes	Alzheimer's disease	Unintentional injuries
				(Number per 100,000 population)					
All	4,198	1,062	915	247	277	97	119	200	105
Sex									
Men	4,838	1,302	1,140	243	314	116	144	161	131
Women	3,724	887	755	247	252	85	101	222	86
Race and Hispanic origin									
Non-Hispanic White	4,323	1,090	944	246	310	98	106	210	113
Non-Hispanic Black	4,609	1,207	1,023	313	179	97	212	178	70
Hispanic	3,082	766	648	203	126	82	155	156	67

[a] Includes other causes of death not shown separately.

NOTE: Rates are age adjusted using the 2000 standard population. Ranking of causes of death are based on crude rates of death, not the age-adjusted rates shown here.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Vital Statistics System.

INDICATOR 17: **Chronic Health Conditions**

Table 17a. Percentage of people age 65 and over who reported having selected chronic health conditions, by sex and race and Hispanic origin, 2013–2014

Sex and race and Hispanic origin	Heart disease	Hyper-tension	Stroke	Asthma	Chronic bronchitis or emphysema	Cancer	Diabetes	Arthritis
Total	29.4	55.9	7.9	10.6	8.1	23.4	20.8	49.0
Sex								
Men	35.0	54.9	8.4	8.1	7.6	26.2	22.7	42.6
Women	24.9	56.7	7.4	12.7	8.6	21.2	19.2	54.2
Race and Hispanic origin								
Non-Hispanic White	30.7	54.2	7.6	10.3	8.6	26.0	18.3	50.1
Non-Hispanic Black	26.4	70.6	10.6	13.3	7.7	16.7	32.1	51.3
Hispanic	22.9	57.1	7.8	11.2	6.0	12.5	32.3	43.7

NOTE: Data are based on a 2-year average from 2013–2014. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 17b. Percentage of people age 65 and over who reported having selected chronic health conditions, 1997–1998 through 2013–2014

Year	Heart disease	Hyper-tension	Stroke	Emphysema	Asthma	Chronic bronchitis	Cancer	Diabetes	Arthritis
1997–1998	32.3	46.5	8.2	5.2	7.7	6.4	18.7	13.0	—
1999–2000	29.8	47.4	8.2	5.2	7.4	6.2	19.9	13.7	—
2001–2002	31.5	50.2	8.9	5.0	8.3	6.1	20.8	15.4	—
2003–2004	31.8	51.9	9.3	5.2	8.9	6.0	20.7	16.9	50.0
2005–2006	30.9	53.3	9.3	5.7	10.6	6.1	21.1	18.0	49.5
2007–2008	31.9	55.7	8.8	5.1	10.4	5.4	22.5	18.6	49.5
2009–2010	30.4	55.9	8.6	6.2	11.3	6.2	24.0	20.5	51.2
2011–2012	30.3	55.8	8.3	5.1	10.4	5.7	24.6	20.3	48.9
2013–2014	29.4	55.9	7.9	4.2	10.6	5.3	23.4	20.8	49.0

— Not available.
NOTE: Data are based on 2-year averages.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 18: **Oral Health**

Table 18a. Percentage of people age 65 and over who had dental insurance, had a dental visit in the past year, or had no natural teeth, by age group, 2014

Age group	Dental insurance	Dental visit in past year	No natural teeth
65 and over	25.1	62.4	20.7
65–74	29.7	65.7	16.4
75–84	19.8	58.2	25.0
85 and over	15.5	56.4	31.4

NOTE: Dental insurance is estimated from questions on whether the respondent's private health insurance plan covers dental care and whether the respondent has a single service plan covering dental care. Dental visits in the past year were estimated from responses to the question, "About how long has it been since you last saw or talked to a dentist?" The percentage with no natural teeth was estimated from responses to the question, "Have you lost all of your upper and lower natural (permanent) teeth?" All estimates were calculated from the sample adult component of the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 18b. Percentage of people age 65 and over who had dental insurance, had a dental visit in the past year, or had no natural teeth, by sex and race and Hispanic origin, 2014

Sex and race and Hispanic origin	Dental insurance	Dental visit in past year	No natural teeth
Sex			
Men	28.4	62.2	20.9
Women	22.5	62.5	20.5
Race and Hispanic origin			
Non-Hispanic White	25.7	66.1	19.6
Non-Hispanic Black	23.5	43.0	28.2
Hispanic	20.1	51.3	23.2

NOTE: Dental insurance is estimated from questions on whether the respondent's private health insurance plan covers dental care and whether the respondent has a single service plan covering dental care. Dental visits in the past year were estimated from responses to the question, "About how long has it been since you last saw or talked to a dentist?" The percentage with no natural teeth was estimated from responses to the question, "Have you lost all of your upper and lower natural (permanent) teeth?" All estimates were calculated from the sample adult component of the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 19: **Respondent-Assessed Health Status**

Table 19. Percentage of people age 65 and over with respondent-assessed good to excellent health status, by race and Hispanic origin, sex, and age group, 2012–2014

Selected characteristic	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic (of any race)
Good to excellent health				
Both sexes				
65 and over	77.5	80.1	65.2	66.3
65–74	80.4	83.1	67.5	69.4
75–84	75.8	78.4	63.6	63.0
85 and over	68.1	70.6	55.6	54.7
Men				
65 and over	77.5	79.6	66.5	68.5
65–74	79.9	82.2	67.4	69.9
75–84	76.1	77.9	67.2	67.7
85 and over	67.5	69.0	56.3	57.9
Women				
65 and over	77.5	80.5	64.3	64.7
65–74	80.8	84.0	67.5	69.0
75–84	75.5	78.7	61.5	59.6
85 and over	68.5	71.6	55.2	52.9
Fair or poor health				
Both sexes				
65 and over	22.5	19.9	34.8	33.7
65–74	19.6	16.9	32.5	30.6
75–84	24.2	21.6	36.5	37.0
85 and over	31.9	29.4	44.5	45.3
Men				
65 and over	22.5	20.4	33.5	31.6
65–74	20.1	17.8	32.6	30.1
75–84	23.9	22.1	32.8	32.3
85 and over	32.5	31.0	43.7	42.1
Women				
65 and over	22.5	19.5	35.7	35.3
65–74	19.2	16.0	32.5	31.0
75–84	24.5	21.3	38.5	40.4
85 and over	31.5	28.4	44.8	47.1

NOTE: Data are based on a 3-year average from 2012–2014. Total includes all other races not shown separately. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 20: **Dementia**

Table 20a. Number and percentage of the non-nursing home population age 65 and over with dementia, by age group, 2011

Age group	Number	Percent
65 and over	3,632,567	10.0
65–69	412,085	3.6
70–74	416,914	4.8
75–79	670,987	9.9
80–84	797,865	15.3
85–89	757,214	24.0
90 and over	577,502	36.2

Reference population: These data refer to Medicare beneficiaries not living in nursing homes.
SOURCE: National Health and Aging Trends Study.

Table 20b. Percentage of the non-nursing home population age 65 and over with dementia, by sex and age group, 2011

Age group	Men	Women
65 and over	9.1	10.7
65–74	5.1	3.3
75–84	11.4	12.9
85 and over	23.9	29.9

Reference population: These data refer to Medicare beneficiaries not living in nursing homes.
SOURCE: National Health and Aging Trends Study.

Table 20c. Percentage of the non-nursing home population age 65 and over with dementia, by sex and educational attainment, 2011

Educational attainment	Total	Men	Women
Less than high school	20.6	19.2	21.7
High school graduate	10.0	8.8	10.7
Some college	5.5	5.3	5.7
Bachelor's degree or more	4.6	4.5	4.7

Reference population: These data refer to Medicare beneficiaries not living in nursing homes.
SOURCE: National Health and Aging Trends Study.

Table 20d. Percentage of the non-nursing home population age 65 and over with dementia, by age group and educational attainment, 2011

Educational attainment	65–74	75–84	85 and over
Less than high school	11.6	22.9	37.4
High school graduate	4.0	11.6	27.3
Some college	2.4	6.8	18.6
Bachelor's degree or more	1.2	6.0	20.0

Reference population: These data refer to Medicare beneficiaries not living in nursing homes.
SOURCE: National Health and Aging Trends Study.

INDICATOR 21: **Depressive Symptoms**

Table 21a. Percentage of people age 51 and over with clinically relevant depressive symptoms, by age group and sex, selected years 1998–2014

	1998			2000			2002			2004			2006		
Sex	51 and over	51–64	65 and over	51 and over	51–64	65 and over	51 and over	51–64	65 and over	51 and over	51–64	65 and over	51 and over	51–64	65 and over
Both sexes	15.2	14.7	15.8	15.5	15.4	15.6	15.2	15.1	15.4	14.7	14.8	14.6	15.6	16.6	14.4
Men	11.9	11.9	11.8	11.5	11.7	11.2	11.5	11.6	11.5	12.0	12.5	11.1	12.4	14.1	10.1
Women	17.8	17.0	18.5	18.5	18.4	18.5	17.9	17.8	18.0	16.8	16.7	17.0	18.1	18.7	17.5

	2008			2010			2012			2014		
	51 and over	51–64	65 and over	51 and over	51–64	65 and over	51 and over	51–64	65 and over	51 and over	51–64	65 and over
Both sexes	13.9	14.6	13.3	14.1	15.6	11.9	14.2	15.6	12.5	13.7	14.7	12.8
Men	11.6	12.6	10.5	12.0	13.9	8.9	11.7	13.5	9.4	11.2	12.2	10.1
Women	15.8	16.3	15.2	15.9	17.1	14.2	16.2	17.4	14.8	15.8	16.9	14.9

NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D), adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "four or more symptoms" cut-off can be found in the following documentation: http://hrsonline.isr.umich.edu/sitedocs/userg/dr_005.pdf. Percentages are based on weighted data using the preliminary respondent weights from the 2014 Early Release HRS Tracker File. Some data for 1998–2008 have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Health and Retirement Study.

Table 21b. Percentage of people age 51 and over with clinically relevant depressive symptoms, by age group and sex, 2014

Age group	Both sexes	Men	Women
51–54	17.4	11.4	20.7
55–59	15.2	12.0	18.2
60–64	13.8	12.5	14.9
65–69	12.5	11.3	13.4
70–74	10.4	7.0	13.4
75–79	12.8	8.7	15.9
80–84	16.2	12.7	18.7
85 and over	15.3	13.9	16.0

NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D), adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "four or more symptoms" cut-off can be found in the following documentation: http://hrsonline.isr.umich.edu/sitedocs/userg/dr_005.pdf. Percentages are based on weighted data using the preliminary respondent weight from HRS 2014.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Health and Retirement Study.

INDICATOR 22: **Functional Limitations**

Table 22a. Percentage of people age 65 and over with a disability, by sex and functional domain, 2010 and 2014

Sex and functional domain	2010	2014
Total		
Any disability	22.6	21.6
Vision	3.3	3.7
Hearing	4.2	6.0
Mobility	17.1	14.2
Communication	1.2	1.5
Cognition	2.7	3.1
Self-care	3.0	2.3
Men		
Any disability	20.0	19.3
Vision	2.6	3.4
Hearing	6.0	8.1
Mobility	13.7	10.5
Communication	1.9	1.6
Cognition	2.8	3.1
Self-care	2.3	1.8
Women		
Any disability	24.8	23.5
Vision	4.0	3.9
Hearing	2.8	4.4
Mobility	19.8	17.1
Communication	0.6	1.4
Cognition	2.6	3.0
Self-care	3.5	2.7

NOTE: Disability is defined as "a lot" or "cannot do/unable to do" when asked about difficulty with seeing, even if wearing glasses (vision); hearing, even if wearing hearing aids (hearing); walking or climbing steps (mobility); communicating, for example, understanding or being understood by others (communication); remembering or concentrating (cognition); and self-care, such as washing all over or dressing (self-care). Any disability is defined as having difficulty with at least one of these activities. The data source and measures presented have changed from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey

Table 22b. Percentage of people age 65 and over with a disability, by age group and functional domain, 2014

Functional domain	65–74	75–84	85 and over
Any disability	17.4	21.9	41.9
Vision	2.9	4.1	6.3
Hearing	5.1	5.9	11.0
Mobility	10.6	14.6	30.9
Communication	1.0	1.8	3.6
Cognition	2.2	3.1	7.4
Self-care	1.6	1.6	7.5

NOTE: Disability is defined as "a lot" or "cannot do/unable to do" when asked about difficulty with seeing, even if wearing glasses (vision); hearing, even if wearing hearing aids (hearing); walking or climbing steps (mobility); communicating, for example, understanding or being understood by others (communication); remembering or concentrating (cognition); and self-care, such as washing all over or dressing (self-care). Any disability is defined as having difficulty with at least one of these activities. The data source and measures presented have changed from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 22c. Percentage of people age 65 and over with a disability, by race and Hispanic origin and functional domain, 2014

Functional domain	Non-Hispanic White	Non-Hispanic Black	Hispanic
Any disability	20.7	26.2	26.0
Vision	3.3	4.6	5.6
Hearing	6.1	4.1	7.8
Mobility	13.3	20.6	16.9
Communication	1.1	2.4	3.1
Cognition	2.6	3.2	6.0
Self-care	1.7	4.0	4.6

NOTE: Disability is defined as "a lot" or "cannot do/unable to do" when asked about difficulty with seeing, even if wearing glasses (vision); hearing, even if wearing hearing aids (hearing); walking or climbing steps (mobility); communicating, for example, understanding or being understood by others (communication); remembering or concentrating (cognition); and self-care, such as washing all over or dressing (self-care). Any disability is defined as having difficulty with at least one of these activities. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey. The data source and measures presented have changed from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 22: **Functional Limitations**

Table 22d. Percentage of Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, 1992–2013

Year	Total	IADLs only	1–2 ADLs	3–4 ADLs	5–6 ADLs	Long-term care facility
1992	48.9	13.7	19.6	6.1	3.5	5.9
1993	46.9	13.4	18.1	5.9	3.6	5.9
1994	46.8	14.1	17.7	5.6	3.7	5.7
1995	45.0	12.9	17.2	5.7	3.4	5.8
1996	43.2	12.8	16.7	5.0	3.3	5.4
1997	42.5	12.7	16.6	4.9	3.2	5.1
1998	42.5	12.4	17.1	5.2	3.1	4.7
1999	43.8	12.8	17.9	5.1	3.2	4.8
2000	43.8	13.0	17.4	5.6	3.0	4.8
2001	43.7	13.4	17.2	5.3	3.0	4.8
2002	44.3	13.3	18.3	5.2	2.8	4.6
2003	43.3	12.9	17.6	5.5	3.1	4.2
2004	42.7	13.1	18.2	4.5	2.7	4.2
2005	42.1	12.3	18.3	4.7	2.5	4.3
2006	42.2	12.4	18.0	5.1	2.7	4.1
2007	42.1	13.8	17.7	4.5	2.3	3.9
2008	41.3	11.8	18.9	4.5	2.4	3.8
2009	41.4	12.1	17.6	5.1	2.7	3.9
2010	42.0	11.9	18.7	5.1	2.8	3.5
2011	43.7	12.3	19.7	5.2	3.0	3.6
2012	46.9	11.9	22.0	6.3	3.0	3.7
2013	44.0	11.7	20.0	5.8	2.8	3.7

NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has three or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. Limitations in performing activities of daily living (ADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Limitations performing instrumental activities of daily living (IADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Percentages are age adjusted using the 2000 standard population. Estimates may not sum to the totals because of rounding.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

Table 22e. Percentage of Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, by sex and age group, 2013

	Total	IADLs only	1–2 ADLs	3–4 ADLs	5–6 ADLs	Long-term care facility
Total	44.0	11.7	20.0	5.8	2.8	3.7
Sex						
Men	37.3	9.0	18.4	4.7	2.6	2.6
Women	49.1	13.9	21.3	6.6	2.9	4.4
Age group						
65–74	33.9	10.3	16.3	4.1	1.9	1.2
75–84	48.4	12.8	22.7	6.7	2.6	3.6
85 and over	74.2	14.4	28.1	10.0	7.0	14.7

NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has three or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. Limitations in performing activities of daily living (ADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Limitations performing instrumental activities of daily living (IADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Percentages are age adjusted using the 2000 standard population.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

INDICATOR 23: **Vaccinations**

Table 23a. Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, selected years, 1989–2014

	Influenza			Pneumococcal disease		
Year	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
1989	32.0	17.7	23.8	15.0	6.2	9.8
1991	42.8	26.5	33.2	21.0	13.2	11.0
1993	53.1	31.1	46.2	28.7	13.1	12.2
1994	56.9	37.7	36.6	30.5	13.9	13.7
1995	60.0	39.5	49.5	34.2	20.5	21.6
1997	65.8	44.6	52.7	45.6	22.2	23.5
1998	65.6	45.9	50.3	49.5	26.0	22.8
1999	67.9	49.7	55.1	53.1	32.3	27.9
2000	66.6	47.9	55.7	56.8	30.5	30.4
2001	65.4	47.9	51.9	57.8	33.9	32.9
2002	68.7	49.5	48.5	60.3	36.9	27.1
2003	68.6	47.8	45.4	59.6	37.0	31.0
2004	67.3	45.7	54.6	60.9	38.6	33.7
2005	63.2	39.7	41.7	60.7	40.5	27.5
2006	67.5	46.8	44.9	62.0	35.5	33.4
2007	69.4	55.7	52.3	62.2	44.1	31.8
2008	69.9	50.9	54.9	64.3	44.5	36.4
2009	69.1	53.0	57.0	64.9	44.8	40.1
2010	65.9	52.6	54.6	63.6	45.9	39.0
2011	69.1	53.1	57.3	66.6	47.8	43.1
2012	68.9	53.0	57.8	63.9	46.0	43.4
2013	70.1	55.5	57.2	63.6	48.7	39.2
2014	72.4	57.4	60.8	64.9	49.8	45.2

NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months. Beginning with data from 2005, receipt of nasal spray flu vaccine is included in the estimate of flu vaccinations. For pneumococcal disease, the percentage refers to people who reported ever having a pneumonia vaccination. Questions concerning the use of influenza and pneumonia vaccinations differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States, 2015* Appendix II. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey. Some data for 2005–2010 have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 23b. Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by selected characteristics, 2014

Selected characteristic	Influenza	Pneumococcal disease
Total	70.1	61.3
Sex		
Men	70.2	58.4
Women	70.0	63.7
Age group		
65–74	67.1	55.8
75–84	72.9	69.3
85 and over	77.9	69.4
Education		
Less than high school graduate	64.4	55.3
High school graduate or higher	71.7	62.9

NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu shot during the past 12 months and includes receipt of nasal spray flu vaccines. For pneumococcal disease, the percentage refers to people who reported ever having a pneumonia vaccination.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 24: **Cancer Screenings**

Table 24. Percentage of women ages 50–74 who had breast cancer screening and percentage of people ages 50–75 who had colorectal cancer screening, by sex and age group, selected years, 2000–2013

Selected characteristic	2000	2003	2005	2008	2010	2013
Breast cancer screening						
Women						
50–64	78.7	76.2	71.8	74.2	72.6	71.4
65–74	74.0	74.6	72.5	72.6	71.9	75.3
Colorectal cancer (CRC) screening						
Men						
50–64	28.6	36.3	39.2	47.3	54.0	51.2
65–75	43.4	49.9	58.2	62.4	70.1	69.8
Women						
50–64	31.0	34.8	41.1	49.0	55.9	54.3
65–75	41.3	45.8	51.9	58.6	65.9	69.1

NOTE: Breast cancer screening is defined as reporting having had a mammogram in the last 2 years. Colorectal cancer (CRC) screening is defined as reporting a fecal occult blood test (FOBT) in the past year, a sigmoidoscopy procedure in the past 5 years with FOBT in the past 3 years, or a colonoscopy in the past 10 years. Questions concerning use of CRC screening and mammography differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States, 2015*, Appendix II. Breast cancer screening is reported for women ages 50–74, and colorectal cancer screening is reported for men and women ages 50–75.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 25: **Diet Quality**

Table 25. Healthy Eating Index-2010 average total scores and component scores expressed as a percentage of the HEI maximum score for the population age 65 and over, by age group, 2011–2012

	65 and over		
Dietary component	Total	65–74	75 and over
Total Healthy Eating Index-2010 score	68.3	68.4	67.8
Dietary adequacy components[a]			
Total fruit	76.8	74.2	80.8
Whole fruit	99.8	99.2	100.0
Total vegetables	83.3	86.4	78.6
Greens and beans	71.5	80.5	56.3
Whole grains	42.3	38.6	47.9
Dairy	59.9	57.6	63.5
Total protein foods	100.0	100.0	100.0
Seafood and plant proteins	98.2	99.0	91.3
Fatty acids	56.0	57.4	54.1
Dietary moderation components[b]			
Refined grains	73.4	71.7	75.9
Sodium	36.6	35.8	38.0
Empty calories[c]	74.9	76.5	72.6

[a] Higher scores reflect higher intakes.

[b] Higher scores reflect lower intakes.

[c] Empty calories are calories from solid fats (i.e., sources of saturated fats and trans fats) and added sugars (i.e., sugars not naturally occurring).

NOTE: The Healthy Eating Index-2010 (HEI-2010) is a dietary assessment tool comprising 12 components designed to measure quality in terms of how well diets meet the recommendations of the *2010 Dietary Guidelines for Americans* and the USDA Food Patterns.[31,56,57] The HEI-2010 has 12 components; intakes equal to or better than the standards set for each component are assigned a maximum score. For the nine adequacy components (e.g., total fruit), no intake receives a score of zero and scores increase up to the maximum as the intakes increase toward the standard. The three moderation components (e.g., sodium) are scored in reverse so that excessively high intakes receive zeroes and as intakes decrease toward the standard, scores increase. Higher scores reflect lower intakes because lower intakes of the moderation components are more desirable. A higher score indicates a higher quality diet that aligns with the *Dietary Guidelines for Americans*. Scores are averaged across all adults based on usual dietary intakes.

Reference population: These data refer to the resident noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey, and U.S. Department of Agriculture, Center for Nutrition Policy and Promotion and National Cancer Institute. Healthy Eating Index-2010.

INDICATOR 26: **Physical Activity**

Table 26a. Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the 2008 Federal physical activity guidelines, by age group, 1998–2014

	65 and over			
Year	Total	65–74	75–84	85 and over
1998	5.5	7.0	3.9	2.0
1999	5.9	7.7	4.5	0.9
2000	6.9	8.4	5.7	1.9
2001	6.7	7.7	6.1	3.1
2002	7.1	8.8	5.8	2.1
2003	7.6	9.2	6.7	2.9
2004	7.8	9.7	6.4	3.5
2005	7.9	10.5	5.7	3.0
2006	7.5	9.1	6.5	3.0
2007	7.9	9.5	6.6	4.1
2008	9.5	11.3	9.3	2.3
2009	10.0	12.8	7.9	2.8
2010	10.5	13.6	7.3	4.0
2011	11.3	14.3	8.9	4.5
2012	11.9	14.8	9.1	4.7
2013	11.7	14.7	9.0	4.2
2014	11.7	14.5	9.0	5.1

NOTE: This measure of physical activity reflects the 2008 Federal physical activity guidelines for Americans (available from: http://www.health.gov/PAGuidelines/). The 2008 Federal guidelines recommend that adults age 65 and over who are fit and have no limiting chronic conditions perform at least 150 minutes (2 hours and 30 minutes) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) a week of vigorous-intensity aerobic physical activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. Aerobic activity should be performed in episodes of at least 10 minutes, and preferably, it should be spread throughout the week. In addition, they should perform muscle-strengthening activities that are moderate or high intensity and involve all major muscle groups on two or more days a week, because these activities provide additional health benefits. The measure shown here presents the percentage of people who fully met both the aerobic activity and muscle-strengthening guidelines, irrespective of their chronic condition status.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 26: **Physical Activity**

Table 26b. Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the 2008 Federal physical activity guidelines, by sex and race and Hispanic origin, 2014

Activity and race and Hispanic origin	Total	Men	Women
Aerobic and muscle-strengthening activities			
Total	11.7	14.9	9.2
Non-Hispanic White	12.5	15.6	9.9
Non-Hispanic Black	8.9	12.9	6.2
Hispanic (of any race)	7.4	8.7	6.5
Aerobic activity			
Total	36.5	41.6	32.5
Non-Hispanic White	37.9	42.9	33.9
Non-Hispanic Black	26.4	33.7	21.5
Hispanic (of any race)	29.0	30.5	27.9
Muscle-strengthening activity			
Total	16.5	19.1	14.5
Non-Hispanic White	17.2	19.9	14.9
Non-Hispanic Black	13.5	17.1	11.1
Hispanic (of any race)	13.4	12.5	14.0

NOTE: This measure of physical activity reflects the 2008 Federal physical activity guidelines for Americans (available from: http://www.health.gov/PAGuidelines/). The 2008 Federal guidelines recommend that adults age 65 and over who are fit and have no limiting chronic conditions perform at least 150 minutes (2 hours and 30 minutes) a week of moderate-intensity, or 75 minutes (1 hour and 15 minutes) a week of vigorous-intensity aerobic physical activity or an equivalent combination of moderate- and vigorous-intensity aerobic activity. Aerobic activity should be performed in episodes of at least 10 minutes, and preferably, it should be spread throughout the week. In addition, they should perform muscle-strengthening activities that are moderate or high intensity and involve all major muscle groups on two or more days a week, because these activities provide additional health benefits. The combined measure shown here presents the percentage of people who fully met both the aerobic activity and muscle-strengthening guidelines, irrespective of their chronic condition status. Total includes all other races not shown separately.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 27: **Obesity**

Table 27. Percentage of people age 65 and over overweight and with obesity, by sex and age group, selected years, 1976–2014

Sex and age group	1976–1980	1988–1994	1999–2002	2003–2006	2007–2010	2011–2014
Overweight						
Both sexes						
65 and over	—	60.1	68.8	69.5	72.0	70.9
65–74	57.2	64.1	73.3	73.8	75.7	73.5
75 and over	—	53.9	62.8	63.9	67.2	67.3
Men						
65 and over	—	64.4	72.8	73.0	75.7	74.2
65–74	54.2	68.5	76.2	78.0	77.5	76.1
75 and over	—	56.5	67.4	65.8	73.2	71.0
Women						
65 and over	—	56.9	65.9	66.7	69.1	68.4
65–74	59.5	60.3	70.9	70.3	74.2	71.2
75 and over	—	52.3	59.9	62.6	63.2	64.6
Obese						
Both sexes						
65 and over	—	22.2	29.6	30.1	35.1	34.7
65–74	17.9	25.6	35.7	34.8	40.8	38.6
75 and over	—	17.0	21.3	24.1	27.8	29.0
Men						
65 and over	—	20.3	26.2	29.3	35.3	32.6
65–74	13.2	24.1	31.6	33.0	41.5	36.2
75 and over	—	13.2	17.7	24.0	26.5	26.8
Women						
65 and over	—	23.6	32.0	30.8	34.9	36.4
65–74	21.5	26.9	39.0	36.4	40.3	40.7
75 and over	—	19.2	23.6	24.2	28.7	30.5

— Not available.

NOTE: Data are based on measured height and weight. Height was measured without shoes. Overweight is defined as having a body mass index (BMI) greater than or equal to 25 kilograms/meter^2. Obese is defined by a BMI of 30 kilograms/meter^2 or greater. The percentage of people with obesity is a subset of the percentage of those who are overweight. See glossary for the definition of BMI. Beginning in 1999, the National Health and Nutrition Examination Survey has been in the field continuously with data released every 2 years. Some data have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health and Nutrition Examination Survey.

INDICATOR 28: **Cigarette Smoking**

Table 28a. Percentage of people age 65 and over who are current cigarette smokers, by sex and race, selected years, 1965–2014

	Men			Women		
Year	Total	White	Black or African American	Total	White	Black or African American
1965	28.5	27.7	36.4	9.6	9.8	7.1
1974	24.8	24.3	29.7	12.0	12.3	*8.9
1979	20.9	20.5	26.2	13.2	13.8	*8.5
1983	22.0	20.6	38.9	13.1	13.2	*13.1
1985	19.6	18.9	27.7	13.5	13.3	14.5
1987	17.2	16.0	30.3	13.7	13.9	11.7
1988	18.0	16.9	29.8	12.8	12.6	14.8
1990	14.6	13.7	21.5	11.5	11.5	11.1
1991	15.1	14.2	24.3	12.0	12.1	9.6
1992	16.1	14.9	28.3	12.4	12.6	*11.1
1993	13.5	12.5	*27.9	10.5	10.5	*10.2
1994	13.2	11.9	25.6	11.1	11.1	13.6
1995	14.9	14.1	28.5	11.5	11.7	13.3
1997	12.8	11.5	26.0	11.5	11.7	10.7
1998	10.4	10.0	16.3	11.2	11.2	11.5
1999	10.5	10.0	17.3	10.7	10.5	13.5
2000	10.2	9.8	14.2	9.3	9.1	10.2
2001	11.5	10.7	21.1	†9.1	9.4	9.3
2002	10.1	9.3	19.4	8.6	8.5	9.4
2003	10.1	9.6	18.0	8.3	8.4	8.0
2004	9.8	9.4	14.1	8.1	8.2	6.7
2005	8.9	7.9	16.8	8.3	8.4	10.0
2006	12.6	12.6	16.0	8.3	8.4	9.3
2007	9.3	8.9	14.3	7.6	8.0	6.4
2008	10.5	9.9	17.5	8.3	8.6	8.1
2009	9.5	9.3	14.0	9.5	9.6	11.5
2010	9.7	9.6	10.0	9.3	9.4	9.4
2011	8.9	8.7	13.7	7.1	7.0	9.1
2012	10.6	10.3	17.4	7.5	7.5	9.1
2013	10.6	10.0	15.5	7.5	7.9	6.5
2014	9.8	9.4	13.9	7.5	7.6	8.2

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error of 20 to 30 percent.

† The value for all women includes other races who may have very low rates of cigarette smoking. Thus, the weighted average for all women is lower than that for the race groups shown in the table.

NOTE: Questions concerning cigarette smoking differed slightly on the National Health Interview Survey across the years for which data are shown. Data starting in 1997 are not strictly comparable with data for earlier years due to the 1997 National Health Interview Survey (NHIS) questionnaire redesign. Total includes all other races not shown separately. See data sources for the definition of race and Hispanic origin in the NHIS. For details, see *Health, United States, 2015,* Appendix II.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 28: **Cigarette Smoking**

Table 28b. Percentage distribution of people age 18 and over, by cigarette smoking status, sex, and age group, 2014

Sex and age group	Current smokers			Former smokers	Non-smokers
	Total	Every day smokers	Some day smokers		
Both sexes	16.8	12.9	3.9	21.9	61.3
Men					
18–44	21.7	15.0	6.7	14.7	63.6
45–64	19.4	15.5	3.8	27.8	52.8
65 and over	9.8	8.0	1.7	49.6	40.6
Women					
18–44	16.6	12.9	3.7	11.3	72.1
45–64	16.8	13.8	3.0	22.0	61.2
65 and over	7.5	6.2	1.3	30.3	62.2

NOTE: Current cigarette smokers were defined as ever smoking 100 cigarettes in their lifetime and smoking now, every day or some days. Former smokers smoked at least 100 cigarettes in their lifetime but do not currently smoke. Non-smokers had never smoked or smoked fewer than 100 cigarettes in their lifetime. The sum of every day smokers and some day smokers may not equal total smokers due to rounding.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 28c. Percentage of people age 65 and over who are current cigarette smokers, by sex and poverty status, 2014

Sex	All	Poverty threshold		
		Below 100 percent	100–199 percent	200 percent or more
Both sexes	8.5	13.9	11.3	6.9
Men	9.8	21.1	14.0	7.5
Women	7.5	9.5	9.7	6.3

NOTE: Current cigarette smokers were defined as ever smoking 100 cigarettes in their lifetime and smoking now, every day or some days. Poverty status is calculated according to the U.S. Census Bureau thresholds for the corresponding year. See glossary for definition of poverty.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 29: **Use of Health Care Services**

Table 29a. Use of Medicare-covered health care services per 1,000 Medicare beneficiaries age 65 and over, 1992–2013

Year	Utilization measure: Hospital stays	Skilled nursing facility stays	Physician visits and consultations	Home health care visits	Average length of hospital stay
	Number per 1,000				Days
1992	306	28	—	3,822	8.4
1993	300	33	—	4,648	8.0
1994	331	43	—	6,352	7.5
1995	336	50	—	7,608	7.0
1996	341	59	—	8,376	6.6
1997	351	67	—	8,227	6.3
1998	354	69	—	5,058	6.1
1999	365	67	11,395	3,708	6.0
2000	361	67	11,490	2,913	6.0
2001	364	69	11,546	2,295	5.9
2002	361	72	12,232	2,358	5.9
2003	359	74	12,662	2,440	5.8
2004	353	75	12,730	2,594	5.7
2005	350	79	13,302	2,770	5.7
2006	343	80	13,193	3,072	5.6
2007	336	81	14,599	3,409	5.6
2008	331	82	14,839	3,609	5.6
2009	320	80	14,975	3,864	5.4
2010	338	80	15,045	3,687	5.3
2011	307	79	14,767	3,555	5.3
2012	291	75	14,635	3,321	5.2
2013	276	73	14,587	3,276	5.3

— Data not available.

NOTE: Data are for Medicare beneficiaries in fee-for-service only. Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. The database used to generate rates of physician visits and consultations in previous *Older Americans* reports is no longer available. This table uses two different databases based on availability of data to estimate rates of physician visits and consultations. The first database provides data from 1999 through 2006, and the second database has data beginning with 2007. A comparison of overlapping years shows that the two databases yield slightly different rates. As a result, some data for 2007–2009 have been revised and differ from previous editions of *Older Americans*. Beginning in 1994, managed care beneficiaries were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care beneficiaries were included in the denominators; they made up 7 percent or less of the Medicare population. See glossary for definition of fee-for-service.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

Table 29b. Use of Medicare-covered home health care and skilled nursing facility services per 1,000 Medicare beneficiaries age 65 and over, by age group, 2013

Utilization measure	65–74	75–84	85 and over
		Number per 1,000	
Skilled nursing facility stays	67	185	204
Home health care visits	1,475	4,129	8,604

NOTE: Data are for Medicare beneficiaries in fee-for-service only.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

INDICATOR 30: **Health Care Expenditures**

Table 30a. Average annual health care costs, in 2012 dollars, for Medicare beneficiaries age 65 and over, by age group, 1992–2012

Age group	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
	(Average cost in 2012 dollars)										
Total	$15,801	$16,524	$17,443	$17,819	$17,551	$17,558	$16,907	$17,020	$17,086	$17,535	$18,521
65–74	11,759	11,986	12,888	12,966	12,704	12,405	11,828	12,922	12,724	13,332	14,275
75–84	17,291	18,887	19,319	19,499	19,756	19,506	18,809	18,048	18,625	19,500	20,112
85 and over	30,563	30,913	32,688	33,707	32,134	31,813	31,587	29,890	29,457	29,255	30,024

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
	(Average cost in 2012 dollars)									
Total	$18,279	$18,083	$18,523	$18,342	$17,668	$16,752	$16,954	$17,211	$16,350	$16,970
65–74	13,842	13,441	13,984	13,727	13,207	12,576	12,967	12,765	12,331	13,206
75–84	20,428	19,692	20,473	20,499	19,813	19,365	18,972	20,020	18,786	19,311
85 and over	28,723	30,350	29,393	28,780	28,141	25,265	26,122	26,564	25,304	25,900

NOTE: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation adjusted to 2012 using the Consumer Price Index (Series CPI-U-RS). Some data have been revised from previously published tables as a result of a CPI adjustment.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

Table 30b. Total amount and percentage distribution of annual health care costs among Medicare beneficiaries age 65 and over, by major cost component, 2008 and 2012

	2008		2012	
Major cost component	Total dollars	Percent	Total dollars	Percent
Total	$593,814,582,768	100	$718,814,057,899	100
Inpatient hospital	144,225,616,200	24	157,288,552,385	22
Physician/outpatient hospital	214,888,544,309	36	253,728,764,587	35
Nursing home/long-term institution	72,458,957,283	12	88,104,428,735	12
Home health care	19,976,448,445	3	23,853,729,622	3
Prescription drugs	90,800,824,928	15	121,139,985,089	17
Other (short-term institution/hospice/dental)	51,464,191,603	9	74,698,597,482	10

NOTE: Data include both out-of-pocket costs and costs covered by insurance. Dollars are not inflation adjusted. Estimates may not sum to the totals because of rounding.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

INDICATOR 30: **Health Care Expenditures**

Table 30c. Average annual health care costs among Medicare beneficiaries age 65 and over, by selected characteristics, 2012

Selected characteristic	Cost
Total	$16,970
Race and ethnicity	
Non-Hispanic White	16,862
Non-Hispanic Black	18,962
Hispanic	17,002
Other	15,512
Institutional status	
Community	13,831
Long-term care facility	71,739
Annual income	
Under $10,000	24,596
$10,000–$20,000	19,937
$20,001–$30,000	15,662
$30,001 and over	14,687
Number of chronic conditions	
0	6,533
1–2	11,445
3–4	18,931
5 and over	30,253
Veteran status (men only)	
Yes	16,274
No	16,997

NOTE: Data include both out-of-pocket costs and costs covered by insurance. See data sources for the definition of race and Hispanic origin in the Medicare Current Beneficiary Survey. Chronic conditions include cancer (other than skin cancer), stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions (emphysema/asthma/chronic obstructive pulmonary disease). Annual income includes that of respondent and spouse.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

INDICATOR 30: **Health Care Expenditures**

Table 30d. Average annual health care costs among Medicare beneficiaries age 65 and over, by age group and major cost component, 2012

Major cost component	65–74	75–84	85 and over
Total	$13,206	$19,311	$25,900
Inpatient hospital	2,813	4,579	4,651
Physician/outpatient hospital	2,718	3,218	3,082
Nursing home/long-term institution	718	1,856	7,175
Home health care	245	755	1,241
Prescription drugs	2,764	3,061	2,356
Other (short-term institution/hospice/dental)	332	650	1,303

NOTE: Data include both out-of-pocket costs and costs covered by insurance.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

Table 30e. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who reported problems with access to health care, 1992–2012

Problem with access to health care	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Difficulty obtaining care	3.1	2.6	2.6	2.6	2.3	2.4	2.4	2.8	2.9	2.8	2.5
Delayed getting care due to cost	9.8	9.1	7.6	6.8	5.5	4.8	4.4	4.7	4.8	5.1	6.1

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Difficulty obtaining care	2.3	2.3	2.5	2.8	2.7	2.6	2.8	3.0	3.1	2.7
Delayed getting care due to cost	5.3	5.3	4.8	5.3	4.6	5.2	4.6	5.8	6.4	6.3

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use and Access to Care.

INDICATOR 31: **Prescription Drugs**

Table 31a. Average prescription drug costs, in 2012 dollars, among noninstitutionalized Medicare beneficiaries age 65 and over, by sources of payment, 1992–2012

Sources of payment	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Total	$1,041	$1,348	$1,401	$1,435	$1,508	$1,612	$1,840	$2,018	$2,233	$2,434	$2,658
Out-of-pocket	626	783	762	753	749	799	851	887	937	973	1,049
Private	265	338	385	424	501	526	644	706	778	847	968
Public	150	226	255	259	258	288	345	425	519	614	641

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Total	$2,793	$2,919	$3,287	$3,098	$3,054	$3,022	$3,272	$3,077	$3,024	$3,201
Out-of-pocket	1,047	1,057	1,169	910	750	707	751	712	709	719
Private	1,063	1,122	1,348	992	757	717	733	625	573	563
Public	683	740	770	1,196	1,547	1,598	1,788	1,740	1,742	1,919

NOTE: Dollars have been inflation adjusted to 2012 using the Consumer Price Index (Series CPI-U-RS). Some data have been revised from previously published tables as a result of a CPI adjustment. Reported costs have been adjusted to account for underreporting of prescription drug use. The adjustment factor changed in 2006 with the initiation of the Medicare Part D prescription drug program. Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other State and Federal programs.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

Table 31b. Percentage distribution of annual prescription drug costs among noninstitutionalized Medicare beneficiaries age 65 and over, 2012

Cost in dollars	Percent of beneficiaries
Total	100.0
$0	5.4
1–499	22.8
500–999	13.4
1,000–1,499	9.0
1,500–1,999	6.9
2,000–2,499	5.6
2,500–2,999	5.4
3,000–3,499	4.2
3,500–3,999	3.4
4,000–4,499	3.1
4,500–4,999	2.4
5,000 or more	18.3

NOTE: Reported costs have been adjusted to account for underreporting of prescription drug use.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

INDICATOR 31: **Prescription Drugs**

Table 31c. Number of Medicare beneficiaries age 65 and over who enrolled in Part D prescription drug plans or who were covered by retiree drug subsidy payments, 2006 and 2014

Part D benefit categories	2006	2014
All Medicare beneficiaries age 65 and over	36,454,840	45,312,272
Enrollees in prescription drug plans	16,935,231	31,090,534
Type of plan		
Stand-alone plan	11,345,012	18,834,209
Medicare Advantage plan	5,590,219	12,256,326
Low-income subsidy		
Yes	5,560,171	6,869,995
No	11,375,060	24,220,540
Retiree drug subsidy	6,548,138	2,569,243
Other	12,971,471	11,652,495

NOTE: Some data for 2006 have been revised and differ from previous editions of *Older Americans.*

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

Table 31d. Average prescription drug costs among noninstitutionalized Medicare beneficiaries age 65 and over, by selected characteristics, selected years 2000–2012

Selected characteristic	2000	2004	2008	2012
Number of chronic conditions				
0	$837	$1,108	$1,312	$1,389
1–2	1,752	2,412	2,427	2,559
3–4	3,085	3,942	3,895	4,488
5 and over	4,212	5,351	5,651	8,263
Annual income				
Under $10,001	2,102	2,685	3,764	4,043
$10,001–$20,000	2,130	2,882	3,090	3,447
$20,001–$30,000	2,387	2,962	2,942	2,894
$30,001 and over	2,310	3,033	2,843	3,068

NOTE: Dollars have been inflation adjusted to 2012 using the Consumer Price Index (Series CPI-U-RS). Some data have been revised from previously published tables as a result of a CPI adjustment. Reported costs have been adjusted to account for underreporting of prescription drug use. Chronic conditions include cancer (other than skin cancer), stroke, diabetes, heart disease, hypertension, arthritis, and respiratory conditions (emphysema/asthma/chronic obstructive pulmonary disease). Annual income includes that of respondent and spouse.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

INDICATOR 32: **Sources of Health Insurance**

Table 32a. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over with supplemental health insurance, by type of insurance, 1991–2013

Type of insurance	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002
Private (employer- or union-sponsored)	40.7	41.0	40.8	40.3	39.1	37.8	37.6	37.0	35.8	35.9	36.0	36.1
Private (Medigap)[a]	44.8	45.0	45.3	45.2	44.3	38.6	35.8	33.9	33.2	33.5	34.5	37.5
Medicare Advantage/ Capitated Payment Plans	6.3	5.9	7.7	9.1	10.9	13.8	16.6	18.6	20.5	20.4	18.0	15.5
Medicaid	8.9	9.0	9.4	9.9	10.1	9.5	9.4	9.6	9.7	9.9	10.6	10.7
TRICARE	—	—	—	—	—	—	—	—	—	—	—	—
Other public	4.0	5.3	5.8	5.5	5.0	4.8	4.7	4.8	5.1	4.9	5.4	5.5
No supplement	11.3	10.4	9.7	9.3	9.1	9.4	9.2	8.9	9.0	9.7	10.1	12.3

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Private (employer- or union-sponsored)	36.1	36.6	36.1	34.9	35.3	34.2	32.5	31.6	29.8	29.4	28.0
Private (Medigap)[a]	34.3	33.7	34.6	32.5	31.5	29.5	27.8	26.5	26.4	25.4	25.4
Medicare Advantage/ Capitated Payment Plans	14.8	15.6	15.5	20.7	21.5	23.2	28.5	29.2	31.3	32.3	33.8
Medicaid	11.6	11.3	11.8	11.9	11.9	11.7	11.8	12.5	12.9	13.1	12.8
TRICARE	4.5	4.2	5.1	5.2	5.1	5.4	5.2	5.0	4.9	5.2	5.0
Other public	5.7	5.2	5.6	4.3	4.0	3.9	3.6	3.3	3.2	2.7	2.3
No supplement	9.1	9.7	8.9	9.4	10.5	10.5	9.3	9.9	10.0	10.6	10.8

— Not available.

[a] Includes people with private supplement of unknown sponsorship.

NOTE: Medicare Advantage/Capitated Payment Plans include Health Maintenance Organizations (HMOs), Preferred Provider Organizations (PPOs), and private fee-for-service (PFFS) plans. Not all types of plans were available in all years. Since 2003 these types of plans have been known collectively as Medicare Advantage and/or Medicare Part C. Estimates are based on beneficiaries' insurance status in the fall of each year. Categories are not mutually exclusive (i.e., individuals may have more than one supplemental policy). Table excludes beneficiaries whose primary insurance is not Medicare (approximately 1 to 3 percent of beneficiaries). Medicaid coverage was determined from both survey responses and Medicare administrative records. TRICARE coverage was added to Medicare Current Beneficiary Survey Access to Care files beginning in 2003. Previous versions of the *Older Americans* did not include data on TRICARE coverage. Adding TRICARE coverage to the table changes the percentage of beneficiaries in the "No supplement" group. Some data for 2009 have been revised and differ from previous editions of *Older Americans*.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

INDICATOR 32: **Sources of Health Insurance**

Table 32b. Percentage of people ages 55–64 with health insurance coverage, by poverty status and type of insurance, 2014

		Poverty threshold		
Type of insurance	Total	Below 100 percent	100–199 percent	200 percent or more
Private	71.7	18.5	42.3	85.3
Medicaid	9.7	43.6	19.4	2.9
Medicare	5.0	8.8	13.3	2.8
Other coverage	3.8	4.4	4.7	3.6
Uninsured	9.7	24.6	20.3	5.4

NOTE: Classification of health insurance is based on a hierarchy of mutually exclusive categories. People with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The "uninsured" category includes people who had no coverage as well as those who only had Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care. See glossary for definition of poverty.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

Table 32c. Percentage of people ages 55–64 with health insurance coverage, by type of insurance, 2010–2014

Year	Private	Medicaid	Medicare	Other coverage	Uninsured
2010	71.8	6.5	4.4	4.5	12.8
2011	71.2	6.8	4.7	4.3	13.0
2012	70.4	7.5	4.8	4.0	13.2
2013	69.1	7.9	5.5	4.0	13.5
2014	71.7	9.7	5.0	3.8	9.7

NOTE: Classification of health insurance is based on a hierarchy of mutually exclusive categories. People with more than one type of health insurance were assigned to the first appropriate category in the hierarchy. The "uninsured" category includes people who had no coverage as well as those who only had Indian Health Service coverage or had only a private plan that paid for one type of service such as accidents or dental care.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Health Interview Survey.

INDICATOR 33: **Out-of-Pocket Health Care Expenditures**

Table 33a. Percentage of people age 55 and over with out-of-pocket expenditures for health care service use, by age group, 1977, 1987, 1996, and 2000–2013

Age group	1977	1987	1996	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
55–64	81.9	84.0	89.6	90.2	90.4	90.9	90.4	90.0	90.5	88.9	89.5	90.1	88.5	89.4	89.1	90.0	88.2
55–61	81.6	83.9	89.5	89.4	90.2	90.7	89.6	89.5	89.6	88.4	88.7	89.0	88.6	88.3	87.9	89.4	87.1
62–64	82.6	84.3	89.7	92.4	91.1	91.3	92.7	91.6	93.3	90.6	91.9	93.0	88.3	92.2	92.0	91.6	91.3
65 and over	83.3	88.6	92.4	93.6	94.7	94.4	94.7	95.5	95.0	95.0	94.3	95.0	94.3	93.7	94.0	94.3	92.7
65–74	83.4	87.9	91.8	93.3	94.1	94.4	93.7	95.1	94.2	94.1	93.2	94.3	93.8	93.4	93.7	93.6	92.2
75–84	83.8	90.0	92.9	93.5	95.6	94.6	95.7	95.8	96.1	96.2	95.3	95.7	94.8	94.1	94.9	95.9	94.7
85 and over	80.8	88.6	93.9	95.2	94.6	93.8	95.8	96.3	95.1	95.5	95.6	95.8	95.1	93.9	93.1	93.7	89.9

NOTE: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Data for the 1987 survey have been adjusted to permit comparability across years; for details, see Zuvekas and Cohen.[58]

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) and MEPS predecessor surveys.

Table 33b. Ratio of out-of-pocket expenditures to household income per person among people age 55 and over, by selected characteristics, 1977, 1987, 1996, and 2000–2013

Selected characteristic	1977	1987	1996	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Total																	
55–64	5.2	5.8	7.1	7.0	7.6	7.1	7.3	7.5	7.1	7.1	6.0	6.2	6.2	6.1	6.5	5.6	5.6
55–61	5.1	5.7	6.2	6.1	6.9	6.6	6.9	7.1	6.7	6.6	5.8	5.8	5.8	5.8	6.1	5.7	5.7
62–64	5.5	5.9	9.5	9.3	9.6	8.5	8.4	8.8	8.2	8.5	6.6	7.3	7.4	7.1	7.6	5.4	5.5
65 and over	7.2	8.8	8.4	9.1	10.0	10.8	11.6	11.6	10.9	10.0	8.6	8.4	8.1	7.8	7.1	7.0	6.5
65–74	6.4	7.2	7.7	8.1	8.7	9.5	9.2	10.7	9.2	9.1	7.2	7.0	7.0	7.4	6.3	5.9	5.3
75–84	8.8	11.0	9.0	10.4	11.4	11.9	13.4	11.8	12.5	10.5	10.0	9.5	9.3	7.5	7.7	7.2	6.9
85 and over	7.9	12.0	9.8	10.1	11.8	12.7	16.4	14.9	13.0	12.2	10.1	10.7	9.4	10.2	8.9	10.5	11.0
Income category																	
Poor/near poor																	
55–64	16.1	18.1	30.0	29.9	31.2	27.1	29.9	30.0	27.7	28.8	23.3	24.3	26.1	24.8	25.3	21.7	20.2
55–61	17.5	19.8	27.6	28.1	29.6	26.5	30.0	29.6	27.9	27.7	24.1	24.2	25.1	24.3	23.8	23.2	21.1
62–64	13.3	14.0	34.3	*	34.9	28.5	29.9	30.9	27.3	31.5	21.2	24.4	28.5	26.1	28.6	18.2	17.4
65 and over	12.3	15.8	19.2	22.6	23.5	27.6	27.8	29.3	27.6	28.1	21.9	19.4	22.4	21.4	20.5	20.0	17.5
65–74	11.0	13.7	21.6	24.4	25.7	27.7	23.4	29.0	26.2	29.4	20.2	19.4	23.3	27.1	21.0	19.5	15.3
75–84	14.4	19.0	18.3	22.9	23.3	28.4	30.2	29.4	28.6	27.9	24.5	18.3	21.5	15.3	20.2	17.5	15.9
85 and over	12.4	14.7	*	17.6	18.7	25.7	32.4	30.0	28.6	24.9	20.0	21.6	22.5	19.9	20.1	25.2	25.1
Low/middle/high																	
55–64	3.9	3.7	3.2	3.4	4.2	4.1	4.5	4.1	4.2	4.0	3.8	3.8	3.4	3.4	3.4	3.2	3.3
55–61	3.7	3.4	2.9	3.1	3.9	3.8	4.2	4.0	3.9	3.8	3.5	3.4	3.2	3.0	3.3	3.1	3.1
62–64	4.2	4.6	3.8	4.3	5.3	5.0	5.5	4.8	5.3	4.8	4.5	4.9	4.0	4.3	3.6	3.3	3.7
65 and over	5.4	7.0	5.6	6.3	7.3	7.2	8.0	8.1	7.4	6.0	5.6	5.9	5.2	5.2	4.7	4.5	4.5
65–74	5.0	5.9	4.9	5.6	6.2	6.4	6.9	7.4	6.2	5.2	4.9	4.8	4.3	4.3	4.1	3.9	3.8
75–84	6.2	8.4	6.3	6.9	8.4	8.2	9.1	8.2	8.8	6.5	6.1	7.2	6.2	5.8	5.2	5.0	5.1
85 and over	5.2	10.9	7.8	7.6	9.3	7.9	10.3	11.1	8.2	8.2	7.2	7.4	6.4	7.8	5.7	5.8	6.6
Health status category																	
Poor or fair health																	
55–64	8.7	8.5	13.0	14.1	13.6	13.3	13.3	13.8	12.7	13.2	10.0	11.3	9.8	10.9	12.0	9.5	10.0
55–61	8.8	9.0	11.8	12.8	12.9	12.8	12.4	13.5	11.8	12.9	9.8	10.9	10.2	10.9	11.3	10.0	11.1
62–64	8.6	7.6	15.9	17.4	15.2	14.7	15.9	14.7	15.3	14.0	10.5	12.2	8.8	11.1	13.6	8.1	7.3
65 and over	9.5	11.0	11.7	13.1	13.9	14.6	16.0	15.2	15.5	12.9	11.3	11.8	10.5	10.9	9.0	9.7	8.7
65–74	8.7	10.0	10.7	11.8	13.5	14.4	13.8	14.3	14.3	13.1	11.3	11.4	9.6	11.0	8.3	8.8	6.9
75–84	11.3	12.4	11.8	14.6	14.7	15.2	17.5	15.4	17.1	13.0	11.3	11.2	11.9	9.8	9.9	9.7	8.6
85 and over	8.9	12.2	*	13.8	13.2	13.5	19.5	17.9	14.5	12.2	11.2	14.4	10.0	13.2	9.2	11.9	13.5

See notes at end of table.

INDICATOR 33: **Out-of-Pocket Health Care Expenditures**

Table 33b. Ratio of out-of-pocket expenditures to household income per person among people age 55 and over, by selected characteristics, 1977, 1987, 1996, and 2000–2013—continued

Selected characteristic	1977	1987	1996	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Excellent, very good, or good health																	
55–64	3.9	4.6	5.0	4.0	5.2	4.6	5.0	5.0	4.9	4.8	4.4	4.1	4.8	4.3	4.3	4.1	3.9
55–61	3.9	4.5	4.1	3.5	4.8	4.4	4.9	4.5	4.6	4.3	4.3	3.9	4.1	4.0	3.9	4.0	3.7
62–64	4.1	4.9	7.3	5.6	6.6	5.6	5.4	6.4	5.6	6.3	5.0	4.8	6.8	5.3	5.2	4.3	4.7
65 and over	6.1	7.1	6.6	6.7	7.6	8.4	8.9	9.4	8.1	8.2	7.0	6.4	6.8	6.1	6.1	5.6	5.5
65–74	5.3	5.4	6.3	6.2	6.2	7.1	6.9	8.9	6.6	7.1	5.3	5.0	5.7	5.8	5.5	4.7	4.7
75–84	7.5	9.7	7.2	7.5	9.1	9.6	10.7	9.3	9.2	8.8	9.2	8.3	7.8	6.0	6.3	5.9	6.0
85 and over	7.6	11.8	6.4	7.1	10.6	11.9	13.9	12.8	11.9	12.2	9.2	7.9	9.0	7.8	8.7	9.2	8.8

* Base is not large enough to produce reliable results.

NOTE: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care in all years. People are classified into the "poor/near poor" income category if their household income is below 125 percent of the poverty level; otherwise, people are classified into the "low/middle/high" income category. The poverty level is calculated according to the U.S. Census Bureau guidelines for the corresponding year. The ratio of a person's out-of-pocket expenditures to their household income was calculated based on the person's per capita household income. For people whose ratio of out-of-pocket expenditures to income exceeded 100 percent, the ratio was capped at 100 percent. For people with out-of-pocket expenditures, and with zero income (or negative income), the ratio was set at 100 percent. For people with no out-of-pocket expenditures the ratio was set to zero. These methods differ from those used in *Older Americans 2004,* which excluded persons with no out-of-pocket expenditures from the calculations (17 percent of the population age 65 and over in 1977, and 4.5 percent of the population age 65 and over in 2004). Data from the 1987 survey have been adjusted to permit comparability across years; for details see Zuvekas and Cohen.[58]

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS) and MEPS predecessor surveys.

Table 33c. Percentage distribution of total out-of-pocket health care expenditures among people age 55 and over, by age group and type of health care service, 2000–2013

	55–64			65 and over			
Year and type of health care service	Total	55–61	62–64	Total	65–74	75–84	85 and over
2000							
Hospital care	8.5	7.5	*	6.4	7.3	4.6	8.6
Office-based medical provider services	18.9	19.8	16.7	9.8	11.6	9.0	6.0
Dental services	20.0	21.3	17.0	15.8	17.5	15.9	9.6
Prescription drugs	44.7	44.0	46.5	53.6	57.1	51.5	48.0
Other health care	7.8	7.5	8.7	14.3	6.6	19.0	27.9
2001							
Hospital care	9.8	9.4	10.7	5.4	5.2	5.8	*
Office-based medical provider services	19.8	19.9	19.7	9.4	10.5	9.6	6.0
Dental services	18.6	20.0	15.2	13.0	15.6	11.9	8.3
Prescription drugs	45.7	44.3	48.9	56.0	57.2	58.9	45.1
Other health care	6.1	6.4	5.5	16.2	11.5	13.8	*
2002							
Hospital care	10.2	9.2	13.1	5.0	4.6	5.5	5.1
Office-based medical provider services	21.3	21.6	20.3	10.5	12.3	9.3	7.8
Dental services	18.1	18.3	17.7	14.0	17.6	12.3	6.2
Prescription drugs	43.8	43.5	44.7	58.2	57.9	56.6	65.5
Other health care	6.6	7.4	4.3	12.3	7.7	16.3	15.4
2003							
Hospital care	9.2	8.8	10.1	5.2	5.9	4.5	5.1
Office-based medical provider services	18.8	18.3	19.9	8.7	9.4	9.1	5.4
Dental services	16.7	16.7	16.9	11.8	14.5	9.5	9.5
Prescription drugs	48.5	49.0	47.5	58.3	61.3	54.5	59.8
Other health care	6.8	7.3	5.6	16.0	8.9	22.4	20.2

See notes at end of table

INDICATOR 33: **Out-of-Pocket Health Care Expenditures**

Table 33c. Percentage distribution of total out-of-pocket health care expenditures among people age 55 and over, by age group and type of health care service, 2000–2013—continued

	56–64			65 and over			
Year and type of health care service	Total	55–61	62–64	Total	65–74	75–84	85 and over
2004							
Hospital care	9.2	10.1	6.9	5.0	5.1	4.5	*
Office-based medical provider services	20.1	18.7	23.6	10.1	12.4	9.2	5.3
Dental services	16.9	18.5	12.8	11.8	13.2	12.0	7.5
Prescription drugs	46.0	45.0	48.7	61.4	61.9	64.8	51.9
Other health care	7.8	7.7	8.1	11.8	7.4	9.5	29.5
2005							
Hospital care	12.2	12.8	10.8	5.4	5.1	5.7	5.4
Office-based medical provider services	19.6	19.6	19.9	11.4	11.4	12.3	8.7
Dental services	15.7	16.3	14.3	15.3	19.4	12.6	9.8
Prescription drugs	45.9	44.7	49.0	57.8	57.9	59.1	53.3
Other health care	6.5	6.7	6.1	10.1	6.2	10.4	22.7
2006							
Hospital care	*	9.4	*	7.2	6.6	5.9	12.2
Office-based medical provider services	19.8	20.9	17.4	12.3	14.1	11.0	9.5
Dental services	13.9	15.4	10.6	16.2	19.7	15.3	7.6
Prescription drugs	43.2	48.5	32.0	51.1	51.5	53.2	45.2
Other health care	5.5	5.8	4.9	13.2	8.1	14.7	25.5
2007							
Hospital care	12.4	12.6	11.9	*	4.4	*	*
Office-based medical provider services	22.1	21.7	23.1	13.7	15.5	12.7	10.4
Dental services	21.1	21.3	20.7	18.5	21.4	16.4	14.9
Prescription drugs	38.8	38.8	38.7	47.3	49.5	45.4	45.3
Other health care	5.6	5.7	5.5	11.6	9.2	10.2	21.6
2008							
Hospital care	14.2	14.7	13.3	6.3	7.3	5.9	4.5
Office-based medical provider services	23.1	24.0	21.4	15.0	17.3	14.9	9.3
Dental services	19.9	19.8	20.2	19.6	21.4	19.8	14.2
Prescription drugs	35.9	35.8	36.3	42.0	44.8	41.2	35.9
Other health care	6.8	5.8	8.8	17.1	9.2	18.2	36.1
2009							
Hospital care	16.0	13.3	*	10.6	6.4	14.5	12.7
Office-based medical provider services	23.2	24.6	20.3	15.8	18.8	14.0	11.8
Dental services	21.6	23.0	18.6	18.7	23.0	15.4	15.0
Prescription drugs	32.2	32.2	32.1	41.3	44.2	40.2	36.1
Other health care	7.0	6.9	7.1	13.6	7.7	15.9	24.4
2010							
Hospital care	12.2	12.6	11.4	7.9	7.8	6.8	10.8
Office-based medical provider services	24.7	24.4	25.4	15.8	17.5	14.6	13.0
Dental services	20.6	19.2	23.4	20.4	21.4	22.2	13.4
Prescription drugs	36.3	37.6	33.9	44.4	46.3	44.0	39.3
Other health care	6.2	6.4	5.8	11.4	7.0	12.4	23.5

See notes at end of table.

INDICATOR 33: **Out-of-Pocket Health Care Expenditures**

Table 33c. Percentage distribution of total out-of-pocket health care expenditures among people age 55 and over, by age group and type of health care service, 2000–2013—continued

	55–64			65 and over			
Year and type of health care service	Total	55–61	62–64	Total	65–74	75–84	85 and over
2011							
Hospital care	16.6	15.5	19.1	7.8	8.6	7.4	6.0
Office-based medical provider services	24.1	23.7	24.9	15.9	18.0	14.8	12.0
Dental services	18.3	18.5	18.1	20.0	20.2	24.3	11.4
Prescription drugs	34.6	35.0	33.7	40.2	42.4	41.5	30.7
Other health care	6.4	7.3	4.2	16.1	10.9	11.9	39.9
2012							
Hospital care	18.0	15.5	*	9.2	10.0	8.2	*
Office-based medical provider services	23.7	24.3	22.4	15.6	19.7	13.5	8.6
Dental services	17.3	18.1	15.6	22.1	23.0	26.7	*
Prescription drugs	34.9	36.2	32.1	34.2	37.7	39.4	18.4
Other health care	6.2	6.0	6.5	18.8	9.5	12.2	50.8
2013							
Hospital care	16.0	18.4	10.9	7.7	7.4	9.6	5.6
Office-based medical provider services	27.2	25.5	30.8	19.2	22.1	16.9	14.5
Dental services	18.5	17.7	20.0	21.0	23.2	23.6	10.5
Prescription drugs	30.5	29.9	31.7	33.3	35.7	35.5	22.6
Other health care	7.9	8.5	6.7	18.8	11.7	14.3	46.9

* Estimate not shown due to a relative standard error greater than 30 percent.

NOTE: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Hospital care includes hospital inpatient care and care provided in hospital outpatient departments and emergency rooms. Office-based medical provider services include services provided by medical providers in non-hospital-based medical offices or clinic settings. Dental services include care provided by any type of dental provider. Prescription drugs include prescribed medications purchased, including refills. Other health care includes care provided by home health agencies and independent home health providers and expenses for eyewear, ambulance services, orthopedic items, hearing devices, prostheses, bathroom aids, medical equipment, disposable supplies, and other miscellaneous services. The majority of expenditures in the "other" category are for home health services and eyeglasses. Estimates might not sum to 100 percent because of rounding.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey (MEPS).

INDICATOR 34: **Sources of Payment for Health Care Services**

Table 34a. Average cost per beneficiary and percentage distribution of sources of payment for health care services for Medicare beneficiaries age 65 and over, by type of service, 2012

Type of service	Average cost per beneficiary	Sources of payment				
		Total	Medicare	Medicaid	Out-of-pocket	Other
All	$16,959	100.0	59.0	6.8	17.7	16.4
Hospice	343	100.0	100.0			
Inpatient hospital	3,627	100.0	87.0	0.8	*2.2	9.9
Home health care	550	100.0	76.8	**	19.0	**
Short-term institution	933	100.0	70.4	11.9	8.8	8.8
Physician/medical	4,050	100.0	61.5	1.2	16.7	20.6
Outpatient hospital	1,801	100.0	71.8	1.4	7.3	19.6
Prescription drugs	2,793	100.0	50.5	0.3	21.3	27.8
Dental	447	100.0	1.8	**	77.3	20.6
Long-term care facility	2,032	100.0	**	44.3	45.0	9.7

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error of 20 to 30 percent.

** Estimate not shown due to a relative standard error greater than 30 percent.

NOTE: "Other" refers to private insurance, Department of Veterans Affairs, uncollected liability, and other public programs. Estimates may not sum to the totals because of rounding or suppression due to high relative standard errors.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

Table 34b. Average cost per beneficiary and percentage distribution of sources of payment for health care services for Medicare beneficiaries age 65 and over, by income, 2012

Income	Average cost per beneficiary	Sources of payment				
		Total	Medicare	Medicaid	Out-of-pocket	Other
All	$16,959	100.0	59.0	6.8	17.7	16.4
Under $10,000	24,585	100.0	61.8	20.2	11.2	6.8
$10,000–$20,000	19,925	100.0	62.8	11.4	15.7	10.1
$20,001–$30,000	15,649	100.0	63.3	4.1	17.8	14.8
$30,001 and over	14,679	100.0	54.0	1.0	20.9	23.8

NOTE: Income refers to annual income of respondent and spouse. "Other" refers to private insurance, Department of Veterans Affairs, uncollected liability, and other public programs. Estimates may not sum to the totals because of rounding.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use.

INDICATOR 35: **Veterans' Health Care**

Table 35a. Total number of veterans age 65 and over who are enrolled in the Veterans Health Administration, by age group, 1999–2014 and projected 2019–2034

		65 and over					
Year	All ages	Total	65–69	70–74	75–79	80–84	85 and over
Actual							
1999	4,542,964	1,880,346	540,126	546,299	516,076	213,069	64,776
2004	7,356,161	3,355,949	690,284	882,646	847,977	670,116	264,926
2009	8,165,680	3,494,830	724,280	675,320	811,308	694,053	589,869
2014	9,078,615	4,317,646	1,486,698	758,428	632,674	680,238	759,608
Projected							
2019	9,578,000	4,715,000	1,135,000	1,469,000	746,000	552,000	814,000
2024	9,698,000	4,875,000	1,004,000	1,116,000	1,359,000	650,000	747,000
2029	9,651,000	4,945,000	973,000	993,000	1,031,000	1,143,000	804,000
2034	9,455,000	4,863,000	913,000	966,000	921,000	861,000	1,202,000

NOTE: Department of Veterans Affairs (VA) enrollees are veterans who have signed up to receive health care from the Veterans Health Administration (VHA). Counts for 2019–2034 are projections from the 2015 VA Enrollee Health Care Projection Model.

Reference population: These data refer to the count of unique VHA enrollees per fiscal year.

SOURCE: Department of Veterans Affairs, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, 2015 VA Enrollee Health Care Projection Model.

Table 35b. Percentage of enrolled veterans age 65 and over with service-connected disabilities, by service-connected disability rating, 2004–2014 and projected 2019–2034

Year	70 percent or more service-connected disability	10 percent or more service-connected disability	No service-connected disability
Actual			
2004	4.5	21.8	78.2
2009	6.5	24.8	75.2
2014	13.2	35.9	64.1
Projected			
2019	18.0	43.3	56.7
2024	21.4	48.2	51.8
2029	24.4	52.0	48.0
2034	27.0	55.0	45.0

NOTE: Department of Veterans Affairs (VA) enrollees service-connected disability ratings reflect the severity of the disability and how much the impairment impacts the ability to work.

Reference population: These data refer to the count of unique VHA enrollees per fiscal year.

SOURCE: Department of Veterans Affairs, Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, 2015 VA Enrollee Health Care Projection Model.

INDICATOR 36: **Residential Services**

Table 36a. Percentage distribution of Medicare beneficiaries age 65 and over residing in selected residential settings, by age group, 2013

	65 and over			
Residential setting	Total	65–74	75–84	85 and over
Total	100.0	100.0	100.0	100.0
Traditional community	93.2	97.5	93.4	77.1
Community housing with services	2.8	1.3	3.1	8.2
Long-term care facilities	3.9	1.2	3.6	14.7
Number (in thousands)	40,700	21,800	12,900	6,000

NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, or help with medications. Respondents were asked about access to these services, but not whether they actually used the services. A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a non-family, paid caregiver.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

Table 36b. Percentage distribution of Medicare beneficiaries age 65 and over with limitations in performing activities of daily living (ADLs) and instrumental activities of daily living (IADLs), by residential setting, 2013

Functional status	Overall	Traditional community	Community housing with services	Long-term care facilities
Total	100.0	100.0	100.0	100.0
No functional limitations	55.8	58.5	36.4	4.9
IADL limitation(s) only	12.2	12.1	15.0	11.7
1–2 ADL limitations	20.7	20.6	32.0	16.4
3 or more ADL limitations	11.3	8.8	16.7	67.0

NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, or help with medications. Respondents were asked about access to these services, but not whether they actually used the services. A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a non-family, paid caregiver. Long-term care facility residents with no limitations may include individuals with limitations in performing certain IADLs, such as doing light or heavy housework or meal preparation. These questions were not asked of facility residents.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

Table 36c. Percent availability of specific services among Medicare beneficiaries age 65 and over residing in community housing with services, 2013

Access to service	Percent
Prepared meals	86.0
Housekeeping, maid, or cleaning services	79.4
Laundry services	68.5
Help with medications	49.3

NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations AND who reported they had access to one or more services listed in the table through their place of residence. Respondents were asked about access to these services, but not whether they actually used the services.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

INDICATOR 36: **Residential Services**

Table 36d. Percentage distribution of annual income of Medicare beneficiaries age 65 and over, by residential setting, 2013

Income	Traditional community	Community housing with services	Long-term care facilities
Total	100.0	100.0	100.0
Under $10,000	8.3	8.4	32.5
$10,001–$20,000	19.5	32.8	37.8
$20,001–$30,000	17.8	20.3	13.7
$30,001 and over	54.4	38.5	16.1

NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, or help with medications. Respondents were asked about access to these services, but not whether they actually used the services. A residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; or has 3 or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a non-family, paid caregiver. Income refers to annual income of respondent and spouse. Table excludes data for respondents who reported only that their income was greater or less than $25,000.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

Table 36e. Characteristics of services available to Medicare beneficiaries age 65 and over residing in community housing with services, 2013

Selected characteristic	Percent
Services included in housing costs	100.0
All included	46.5
Some included/some separate	41.8
All separate	11.7
Can continue living there if they need substantial services	100.0
Yes	60.7
No	39.3

NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations AND who reported they had access to one or more of the following services through their place of residence: meal preparation, cleaning or housekeeping services, laundry services, or help with medications. Respondents were asked about access to these services, but not whether they actually used the services.

Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

INDICATOR 37: **Personal Assistance and Equipment**

Table 37a. Percentage distribution of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs), by type of assistance, 1992–2013

Year	Personal assistance only	Equipment only	Personal assistance and equipment	None
1992	9.2	28.3	20.9	41.6
1993	9.0	28.6	20.8	41.5
1994	8.2	31.4	22.4	38.0
1995	8.2	32.0	22.1	37.7
1996	7.7	32.5	22.4	37.5
1997	5.6	34.2	21.4	38.8
1998	6.1	30.7	23.0	40.2
1999	6.7	34.7	19.7	39.0
2000	6.6	35.6	20.7	37.0
2001	6.3	36.3	22.0	35.3
2002	6.7	35.7	21.8	35.9
2003	6.2	34.8	22.9	36.2
2004	6.9	33.5	22.2	37.4
2005	6.6	36.3	21.9	35.2
2006	6.9	36.3	23.1	33.8
2007	6.0	37.6	22.1	34.3
2008	5.4	38.1	21.4	35.1
2009	6.4	38.4	23.4	31.8
2010	7.0	36.9	22.5	33.6
2011	5.7	38.6	22.9	32.8
2012	7.8	33.1	24.5	34.6
2013	7.0	35.3	25.4	32.4

NOTE: Limitations in performing activities of daily living (ADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Respondents who report difficulty with an activity are subsequently asked about receiving help or supervision from another person with the activity and about using special equipment or aids. In this table, personal assistance does not include supervision. Percentages are age adjusted using the 2000 standard population. Estimates may not sum to the totals because of rounding.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more ADLs.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

Table 37b. Percentage distribution of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs), by type of assistance, age group, and sex, 2013

Age group and sex	Personal assistance only	Equipment only	Personal assistance and equipment	None
65 and over	7.0	35.3	25.4	32.4
Men	6.2	34.6	22.9	36.2
Women	7.4	35.6	27.0	30.0
65–74	6.7	31.0	21.5	40.8
75–84	7.5	39.9	26.0	26.6
85 and over	6.5	39.9	40.5	13.2

NOTE: Limitations in performing activities of daily living (ADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Respondents who report difficulty with an activity are subsequently asked about receiving help or supervision from another person with the activity and about using special equipment or aids. In this table, personal assistance does not include supervision. Estimates for persons age 65 or over are age adjusted using the 2000 standard population.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more ADLs.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

INDICATOR 37: **Personal Assistance and Equipment**

Table 37c. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing instrumental activities of daily living (IADLs) and who receive personal assistance, by age group, 1992–2013

		65 and over		
Year	Total	65–74	75–84	85 and over
1992	61.6	58.9	63.2	69.2
1993	59.6	56.6	59.4	73.3
1994	61.3	60.2	59.8	71.4
1995	61.9	59.1	64.5	66.1
1996	61.2	59.8	61.2	66.7
1997	63.6	61.8	63.2	71.1
1998	65.7	64.9	65.3	70.1
1999	62.9	61.5	62.8	68.7
2000	62.7	56.8	64.4	76.6
2001	65.2	60.9	66.5	73.7
2002	68.0	68.1	66.7	71.9
2003	66.8	66.4	65.0	72.9
2004	65.4	64.2	65.6	68.8
2005	66.4	62.7	67.4	74.0
2006	63.7	63.2	61.7	70.5
2007	66.3	65.4	66.0	69.7
2008	68.2	69.7	66.6	67.8
2009	66.2	64.8	67.3	67.6
2010	65.7	64.2	64.5	72.2
2011	67.1	65.6	66.3	72.1
2012	69.7	70.1	66.4	75.8
2013	68.1	63.3	71.2	75.8

NOTE: Limitations in performing instrumental actitivites of daily living (IADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Respondents who report difficulty with an activity are subsequently asked about receiving help from another person with the activity. In this table, personal assistance does not include supervision or special equipment.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more IADLs.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

Table 37d. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing instrumental activities of daily living (IADLs) and who receive personal assistance, by sex and age group, 2013

Age group	Men	Women
65–74	58.5	66.0
75–84	75.0	69.5
85 and over	83.8	71.7

NOTE: Limitations in performing instrumental activities of daily living (IADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money. Respondents who report difficulty with an activity are subsequently asked about receiving help from another person with the activity. In this table, personal assistance does not include supervision or special equipment.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more IADLs.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

INDICATOR 38: **Long-Term Care Providers**

Table 38a. Number of users of long-term care services, by sector and age group, 2013 and 2014

Age group	Nursing homes	Residential care communities	Adult day services centers	Home health agencies	Hospices
Less than 65	206,825	60,134	102,721	863,555	75,079
65–74	220,522	86,861	56,440	1,258,323	229,260
75–84	372,558	249,725	77,605	1,534,661	402,210
85 and over	569,795	439,315	45,716	1,282,996	634,151

NOTE: Long-term care services are provided by paid, regulated providers. They comprise both health care-related and non-health care-related services, including post-acute care and rehabilitation. People can receive more than one type of service. The estimated number of users of nursing homes, residential care communities, and adult day services centers represents participants or residents enrolled on the day of data collection in 2014. The estimated number of users of home health agencies represents patients who ended care (i.e., were discharged) in 2013. The estimated number of users of hospice represents patients who received care at any time in 2013. The number in each age group is calculated by applying the percentage distribution by age to the estimated total number of users. See http://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf for definitions.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Study of Long-Term Care Providers.

Table 38b. Percentage of users of long-term care services needing any assistance with activities of daily living (ADLs), by sector and activity, 2013 and 2014

Activity	Nursing homes	Residential care communities	Adult day services centers	Home health agencies
Bathing	96.4	62.4	41.0	96.4
Dressing	91.8	47.4	37.1	88.4
Toileting	87.9	39.3	35.6	73.2
Walking or locomotion	90.7	29.1	33.7	94.0
Transferring in/out of bed or chair	85.2	29.7	29.8	87.8
Eating	58.0	19.8	24.3	56.7

NOTE: Long-term care services are provided by paid, regulated providers. They comprise both health care-related and non-health care-related services, including post-acute care and rehabilitation. People can receive more than one type of service. The estimated number of users of nursing homes, residential care communities, and adult day services centers represents participants or residents enrolled on the day of data collection in 2014. The estimated number of users of home health agencies represents patients who ended care (i.e., were discharged) in 2013. Users of formal long-term care include persons of all ages. In nursing homes, 85 percent of residents were age 65 and over. In residential care communities, 93 percent of residents were age 65 and over. In adult day services centers, 64 percent of participants were age 65 and over. Among home health care patients, 83 percent were age 65 and over. Data were not available for hospice patients. Participants, patients, or residents were considered needing any assistance with a given activity if they needed help or supervision from another person or used special equipment to perform the activity. See http://www.cdc.gov/nchs/data/series/sr_03/sr03_038.pdf for definitions.

Reference population: These data refer to the resident population.

SOURCE: Centers for Disease Control and Prevention, National Center for Health Statistics, National Study of Long-Term Care Providers.

INDICATOR 39: **Use of Time**

Table 39a. Average number of hours per day and percentage of day that people age 55 and over spent doing selected activities on an average day, by age group, 2014

	55 and over		55–64		65–74		75 and over	
Selected activity	Average hours per day	Percent of day	Average hours per day	Percent of day	Average hours per day	Percent of day	Average hours per day	Percent of day
Sleeping	8.73	36.4	8.43	35.1	8.88	37.0	9.16	38.2
Leisure activities	6.48	27.0	5.45	22.7	6.94	28.9	8.02	33.4
Work and work-related activities	2.37	9.9	4.02	16.8	1.32	5.5	0.33	1.4
Household activities	2.18	9.1	2.01	8.4	2.44	10.2	2.19	9.1
Caring for and helping others	0.36	1.5	0.41	1.7	0.36	1.5	0.28	1.2
Eating and drinking	1.30	5.4	1.21	5.0	1.37	5.7	1.41	5.9
Purchasing goods and services	0.84	3.5	0.82	3.4	0.90	3.8	0.81	3.4
Grooming	0.65	2.7	0.69	2.9	0.62	2.6	0.61	2.5
Other activities	1.07	4.5	0.94	3.9	1.17	4.9	1.19	5.0

NOTE: "Other activities" includes activities such as educational activities; organizational, civic, and religious activities; and telephone calls. Table includes people who did not work at all.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, American Time Use Survey.

Table 39b. Average number of hours and percentage of total leisure time that people age 55 and over spent doing selected leisure activities on an average day, by age group, 2014

	55 and over		55–64		65–74		75 and over	
Selected leisure activity	Average hours per day	Percent of leisure time	Average hours per day	Percent of leisure time	Average hours per day	Percent of leisure time	Average hours per day	Percent of leisure time
Socializing and communicating	0.65	10.1	0.58	10.6	0.73	10.5	0.71	8.8
Watching TV	3.78	58.2	3.25	59.6	4.03	58.1	4.52	56.3
Participation in sports, exercise, and recreation	0.23	3.6	0.24	4.3	0.27	3.9	0.17	2.1
Relaxing and thinking	0.40	6.2	0.30	5.6	0.35	5.0	0.69	8.7
Reading	0.61	9.4	0.37	6.8	0.63	9.1	1.09	13.5
Other leisure activities	0.81	12.5	0.71	13.0	0.93	13.4	0.85	10.5

NOTE: "Other leisure activities" includes activities such as playing games, using the computer for leisure, doing arts and crafts as a hobby, experiencing arts and entertainment (other than sports), and engaging in related travel.

Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, American Time Use Survey.

INDICATOR 40: **Air Quality**

Table 40a. Percentage of people age 65 and over living in counties with "poor air quality," by selected pollutant measures, 2000–2014

Pollutant measures	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Particulate Matter ($PM_{2.5}$)	50.1	47.7	47.1	43.0	37.8	45.6	35.5	38.4	25.7	17.7	15.0	14.1	7.2	9.4	9.1
Ozone	51.4	54.5	53.4	53.5	34.4	51.1	49.0	47.1	35.6	16.4	31.6	35.3	38.9	14.1	11.3
Any standard	65.5	64.8	62.7	63.2	54.6	62.4	59.1	57.6	45.3	27.1	38.4	40.4	41.6	21.1	16.5

NOTE: The term "poor air quality" is defined as air quality concentrations above the level of the National Ambient Air Quality Standards (NAAQS). The term "any standard" refers to any NAAQS for ozone, particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide, or lead. Data for previous years have been computed using the the standards in effect as of August 2015 to enable comparisons over time. This results in percentages that are not comparable to those in previous publications of *Older Americans*. Measuring concentrations above the level of a standard is not equivalent to violating the standard. The level of a standard may be exceeded on multiple days before the exceedance is considered a violation of the standard.

Reference population: These data refer to the resident population.

SOURCE: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Air Quality System; U.S. Census Bureau, 2010 Population.

Table 40b. Counties with "poor air quality" for any standard in 2014

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
Alaska	Anchorage Municipality	291,826	21,139
Alaska	Fairbanks North Star Borough	97,581	6,375
Alaska	Kenai Peninsula Borough	55,400	6,276
Alaska	Matanuska-Susitna Borough	88,995	7,069
Arizona	Cochise County	131,346	22,688
Arizona	Gila County	53,597	12,450
Arizona	Maricopa County	3,817,117	462,641
Arizona	Pinal County	375,770	52,071
Arizona	Santa Cruz County	47,420	6,224
Arizona	Yavapai County	211,033	50,767
Arizona	Yuma County	195,751	30,646
California	Alameda County	1,510,271	167,746
California	El Dorado County	181,058	26,524
California	Fresno County	930,450	93,421
California	Imperial County	174,528	18,152
California	Inyo County	18,546	3,535
California	Kern County	839,631	75,437
California	Kings County	152,982	12,030
California	Los Angeles County	9,818,605	1,065,699
California	Madera County	150,865	17,262
California	Mariposa County	18,251	3,821
California	Merced County	255,793	23,960
California	Mono County	14,202	1,377
California	Nevada County	98,764	19,174
California	Orange County	3,010,232	349,677
California	Placer County	348,432	53,562
California	Plumas County	20,007	4,154

See notes at end of table.

INDICATOR 40: **Air Quality**

Table 40b. Counties with "poor air quality" for any standard in 2014—continued

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
California	Riverside County	2,189,641	258,586
California	Sacramento County	1,418,788	158,551
California	San Bernardino County	2,035,210	181,348
California	San Diego County	3,095,313	351,425
California	San Joaquin County	685,306	71,181
California	San Luis Obispo County	269,637	41,022
California	Santa Barbara County	423,895	54,398
California	Siskiyou County	44,900	8,782
California	Stanislaus County	514,453	54,831
California	Tehama County	63,463	10,071
California	Tulare County	442,179	41,779
California	Ventura County	823,318	96,309
Colorado	Alamosa County	15,445	1,752
Colorado	Jefferson County	534,543	67,411
Colorado	Prowers County	12,551	1,835
Connecticut	Fairfield County	916,829	124,075
Connecticut	Hartford County	894,014	130,119
Connecticut	Middlesex County	165,676	25,621
Connecticut	Tolland County	152,691	18,220
Georgia	Rockdale County	85,215	9,066
Hawaii	Hawaii County	185,079	26,834
Idaho	Lemhi County	7,936	1,758
Idaho	Shoshone County	12,765	2,537
Illinois	Tazewell County	135,394	21,139
Indiana	Daviess County	31,648	4,461
Indiana	Gibson County	33,503	5,122
Indiana	Marion County	903,393	96,102
Indiana	Morgan County	68,894	8,919
Indiana	Pike County	12,845	2,175
Indiana	Vigo County	107,848	14,511
Iowa	Linn County	211,226	27,488
Iowa	Muscatine County	42,745	5,843
Kentucky	Jefferson County	741,096	99,095
Louisiana	St. Bernard Parish	35,897	3,288
Michigan	Allegan County	111,408	14,438
Missouri	Iron County	10,630	1,899
Missouri	Jackson County	674,158	83,990
Missouri	Jefferson County	218,733	24,394
Missouri	St. Louis city	319,294	35,175
Montana	Yellowstone County	147,972	20,868
Nevada	Clark County	1,951,269	220,445
Nevada	Nye County	43,946	10,301
Nevada	Washoe County	421,407	50,879
New Jersey	Warren County	108,692	15,292
New Mexico	Bernalillo County	662,564	81,014
New Mexico	Doña Ana County	209,233	25,881
New Mexico	Luna County	25,095	4,907

See notes at end of table.

INDICATOR 40: **Air Quality**

Table 40b. Counties with "poor air quality" for any standard in 2014—continued

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
North Dakota	Williams County	22,398	3,328
Ohio	Cuyahoga County	1,280,122	198,541
Ohio	Hamilton County	802,374	106,863
Ohio	Morgan County	15,054	2,611
Oklahoma	Adair County	22,683	2,934
Oklahoma	Love County	9,423	1,618
Oregon	Crook County	20,978	4,203
Oregon	Lake County	7,895	1,612
Oregon	Lane County	351,715	52,781
Pennsylvania	Allegheny County	1,223,348	205,059
Pennsylvania	Beaver County	170,539	31,660
Pennsylvania	Delaware County	558,979	79,726
Pennsylvania	Lancaster County	519,445	77,780
Pennsylvania	Lebanon County	133,568	22,729
Pennsylvania	Philadelphia County	1,526,006	185,309
Pennsylvania	Warren County	41,815	7,840
Pennsylvania	Washington County	207,820	36,366
Tennessee	Sullivan County	156,823	29,215
Texas	Denton County	662,614	46,043
Texas	Tarrant County	1,809,034	161,385
Utah	Cache County	112,656	8,694
Utah	Davis County	306,479	24,992
Utah	Salt Lake County	1,029,655	89,367
Utah	Uintah County	32,588	2,997
Utah	Utah County	516,564	33,457
Wisconsin	Brown County	248,007	28,789
Wisconsin	Kenosha County	166,426	18,679
Wisconsin	Oneida County	35,998	7,800
Wyoming	Carbon County	15,885	2,044
Wyoming	Sweetwater County	43,806	3,643
Puerto Rico	Arecibo Municipio, Puerto Rico	96,440	15,727

NOTE: The term "poor air quality" is defined as air quality concentrations above the level of the National Ambient Air Quality Standards (NAAQS). The term "any standard" refers to any NAAQS for ozone, particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide, or lead. Measuring concentrations above the level of a standard is not equivalent to violating the standard. The level of a standard may be exceeded on multiple days before the exceedance is considered a violation of the standard.

Reference population: These data refer to the resident population.

SOURCE: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Air Quality System; U.S. Census Bureau, 2010 Population.

INDICATOR 41: **Transportation**

Table 41. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who made a change in transportation mode due to a health or physical problem, by age group and type of change, 2013

	65 and over			
Type of change	Total	65–74	75–84	85 and over
Limits driving to daytime	33.4	24.8	39.2	55.3
Has given up driving altogether	19.1	11.3	21.2	46.5
Has trouble getting places	24.5	18.5	26.5	44.6
Has reduced travel	33.8	25.9	37.3	58.4

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care.

SPECIAL FEATURE: **Informal Caregiving**

Table CG1. Number of informal caregivers, by age group and sex, 2011

Sex	Less than 45	45–54	55–64	65–74	75 and over
		Number (in thousands)			
Total	2,738	4,358	4,960	3,464	2,428
Men	999	1,727	1,512	1,412	1,204
Women	1,740	2,631	3,449	2,052	1,224

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.

Table CG2. Number of informal caregivers and percentage distribution of caregiving hours provided, by relationship to care recipient, 2011

Relationship to care recipient	Number of caregivers (in thousands)	Percentage of caregivers	Number of aggregate monthly hours (in thousands)	Percentage of caregiving hours
Total	17,949	100.0	1,342,520	100.0
Spouse	3,802	21.2	417,018	31.1
Daughter	5,263	29.3	411,138	30.6
Son	3,287	18.3	213,530	15.9
Other relative	4,011	22.3	245,508	18.3
Non-relative	1,586	8.8	55,326	4.1

NOTE: Estimates may not sum to the totals because of rounding.

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.

SPECIAL FEATURE: **Informal Caregiving**

Table CG3. Percentage of caregivers providing assistance, by sex of caregiver and type of assistance, 2011

Type of assistance	Total	Men	Women
Self care	49.3	45.5	51.6
Mobility	71.6	76.4	68.7
Transportation	86.4	86.4	86.3
Medical or health care	57.1	55.4	58.1

NOTE: Respondents reported whether they helped with different types of activities. Self-care activities include bathing, dressing, eating, and toileting. Mobility-related activities include getting out of bed, getting around inside one's home or building, and leaving one's home or building. Health or medical care tasks were assistance with diet, foot care, giving injections, and managing medical tasks, such as ostomy care, IV therapy assistance, or blood tests.

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.

Table CG4. Percentage of caregiver recipients, caregivers, and hours of help provided, by level of assistance needed by care recipients, 2011

Level of assistance	Care recipients	Caregivers	Hours of help
Household activities only	33.3	31.1	21.2
1–2 self-care/mobility tasks	39.4	38.0	32.4
3 or more self-care/mobility tasks	27.3	30.9	46.4

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.

Table CG5. Percentage of informal caregivers reporting positive and negative aspects of caregiving, by level of impact, 2011

	Level of impact	
Aspects of caregiving	Some	Substantial
Positive aspects		
More confident about abilities	34.8	45.5
Brought you closer to care receipient	21.2	68.7
Satisfied that recipient is well-cared for	12.5	86.3
Negative aspects		
Financial difficulties	11.4	6.6
Emotional difficulties	23.7	13.5
Physical difficulties	11.8	6.3
Have more things than you can handle	27.1	18.8
Don't have time for yourself	26.4	15.1

Reference population: People of all ages who, in the last month, helped with one or more self-care, household, or medical activities for a Medicare enrollee age 65 or over who had a chronic disability.

SOURCE: National Study on Caregiving.

Data Sources

Air Quality System

The Air Quality System (AQS) contains ambient air pollution data collected by the U.S. Environmental Protection Agency (EPA) and state, local, and tribal air pollution control agencies. Data on criteria pollutants consist of air quality measurements collected by sensitive equipment at thousands of monitoring stations located across all 50 states plus the District of Columbia, Puerto Rico, and the U.S. Virgin Islands. Each monitor measures the concentration of a particular pollutant in the air. Monitoring data indicate the average pollutant concentration during a specified time interval (usually 1 hour or 24 hours). AQS also contains meteorological data, descriptive information about each monitoring station (including its geographic location and its operator), and data quality assurance or quality control information. The system is administered by EPA, Office of Air Quality Planning and Standards, Outreach and Information Division, located in Research Triangle Park, NC.

For more information, contact:
Nick Mangus
U.S. Environmental Protection Agency
Phone: 919-541-5549
Website: http://www.epa.gov/aqs

American Housing Survey

The American Housing Survey (AHS) was mandated by Congress in 1968 to provide data for evaluating progress toward "a decent home and a suitable living environment for every American family." It is the primary source of detailed information on housing in the United States and is used to generate a biennial report to Congress on the conditions of housing in the United States, among other reports. The survey is conducted for the Department of Housing and Urban Development by the U.S. Census Bureau. The AHS encompasses a national survey and 60 metropolitan surveys and is designed to collect data from the same housing units for each survey. The national survey, a representative sample of approximately 45,000 housing units as of 2015, is conducted biennially in odd-numbered years; the metropolitan surveys, representative samples of 3,000 housing units, are conducted in odd-numbered years on a 4-year cycle. The AHS collects data about the inventory and condition of housing in the United States and the demographics of its inhabitants. The survey provides detailed data on the types of housing in the United States and their characteristics and conditions; financial data on housing costs, utilities, mortgages, equity loans, and market value; and demographic data on family composition, income, education, and race and ethnicity. Rotating supplements to the survey collect information on neighborhood quality, walkability, public transportation and recent movers; the health and safety aspects of a home; accommodations for older and disabled household members; doubling up of households; working from home; access to arts and culture; use of housing counseling; food security; and energy efficiency.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:
Meena Bavan
U.S. Department of Housing and Urban Development
E-mail: Meena.Bavan@hud.gov
Phone: 202-708-0614
Website: http://www.huduser.gov/portal/datasets/ahs.html

American Time Use Survey

The American Time Use Survey (ATUS) is a nationally representative sample survey conducted for the Bureau of Labor Statistics by the U.S. Census Bureau. The ATUS measures how people living in the United States spend their time. Estimates show the kinds of activities people do and the time they spend doing them by sex, age, educational attainment, labor force status, and other characteristics, as well as by weekday and weekend day.

ATUS respondents are interviewed one time about how they spent their time on the previous day, where they were, and whom they were with. The survey is a continuous survey, with interviews conducted nearly every day of the year and a sample that builds over time. About 12,000 members of the civilian noninstitutionalized population age 15 and over are interviewed each year.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:
American Time Use Survey Staff
Bureau of Labor Statistics
U.S. Department of Labor
E-mail: atusinfo@bls.gov
Phone: 202-691-6339
Website: http://www.bls.gov/tus/

Consumer Expenditure Survey

The Consumer Expenditure Survey (CE) is conducted for the Bureau of Labor Statistics by the U.S. Census Bureau. The survey consists of two separate components, the

Quarterly Interview Survey and the Diary Suvey. Data are integrated before publication. The data presented in this Chartbook are derived from the integrated data available on the CE website. The published data are weighted to reflect the U.S. population.

The Quarterly Interview Survey is designed to obtain data on the types of expenditures respondents can recall for a period of 3 months or longer. These include relatively large expenditures, such as those for property, automobiles, and major durable goods and those that occur on a regular basis, such as rent and utilities. Each consumer unit is interviewed once per quarter for four consecutive quarters. The Diary Survey is designed to obtain data on frequently purchased smaller items, including food and beverages both at home and in food establishments, housekeeping supplies, tobacco, nonprescription drugs, and personal care products and services. Each consumer unit records its expenditures in a diary for two consecutive 1-week periods. Respondents are less likely to recall such purchases over longer periods.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:
Bureau of Labor Statistics
U.S. Department of Labor
E-mail: CEXINFO@bls.gov
Phone: 202-691-6900
Website: http://www.bls.gov/cex/

Current Population Survey

The Current Population Survey (CPS) is a nationally representative sample survey of about 60,000 households conducted monthly for the Bureau of Labor Statistics (BLS) by the U.S. Census Bureau. The CPS is the primary source of information on the labor force characteristics of the civilian noninstitutionalized population age 16 and over, including a comprehensive body of monthly data on the labor force, employment, unemployment, persons not in the labor force, hours of work, earnings, and other demographic and labor force characteristics.

In most months, CPS supplements provide additional demographic and social data. The Annual Social and Economic Supplement (ASEC) is the primary source of detailed information on income and poverty in the United States. The ASEC is used to generate the annual Population Profile of the United States, reports on geographical mobility and educational attainment, and is the primary source of detailed information on income and poverty in the United States. The ASEC, historically referred to as the March supplement, now is conducted in February, March, and April with a sample of about 100,000 addresses. The questionnaire asks about income from more than 50 sources and records up to 27 different income amounts, including receipt of many noncash benefits, such as food stamps and housing assistance.

Race and Hispanic origin: CPS respondents are asked to identify themselves as belonging to one or more of five racial groups (White, Black, American Indian and Alaska Native, Asian, and Native Hawaiian and other Pacific Islander). People who responded to the question on race by indicating only one race are referred to as the race alone or single-race population, and individuals who chose more than one race category are referred to as the Two or more races population.

The CPS includes separate questions on Hispanic origin. People who identify themselves as Hispanic, Latino, or Spanish are further classified by detailed Hispanic ethnicity (such as Mexican, Puerto Rican, or Cuban). People of Hispanic origin may be of any race.

For more information regarding the CPS, its sampling structure, and estimation methodology, see "Explanatory Notes and Estimates of Error."[59]

For more information, contact:
Bureau of Labor Statistics
U.S. Department of Labor
E-mail: cpsinfo@bls.gov
Phone: 202-691-6378
Website: http://www.bls.gov/cps
Additional website: http://www.census.gov/cps/

Decennial Census

Every 10 years, beginning with the first census in 1790, the United States government conducts a census, or count, of the entire population as mandated by the U.S. Constitution. For most data collections, Census Day was April 1 of the respective year.

For the 2010 Census, the Bureau devised a short-form questionnaire that asked for the age, sex, race, and ethnicity (Hispanic or Not Hispanic) of each household resident; his or her relationship to the person filling out the form; and whether the housing unit was rented or owned by a member of the household. The census long form, which for decades collected detailed socioeconomic and housing data from a sample of the population on education, housing, jobs, etc., was replaced by the American Community Survey (ACS), an ongoing survey

of about 295,000 addresses per month that gathers largely the same data as its predecessor.

Race and Hispanic origin: Starting with Census 2000, and continuing in the 2010 Census, respondents were given the option of selecting one or more race categories to indicate their racial identities. People who responded to the question on race by indicating only one of the six race categories (White, Black, American Indian and Alaska Native, Asian, Native Hawaiian and other Pacific Islander, and Some Other Race) are referred to as the race alone or single-race population. Individuals who chose more than one of the race categories are referred to as the Two or More Races population. The six single-race categories—which made up nearly 98 percent of all respondents—and the Two or More Races category sum to the total population. Because respondents were given the option of selecting one or more race categories in Census 2000 and the 2010 Census, these data are not directly comparable with data from the 1990 or earlier censuses.

As in earlier censuses, the 2010 Census included a separate question on Hispanic origin. In the 2010 Census, people of Spanish/Hispanic/Latino origin could identify themselves as Mexican, Mexican American or Chicano, Puerto Rican, Cuban, or Another Hispanic, Latino, or Spanish origin. People of Hispanic origin may be of any race.

For more information, contact:
Sex and Age Statistics Branch
Phone: 301-763-2378
Website: https://www.census.gov/2010census/

Federal Reserve Board

The Board of Governors of the Federal Reserve, also called the Federal Reserve Board, publish the "Financial Accounts of the United States" (Z.1) data quarterly (about 10 weeks after the end of the quarter) on their website. This data release presents the financial flows and levels of sectors in the U.S. economy as well as selected balance sheets, supplemental tables, and the Integrated Macroeconomic Accounts (IMA).

The IMA relate production, income, saving, and capital formation from the national income and product accounts (NIPA) to changes in net worth from the "Financial Accounts" on a sector-by-sector basis. The IMA are published jointly by the Federal Reserve Board and the Bureau of Economic Analysis and are based on international guidelines and terminology as defined in the System of National Accounts (SNA 2008).

Data shown for the most recent quarters are based on preliminary and potentially incomplete information. Nonetheless, when source data are revised or estimation methods are improved, all data are subject to revision. There is no specific revision schedule; rather, data are revised on an ongoing basis. In each release of the "Financial Accounts," major revisions are highlighted at the beginning of the publication.

The data in the "Financial Accounts" come from a large variety of sources and are subject to limitations and uncertainty due to measurement errors, missing information, and incompatibilities among data sources. The size of this uncertainty cannot be quantified, but its existence is acknowledged by the inclusion of "statistical discrepancies" for various sectors and financial instruments.

For more information, contact:
Federal Reserve Board of Governors
E-mail: rs-z1-staff@frb.gov
Website: http://www.federalreserve.gov/apps/fof/

Form 5500 Filings

Each year, most private pension and many private welfare benefit plans satisfy their annual reporting requirement by filing a Form 5500 Annual Return/Report regarding their financial condition, investments, and operations with the U.S. Department of Labor, Internal Revenue Service, and the Pension Benefit Guaranty Corporation.

The pension research sample supports analysis of the plan, participant, and financial characteristics of the private pension plan universe and is used to produce the Private Pension Plan Bulletin Abstract of Form 5500 Annual Reports, an annual publication that summarizes data on private pension plans.

For more information, contact:
Employee Benefits Security Administration
U.S. Department of Labor
Phone: 202-693-8410
Website: http://www.dol.gov/ebsa/publications/form5500dataresearch.html

Health and Retirement Study

The Health and Retirement Study (HRS) is a national panel study conducted by the University of Michigan's Institute for Social Research under a cooperative agreement with the National Institute on Aging (NIA). In 1992, the study had an initial sample of over 12,600 people from the 1931–1941 birth cohort and their

spouses. The HRS was joined in 1993 by a companion study, Asset and Health Dynamics Among the Oldest Old (AHEAD), with a sample of 8,222 respondents (who were born before 1924 and were age 70 and over) and their spouses. In 1998, these two data collection efforts were combined into a single survey instrument and field period and were expanded through the addition of baseline interviews with two new birth cohorts: Children of the Depression Age (1924–1930) and War Babies (1942–1947). The HRS steady-state design calls for the addition of a new 6-year cohort of Americans entering their 50s. Thus, the Early Boomer birth cohort (1948–1953) was added in 2004, the Mid-"Baby Boomer" birth cohort (1954–1959) was added in 2010, and the Late "Baby Boomers" (1960–1965) will be added in 2016. The 2010 wave also included an expansion of the minority sample of Early and Mid-"Baby Boomers." Telephone follow-ups are conducted every second year, with proxy interviews after death. Beginning with the 2006 wave, one-half of the sample goes through an enhanced face-to-face interview that includes the collection of physical measures and biomarker collection. The Aging, Demographics, and Memory Study (ADAMS) and forthcoming Harmonized Cognitive Assessment Protocol (HCAP) supplement the HRS with data to support a population-based study of dementia. A genome-wide scan on 2012 samples is still being processed, after which approximately 19,000 HRS participants will support genetic and genomic studies.

The combined studies, which are collectively called the HRS, have become a steady state sample that is representative of the entire U.S. population age 50 and over (excluding people who resided in a nursing home or other institutionalized setting at the time of sampling). The HRS will follow respondents longitudinally until they die (including following people who move into a nursing home or other institutionalized setting).

The HRS is designed to explain the antecedents and consequences of retirement; examine the relationship between health, income, and wealth over time; examine life cycle patterns of wealth accumulation and consumption; monitor work disability; provide a rich source of interdisciplinary data, including linkages with administrative data; monitor transitions in physical, functional, and cognitive health in advanced old age; relate late-life changes in physical and cognitive health to patterns of spending down assets and income flows; relate changes in health to economic resources and intergenerational transfers; and examine how the mix and distribution of economic, family, and program resources affect key outcomes, including retirement, spending down assets, health declines, and institutionalization.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:
Health and Retirement Study
E-mail: hrsquest@isr.umich.edu
Phone: 734-936-0314
Website: http://hrsonline.isr.umich.edu/

Intercensal Population Estimates: 2000 to 2010

Intercensal population estimates are produced for the years between two decennial censuses when both the beginning and ending populations are known. They are produced by adjusting the existing time series of postcensal estimates for the entire decade to smooth the transition from one decennial census count to the next. They differ from the annually released postcensal estimates in that they rely on mathematical formulae that redistribute the difference between the April 1 postcensal estimate and April 1 census count for the end of the decade across the postcensal estimates for that decade. For dates when both postcensal and intercensal estimates are available, intercensal estimates are preferred.

The 2000–2010 intercensal estimates reconcile the postcensal estimates with the 2010 Census counts and provide a consistent time series of population estimates that reflect the 2010 Census results. The 2000–2010 intercensal estimates were produced for the nation, states, and counties by demographic characteristics (age, sex, and race and Hispanic origin).

For a more detailed discussion of the methods used to create the intercensal estimates, see http://www.census.gov/popest/data/intercensal/index.html.

For more information, contact:
Population Estimates Branch
Phone: 301-763-2385
Website: http://www.census.gov/popest/index.html

International Data Base

The U.S. Census Bureau produces the International Data Base (IDB), which includes regularly updated population estimates and projections for over 200 countries and areas. The series of estimates and projections provide a consistent set of demographic indicators, including population size and growth, mortality, fertility, and net migration. The IDB is accessible via the Internet at www.census.gov/population/international/data/idb.

For more information, contact:
Demographic and Economic Studies Branch
International Programs
Population Division
Phone: 301-763-1360
Website: http://www.census.gov/population/international/data/

Master Beneficiary Record

The Social Security Administration maintains a record of Social Security Title II benefits for each beneficiary and applicant for benefits. The administrative database is for each disabled insurance, retired worker insurance, survivor insurance, and spouse insurance beneficiary. The system of records is the Master Beneficiary Record (MBR). The MBR extract file contains a record for every person who has a record on the MBR. This general-purpose extract file is comprised of 134 variables. The MBR extract is produced semi-annually, and is used to support a variety of research and statistical projects.

The data in Indicator 10 on Social Security beneficiaries come from tabulations of the MBR data that are published annually in the Statistical Supplement to the Social Security Bulletin. The Supplement tables used in Indicator 10 include 5A.1.2, 5A1.6, 5A5, 5A.6, 5A, and 6B5.1.

For more information, contact:
Email: statistics@ssa.gov
Website: https://www.socialsecurity.gov/policy/docs/statcomps/supplement

Medicare Claims and Enrollment Data

The Medicare claims and enrollment data are captured in the Chronic Condition Warehouse. The Centers for Medicare & Medicaid Services (CMS) launched the Chronic Condition Data Warehouse (CCW), a research database, in response to the Medicare Modernization Act of 2003 (MMA). Section 723 of the MMA outlines a plan to improve the quality of care and reduce the cost of care for chronically ill Medicare beneficiaries. In addition to chronic conditions, the CCW supports health policy analysis and other CMS initiatives.

The CCW data files were designed to facilitate research across the continuum of care, using data files that could be easily merged and analyzed by beneficiary. Each beneficiary in the CCW is assigned a unique, unidentifiable link key, which allows researchers to easily merge data files and perform relevant analyses across different claim types, enrollment files, Part D event data, assessment data, and other CCW file types. CCW data files are available upon request from CMS.

The CCW claims data files have been streamlined to include only those variables determined by CMS to be of value and useful for research or analytic purposes. The data files delivered from the CCW contain a subset of the original source files. Variables used infrequently or not applicable to a particular setting have been removed.

For more information, contact:
The Research Data Assistance Center
E-mail: resdac@umn.edu
Phone: 1-888-973-7322
Website: http://www.resdac.umn.edu

Chronic Conditions Data Warehouse
E-mail: CCWHelp@gdit.com
Phone: 1-866-766-1915
Website: https://www.ccwdata.org/web/guest/home

Medicare Current Beneficiary Survey

The Medicare Current Beneficiary Survey (MCBS) is a continuous, multipurpose survey of a representative sample of the Medicare population designed to help the Centers for Medicare & Medicaid Services (CMS) administer, monitor, and evaluate the Medicare program. The MCBS collects information on health care use, cost, and sources of payment; health insurance coverage; household composition; sociodemographic characteristics; health status and physical functioning; income and assets; access to care; satisfaction with care; usual source of care; and how beneficiaries get information about Medicare.

MCBS data enable CMS to determine sources of payment for all medical services used by Medicare beneficiaries, including copayments, deductibles, and non-covered services; develop reliable and current information on the use and cost of services not covered by Medicare (such as long-term care); ascertain all types of health insurance coverage and relate coverage to sources of payment; and monitor the financial effects of changes in the Medicare program. Additionally, the MCBS is the only source of multidimensional person-based information about the characteristics of the Medicare population and their access to and satisfaction with Medicare services and information about the Medicare program. The MCBS sample consists of Medicare enrollees in the community and in institutions.

The survey is conducted in three rounds each year, with each round being about 4 months in length. The MCBS has a multistage, stratified, random sample design and

a rotating panel survey design. Each panel is followed for 12 interviews. In-person interviews are conducted using computer-assisted personal interviewing. A sample of approximately 16,000 people are interviewed in each round. However, because of the rotating panel design, only 12,000 people receive all three interviews in a given calendar year. Information collected in the survey is combined with information from CMS administrative data files.

The MCBS has two components: the Cost and Use file and the Access to Care file. Medicare claims are linked to survey-reported events to produce the Cost and Use file, which provides complete expenditure and source-of-payment data on all health care services, including those not covered by Medicare. The Access to Care file contains information on beneficiaries' access to health care, satisfaction with care, and usual source of care. The sample for this file represents the "always enrolled" population—those who participated in the Medicare program for the entire year. In contrast, the Cost and Use file represents the "ever enrolled" population, including those who entered Medicare and those who died during the year.

Race and Hispanic origin: The MCBS defines race as White, Black, Asian, Native Hawaiian or Pacific Islander, American Indian or Alaska Native, or Other. People are allowed to choose more than one category. There is a separate question on whether the person is of Hispanic or Latino origin. The "Other" category in Table 30c consists of people who answered "No" to the Hispanic/Latino question and who answered something other than "White" or "Black" to the race question. People who answer with more than one racial category are assigned to the "Other" category.

For more information, contact:
MCBS Staff
Centers for Medicare & Medicare Services
E-mail: MCBS@cms.hhs.gov
Website: http://www.cms.hhs.gov/mcbs

The Research Data Assistance Center
E-mail: resdac@umn.edu
Phone: 1-888-973-7322
Website: http://www.resdac.umn.edu

Medical Expenditure Panel Survey

The Medical Expenditure Panel Survey (MEPS) is an ongoing annual survey of the civilian noninstitutionalized population that collects detailed information on health care use and expenditures (including sources of payment), health insurance, income, health status, access, and quality of care. The MEPS, which began in 1996, is the third in a series of national probability surveys conducted by the Agency for Healthcare Research and Quality (AHRQ) on the financing and use of medical care in the United States. MEPS predecessor surveys are the National Medical Care Expenditure Survey (NMCES) conducted in 1977 and the National Medical Expenditure Survey (NMES) conducted in 1987. Each of the three surveys (NMCES, NMES, and MEPS) used multiple rounds of in-person data collection to elicit expenditures and sources of payments for each health care event experienced by household members during the calendar year. The current MEPS Household Component (HC) sample is drawn from respondents to the National Health Interview Survey (NHIS) conducted by the National Center for Health Statistics (NCHS). To yield more complete information on health care spending and payment sources, followback surveys of health providers were conducted for a subsample of events in the MEPS (and events in the MEPS predecessor surveys).

Since 1977, the structure of billing mechanism for medical services has grown more complex as a result of increasing penetration of managed care and health maintenance organizations and various cost containment reimbursement mechanisms instituted by Medicare, Medicaid, and private insurers. As a result, there has been substantial discussion about what constitutes an appropriate measure of health care expenditures.[60] Health care expenditures presented in this report refer to what is actually paid for health care services. More specifically, expenditures are defined as the sum of direct payments for care received, including out-of-pocket payments for care received. This definition of expenditures differs somewhat from what was used in the 1987 NMES, which used charges (rather than payments) as the fundamental expenditure construct. To improve comparability of estimates between the 1987 NMES and the 1996 and 2001 MEPS, the 1987 data presented in this report were adjusted using the method described by Zuvekas and Cohen.[58] Adjustments to the 1977 data were considered unnecessary because virtually all of the discounting for health care services occurred after 1977 (essentially equating charges with payments in 1977).

A number of quality-related enhancements were made to the MEPS beginning in 2000, including the fielding of an annual adult self-administered questionnaire (SAQ). This questionnaire contains items regarding patient satisfaction and accountability measures from the Consumer Assessment of Healthcare Providers and Systems

(CAHPS®; previously known as the Consumer Assessment of Health Plans), the SF-12 physical and mental health assessment tool, EQ-5D EuroQol 5 dimensions with visual scale (2000–2003), and several attitude items. Starting in 2004, the K–6 Kessler mental health distress scale and the PH2 two-item depression scale were added to the SAQ.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information:
Agency for Healthcare Research and Quality
Website: http://meps.ahrq.gov/mepsweb

National Health and Aging Trends Study and National Study of Caregiving

The National Health and Aging Trends Study (NHATS) is a scientific study of how Americans function in later life that is conducted by the Johns Hopkins University Bloomberg School of Public Health, with data collection by Westat and support from the National Institute on Aging. The NHATS is intended to foster research that will guide efforts to reduce disability, maximize health and independent functioning, and enhance quality of life at older ages.

Since 2011, the NHATS has been gathering information on a nationally representative sample of Medicare beneficiaries ages 65 and over through annual in-person interviews. The interviews collect detailed information on activities of daily life, living arrangements, economic status and well-being, aspects of early life, and quality of life. Among the specific content areas included are the general and technological environment of the home, health conditions, work status and participation in valued activities, mobility and use of assistive devices, cognitive functioning, and help provided with daily activities (self-care, household, and medical). Study participants are re-interviewed every year in order to compile a record of change over time. The content and questions included in the NHATS were developed by a multidisciplinary team of researchers from the fields of demography, geriatric medicine, epidemiology, health services research, economics, and gerontology. As the population ages, the NHATS will provide the basis for understanding trends in late-life functioning, how these differ for various population subgroups, and the economic and social consequences of aging and disability for individuals, families, and society.

The National Study of Caregiving (NSOC) is a national study of people who help older family members and friends with their daily activities and is conducted as a supplement to the NHATS. NHATS respondents who reported receiving assistance with household, mobility, or self-care activities were asked to identify all persons providing help with each activity. Caregivers were eligible to participate in the NSOC if they were a family member or an unpaid caregiver who was not a relative and helped with any of the activities. NSOC participants took part in telephone interviews and provided information about the caregiving experience, caregiving support, and demographic, socioeconomic, and family characteristics, as well as type and amount of help provided and family situation, positive and negative aspects of caregiving (i.e., gains from and burdens of caregiving activities), physical and mental health (including symptoms and impairments that limited participants' activities), participation in valued activities and whether caregiving limited participation, and subjective well-being. The NSOC was conducted in 2011 and 2015, concurrent with the "refreshing" of the NHATS sample.

For more information, contact:
National Health and Aging Trends Study
E-mail: NHATSdata@westat.com
Website: http://www.nhats.org/

National Health Interview Survey

The National Health Interview Survey (NHIS) is the principal source of information on the health of the civilian noninstitutionalized population of the United States. It is also one of the major data collection programs of the National Center for Health Statistics (NCHS), which is part of the Centers for Disease Control and Prevention (CDC).

The main objective of the NHIS is to monitor the health of the United States population through the collection and analysis of data on a broad range of health topics. A major strength of this survey is its ability to display these health characteristics by many demographic and socioeconomic characteristics.

The NHIS covers the civilian noninstitutionalized population residing in the United States at the time of the interview. Because of technical and logistical problems, several segments of the population are not included in the sample or in the estimates from the survey. Examples of persons excluded are patients in long-term care facilities, persons on active duty with the Armed Forces (though

their dependents are included), persons incarcerated in the prison system, and U.S. nationals living in foreign countries.

Race and Hispanic origin: Starting with data year 1999, race-specific estimates in the NHIS are tabulated according to 1997 standards for federal data on race and ethnicity and are not strictly comparable with estimates for earlier years. In Older Americans 2016, the NHIS estimates by race represent people who report one race, or if they reported more than one race, identified one race as best representing their race. See *Health, United States, 2015,* Appendix II for details on race and ethnicity in the NHIS.

For more information, contact:
Division of Health Interview Statistics
E-mail: cdcinfo@cdc.gov
Phone: 1-800-232-4636
Website: http://www.cdc.gov/nchs/nhis.htm

National Health and Nutrition Examination Survey

The National Health and Nutrition Examination Survey (NHANES) is a program of studies designed to assess the health and nutritional status of adults and children in the United States. The survey is unique in that it combines interviews and physical examinations. NHANES is a major program of the National Center for Health Statistics (NCHS). NCHS is part of the Centers for Disease Control and Prevention (CDC) and is responsible for producing vital and health statistics for the nation.

The NHANES program began in the early 1960s and has been conducted as a series of surveys focusing on different population groups and health topics. In 1999, the survey became a continuous program with a changing focus on a variety of health and nutrition measurements to meet emerging needs. The survey examines a nationally representative sample of about 5,000 persons each year. These persons are located in counties across the country, 15 of which are visited each year.

The NHANES interview includes demographic, socioeconomic, dietary, and health-related questions. The examination component consists of medical, dental, and physiological measurements, as well as laboratory tests administered by highly trained medical personnel.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:
Division of Health and Nutrition Examination Survey
E-mail: cdcinfo@cdc.gov
Phone: 1-800-232-4636
Website: http://www.cdc.gov/nchs/nhanes.htm

National Study of Long-Term Care Providers

The 2014 National Study of Long-Term Care Providers (NSLTCP) is designed to provide nationally representative statistical information about the supply and use of long-term care services in the United States. NSLTCP includes five sectors: residential care communities, adult day services centers, nursing homes, home health agencies, and hospices. NSLTCP replaces three previous National Center for Health Statistics (NCHS) surveys: the National Nursing Home Survey, National Home and Hospice Care Survey, and National Survey of Residential Care Facilities.

NSLTCP comprises two components: (1) primary data collected by NCHS through surveys of residential care communities and adult day services centers, and (2) administrative data on nursing homes, home health agencies, and hospices obtained from the Centers for Medicare & Medicaid Services. Estimates in *Older Americans 2016* are from the study's second wave and use data from surveys about adult day services centers and participants; residential care communities and residents (fielded by NCHS between June 2014 and January 2015); and administrative records obtained from CMS on home health agencies and patients, hospices and patients, and nursing homes and residents, which reflect these providers and services users between 2013 and 2014.

Race and Hispanic origin: Data from this survey are not shown by race and Hispanic origin in this report.

For more information, contact:
Long-Term Care Statistics Branch
E-mail: cdcinfo@cdc.gov
Phone: 1-800-232-4636
Website: http://www.cdc.gov/nchs/nsltcp.htm

National Vital Statistics System

The National Vital Statistics System (NVSS) collects and publishes official national statistics on births, deaths, fetal deaths, and—prior to 1996—marriages and divorces occurring in the United States, based on U.S. Standard Certificates.

NVSS collects and presents U.S. resident data for the aggregate of 50 states, New York City, and Washington, D.C., as well as for each individual state and D.C. and the U.S. dependent areas of Puerto Rico, the Virgin Islands,

Guam, American Samoa, and the Northern Marianas. Vital events occurring in the United States to non-U.S. residents and vital events occurring abroad to U.S. residents are excluded.

By law, the registration of deaths is the responsibility of the funeral director. The funeral director obtains demographic data for the death certificate from an informant. The physician in attendance at the death is required to certify the cause of death. When a death is from other than natural causes, a coroner or medical examiner may be required to examine the body and certify the cause of death. The National Center for Health Statistics (NCHS) is responsible for compiling and publishing annual national statistics on causes of death. In carrying out this responsibility, NCHS adheres to the World Health Organization (WHO) Nomenclature Regulations. These regulations require (a) that cause of death be coded in accordance with the applicable revision of the *International Classification of Diseases (ICD),* and (b) that underlying cause of death be selected in accordance with international rules.

Race and Hispanic origin: Race and Hispanic origin are reported separately on the death certificate. Therefore, data by race shown in Indicator 15 (Life Expectancy) include people of Hispanic or non-Hispanic origin. See Appendix II of *Health, United States 2015* for more information on race in the mortality files of the NVSS.

For more information, contact:
Division of Vital Statistics
E-mail: cdcinfo@cdc.gov
Phone: 1-800-232-4636
Website: http://www.cdc.gov/nchs/nvss.htm

Population Projections

The 2014 National Population Projections provide projections of the resident population and demographic components of change (births, deaths, and international migration) through 2060. Population projections are available by age, sex, and race and Hispanic origin. Where both estimates and projections are available for the same time period, the Census Bureau recommends the use of the population estimates. Below is a general description of the methods used to produce the 2014 National Population Projections.

The 2014 National Population Projections start with the Vintage July 1, 2013, population estimates and are developed using a cohort-component method. Many of the characteristics of the U.S. resident population, as measured by the 2010 Census, are preserved as demographic patterns that work their way through the projection period. The components of population change (births, deaths, and international migration) are projected for each birth cohort (persons born in a given year). For each passing year, the Census Bureau advances the population 1 year of age. The Census Bureau updates the new age categories using survival rates and levels of international migration projected for the passing year. A new birth cohort is added to form the population under 1 year of age by applying projected age-specific fertility rates to the female population age 14 to 54, and by updating the new cohort for the effects of mortality and international migration.

The assumptions for the components of change are based on time series analysis. Because of limited information about racial characteristics in the fertility and mortality historical series, the assumptions were developed for mutually exclusive and exhaustive groups. Five groups were used for the fertility assumptions: native-born Asian/Pacific Islander, all other native-born, foreign-born non-Hispanic Asian/Pacific Islander, all other non-Hispanic foreign-born, and foreign-born Hispanic. Three groups were used for the mortality assumptions: non-Hispanic White/Asian/Native Hawaiian/Pacific Islander, non-Hispanic Black/American Indian/Alaska Native, and Hispanic of any race. The resulting births and deaths were then applied to the matching racial and ethnic categories to project the population.

For more information, contact:
Population Evaluation
Analysis and Projections Branch
Phone: 301-763-2438
Website: https://www.census.gov/population/projections/data/national/2014.html

Postcensal Population Estimates

Each year, the United States Census Bureau produces and publishes population estimates of the nation, states, counties, state/county equivalents, and Puerto Rico.[61] The Census Bureau estimates the resident population for each year since the most recent decennial census by using measures of population change. The resident population includes all people currently residing in the United States.

The population estimates are used for federal funding allocations, as controls for major surveys including the Current Population Survey and the American Community Survey, for community development, to aid business planning, and as denominators for statistical rates.

Overall, the estimate time series from 2000 to 2010 was very accurate, even accounting for 10 years of population change. The average absolute difference between the final total resident population estimates and 2010 Census counts was only about 3.1 percent across all counties.[62]

The population estimate at any given time point starts with a population base (the last decennial census or the previous point in the time series), adds births, subtracts deaths, and adds net migration (both international and domestic).[63] The individual methods used by the Census Bureau account for additional factors such as input data availability and the requirement that all estimates be consistent by geography, age, sex, and race and Hispanic origin.

The Census Bureau produces these estimates using a "top-down" approach. It first estimates the national population and the populations of states and counties. All of these follow a cohort component method. One key principle used by the Census Bureau is that all estimates produced must be consistent across geography and demographic characteristics. To accomplish this, the Census Bureau controls the estimates of the smaller geographic areas so that they sum to the totals produced at higher levels.

For more information contact:
Population Estimates Branch
Phone: 301-763-2385
Website: http://www.census.gov/popest/methodology/index.html

Supplemental Poverty Measure

Concerns about the adequacy of the official measure of poverty culminated in a congressional appropriation in 1990 for an independent scientific study of the concepts, measurement methods, and information needed for a poverty measure. In response, the National Academy of Sciences (NAS) established the Panel on Poverty and Family Assistance, which released its report in the spring of 1995.[64]

In 2010, an interagency technical working group, which included representatives from the Bureau of Labor Statistics (BLS), the U.S. Census Bureau, the Economics and Statistics Administration, the Council of Economic Advisers, the U.S. Department of Health and Human Services, and the Office of Management and Budget, issued a series of suggestions to the Census Bureau and the BLS on how to develop the Supplemental Poverty Measure (SPM). Their suggestions drew on the recommendations of the 1995 NAS report and the extensive research on poverty measurement conducted after the report's publication.[65]

Since 2011, the Census Bureau has published poverty estimates using the new measure based on these suggestions.[66] The SPM serves as an additional indicator of economic well-being and provides a deeper understanding of economic conditions and policy effects. The SPM creates a more complex statistical picture incorporating additional items such as tax payments, work expenses, and medical out-of-pocket expenditures in its family resource estimates. The resource estimates also take into account the value of noncash benefits, including nutritional, energy, and housing assistance. Thresholds used in the new measure are derived by staff at the BLS from Consumer Expenditure Survey expenditure data on basic necessities (food, shelter, clothing, and utilities) and are adjusted for geographic differences in the cost of housing.

In addition to the annual report, the Census Bureau makes available a research data file that enables analysts to create their own SPM estimates and cross tabulations.[67]

For more information, contact:
Dr. Trudi J. Renwick
U.S. Census Bureau
E-mail: trudi.j.renwick@census.gov
Phone: 301-763-5133
Website: http://www.census.gov/hhes/povmeas/methodology/supplemental/overview.html

Survey of Consumer Finances

The Survey of Consumer Finances (SCF) is a triennial, cross-sectional, national survey of noninstitutionalized Americans conducted by the Federal Reserve Board with the cooperation of the Statistics of Income Division of the Internal Revenue Service. It includes data on household assets and debts, use of financial services, income, demographics, and labor force participation.

The survey is considered one of the best sources for wealth measurement because of its detailed treatment of assets and debts, and because it oversamples wealthy households.[68,69] The data for the panels of the SCF used in this study were collected by the National Opinion Research Center at the University of Chicago. The SCF uses a dual-frame sample consisting of both a standard random sample and a special over-sample of wealthier households in order to correct for the under-representation of high-income families in the survey. It uses multiple imputation techniques to deal with missing data, which results in the creation of five data

sets called "implicates." There are five implicates for every record. In the SCF, a household unit is divided into a "primary economic unit" (PEU)—the family—and everyone else in the household. The PEU is intended to be the economically dominant single person or couple (whether married or living together as partners) and all other persons in the household who are financially interdependent with the economically dominant person or couple.[70] The Indicator 11 data represent the PEU, which are referred to as households in the chart and discussion.

Race and Hispanic origin: Data in this report for the head of the primary economic unit are shown for White and Black. Data are not shown by Hispanic origin.

For more information, contact:
Chris Angelov
E-mail: chris.angelov@ssa.gov
Phone: 202-755-3114

VA Enrollee Health Care Projection Model

The Veterans Administration (VA) uses the VA Enrollee Health Care Projection Model (Model) to project enrollment and utilization of the enrolled veteran population for 20 years into the future for more than 90 categories of health care services. First, the VA uses the Model to determine how many veterans will be enrolled each year and their age, priority, and geographic location. Next, the VA uses the Model to project the total health care services needed by those enrollees and then estimates the portion of that care that those enrollees will demand from the VA.

The Model accounts for the unique demographic characteristics of the enrolled veteran population, including Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) and other enrollee cohorts, as well as other factors that impact a veteran's decision to enroll in the VA and use VA health care services:

- Enrollee age, gender, income, travel distance to VA facilities, and geographic migration patterns
- Significant morbidity of the enrolled veteran population, particularly for mental health services
- Economic conditions, including changes in local unemployment rates and home values (as a proxy for asset values) and the long-term downward trend in labor force participation, particularly for high school-educated males
- Enrollee transition between enrollment priorities as a result of movement into service-connected priorities or changes in income
- Enrollee reliance on VA health care versus the other health care options available to them, i.e., Medicare, Medicaid, TRICARE, and commercial insurance
- Unique health care utilization patterns of OEF/OIF/OND, female, and new enrollees, and other enrollee cohorts with unique utilization patterns for particular services
- New policies, regulations, and legislation, such as the implementation of the Medicare drug benefit
- VA health care initiatives, such as the mental health capacity improvement initiative
- A continually evolving VA health care system, i.e., quality and efficiency initiatives
- Changes in health care practice and technology such as new diagnostics, drugs, and treatments

For more information, contact:
Carolyn Stoesen
Veterans Health Administration
Office of Policy and Planning
E-mail: carolyn.stoesen@va.gov
Phone: 202-461-7151
Website: http://www.va.gov/HEALTHPOLICYPLANNING/planning.asp

Veteran Population Estimates and Projections

The VA Office of the Chief Actuary (OACT) provided veteran population projection by key demographic characteristics such as age and gender as well as geographic areas. VetPop2014 was last updated using Census 2000 data, VA administrative data, and Department of Defense data. VetPop2016 will be released in Winter 2017.

Race and Hispanic origin: Data from this model are not shown by race and Hispanic origin in this report.

For more information, contact:
The National Center for Veterans Analysis and Statistics
E-mail: VANCVAS@va.gov
Website: http://va.gov/vetdata/veteran_population.asp

Glossary

Glossary

Activities of daily living (ADLs): Activities of daily living (ADLs) are basic activities that support survival, including eating, bathing, and toileting. *See Instrumental activities of daily living (IADLs).*

In the Medicare Current Beneficiary Survey, ADL disabilities are measured as difficulty performing (or inability to perform because of a health reason) one or more of the following activities: eating, getting in/out of chairs, walking, dressing, bathing, or toileting.

Asset income: Asset income includes money income reported in the Current Population Survey from interest (on savings or bonds), dividends, income from estates or trusts, and net rental income. Capital gains are not included.

Auxiliary benefits: These benefits provide wives of dependents with half of their husband's basic benefit and surviving widows with their husband's full basic benefit. Divorced women can receive auxiliary spouse/widow benefits based on a marriage of at least 10 years' duration.

Body mass index (BMI): This is a measure of body weight adjusted for height that correlates with body fat. A tool for indicating weight status in adults, BMI is generally computed using metric units and is defined as weight divided by height^2 or kilograms/meters^2. The categories used in this report are consistent with those set by the World Health Organization. For adults 20 years of age and over, underweight is defined as having a BMI less than 18.5; healthy weight is defined as having a BMI of at least 18.5 and less than 25; overweight is defined as having a BMI equal to 25 or greater; and obese is defined as having a BMI equal to 30 or greater. To calculate your own body mass index, go to http://www.nhlbi.nih.gov/health/educational/lose_wt/BMI/bmicalc.htm. For more information about BMI, see "Clinical guidelines on the identification, evaluation, and treatment of overweight and obesity in adults."[71]

Cause of death: For the purpose of national mortality statistics, every death is attributed to one underlying condition, based on information reported on the death certificate and using the international rules for selecting the underlying cause of death from the conditions stated on the death certificate. In addition to the underlying cause, all other conditions reported on the death certificate are captured and coded and are referred to as multiple causes of death. Cause of death is coded according to the appropriate revision of the International Classification of Diseases (ICD). Effective with deaths occurring in 1999, the United States began using the Tenth Revision of the ICD (ICD–10).[72]

Civilian noninstitutionalized population: *See Population.*

Civilian population: *See Population.*

Crowded housing: Crowded housing is defined as households that have more than one person per room.

Death rate: The death rate is calculated by dividing the number of deaths in a population in a year by the midyear resident population. For census years, rates are based on unrounded census counts of the resident population as of April 1. Death rates are expressed as the number of deaths per 100,000 people. The rate may be restricted to deaths in specific age, race, sex, or geographic groups or from specific causes of death (specific rate), or it may be related to the entire population (crude rate).

Defined benefit plan: A plan that promises a specified monthly benefit at retirement. The plan may state this promised benefit as an exact dollar amount, such as $100 per month at retirement. Or, more often, it may calculate a benefit through a plan formula that considers such factors as salary and service (e.g., 1 percent of average salary for the last 5 years of employment for every year of service with an employer).

Defined contribution plan: A plan that does not promise a specific benefit amount at retirement. Instead, employers and/or employees contribute money to each employee's individual account in the plan. In many cases, employees are responsible for choosing how these contributions are invested and deciding how much to contribute from their paychecks through pretax deductions. Employers may add to employees' accounts, in some cases, by matching a certain percentage of the employee's contributions. The value of an employee's account depends on how much is contributed and how well the investments perform.

Dental services: In the Medicare Current Beneficiary Survey (Indicators 30 and 34), the Medical Expenditure Panel Survey (MEPS), and the data used from the MEPS predecessor surveys used in this report (Indicator 33) this category covers expenses for any type of dental care provider, including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists. In Indicator 30, dental services are included as part of the "Other" category; in Indicator 34, dental services are included as a separate category.

Disability rating: Ratings reflect the severity of the disability and how much the impairment impacts the ability to work.

Earnings: Earnings are considered money income reported in the Current Population Survey from wages or salaries and net income from self-employment (farm and nonfarm).

Emergency room services: In the Medical Expenditure Panel Survey (MEPS) and the data used from the MEPS predecessor surveys used in this report (Indicator 33), this category includes expenses for visits to medical providers seen in emergency rooms (except visits resulting in a hospital admission). These expenses include payments for services covered under the basic facility charge and those for separately billed physician services. In the Medicare Current Beneficiary Survey (Indicators 30 and 34) emergency room services are included as a hospital outpatient service unless they are incurred immediately prior to a hospital stay, in which case they are included as a hospital inpatient service.

Fee-for-service: This is the method of reimbursing health care providers on the basis of a fee for each health service provided to the insured person.

Full Retirement Age (FRA): The age when benefits are not reduced for early retirement. Benefits are increased by about 8 percent a year until age 70 for delayed retirement. Early Retirement Age (ERA) for retired workers begins at age 62 with a 25 percent reduced level from benefits at Full Retirement Age (FRA), age 66 in 2014. Initial benefits at age 62 increase approximately 75 percent for a delay from ERA to age 70. The FRA was age 65 until 1937 and increased at 2 months per year for each birth year after 1937 until 1943. Please note that the percentages are not the probabilities of claiming at an age because different birth year cohorts are in each age group in a given year and somewhat vary in the size of the eligible population.

Group quarters: A group quarters is a place where people live or stay in a group living arrangement that is owned or managed by an entity or organization providing housing and/or services for the residents. This is not a typical household-type living arrangement. These services may include custodial or medical care as well as other types of assistance, and residency is commonly restricted to those receiving these services. People living in group quarters are usually not related to each other. The group quarters definitions used in the 2010 Census are available in Appendix B at: http://www.census.gov/prod/cen2010/doc/sf1.pdf.

Head of household: The Survey of Consumer Finances (SCF) estimates wealth for the "Primary Economic Unit," which is similar to the Census Bureau's Household. The "Primary Economic Unit" is the economically dominant single person or couple (whether married or living together as partners) and all other persons in the household who are financially interdependent with the economically dominant person or couple. If a couple is economically dominant in the PEU, the head is the male in a mixed sex couple or the older person in a same-sex couple. If a single person is economically dominant, that person is designated as the family head in this report.

Health care expenditures: In the Consumer Expenditure Survey (Indicator 14), health care expenditures include out-of-pocket expenditures for health insurance, medical services, prescription drugs, and medical supplies. In the Medicare Current Beneficiary Survey (Indicators 30 and 34), health care expenditures include all expenditures for inpatient hospital, medical, nursing home, outpatient (including emergency room visits), dental, prescription drugs, home health care, and hospice services, including both out-of-pocket expenditures and expenditures covered by insurance. Personal spending for health insurance premiums is excluded. In the Medical Expenditure Panel Survey (MEPS) and the data used from the MEPS predecessor surveys used in this report (Indicator 33), health care expenditures refer to payments for health care services provided during the year. (Data from the 1987 survey have been adjusted to permit comparability across years; see Zuvekas and Cohen.[58]) Out-of-pocket health care expenditures are the sum of payments paid to health care providers by the person, or the person's family, for health care services provided during the year. Health care services include inpatient hospital, hospital emergency room, and outpatient department care; dental services; office-based medical provider services; prescription drugs; home health care; and other medical equipment and services. Personal spending for health insurance premium(s) is excluded.

Health maintenance organization (HMO): An HMO is a prepaid health plan delivering comprehensive care to members through designated providers, having a fixed monthly payment for health care services, and requiring members to be in a plan for a specified period of time (usually 1 year).

Health Eating Index-2010 (HEI-2010): A measure of diet quality that assesses conformance to the *Dietary Guidelines for Americans.* The primary use of the HEI is to monitor the diet quality of the U.S. population. The HEI-2010[31] has 12 components, nine of which are adequacy components and three are moderation components.

Intakes equal to or better than the standards set for each component are assigned a maximum score. For the nine adequacy components (e.g., total fruit, total vegetable), no intake gets zero and scores increase up to the maximum as the intakes increase towards the standard. The three moderation components (e.g., refined grains, sodium) are scored in reverse; that is, excessively high intakes get zeros and as intakes decrease toward the standard, scores increase; higher scores reflect lower intakes because lower intakes are more desirable. A higher score indicates a higher quality diet that aligns with the *2010 Dietary Guidelines for Americans.* Scores are averaged across all adults based on usual dietary intakes.

Hispanic origin: *See specific data source descriptions.*

Home health care/services/visits: Home health care is care provided to individuals and families in their places of residence for promoting, maintaining, or restoring health or for minimizing the effects of disability and illness, including terminal illness. In the Medicare Current Beneficiary Survey and Medicare claims data (Indicators 29, 30, and 34), home health care refers to skilled nursing care, physical therapy, speech language pathology services, occupational therapy, and home health aide services provided to homebound patients. In the Medical Expenditure Panel Survey (Indicator 33), home health care services are classified into the "Other health care" category and are considered any paid formal care provided by home health agencies and independent home health providers. Services can include visits by professionals, including nurses, doctors, social workers, and therapists, as well as home health aides, homemaker services, companion services, and home-based hospice care. Home care provided free of charge (informal care by family members) is not included.

Hospice care/services: Hospice care is a program of palliative and supportive care services providing physical, psychological, social, and spiritual care for dying persons, their families, and other loved ones by a hospice program or agency. Hospice services are available in home and inpatient settings. In the Medicare Current Beneficiary Survey (MCBS) (Indicators 30 and 34) hospice care includes only those services provided as part of a Medicare benefit. In Indicator 30, hospice services are part of the "Other" category. In Indicator 34, hospice services are a separate category. In the Medical Expenditure Panel Survey (MEPS) (Indicator 33), hospice care provided in the home (regardless of the source of payment) is included in the "Other health care" category, while hospice care provided in an institutional setting (e.g., nursing home) is excluded from the MEPS universe.

Hospital care: Hospital care in the Medical Expenditure Panel Survey (Indicator 33) includes hospital inpatient care and care provided in hospital outpatient departments and emergency rooms. Care can be provided by physicians or other health practitioners. Payments for hospital care include payments billed directly by the hospital and those billed separately by providers for services provided in the hospital.

Hospital inpatient services: In the Medicare Current Beneficiary Survey (Indicators 30 and 34) hospital inpatient services include room and board and all hospital diagnostic and laboratory expenses associated with the basic facility charge, as well as emergency room expenses incurred immediately prior to inpatient stays. Expenses for hospital stays with the same admission and discharge dates are included if the Medicare bill classified the stay as an "inpatient" stay. Payments for separate billed physician inpatient services are excluded. In the Medical Expenditure Panel Survey (Indicator 33) these services include room and board and all hospital diagnostic and laboratory expenses associated with the basic facility charge, payments for separately billed physician inpatient services, and emergency room expenses incurred immediately prior to inpatient stays. Expenses for reported hospital stays with the same admission and discharge dates are also included.

Hospital outpatient services: These services in the Medicare Current Beneficiary Survey (Indicators 30 and 34) include visits to both physicians and other medical providers seen in hospital outpatient departments or emergency rooms (provided the emergency room visit does not result in an inpatient hospital admission), as well as diagnostic laboratory and radiology services. Payments for these services include those covered under the basic facility charge. Expenses for in-patient hospital stays with the same admission and discharge dates and classified on the Medicare bill as "outpatient" are also included. Separately billed physician services are excluded.

Hospital stays: Hospital stays in the Medicare claims data (Indicator 29) refers to admission to and discharge from a short-stay acute care hospital.

Housing cost burden: In the American Housing Survey, housing cost burden is defined as expenditures on housing and utilities in excess of 30 percent of household reported income.

Housing expenditures: In the Consumer Expenditure Survey's Interview Survey, housing expenditures include payments for mortgage interest; property taxes; maintenance, repairs, insurance, and other expenses;

rent; rent as pay (reduced or free rent for a unit as a form of pay); maintenance, insurance, and other expenses for renters; and utilities.

Income: In the Current Population Survey, income includes money income (prior to payments for personal income taxes, Social Security, union dues, Medicare deductions, etc.) from: (1) money wages or salary; (2) net income from nonfarm self-employment; (3) net income from farm self-employment; (4) Social Security or Railroad Retirement; (5) Supplemental Security Income; (6) public assistance or welfare payments; (7) interest (on savings or bonds); (8) dividends, income from estates or trusts, or net rental income; (9) veterans' payment or unemployment and worker's compensation; (10) private pensions or government employee pensions; (11) distributions from retirement accounts; and (12) alimony or child support, regular contributions from people not living in the household, and other periodic income. Certain money receipts such as capital gains are not included.

In the Medicare Current Beneficiary Study, income is for the sample person or the sample person and spouse if the sample person was married at the time of the survey. All sources of income from jobs, pensions, Social Security benefits, Railroad Retirement and other retirement income, Supplemental Security Income, interest, dividends, and other income sources are included.

Income, household: Household income from the Medical Expenditure Panel Survey (MEPS) and the MEPS predecessor surveys used in this report was created by summing personal income from each household member to create family income. Family income was then divided by the number of people that lived in the household during the year to create per capita household income. Potential income sources asked about in the survey interviews include annual earnings from wages, salaries, or withdrawals; Social Security and VA payments; Supplemental Security Income and cash welfare payments from public assistance; Temporary Assistance for Needy Families, formerly known as Aid to Families with Dependent Children; gains or losses from estates, trusts, partnerships, C corporations, rent, and royalties; and a small amount of other income. *See Poverty Indicator 33: Out-of-Pocket Health Care Expenditures.*

Income fifths: A population can be divided into groups with equal numbers of people based on the size of their income to show how the population differs on a characteristic at various income levels. Income fifths are five groups of equal size, ordered from lowest to highest income.

Inpatient hospital: *See Hospital inpatient services.*

Institutionalized population: *See Population.*

Institutions: For the 2010 Census, the Census Bureau defined institutions as adult correctional facilities, juvenile facilities, skilled-nursing facilities, and other institutional facilities such as mental (psychiatric) hospitals and in-patient hospice facilities. *See Population.*

Instrumental activities of daily living (IADLs): IADLs are indicators of functional well-being that measure the ability to perform more complex tasks than the related activities of daily living (ADLs). *See Activities of daily living (ADLs).*

In the Medicare Current Beneficiary Survey. IADLs are measured as difficulty performing (or inability to perform because of a health reason) one or more of the following activities: heavy housework, light housework, preparing meals, using a telephone, managing money, or shopping. Only the questions on telephone use, shopping, and managing money are asked of long-term care facility residents.

Long-term care facility: In the Medicare Current Beneficiary Survey (MCBS) (Indicators 22 and 36), a residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; has three or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a non-family, paid caregiver. In the MCBS (Indicators 30 and 34), a long-term care facility excludes "short-term institutions" (e.g., sub-acute care) stays. *See Short-term institution (Indicators 30 and 34), and Skilled nursing home (Indicator 29).*

Mammography: Mammography is an X-ray image of the breast used to detect irregularities in breast tissue.

Mean: The mean is an average of *n* numbers computed by adding the numbers and dividing by *n*.

Median: The median is a measure of central tendency, the point on the scale that divides a group into two parts.

Medicaid: This nationwide health insurance program is operated and administered by the states with Federal financial participation. Within certain broad, federally determined guidelines, states decide who is eligible; the amount, duration, and scope of services covered; rates of payment for providers; and methods of administering the program. Medicaid pays for health care services, community-based supports, and nursing home care for certain low-income people. Medicaid does not cover

all low-income people in every state. The program was authorized in 1965 by Title XIX of the Social Security Act.

Medicare: This nationwide program provides health insurance to people age 65 and over, people entitled to Social Security disability payments for 2 years or more, and people with end-stage renal disease, regardless of income. The program was enacted July 30, 1965, as Title XVIII, Health Insurance for the Aged of the Social Security Act, and became effective on July 1, 1966. Medicare covers acute care services and post-acute care settings such as rehabilitation and long-term care hospitals, and generally does not cover nursing home care. Prescription drug coverage began in 2006.

Medicare Advantage: *See Medicare Part C.*

Medicare Part A: Medicare Part A (Hospital Insurance) covers inpatient care in hospitals, critical access hospitals, skilled nursing facilities, and other post-acute care settings such as rehabilitation and long-term care hospitals. It also covers hospice and some home health care.

Medicare Part B: Medicare Part B (Medical Insurance) covers doctor's services, outpatient hospital care, and durable medical equipment. It also covers some other medical services that Medicare Part A does not cover, such as physical and occupational therapy and some home health care. Medicare Part B also pays for some supplies when they are medically necessary.

Medicare Part C: With the passage of the Balanced Budget Act of 1997, Medicare beneficiaries were given the option to receive their Medicare benefits through private health insurance plans instead of through the original Medicare plan (Parts A and B). These plans were known as "Medicare+Choice" or "Part C" plans. Pursuant to the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the types of plans allowed to contract with Medicare were expanded, and the Medicare Choice program became known as "Medicare Advantage." In addition to offering comparable coverage to Part A and Part B, Medicare Advantage plans may also offer Part D coverage.

Medicare Part D: Medicare Part D subsidizes the costs of prescription drugs for Medicare beneficiaries. It was enacted as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA) and went into effect on January 1, 2006. Beneficiaries can obtain the Medicare drug benefit through two types of private plans: beneficiaries can join a Prescription Drug Plan (PDP) for drug coverage only or they can join a Medicare Advantage plan (MA) that covers both medical services and prescription drugs (MA-PD). Alternatively, beneficiaries may receive drug coverage through a former employer, in which case the former employer may qualify for a retiree drug subsidy payment from Medicare.

Medigap: *See Supplemental health insurance.*

National population adjustment matrix: The national population adjustment matrix adjusts the population to account for net underenumeration. Details on this matrix can be found on the U.S. Census Bureau website: https://www.census.gov/population/www/censusdata/adjustment.html.

Noninstitutional group quarters: For the 2010 Census, the Census Bureau defined noninstitutional group quarters as facilities that house those who are primarily eligible, able, or likely to participate in the labor force while resident. The noninstitutionalized population lives in noninstitutional group quarters such as college/university student housing, military quarters, and other noninstitutional group quarters such as emergency and transitional shelters for people experiencing homelessness and group homes. For more information on noninstitutional group quarters, please see Appendix B at http://www.census.gov/prod/cen2010/doc/sf1.pdf.

Obesity: *See Body mass index.*

Office-based medical provider services: In the Medical Expenditure Panel Survey (Indicator 33), this category includes expenses for visits to physicians and other health practitioners seen in office-based settings or clinics. "Other health practitioner" includes audiologists, optometrists, chiropractors, podiatrists, mental health professionals, therapists, nurses, and physician's assistants, as well as providers of diagnostic laboratory and radiology services. Services provided in a hospital based setting, including outpatient department services, are excluded.

Other health care: In the Medicare Current Beneficiary Survey (Indicator 34), this category includes short-term institution, hospice, and dental services. In the Medical Expenditure Panel Survey (MEPS) (Indicator 33) other health care includes home health services (formal care provided by home health agencies and independent home health providers) and other medical equipment and services. The latter includes expenses for eyeglasses, contact lenses, ambulance services, orthopedic items, hearing devices, prostheses, bathroom aids, medical equipment, disposable supplies, alterations/modifications, and other miscellaneous items or services that were obtained, purchased, or rented during the year.

Other income: Other income is total income minus retirement benefits, earnings, asset income, and public assistance. It includes, but is not limited to, unemployment compensation, worker's compensation, alimony, and child support.

Out-of-pocket health care spending: These are health care expenditures that are not covered by insurance.

Outpatient hospital: *See Hospital outpatient services.*

Overweight: *See Body mass index.*

Pensions: Pensions include money income reported in the Current Population Survey from Railroad Retirement, company or union pensions (including profit sharing and 401(k) payments), distributions from IRAs, distributions from Keoghs, regular payments from annuities and paid-up life insurance policies, Federal government pensions, U.S. military pensions, and state or local government pensions.

Physician/Medical services: In the Medicare Current Beneficiary Survey (Indicator 34), this category includes visits to a medical doctor, osteopathic doctor, and health practitioner as well as diagnostic laboratory and radiology services. Health practitioners include audiologists, optometrists, chiropractors, podiatrists, mental health professionals, therapists, nurses, paramedics, and physician's assistants. Services provided in a hospital-based setting, including outpatient department services, are included.

Physician/Outpatient hospital: In the Medicare Current Beneficiary Survey (Indicator 30), this term refers to "physician/medical services" combined with "hospital outpatient services."

Physician visits and consultations: In Medicare claims data (Indicator 29), physician visits and consultations include visits and consultations with primary care physicians, specialists, and chiropractors in their offices, hospitals (inpatient and outpatient), emergency rooms, patient homes, and nursing homes.

Population: Data on populations in the United States are often collected and published according to several different definitions. Various statistical systems then use the appropriate population for calculating rates.

Resident population: The resident population of the United States includes people resident in the 50 states and the District of Columbia. It excludes residents of the Commonwealth of Puerto Rico and residents of the outlying areas under United State sovereignty or jurisdiction (principally American Samoa, Guam, Virgin Islands of the United States, and the Commonwealth of the Northern Mariana Islands). An area's resident population consists of those persons "usually resident" in that particular area (where they live and sleep most of the time). The resident population includes people living in housing units, nursing homes, and other types of institutional settings. People whose usual residence is outside of the United States, such as the U.S. military and civilian personnel as well as private U.S. citizens living overseas, are excluded from the resident population.

Resident noninstitutionalized population: The resident noninstitutionalized population is the resident population residing in noninstitutional group quarters. *See also the definitions of Resident population and Noninstitutional group quarters.*

Civilian population: The civilian population is the U.S. resident population not in the active-duty Armed Forces.

Civilian noninstitutionalized population: This population includes all U.S. civilians residing in noninstitutional group quarters. *See also the definition of Noninstitutional group quarters.*

Institutionalized population: For the 2010 Census, the Census Bureau defined institutional group quarters as facilities that house those who are primarily ineligible, unable, or unlikely to participate in the labor force while resident.

The institutionalized population is the population residing in institutional group quarters such as adult correctional facilities, juvenile facilities, skilled-nursing facilities, and other institutional facilities such as mental (psychiatric) hospitals and in-patient hospice facilities. People living in noninstitutional group quarters are the noninstitutionalized population. For more information on institutional and noninstitutional group quarters, please see Appendix B at http://www.census.gov/prod/cen2010/doc/sf1.pdf.

Poverty: The official measure of poverty is computed each year by the U.S. Census Bureau and is defined as having income less than 100 percent of the poverty threshold (i.e., $11,354 for one person age 65 and over in 2014).[73] Poverty thresholds are the dollar amounts used to determine poverty status. Each family (including single-person households) is assigned a poverty threshold based upon the family's size and the ages of the family members. All family members have the same poverty status. Several of the indicators included in this report include a poverty status measure. Poverty status (less than 100 percent of the poverty threshold) was computed for

"Indicator 7: Poverty," "Indicator 8: Income," "Indicator 28: Cigarette Smoking," "Indicator 32: Sources of Health Insurance," and "Indicator 33: Out-of-Pocket Health Care Expenditures" using the official U.S. Census Bureau definition for the corresponding year. In addition, the following income-to-poverty categories are used in this report:

Indicator 8: Income: The income categories are derived from the ratio of the family's money income (or an unrelated individual's money income) to the poverty threshold. Being in poverty is having income less than 100 percent of the threshold. Low income is income between 100 percent and 199 percent of the poverty threshold (i.e., between $11,354 and $22,707 for one person age 65 and over in 2014). Middle income is income between 200 percent and 399 percent of the poverty threshold (i.e. between $22,708 and $45,415 for one person age 65 and over in 2014). High income is income 400 percent or more of the poverty threshold.

Indicator 28: Cigarette Smoking: Below poverty is defined as having income less than 100 percent of the poverty threshold. Above poverty is grouped into two categories: (1) income between 100 percent and 199 percent of the poverty threshold and (2) income equal to or greater than 200 percent of the poverty threshold.

Indicator 32: Sources of Health Insurance: Below poverty is defined as having income less than 100 percent of the poverty threshold. Above poverty is grouped into two categories: (1) income between 100 percent and 199 percent of the poverty threshold and (2) income equal to or greater than 200 percent of the poverty threshold.

Indicator 33: Out-of-Pocket Health Care Expenditures: Two income categories were used to examine out-of-pocket health care expenditures using the Medical Expenditure Panel Survey (MEPS) and MEPS predecessor survey data. The categories were expressed in terms of poverty status (i.e., the ratio of the family's income to the Federal poverty thresholds for the corresponding year), which controls for the size of the family and the age of the head of the family. The income categories were (1) poor and near poor and (2) other income. The poor and near poor income category includes people in families with income less than 100 percent of the poverty line, including those whose losses exceeded their earnings, resulting in negative income (i.e., the poor), as well as people in families with income from 100 percent to less than 125 percent of the poverty line (i.e., the near poor). The other income category includes people in families with income greater than or equal to 125 percent of the poverty line. *See Income, household.*

Prescription drugs/medicines: In the Medicare Current Beneficiary Survey (Indicators 30, 31, 34) and in the Medical Expenditure Panel Survey (Indicator 33), prescription drugs are all prescription medications (including refills), except those provided by the doctor or practitioner as samples and those provided in an inpatient setting.

Prevalence: Prevalence is the number of cases of a disease, infected people, or people with some other attribute present during a particular interval of time. It is often expressed as a rate (e.g., the prevalence of diabetes per 1,000 people during a year).

Private supplemental health insurance: *See Supplemental health insurance.*

Public assistance: Public assistance is money income reported in the Current Population Survey from Supplemental Security Income (payments made to low-income people who are age 65 and over, blind, or disabled) and public assistance or welfare payments, such as Temporary Assistance for Needy Families and General Assistance.

Quintiles: *See Income fifths.*

Race: *See specific data source descriptions.*

Rate: A rate is a measure of some event, disease, or condition in relation to a unit of population, along with some specification of time.

Reference population: The reference population is the base population from which a sample is drawn at the time of initial sampling. *See Population.*

Respondent-assessed health status: In the National Health Interview Survey, respondent-assessed health status is measured by asking the respondent, "Would you say [your/subject name's] health is excellent, very good, good, fair, or poor?" The respondent answers for all household members including himself or herself.

Retiree Drug Subsidy: The Retiree Drug Subsidy is designed to encourage employers to continue providing retirees with prescription drug benefits. Under the program, employers may receive a subsidy of up to 28 percent of the costs of providing the prescription drug benefit.

Short-term institution: This category in the Medicare Current Beneficiary Survey (Indicators 30 and 34)

includes skilled nursing facility stays and other short-term (e.g., sub-acute care) facility stays (e.g., a rehabilitation facility stay). Payments for these services include Medicare and other payment sources. *See Skilled nursing facility (Indicator 29), Nursing facility (Indicator 36), and Long-term care facility (Indicators 22, 30, 34, and 37).*

Skilled nursing facility: A skilled nursing facility (SNF) as defined by Medicare (Indicator 29) provides short-term skilled nursing care on an inpatient basis, following hospitalization. These facilities provide the most intensive care available outside of inpatient acute hospital care. In the Medicare Current Beneficiary Survey (Indicators 30 and 34) "skilled nursing facilities" are classified as a type of "short-term institution." *See Short-term institution (Indicators 30 and 34), and Long-term care facility (Indicators 22, 30, 34, and 36).*

Skilled nursing facility stays: Skilled nursing facility stays in the Medicare claims data (Indicator 29) refers to admission to and discharge from a skilled nursing facility, regardless of the length of stay. *See Skilled nursing facility (Indicator 29).*

Social Security benefits: Social Security benefits include money income reported in the Current Population Survey from Social Security old-age, disability, and survivors' benefits.

Standard population: This is a population in which the age and sex composition is known precisely, as a result of a census. A standard population is used as a comparison group in the procedure for standardizing mortality rates.

Supplemental health insurance: Supplemental health insurance is designed to fill gaps in the original Medicare plan coverage by paying some of the amounts that Medicare does not pay for covered services and may pay for certain services not covered by Medicare. Private Medigap is supplemental insurance individuals purchase themselves or through organizations such as AARP or other professional organizations. Employer- or union-sponsored supplemental insurance policies are provided through a Medicare enrollee's former employer or union. For dual-eligible beneficiaries, Medicaid acts as a supplemental insurer to Medicare. Some Medicare beneficiaries enroll in HMOs and other managed care plans that provide many of the benefits of supplemental insurance, such as low copayments and coverage of services that Medicare does not cover.

Supplemental Poverty Measure: Since 2011, the Census Bureau has published poverty estimates using the Supplemental Poverty Measure (SPM). The SPM creates a more complex statistical picture incorporating additional items such as tax payments, work expenses, and medical out-of-pocket expenditures in its family resource estimates. The resource estimates also take into account the value of noncash benefits including nutritional, energy, and housing assistance. Thresholds used in the new measure are derived from Consumer Expenditure Survey expenditure data on basic necessities (food, shelter, clothing, and utilities) and are adjusted for geographic differences in the cost of housing.

TRICARE: TRICARE is the Department of Defense's regionally managed health care program for active duty and retired members of the uniformed services, their families, and survivors.

TRICARE for Life: TRICARE for Life is TRICARE's Medicare wraparound coverage (similar to traditional Medigap coverage) for Medicare-eligible uniformed services beneficiaries and their eligible family members and survivors.

Veteran: Veterans include those who served on active duty in the Army, Navy, Air Force, Marines, Coast Guard, uniformed Public Health Service, or uniformed National Oceanic and Atmospheric Administration; Reserve Force and National Guard called to Federal active duty; and those disabled while on active duty training. Excluded are those dishonorably discharged and those whose only active duty was for training or State National Guard service.

Veterans' health care: Health care services provided by the Veterans Health Administration (Indicator 35) includes preventive care, ambulatory diagnosis and treatment, inpatient diagnosis and treatment, and medications and supplies. This includes home- and community-based services (e.g., home health care) and long-term care institutional services (for those eligible to receive these services).

The Historical Experience of Three Cohorts of Older Americans: A Timeline of Selected Events 1923–2016

1943 Cohort	1933 Cohort	1923 Cohort	Year	Historical Events	Legislative Events
		Born	1923		
		5 years old	1928	1929 – Stock market crashes	
	Born		1933		1934 – Federal Housing Administration created by Congress 1935 – Social Security Act passed
	5 years old	15 years old	1938		1937 – U.S. Housing Act passed, establishing Public Housing
Born			1943	1941 – Pearl Harbor; United States enters WWII 1945 – Yalta Conference; Cold War begins; 1946 – Baby boom begins	
5 years old	15 years old	25 years old	1948	1950 – United States enters Korean War	
			1953	1955 – Nationwide polio vaccination program begins	1956 – Women age 62–64 eligible for reduced Social Security benefits; 1957 – Social Security Disability Insurance implemented; 1959 – Section 202 of the Housing Act established, providing assistance to older adults with low income
15 years old	25 years old	35 years old	1958		1961 – Men age 62–64 eligible for reduced Social Security benefits; 1962 – Self-Employed Individual Retirement Act (Keogh Act) passed
			1963	1964 – United States enters Vietnam War; baby boom ends	1964 – Civil Rights Act passed 1965 – Medicare and Medicaid established; Older Americans Act passed 1967 – Age Discrimination in Employment Act passed
25 years old	35 years old	45 years old	1968	1969 – First man on the moon	
			1973		1972 – Formula for Social Security cost-of-living adjustment established; Social Security Supplemental Security Income legislation passed; 1974 – Employee Retirement Income Security Act (ERISA) passed; IRAs established; 1975 – Age Discrimination Act passed
35 years old	45 years old	55 years old	1978		1978 – 401(k)s established
			1983	1980 – First AIDS case is reported to the Centers for Disease Control and Prevention	1983 – Social Security eligibility age increased for full benefits; 1984 – Widows entitled to pension benefits if spouse was vested 1986 – Mandatory retirement eliminated for most workers 1987 – Reverse mortgage market created by the HUD Home Equity Conversion Program
45 years old	55 years old	65 years old	1988	1989 – Berlin Wall falls; 1990 – United States enters Persian Gulf War	1990 – Americans with Disabilities Act passed
			1993		1996 – Veterans' Health Care Eligibility Reform Act passed, creating access to community based long-term care for all enrollees; 1997 – Balanced Budget Act passed changing Medicare payment policies
55 years old	65 years old	75 years old	1998		2000 – Social Security earnings test eliminated for full retirement age
			2003	2001 – September 11: Terrorists attack United States; 2003 – United States enters Iraq war; 2007 – Economic downturn begins December 2007; 2008 – First Baby Boomers begin to turn 62 years old and become eligible for Social Security retired worker benefits; 2009 – Economic downturn ends June 2009; 2010 – Offshore explosion on the Deepwater Horizon drilling rig causes the largest oil spill in U.S. history	2003 – Medicare Modernization Act passed, creating the Medicare prescription drug benefit 2005 – Deficit Reduction Act passed realigning Medicaid incentives to provide noninstitutionalized long-term care; 2006 – Pension Protection Act passed
65 years old	75 years old	85 years old	2008	2011 – World population reaches 7 billion, 0.9 billion age 60 and over; United States formally ends the Iraq War	
			2013	2012 – First Baby Boomers reach Social Security full-retirement age; 2013 – Supreme Court rules Defense of Marriage Act (DOMA) unconstitutional; Nobel Prize for Medicine and Physiology honored research advancing insights on diabetes and Alzheimer's disease 2014 – Cuba and the United States agree to resume full diplomatic relations	2010 – Patient Protection and Affordable Care Act passed; 2014 – The Multiemployer Pension Reform Act of 2014 passed, enabling certain plans to apply to reduce pension benefits; 2015 – The Medicare Access and CHIP Reauthorization Act passed, reforming Medicare physician reimbursement 2016 – Reauthorization of the Older Americans Act