

2020

# Older Americans

## Key Indicators of Well-Being



# 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 September 2020 are as follows:

## **Consumer Product Safety Commission**

<https://www.cpsc.gov/>

## **Department of Commerce**

U.S. Census Bureau

<https://www.census.gov/>

## **Department of Health and Human Services**

Administration for Community Living

<https://acl.gov/>

Agency for Healthcare Research and Quality

<https://www.ahrq.gov/>

Centers for Medicare & Medicaid Services

<https://www.cms.gov/>

National Center for Health Statistics

<https://www.cdc.gov/nchs/>

National Institute on Aging

<https://www.nia.nih.gov/>

Office of the Assistant Secretary for Planning and Evaluation

<https://aspe.hhs.gov/>

Substance Abuse and Mental Health Services Administration

<https://www.samhsa.gov/>

## **Department of Housing and Urban Development**

<https://www.hud.gov/>

## **Department of Labor**

Bureau of Labor Statistics

<https://www.bls.gov/>

Employee Benefits Security Administration

<https://www.dol.gov/agencies/ebsa>

## **Department of Veterans Affairs**

<https://www.va.gov/>

## **Environmental Protection Agency**

<https://www.epa.gov/>

## **Office of Management and Budget**

Office of Statistical and Science Policy

<https://www.whitehouse.gov/omb/>

## **Social Security Administration**

Office of Research, Evaluation, and Statistics

<https://www.ssa.gov/>

# Older Americans 2020

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## 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 is important for policymakers and the general public to have an accessible, easy-to-understand portrait of how older Americans fare.

*Older Americans 2020: Key Indicators of Well-Being (Older Americans 2020)* provides a comprehensive, easy-to-understand picture of our older population. *Older Americans 2020* is the eighth report prepared by the Federal Interagency Forum on Aging-Related Statistics (Forum). It provides readers with an accessible compendium of indicators drawn from the most reliable and recent official statistics. The indicators are categorized into six broad groups: Population, Economics, Health Status, Health Risks and Behaviors, Health Care, and Environment.

Recognizing that Federal agencies will continue to collect and report data on older Americans over time, these metrics will broaden to address current knowledge gaps and emerging information needs. Measurement and reporting will improve to enhance the quality and utility of information.

The statistics reported in this volume, while the most recent available, are based on data collected prior to the COVID-19 pandemic. Although many of these data collection systems have adapted to accommodate the emerging information needs related to the pandemic,

COVID-19-related data were not available for inclusion in this report. However, provisional data show that the onset of COVID-19 has disproportionately impacted older Americans, resulting in higher mortality because older Americans are more likely to have chronic conditions that contribute to an increased risk of death. As of September 23, 2020, 79 percent (148,737/188,470) of deaths involving COVID-19, based on death certificate data received and coded by the National Center for Health Statistics, occurred among people age 65 and over.<sup>1</sup>

Established in 1986, the goal of the Federal Interagency Forum on Aging-Related Statistics (Forum) is to bring together Federal agencies that share a common interest in improving aging-related data. As the population of older Americans continues to grow, the Forum continues its collaborative effort to provide reliable and relevant information on this vital component of our society. The Forum plays a key role in critically evaluating existing data resources and limitations, stimulating new database development, encouraging cooperation and data sharing among Federal agencies, and preparing collaborative statistical reports (<https://www.agingstats.gov/about.html>).

The Forum appreciates users' requests for greater detail for many existing indicators. We also extend an invitation to all 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](mailto: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. This work would not be possible without the continued cooperation of millions of American citizens who willingly provide the data that are summarized and analyzed by Federal agency staff for the American people.

*Office of the Chief Statistician,  
U.S. Office of Management and Budget*

## Acknowledgments

*Older Americans 2020* is a report of the Forum. This report was prepared by the Forum's planning committee and reviewed by its principal members, which include Vicki Gottlich and Susan Jenkins, Administration for Community Living (ACL); Joel W. Cohen, Agency for Healthcare Research and Quality (AHRQ); Dorinda Allard, Bureau of Labor Statistics (BLS); Roberto Ramirez, U.S. Census Bureau; Debra Reed-Gillette, Centers for Medicare & Medicaid Services (CMS); Steve Hanway, U.S. Consumer Product Safety Commission; Joseph Piacentini and Anja Decressin, Employee Benefits Security Administration (EBSA); Jennifer Madans and Julie Weeks, National Center for Health Statistics (NCHS); John Phillips and Georgeanne Patmios, National Institute on Aging (NIA); Gavin Kennedy and William Marton, Office of the Assistant Secretary for Planning and Evaluation (ASPE), Department of Health and Human Services; Nancy Potok (retired), Office of Management and Budget (OMB); Elizabeth Lopez and Beth Han, Substance Abuse and Mental Health Services Administration (SAMHSA); Katherine Bent and Natalie Lu, Social Security Administration (SSA); and Tom Garin and Melissa Chiu, Department of Veterans Affairs (VA).

The Forum's planning committee and contributing staff members include Traci Cook, Forum Staff Director; Caryn Bruyere, ACL; David Kashiara, AHRQ; Emy Sok, BLS; Wan He and Andrew Roberts, U.S. Census Bureau; Katherine Giuriceo and Nic Schluterman, CMS; Meena Bavan and Barry Steffen, Department of Housing and Urban Development (HUD); Bobbie Joyeux

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Member agencies of the Forum provided funds and valuable staff time to produce this report. NCHS and its contractor, the American Institutes for Research (AIR), facilitated the production, printing, and dissemination of this report. Susan Armstrong, Mandy Dean, Anita Lederer, Katie Mallory, Ashley Roberts, and Max Wylie 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 2020* marks 20 years since the first key indicators describing the overall condition of the U.S. population age 65 and over were released by the Forum. It is the eighth in a series of reports published by the Forum. The reports use data from more than a dozen national data sources to construct broad indicators of well-being for the older population and monitor changes over time. The data trends in these reports present information and opportunities that can improve the lives of older Americans.

In 2016, the Forum conducted a conceptual and methodological review of report indicators and format according to established indicator selection criteria (see “Selection Criteria for Indicators”). This review ensures that the report continues to feature the most current topics and the most reliable, accurate, and accessible statistics.

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 2020* complements other more technical and comprehensive reports from the individual Forum agencies. The report includes indicators grouped in six sections: Population, Economics, Health Status, Health Risks and Behaviors, Health Care, and Environment. Each indicator includes the following:

- 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 in the back matter. A timeline of selected historical events is also included on the back inside cover. For more detailed information on the practices and

parameters for developing consistency in data reported across the report indicators, the Forum’s Operations and Practices and Parameters for Publications, Products, and Activities are available on the Forum’s website at <https://agingstats.gov>.

## 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 the description of trends over time.
- Representative of large segments of the aging population, rather than one particular group.

## Considerations When Examining the Indicators

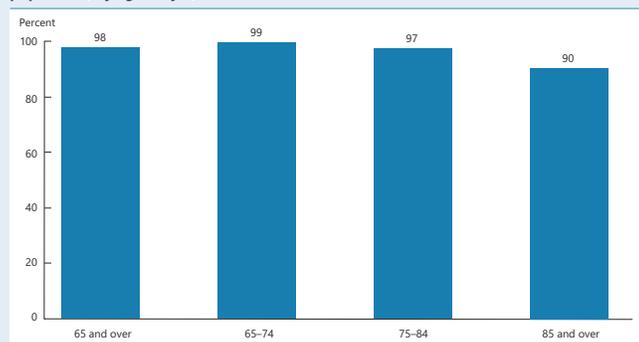
The data in *Older Americans 2020* usually describe the U.S. population age 65 and over. More specific age groups (e.g., ages 65–74, 75–84, and 85 and over) are reported whenever possible.

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 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, 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 10: Net Worth. In Indicator 11: 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.

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. In 2018, 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. For example, the reference population for Indicator 19: Dementia in this year's report has not changed from *Older Americans 2016*—both show the community (noninstitutionalized) population only. The prevalence of dementia in the institutionalized (nursing home) population is higher than in the community population and is not reflected in the indicator chart.

Civilian noninstitutionalized population as a percentage of the total resident population, by age: July 1, 2018



SOURCE: U.S. Census Bureau, Population Estimates, July 1, 2018.

## 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  $p \leq 0.05$  level are discussed in the text. To indicate the reliability of the estimates, standard errors for selected estimates in the report can be found on the Forum's website at <https://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 appear 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. Although charts display rounded numbers, the charts 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 report, along with data 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 <https://agingstats.gov>.

## Data Needs

This year, the Forum assessed data needs related to sources of income for older Americans. It was determined that a better data source is needed to accurately measure the retirement income components of the income sources for older Americans. To address these concerns, the Sources of Income indicator (Indicator 9 in *Older Americans 2016*) is not included in this report because of changes in data collection and reporting; however, the indicator will return in future *Older Americans* reports.

## Mission

The Forum's mission is to encourage cooperation and collaboration among Federal agencies to improve the quality and utility of data on the aging population. The specific goals of the Forum are as follows:

- Widen access to information on the aging population through periodic publications and other means.
- Promote communication among data producers, researchers, and public policymakers.
- Coordinate the development and use of statistical databases among Federal agencies.
- Identify information gaps and data inconsistencies.
- Investigate questions of data quality.
- Encourage cross-national research and data collection on the aging population.
- Address concerns regarding collection, access, and dissemination of data.

## For Further Information

The Forum's website (<https://www.agingstats.gov>) contains data tables (with standard errors, when available); links to previous reports; the Forum's Charter, Operations and Practices, and Parameters for Publications, Products, and Activities; agency contacts; and additional information about the Forum. Follow the Forum on Twitter @agingstats for selected highlights from *Older Americans 2020*.

For more information about *Older Americans 2020* or other Forum activities, contact the Forum as follows:

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Website: <https://agingstats.gov>

## Additional Online Resources

### Administration for Community Living

Profile of Older Americans  
<https://acl.gov/aging-and-disability-in-america/data-and-research/profile-older-americans>

AGing, Independence, and Disability (AGID) Program  
Data Portal

<https://agid.acl.gov/Default.aspx>

ACL Program Evaluations and Related Reports

<https://acl.gov/programs/program-evaluations-and-reports>

### Agency for Healthcare Research and Quality

Research Tools and Data

<https://www.ahrq.gov/research/index.html>

### Bureau of Labor Statistics

Bureau of Labor Statistics Data

<https://www.bls.gov/data>

### U.S. Census Bureau

Age Data

<https://www.census.gov/topics/population/age-and-sex.html>

Statistical Abstract of the United States

[https://www.census.gov/library/publications/time-series/statistical\\_abstracts.html](https://www.census.gov/library/publications/time-series/statistical_abstracts.html)

Longitudinal Employer-Household Dynamics

<https://lehd.ces.census.gov>

### Centers for Medicare & Medicaid Services

CMS Research, Statistics, Data, and Systems

<https://www.cms.gov/research-statistics-data-and-systems/research-statistics-data-and-systems.html>

### Department of Housing and Urban Development

Policy Development and Research Reports and  
Information Services

<https://www.huduser.gov>

### Department of Veterans Affairs

Veteran Data and Information

<https://www.va.gov/vetdata>

### Employee Benefits Security Administration

EBSA's Research

<https://www.dol.gov/agencies/ebsa/researchers>

### National Center for Health Statistics

Health, United States

<https://www.cdc.gov/nchs/hus.htm>

Washington Group on Disability Statistics

<http://www.washingtongroup-disability.com/>

### **National Institute on Aging**

NIA Centers on the Demography of Aging  
<https://agingcenters.org/>

National Archive of Computerized Data on Aging  
<https://www.icpsr.umich.edu/NACDA>

Publicly Available Datasets for Aging-Related Secondary Analysis in the Behavioral and Social Sciences  
<https://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 Behavioral Health, Disability, and Aging Policy  
<https://aspe.hhs.gov/bhdap>

### **Office of Management and Budget**

Federal Committee on Statistical Methodology  
<https://nces.ed.gov/fcsm/>

### **Social Security Administration**

Social Security Administration Statistical Information  
<https://www.ssa.gov/policy>

### **Substance Abuse and Mental Health Services Administration**

Center for Behavioral Health Statistics and Quality  
<https://www.samhsa.gov/data>

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

### **Other Resources**

Data and Statistics About the United States  
<https://www.usa.gov/statistics>

Data.gov  
<https://www.data.gov>

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# Highlights

*Older Americans 2020* is one in a series of periodic reports to the Nation on the condition of older adults in the United States. In this report, 40 indicators depict the well-being of older Americans in the areas of Population, Economics, Health Status, Health Risks and Behaviors, Health Care, and Environment. Selected highlights from each section of the report follow.

## Population

- In 2018, 52 million people age 65 and over lived in the United States, accounting for 16 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 73 million and representing 21 percent of the total U.S. population (Indicator 1: Number of Older Americans).
- The older population is projected to become increasingly diverse, reflecting the demographic changes in the U.S. population as a whole during the last several decades. In 2018, 77 percent of the population was non-Hispanic White alone, 9 percent non-Hispanic Black alone, 5 percent non-Hispanic Asian alone, and 8 percent Hispanic (of any race). By 2060, it is projected that this will change to 55 percent non-Hispanic White alone, 13 percent non-Hispanic Black alone, 8 percent non-Hispanic Asian alone, and 21 percent Hispanic (of any race; Indicator 2: Racial and Ethnic Composition).
- In general, the older population is less likely to be married, and more likely to be widowed, at older ages. Marital status also varies by sex, such that older men were more likely than older women to be married (71 percent versus 46 percent) and less likely to be widowed (11 percent versus 32 percent; Indicator 3: Marital Status).
- In 2018, 86 percent of the population age 65 and over were high school graduates or more, and 29 percent had a bachelor's degree or more (Indicator 4: Educational Attainment).
- In 2019, older men were more likely to live with a spouse than were older women. About 67 percent of older men lived with a spouse while less than half (47 percent) of older women did. In contrast, older women were more likely than older men to live alone (31 percent versus 19 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 7.5 million by 2030, an expected decrease of about 18.5 percent (Indicator 6: Older Veterans).

## Economics

- Among the older population, increased age is associated with higher rates of poverty (9 percent for ages 65–74 compared with 14 percent for age 85 and older). Poverty rates also vary greatly by sex and by race and ethnicity, with the lowest poverty rates seen among the non-Hispanic White alone population and men age 65 and over (Indicator 7: Poverty).
- Between 1974 and 2018, 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 20 percent), and there was an increase in the proportion of people with high income (from 18 percent to 40 percent; Indicator 8: Income).
- The type of Social Security benefits received by older women changed between 1960 and 2018. The percentage receiving spouse-only benefits decreased from 33 percent to 8 percent, and the percentage on widow-only benefits fell from 23 percent to 12 percent. In contrast, the percentage who received earned worker benefits rose from 43 percent to 80 percent (Indicator 9: Social Security Beneficiaries).
- Between 1989 and 2016, the median net worth, in 2016 dollars, of households headed by people age 65 and over increased by about 60 percent, from \$158,225 to \$253,800 (Indicator 10: Net Worth).
- In 2019, labor force participation rates for women age 55 and over remained high after rising steadily for decades. Since the last recession, participation rates for women age 55 and over leveled off. 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 11: Participation in Labor Force).
- The most prevalent housing problem for older American households remains housing cost burden (expenditures on housing and utilities that exceed 30 percent of household income). In 2017, about

39 percent of older owner/renter households and 32 percent of older-member households had housing cost burden problems (Indicator 12: Housing Problems).

- As a share of total expenditures, health care increased dramatically with age. In 2018, for the group age 75 and over, the share (16 percent) was more than double the share for the ages 45–54 group (7 percent) and larger than the share the oldest group allocated to transportation (12 percent) or the share allocated to food (13 percent; Indicator 13: Total Expenditures).

## Health Status

- Life expectancies at both age 65 and age 85 have increased for both sexes and for Hispanics, non-Hispanic Whites, and non-Hispanic Blacks. Overall for men, life expectancy at age 65 increased from 17.2 years to 18.1 years from 2006 to 2018, and the increase for women overall was from 19.9 years to 20.7 years. During the same period, life expectancy at age 85 increased from 5.6 years to 6.0 years for men and from 6.7 years to 7.0 years for women (Indicator 14: Life Expectancy).
- Between 2000 and 2018, age-adjusted death rates among people age 65 and over declined by 20 percent. Death rates declined for heart disease, cancer, chronic lower respiratory diseases, stroke, diabetes, and influenza and pneumonia. Death rates for Alzheimer's disease and unintentional injuries increased during the same period (Indicator 15: Mortality).
- In 2018, 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, hypertension, cancer, and diabetes (Indicator 16: Chronic Health Conditions).
- In 2018, about 66 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 (68 percent versus 57 percent; Indicator 17: Oral Health).
- In 2018, older non-Hispanic Whites were more likely to report good to excellent health than their non-Hispanic Black and Hispanic counterparts (81 percent versus 65 percent and 64 percent, respectively; Indicator 18: Respondent-Assessed Health Status).
- In 2015, 7.4 percent of men and 7.5 percent of women age 65 and over not living in nursing homes had dementia (Indicator 19: Dementia).

- Older women were more likely to report clinically relevant depressive symptoms than older men. In 2018, 13 percent of women age 65 and over reported clinically relevant depressive symptoms, compared with 9 percent of men (Indicator 20: Depressive Symptoms).
- In 2018, 22 percent of the population age 65 and over reported having a disability as defined by having a lot of difficulty or being unable to do at least one of the following functioning domains: vision, hearing, mobility, communication, cognition, or self-care (Indicator 21: Functional Limitations).

## Health Risks and Behaviors

- In 2018, 69 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 70 percent of non-Hispanic Whites reported receiving a flu shot, compared with 60 percent of non-Hispanic Blacks and 63 percent of Hispanics (Indicator 22: Vaccinations).
- The percentage of people ages 50–75 who received colorectal cancer screening increased from 2000 to 2018 (Indicator 23: Cancer Screenings).
- Among older Americans age 65 and over during 2015–2016, Healthy Eating Index-2015 (HEI-2015) component scores were highest for Whole Fruits, Total Protein Foods, and Seafood and Plant Proteins. Overall diet quality, as measured by the total HEI-2015 score, was 64 out of 100 for people age 65 and over (Indicator 24: Diet Quality).
- In 2018, only 14 percent of people age 65 and over participated in leisure-time physical activity that met the *Physical Activity Guidelines for Americans* (Indicator 25: Physical Activity).
- The percentage of people age 65 and over with obesity increased from 22 percent in 1988–1994 to 30 percent in 2003–2006 to 40 percent in 2015–2018 (Indicator 26: Obesity).
- The percentage of people age 65 and over who were current cigarette smokers declined between 1965 and 2018 and has been stable for the past decade. In 2018, 10 percent of men and 7 percent of women age 65 and over were current smokers (Indicator 27: Cigarette Smoking).

## Health Care

- Between 1992 and 2017, the hospitalization rate decreased from 306 hospital stays per 1,000 Medicare beneficiaries to 245 per 1,000 beneficiaries (Indicator 28: Use of Health Care Services).
- After adjusting for inflation, health care costs per capita increased slightly among those age 65 and over between 1992 and 2017. In all years, average costs were substantially higher for those age 85 and over compared with those in the younger age groups (Indicator 29: Health Care Expenditures).
- After adjusting for inflation, average prescription drug costs for noninstitutionalized Americans age 65 and over increased between 1992 and 2017—from \$1,114 to \$4,499 (Indicator 30: 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 35 percent in 2017 (Indicator 31: Sources of Health Insurance).
- From 1977 to 2017, 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 19 percent (Indicator 32: Out-of-Pocket Health Care Expenditures).
- Medicare paid for approximately 65 percent of all health care costs of enrollees age 65 and over in 2017. Medicare financed all hospice costs and most hospital, physician, home health care, and short-term institution costs (Indicator 33: Sources of Payment for Health Care Services).
- The number of veterans age 65 and over enrolled with Veterans Health Administration has been steadily increasing since 1999, when eligibility for this benefit was reformed. The number of veterans age 85 and over enrolled is projected to exceed 1.1 million by 2038 (Indicator 34: Veterans' Health Care).

- In 2017, about 2 percent of the Medicare population age 65 and over resided in community housing with at least one service available (Indicator 35: Residential Services).
- In 2017, about two-thirds of people who had difficulty with one or more activities of daily living (ADLs) received personal assistance or used special equipment: 6 percent received personal assistance only, 39 percent used equipment only, and 29 percent used both personal assistance and equipment (Indicator 36: Personal Assistance and Equipment).
- In 2016, about 1.1 million people age 65 and over were residents of nursing homes. Nearly 760,000 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 37: 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 2018, the percentage of leisure time spent socializing and communicating was about 11 percent for those ages 55–64 and 7 percent for those age 75 and over (Indicator 38: Use of Time).
- The percentage of people age 65 and over living in counties that experienced poor air quality decreased from 69 percent in 2000 to 40 percent in 2018 (Indicator 39: Air Quality).
- In 2017, about 18 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 (41 percent) than for those ages 65–74 (13 percent; Indicator 40: Transportation).

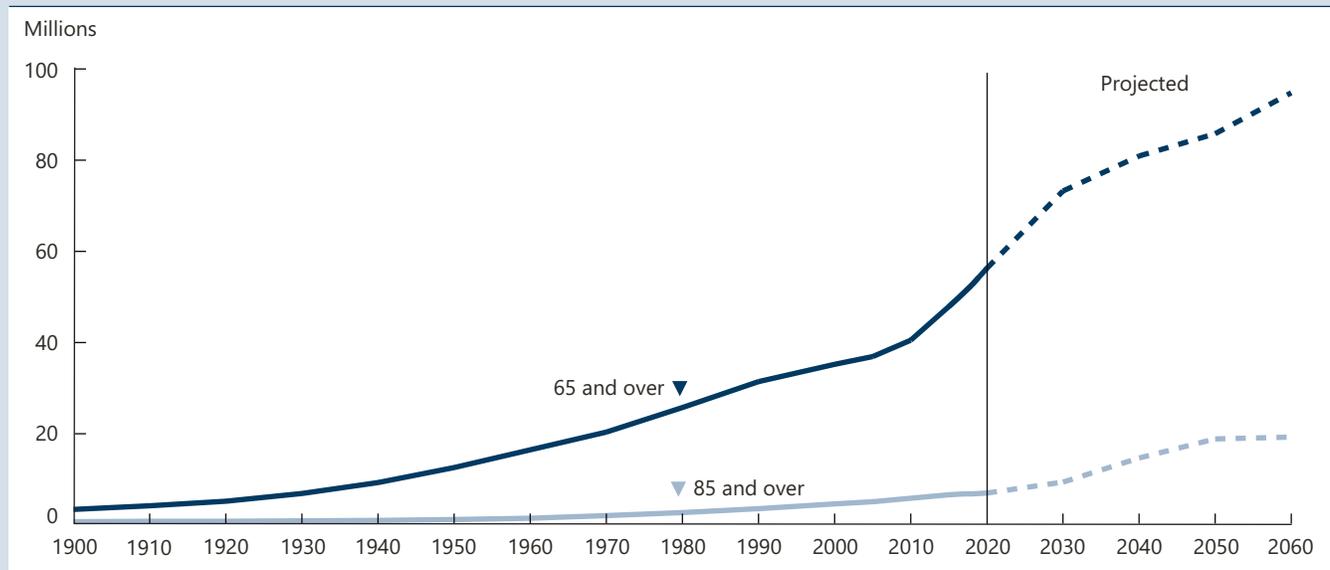


**Population**

## INDICATOR 1: Number of Older Americans

The growth of the population age 65 and over, predicted by researchers to swell in part because of declining death rates at older ages, 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.<sup>2</sup>

**Population age 65 and over and age 85 and over, selected years, 1900–2018, and projected years, 2020–2060**



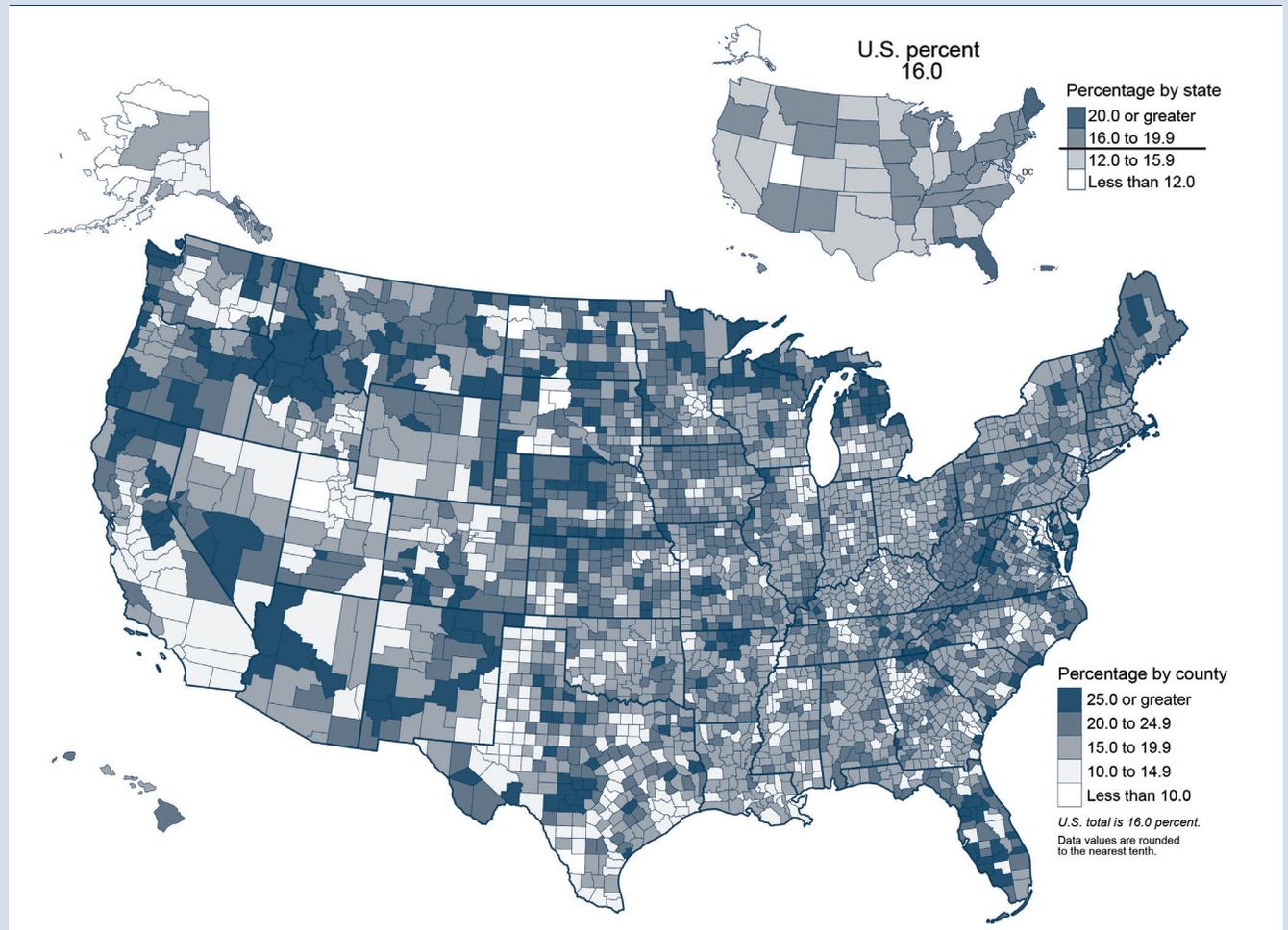
NOTE: Some data for 2020–2060 have been revised and differ from previous editions of *Older Americans*.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, 1900–1940, 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, 2018 (PEPAGESEX); U.S. Census Bureau, Table 3: Projections of the Population by Sex and Selected Age Groups for the United States: 2017 to 2060 (NP2017-T3).

- In 2018, 52 million people age 65 and over lived in the United States, accounting for 16 percent of the total population.
- The older population grew from 3 million in 1900 to 52 million in 2018. The oldest-old population (those age 85 and over) grew from slightly more than 100,000 in 1900 to 7 million in 2018.
- In 2020, around 1 in 6 Americans are age 65 and over, and this is projected to rise to 1 in 5 as soon as 2030. This not only represents a change in age composition, but a large increase in the number of older Americans, from 56 million in 2020 to 73 million in 2030.
- As the Baby Boomers (those born between 1946 and 1964) age, they create dramatic shifts in America's age composition. The first Baby Boomers turned 65 in 2011 and in the 8-year period between 2010 and 2018, the older population grew from 13 percent to 16 percent, the same number of percentage points it had grown in the 40 years prior (1970–2010). The 65 and over age group is expected to continue to increase, though this growth will likely slow starting around 2030 as the Baby Boomers age into the 85 and over age group.
- The oldest-old will break with their relatively stable rise to increase from 2 percent of the population in 2020 to 5 percent by 2060.

## Percentage of population age 65 and over, by county and state, 2018



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, 2018 (PEPAGESEX).

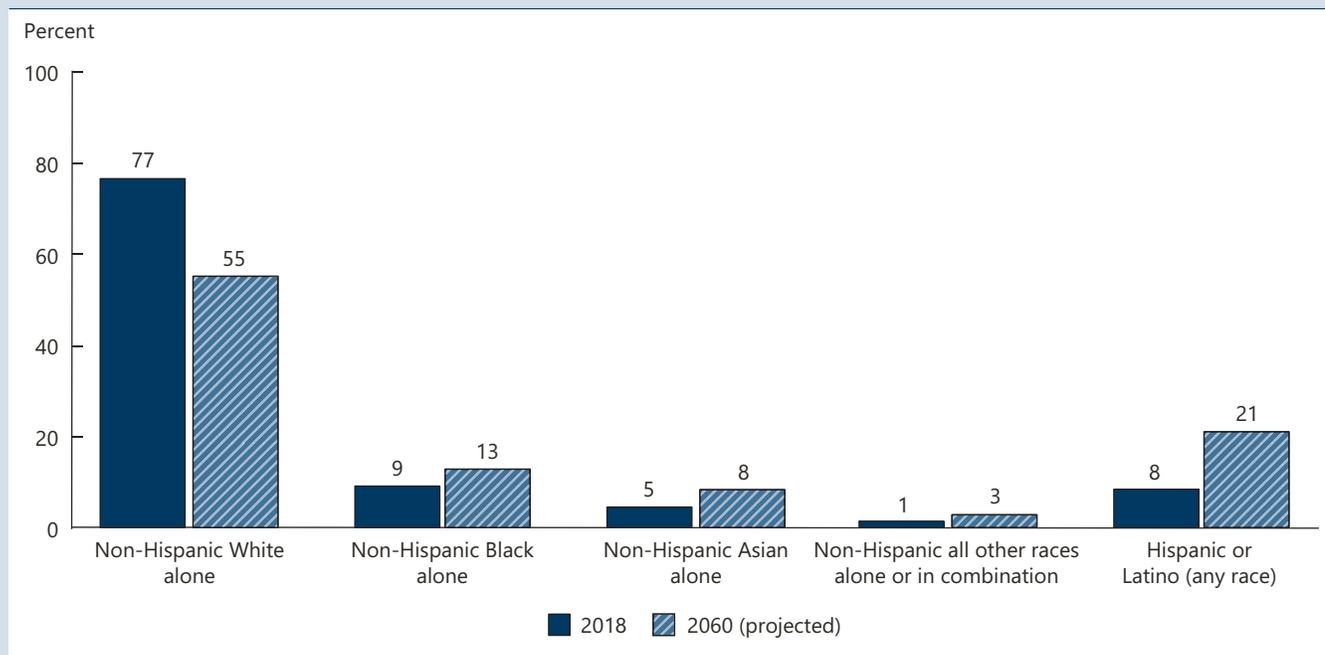
- The proportion of the population age 65 and over varies by state and is partly affected by the state fertility and mortality levels and partly by the number of older and younger people who migrate to and from the state. In 2018, Maine and Florida had the largest proportion, with 1 out of 5 people age 65 and over, while Utah had the smallest proportion, with 1 out of 9.
- The proportion of the population age 65 and over varies even more by county. In 2018, 58 percent of Sumter County, Florida, was age 65 and over, the highest proportion in the country. In fact, 5 of the 20 counties with the highest proportion of people age 65 and over were in Florida. At the other end of the spectrum was Chattahoochee County, Georgia, with only 5 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 2018, women accounted for 56 percent of the population age 65 and over and for 64 percent of the population age 85 and over.
- The United States is fairly young for a developed country, with 16 percent of its population age 65 and over in 2019. Japan had the highest percentage of persons age 65 and over (29 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 greater than 21 percent in Germany, Finland, Italy, and Greece.

*Data for this indicator's charts and bullets can be found in Tables 1a through 1f on pages 72–77.*

## 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 during the last several decades. By 2060, programs and services for older people will have to address the needs of a more diverse population.

**Population age 65 and over, by race and Hispanic origin, 2018 and projected 2060**



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 “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 or Alaska Native alone who are not Hispanic; people who reported Native Hawaiian or 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, 2018 (PEPASR6H); U.S. Census Bureau, Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2017 to 2060 (NP2017\_D1).

- The older population is projected to become increasingly diverse, reflecting the demographic changes in the U.S. population as a whole during the last several decades. In 2018, 77 percent of the population was non-Hispanic White alone, 9 percent non-Hispanic Black alone, 5 percent non-Hispanic Asian alone, and 8 percent Hispanic (of any race). By 2060, it is projected that this will change to 55 percent non-Hispanic White alone, 13 percent non-Hispanic Black alone, 8 percent non-Hispanic Asian alone, and 21 percent Hispanic (of any race).
- Although the older population is projected to increase among all racial and ethnic groups, the older Hispanic population is projected to grow the fastest. This difference in relative growth has implications for

the larger racial and ethnic composition of the older population. For example, in 2018, the older Hispanic population was slightly smaller than the older non-Hispanic Black alone population (4.4 million versus 4.8 million, respectively). However, by 2060, it is projected to be larger—19.9 million compared to 12.1 million.

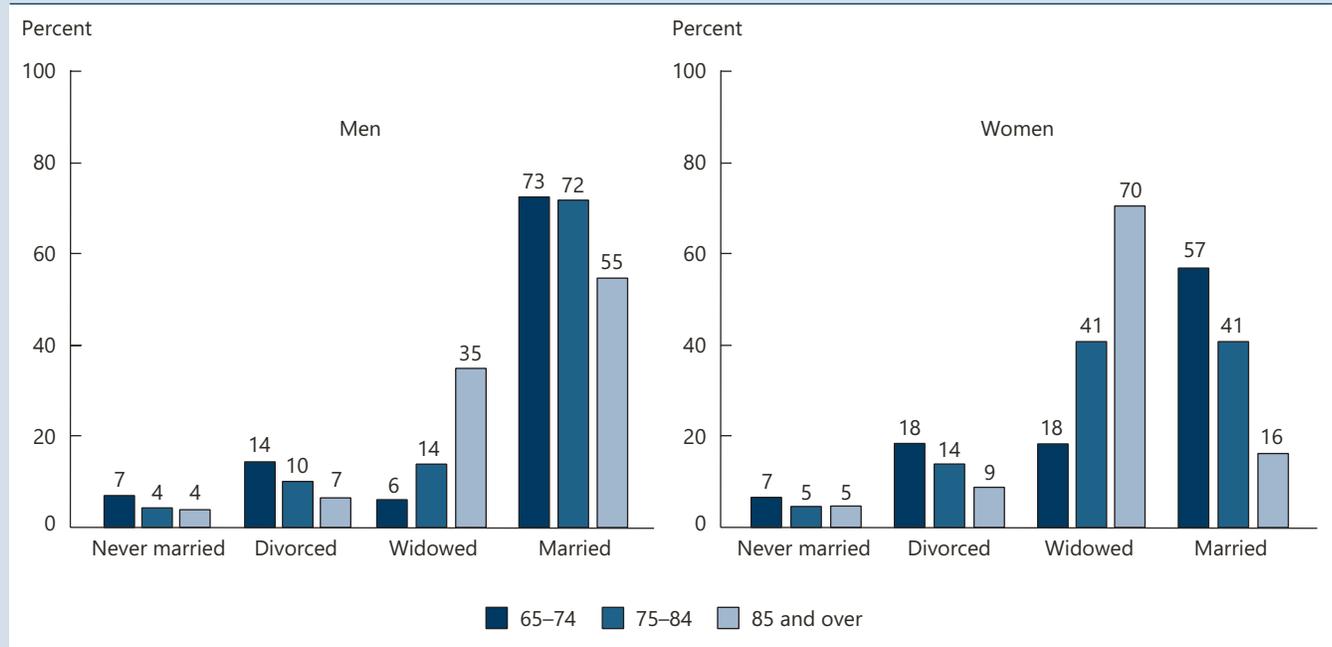
- Although the number of older residents who identify as non-Hispanic, all other races alone or in combination, is projected to increase to 2.6 million in 2060, this represents a small proportion (3 percent) of the older population.

*Data for this indicator’s charts and bullets can be found in Table 2 on page 78.*

## 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, 2018**



NOTE: Married includes separated.

Reference population: These data refer to the resident population. Totals may not sum to 100 percent because of rounding.

SOURCE: U.S. Census Bureau, American Community Survey.

- At older ages, the older population is less likely to be married and more likely to be widowed. In 2018, about 6 out of 10 people ages 65–74 were married compared with only 3 out of 10 people age 85 and over. Conversely, only about 1 out of 10 people ages 65–74 are widowed, compared with almost 6 out of 10 age 85 and over.
- Marital status in older age varied greatly by sex. In general, older men were more likely than women to be married (71 percent versus 46 percent) and less likely to be widowed (11 percent versus 32 percent). This sex difference is more dramatic among the oldest old

(age 85 and over), where a full 70 percent of women—twice the 35 percent of men—were widowed. Among men age 85 and over, a majority are married compared with just 16 percent of women in that age group.

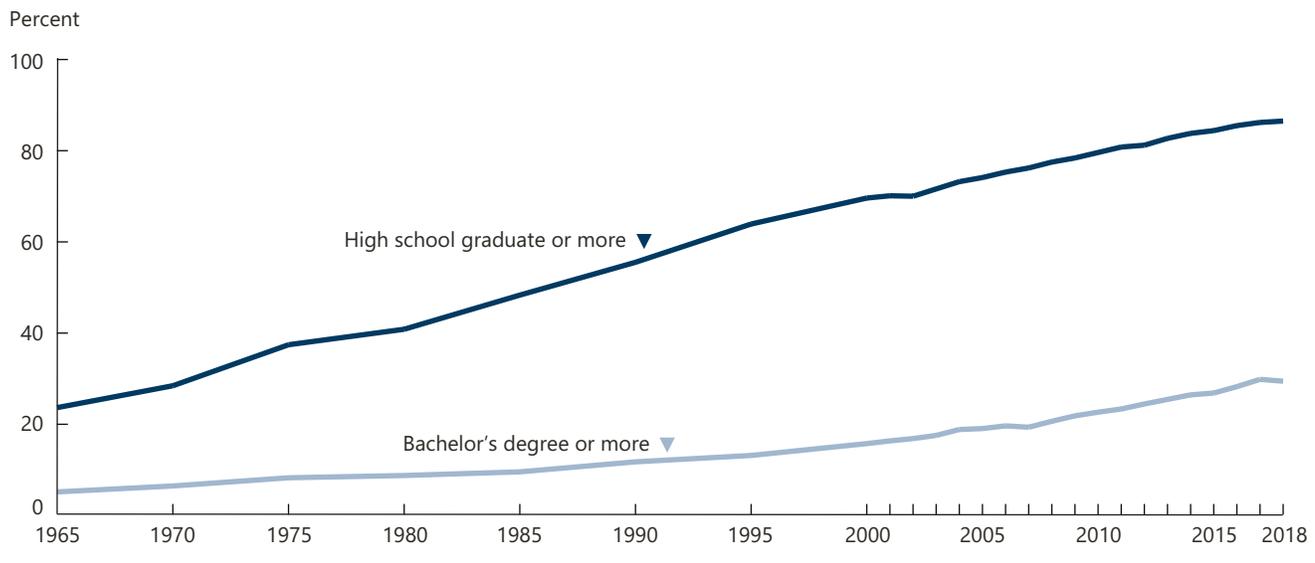
- Relatively small proportions of older men (12 percent) and women (16 percent) reported their marital status as divorced in 2018. An even smaller proportion (6 percent) of both sexes had never married.

*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 78.*

## INDICATOR 4: Educational Attainment

Educational attainment has effects throughout the life course and plays an important 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 and life expectancy.<sup>3,4,5</sup>

**Educational attainment of the population age 65 and over, selected years, 1965–2018**



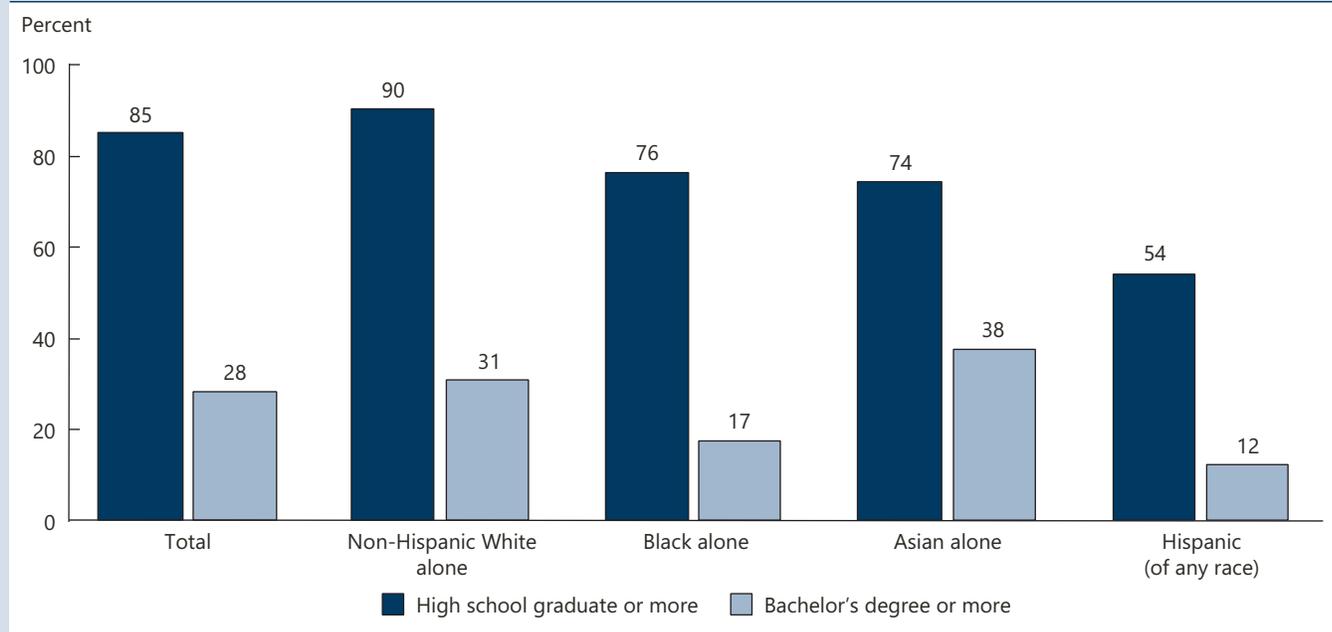
NOTE: A single question that asks for the highest grade or degree completed is used to determine educational attainment. Prior to 1995, educational attainment was measured using data on years of school completed.

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

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

- In 2018, 86 percent of the older population were high school graduates or more, and 29 percent had a bachelor's degree or more.
- In 1965, 24 percent of the older population had graduated from high school, and only 5 percent had at least a bachelor's degree.
- In 2018, 86 percent of older men and 85 percent of older women had at least a high school diploma. Older men had attained at least a bachelor's degree more often than older women (33 percent versus 24 percent, respectively).

## Educational attainment of the population age 65 and over, by race and Hispanic origin, 2018



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 resident population.

SOURCE: U.S. Census Bureau, American Community Survey.

- In 2018, 90 percent of the older non-Hispanic White alone population completed high school, and 31 percent received a bachelor’s degree or more.
- Among older Americans, Hispanics (of any race) had the lowest levels of formal education: 54 percent completed high school, and 12 percent received a bachelor’s degree or more.
- Although a slightly higher proportion of older Black alone Americans than Asian alone Americans completed high school (76 percent and 74 percent, respectively), this relationship switched for higher

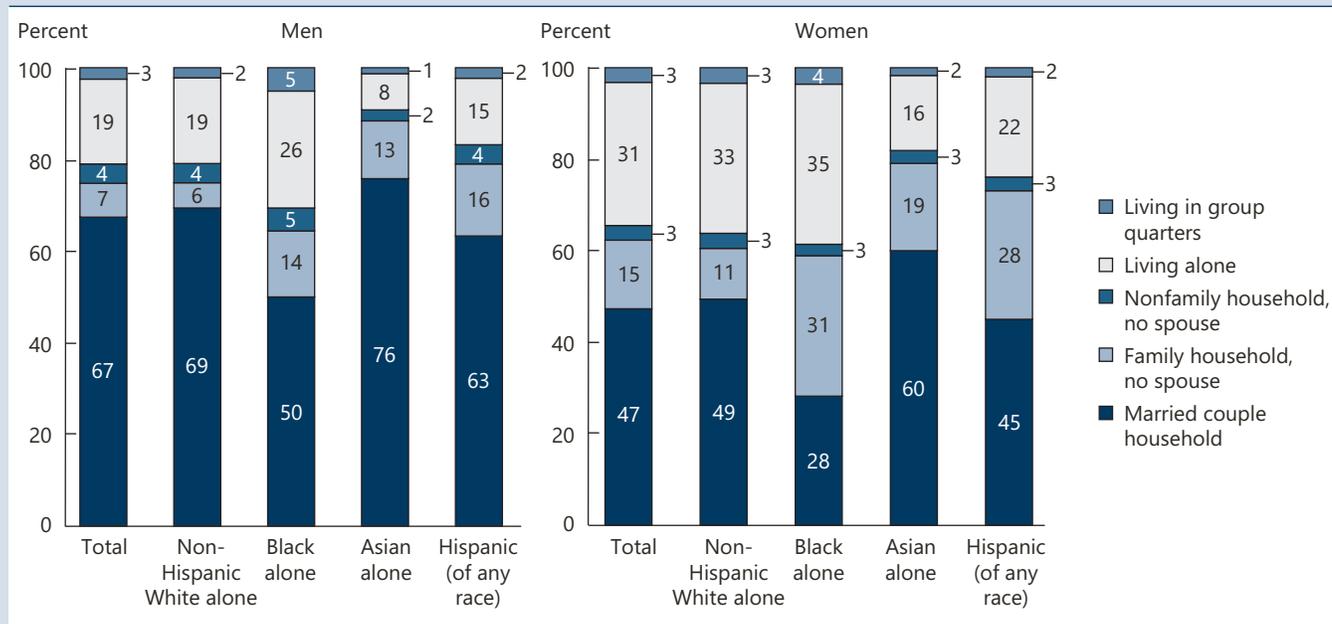
education. Although 17 percent of the older Black alone population received at least a bachelor’s degree, more than twice that proportion, 38 percent, of Asian alone did. In fact, the older Asian alone population had the highest proportion to earn at least a bachelor’s degree, about 7 percentage points higher than non-Hispanic White alone.

*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 79.*

## INDICATOR 5: Living Arrangements

The living arrangements of America’s older population are linked to income, health status, and the availability of caregivers. Living alone, for example, often leads to conditions of social isolation and loneliness, which, in turn, are linked to higher risks for a variety of physical and mental conditions: high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer’s disease, and even death.<sup>6</sup>

**Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2018**



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 resident population.

SOURCE: U.S. Census Bureau, American Community Survey.

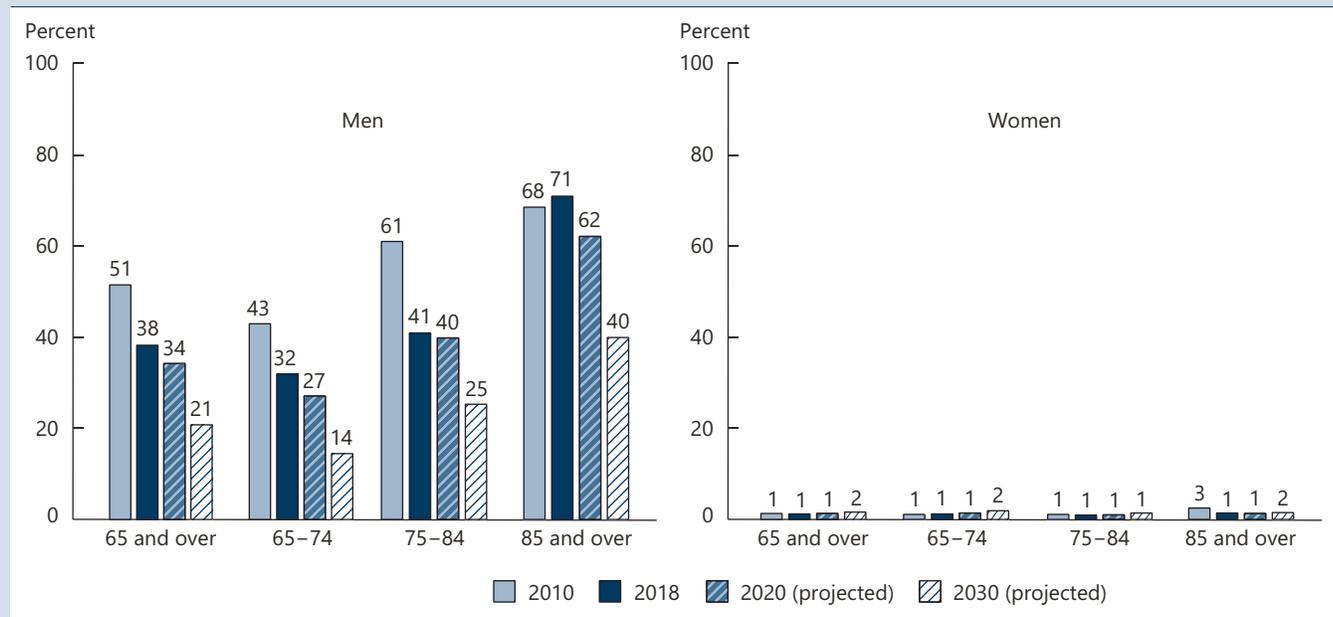
- In 2018, older men were more likely to live with a spouse than were older women. About 67 percent of older men lived with a spouse, while less than half (47 percent) of older women did. In contrast, older women were more likely than older men to live alone (31 percent versus 19 percent).
- Regarding other types of living arrangements, older women (15 percent) were twice as likely to live in other family households (families whose householder was living with children or other relatives but no spouse present) compared with older men (7 percent).
- Living arrangements of older people differed by race and Hispanic origin, but at least 50 percent of older men of all race and Hispanic groups lived with a spouse. Among older women, the proportion living with a spouse was almost 50 percent or more among non-Hispanic White (49 percent) and Asian (60 percent) women.
- Older non-Hispanic White women and Black women were more likely than women of other races to live alone. In 2018, 33 percent of non-Hispanic White and 35 percent of Black women lived alone, compared with about 16 percent for older Asian women and 22 percent for older Hispanic women.
- The percentage of older Black men living alone was about three times as high as the percentage of older Asian men (26 percent versus 8 percent). The percentage of older Black men living alone was also higher than that of older non-Hispanic White men (19 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 5a and 5b on page 80.*

## INDICATOR 6: Older Veterans

As a group, Veterans are older than the U.S. population.<sup>7</sup> Compared with America's older population, older Veterans tend to have 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.<sup>8</sup> 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.<sup>8</sup> Those with chronic conditions (e.g., diabetes, high blood pressure) or disabilities are more likely to need comprehensive care and long-term support services to address their challenges.<sup>7</sup>

**Percentage of population age 65 and over who are veterans, by sex and age group, 2010, 2018, and projected 2020 and 2030**



Reference population: These data refer to the resident population of the United States and Puerto Rico.

SOURCE: U.S. Census Bureau, Population Projections 2020, and 2017 Census Summary File 1; Department of Veterans Affairs, VetPop2016.

- In 2018, 38 percent of men and 1 percent of women age 65 and over in the United States and Puerto Rico were veterans. In addition, 32 percent of men ages 65–74, 41 percent of men ages 75–84, and 71 percent of men age 85 and over were veterans. Women who were veterans tend to be 1 percent in the other age groups.
- Approximately two out of every five men age 65 and over were veterans (8.9 million) in 2018. This percentage is projected to decrease to one out of every five men age 65 and over in 2030 (6.8 million).
- By 2030, the proportion of women age 65 and over who are veterans will have increased from 1 percent (303,000) in 2010 and 1 percent (344,000) in 2018 to 2 percent (635,000). The number of women veterans age 65 and over will increase from 20 percent (389,000) of the woman veteran population in 2020 to 30 percent (635,000) in 2030.
- By 2030, the proportion of men age 85 and over who are veterans will have increased from 68 percent in 2010 and 71 percent in 2018 to 40 percent.

*Data for this indicator's charts and bullets can be found in Tables 6a and 6b on page 81.*



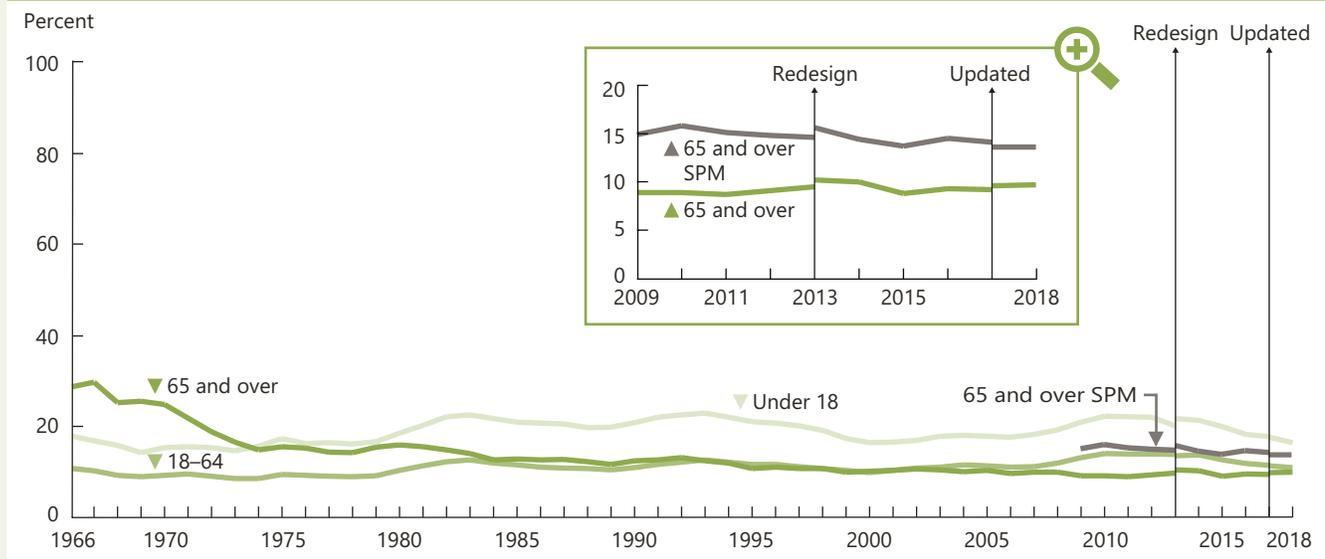


# Economics

## 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 (SPM), 1966–2018



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) 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) that received the redesigned income questions. The redesigned income questions were used for the entire 2015 CPS ASEC sample. A new processing system was implemented starting in 2017. The “2017 (legacy)” data reflect estimates using the previous system. “2017 (updated)” reflect estimates using the new processing system. The official 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. The Supplemental Poverty Measure extends the official poverty measure by taking account of many of the government programs designed to assist low-income families and individuals who 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. Reference population: These data refer to the civilian noninstitutionalized population.

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

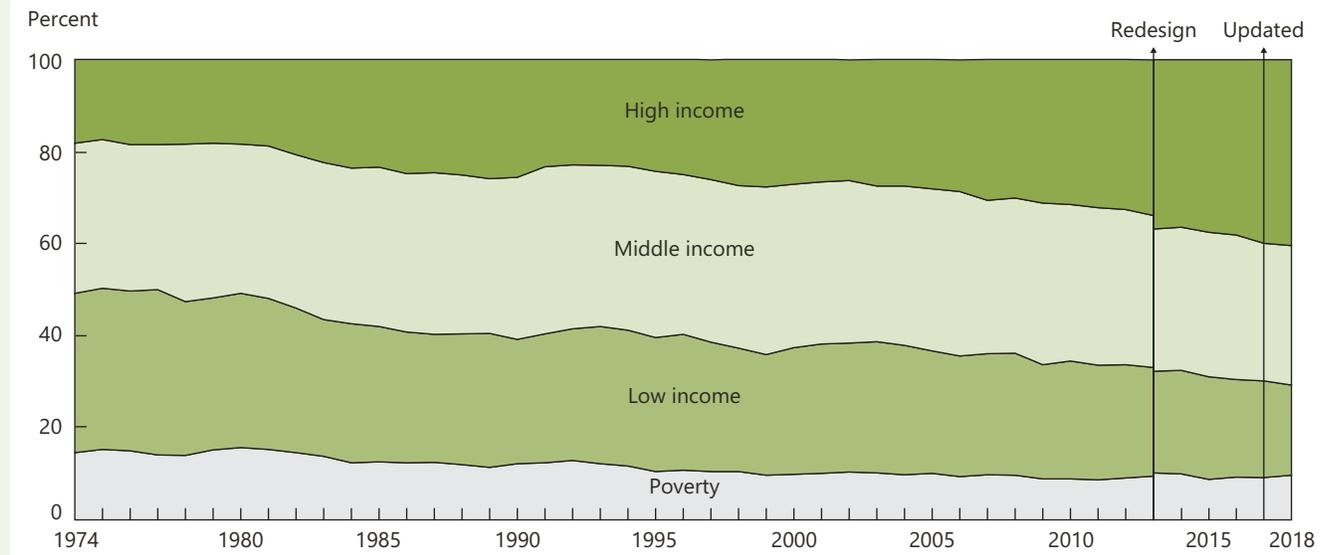
- In 2018, the poverty rate for the population age 65 and over was 9.7 percent.
- Since 2000, the poverty rate among people age 65 and over has stayed relatively stable at around 9 percent or 10 percent—much lower than the almost 30 percent it reached in the 1960s.
- Among the older population, older age is associated with higher rates of poverty (9 percent for ages 65–74 compared with 14 percent for age 85 and over). However, in the general population, children have had higher poverty rates than the working-age population for at least ten years. Children’s higher poverty rates are less pronounced when the Supplemental Poverty Measure, which takes into account noncash government benefits, is used.
- Among the population age 65 and over, poverty rates varied greatly by race and ethnicity as well as sex. For example, the older non-Hispanic White alone population had the lowest poverty rate (7 percent), followed by Asian alone (12 percent), and trailed by Hispanic and Black alone (19 percent and 20 percent, not statistically distinct).
- In general, older women experienced higher poverty rates than older men (11 percent versus 8 percent).
- Non-Hispanic White alone men had a poverty rate of 6 percent, while Hispanic women had a rate of 22 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 82–84.*

## 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, 1974–2018



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. A new processing system was implemented starting in 2017. 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 percent 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.

- In 2018, 10 percent of the older population age 65 and over lived in poverty, and 20 percent of the older population was in the low-income group. People in the high-income group made up the largest single share of older people by income category (40 percent) in 2018.
- The percentage of the population age 65 and over living in poverty and in the low-income group decreased 5 percentage points and 15 percentage points, respectively, between 1974 and 2018. The

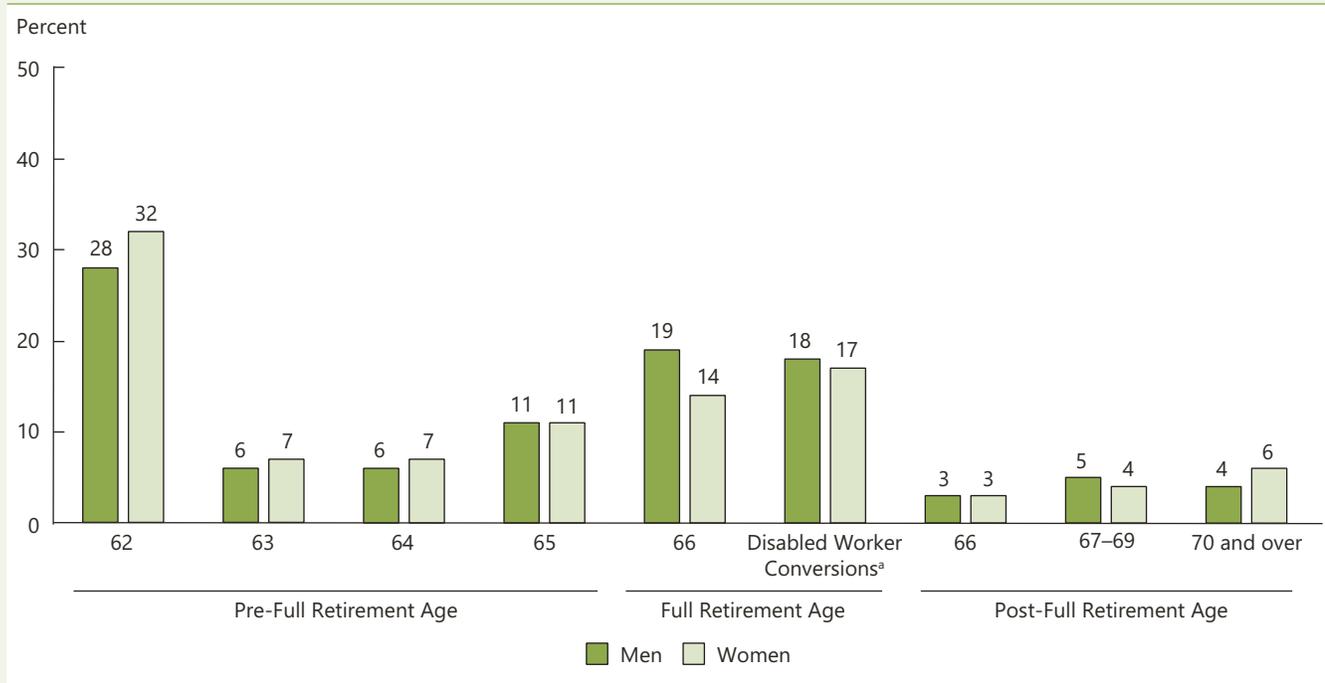
percentage of the older population in the middle-income group decreased from 33 percent in 1974 to 30 percent in 2018. The percentage with a high income increased 22 percentage points between 1974 and 2018.

*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 8a and 8b on pages 84–87.*

## INDICATOR 9: Social Security Beneficiaries

Social Security benefits provide a baseline for retirement income for the majority of older Americans and is one of the most important income sources for the aged. 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. Beneficiaries become entitled to payments once their application for benefits is approved.

**Percentage distribution of people who began receiving Social Security benefits in 2018, by age and sex**



<sup>a</sup> At Full Retirement Age (FRA), persons formerly receiving disabled worker benefits are reclassified and begin receiving retired worker benefits.

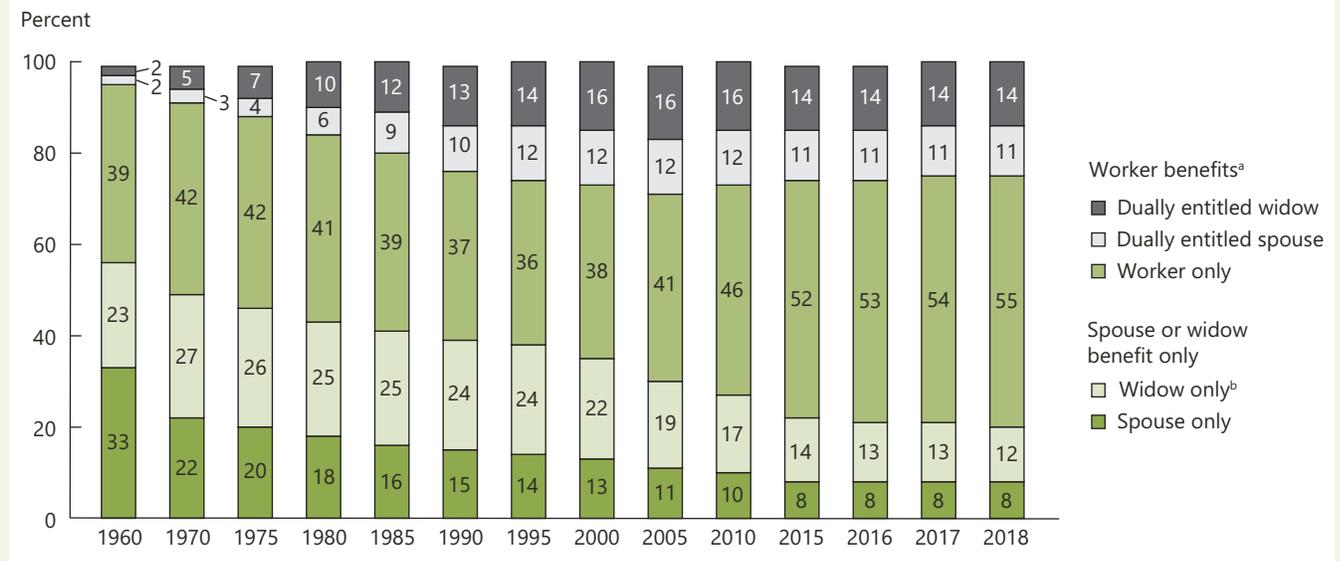
NOTE: FRA is defined as age 66 for those born between 1943 and 1955. The percentages are not probabilities of a birth cohort claiming at a particular age. A person begins receiving Social Security benefits the month after he or she becomes entitled. Totals may not sum to 100 percent because of rounding.

Reference population: Persons fully insured for Social Security retired worker benefits who became entitled to benefits in 2018.

SOURCE: Social Security Administration, Master Beneficiary Record.

- In 2018, the majority (54 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 2018, 28 percent of men and 32 percent of women became entitled at age 62, and about one-quarter of men and women became entitled at ages 63–65. In contrast, 19 percent of men and 14 percent of women became entitled at FRA, and few (12 percent of both men and women) became entitled post-FRA.
- Of new Social Security retired worker beneficiaries in 2018, 18 percent of men and 17 percent of women converted from receiving disabled worker benefits to receiving retired worker benefits at FRA.

## Percentage distribution of female Social Security beneficiaries age 62 and over, by type of benefit received, selected years 1960–2018



<sup>a</sup> Worker benefits include retired and disabled worker benefits.

<sup>b</sup> 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 2018, 80 percent of women beneficiaries age 62 and over received earned worker benefits. The remaining portion of women (20 percent) received benefits only as the spouse or surviving widow of an entitled worker. In 2018, about 8 percent of women received spouse-only benefits, and 12 percent received widow-only benefits.
- The type of benefits received by women age 62 and over dramatically changed between 1960 and 2018. The percentage of female Social Security beneficiaries who received spouse-only benefits decreased from 33 percent to 8 percent, and the percentage receiving widow-only benefits decreased from 23 percent to 12 percent. In contrast, the percentage of female

Social Security beneficiaries who received earned worker benefits increased from 43 percent in 1960 to 80 percent in 2018.

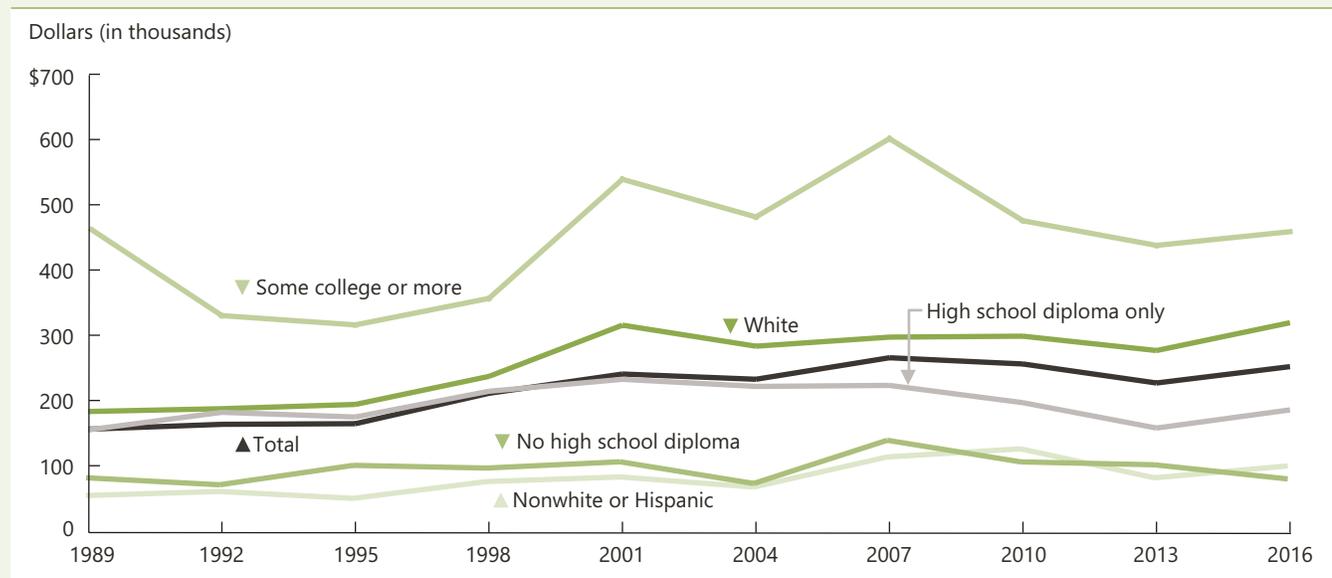
- Women entitled to their own earned worker benefits and to higher auxiliary benefits, such as spouse or widow benefits, are considered dually entitled. Of female Social Security beneficiaries age 62 and over in 2018, about 55 percent received only earned worker benefits, 11 percent received both earned worker and spouse benefits, and 14 percent received both earned worker and widow benefits.

*Data for this indicator's charts and bullets can be found in Tables 9a and 9b on page 88.*

## INDICATOR 10: 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 because of job loss, health problems, or family changes such as divorce.

### Median household net worth, in 2016 dollars, by race and educational attainment of head of household age 65 and over, selected years, 1989–2016



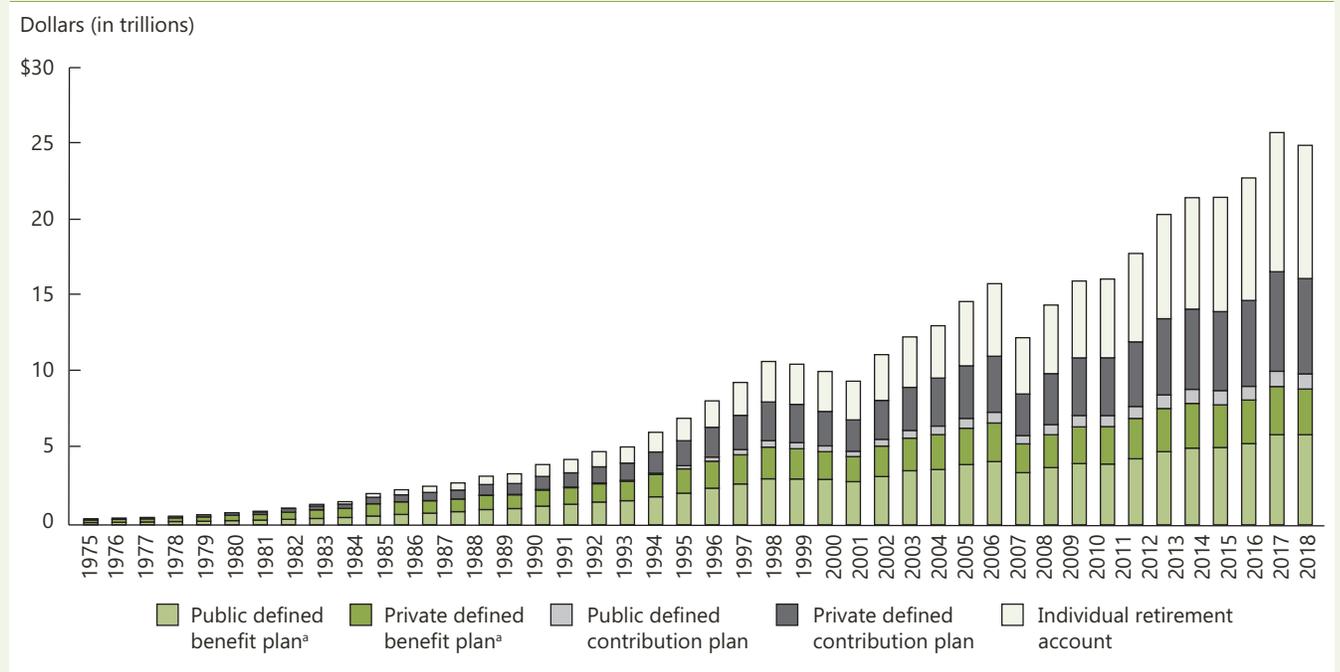
NOTE: Median net worth is measured in constant 2016 dollars. Net worth includes assets held in investment retirement accounts such as individual retirement accounts, Keoghs, and 401(k)-type plans. All observations are weighted for analysis. The term “household” in this indicator is from the codebook of the 2016 Survey of Consumer Finances (<https://www.federalreserve.gov/data.htm>). The data are for the “primary economic unit” (PEU), which 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. Some estimates have been revised and may differ from previous editions of *Older Americans*. Please note that the format of this indicator has changed from the previous edition. Changes to the indicator are to improve clarity and show trends over time.

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

SOURCE: Survey of Consumer Finances.

- In 2016, the median net worth, in 2016 dollars (including the value of retirement investment accounts), of households headed by people age 65 and over was \$253,800.
- Between 1989 and 2016, the median net worth, in 2016 dollars, of households headed by people age 65 and over increased by about 60 percent, from \$158,225 to \$253,800. The rate of change was quite variable during 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 1989 and 2016, the median net worth of households headed by White people age 65 and over increased by nearly 75 percent, from \$185,280 to \$320,920. The median net worth of households headed by nonwhite or Hispanic people age 65 and over almost doubled during the same period, increasing from \$56,853 to \$102,000.
- In 1989, the median net worth of households headed by White people age 65 and over was more than three times that of households headed by nonwhite or Hispanic people age 65 and over. In 2016, the median net worth of households headed by older White people was about three times that of households headed by older nonwhite or Hispanic people.
- Between 1989 and 2016, the median net worth of people age 65 and over either without a high school diploma or with some college had similar decreases (2 percent and 1 percent, respectively). In 2016, households headed by persons age 65 and over who attended college had a median net worth about five and a half times greater than persons without a high school diploma.

## Amount of funds held in retirement assets, by sector and type of plan, 1975–2018



<sup>a</sup> Public and private defined benefit retirement assets do not include claims of pension funds on sponsor.

NOTE: Some estimates have been revised and may differ from previous editions of *Older Americans*.

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

SOURCE: Federal Reserve Board Z.1 Statistical Release for Dec. 12, 2019.

- Retirement savings held in public and private pension plans or individual retirement accounts (IRAs) play a large role in the net worth of older Americans. In 2018, IRAs held about \$8.7 trillion in assets, public and private defined contribution plans held about \$7.2 trillion in assets, and public and private defined benefit plans held about \$8.9 trillion in assets.
- Between 1975 and 2018, an increasing proportion of retirement assets shifted from traditional defined

benefit plans to individual account-based retirement vehicles such as defined contribution plans and IRAs.

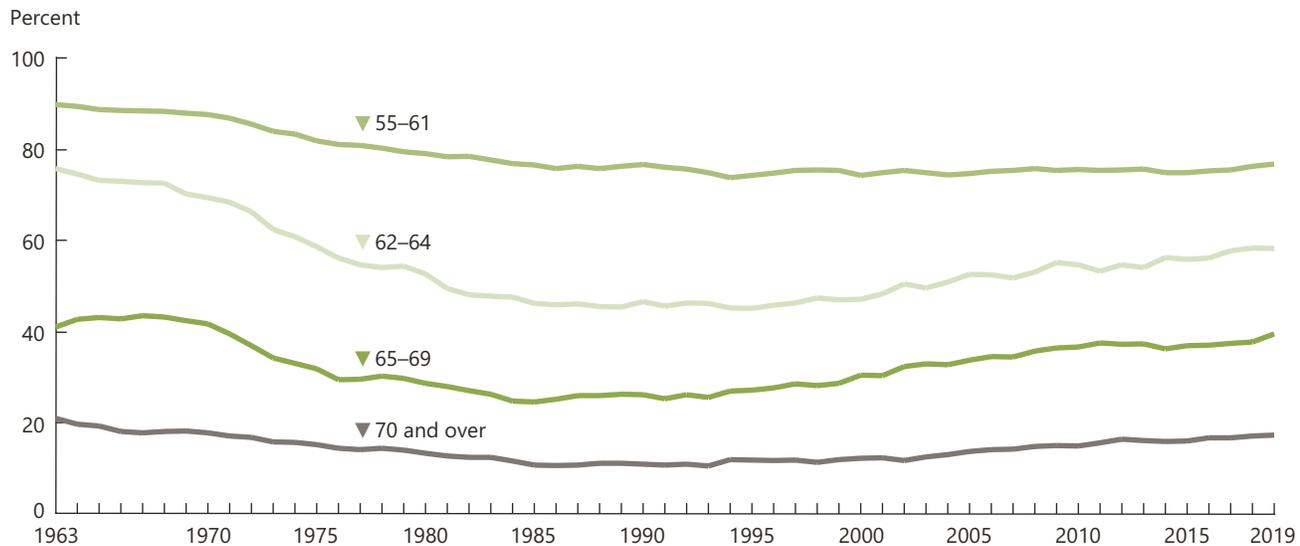
- Although defined contribution plans are more commonly provided in the private sector, defined benefit plans have been largely dominant in the public sector.

*Data for this indicator's charts and bullets can be found in Tables 10a through 10c on pages 89–91.*

## INDICATOR 11: 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 driven back into the job market or stay employed because of 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, 1963–2019**



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

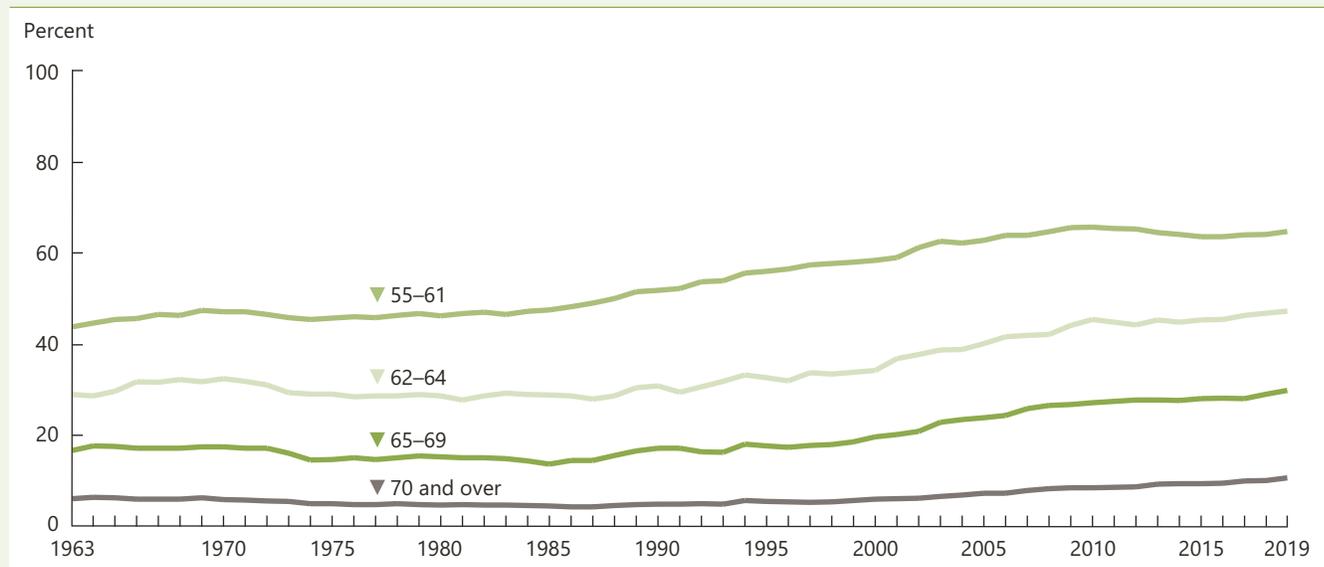
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: Bureau of Labor Statistics, Current Population Survey.

- In 2019, the labor force participation rate for men ages 55–61 was 77 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. By 2019, the participation rate for men ages 62–64 had increased to 58 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 percent to 26 percent. In the mid-1990s, the labor force participation rate for men in this age group began to increase and reached 39 percent in 2019.
- From 1963 to 2019, 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 and reached 17 percent in 2019.

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, 1963–2019



NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years because of 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.

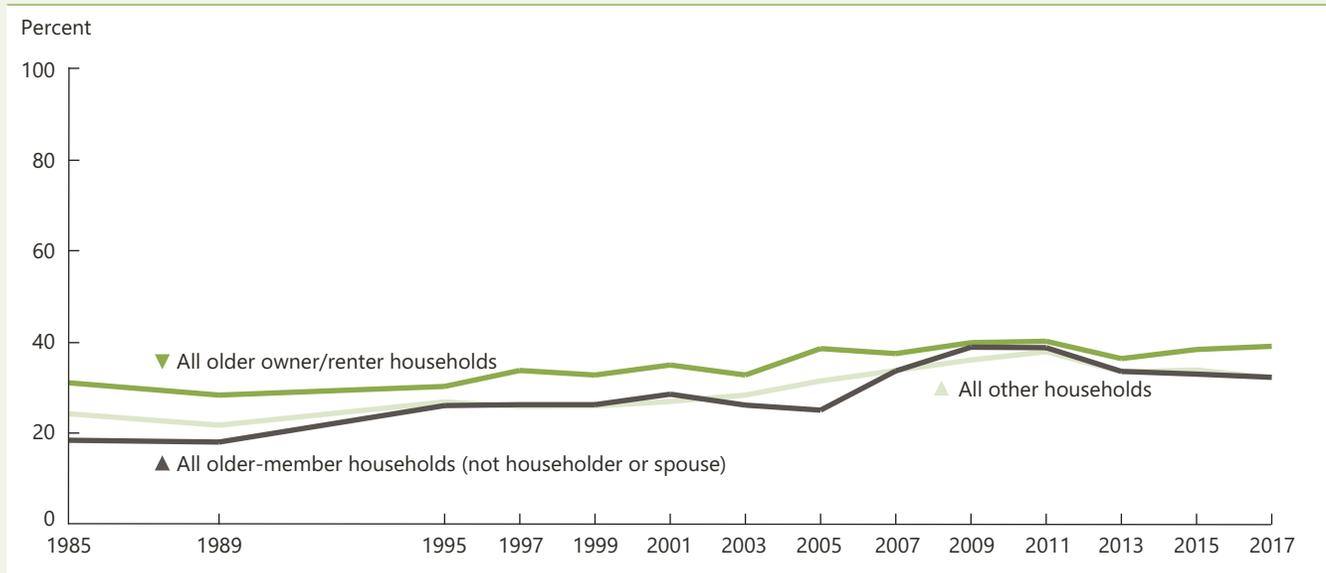
- In 2019, 65 percent of women ages 55–61 were in the labor force compared with 44 percent in 1963. During the same period, the labor force participation rate for women ages 62–64 increased from 29 percent to 47 percent, and the rate for women ages 65–69 increased from 17 percent to 30 percent.
- Among women age 55 and over, the labor force participation rate has been fairly stable since about 2010 after rising steadily in the prior four decades. During that rise, the increase has been largest among women ages 55–61, with participation rates rising from 44 percent in 1963 to 66 percent in 2010, but the rates have leveled off in recent years. For women ages 62–64, 65–69, and 70 and over, labor force participation rates continue to increase.
- 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 2019 was 12 percentage points, compared with 46 percentage points in 1963.

*Data for this indicator’s charts and bullets can be found in Table 11 on pages 92–93.*

## INDICATOR 12: Housing Problems

Most older Americans live in adequate, affordable housing. Some, however, live in costly, physically inadequate, and/or crowded housing, which can pose serious problems for an older person's physical or psychological well-being. Housing cost burden has remained the most prevalent housing problem for all older American households over the years. The prevalence of housing cost burden is examined for two different groups of older American households compared with all other U.S. households.

**Percentage of older American households and all other U.S. households that report housing cost burden, selected years 1985–2017**



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.

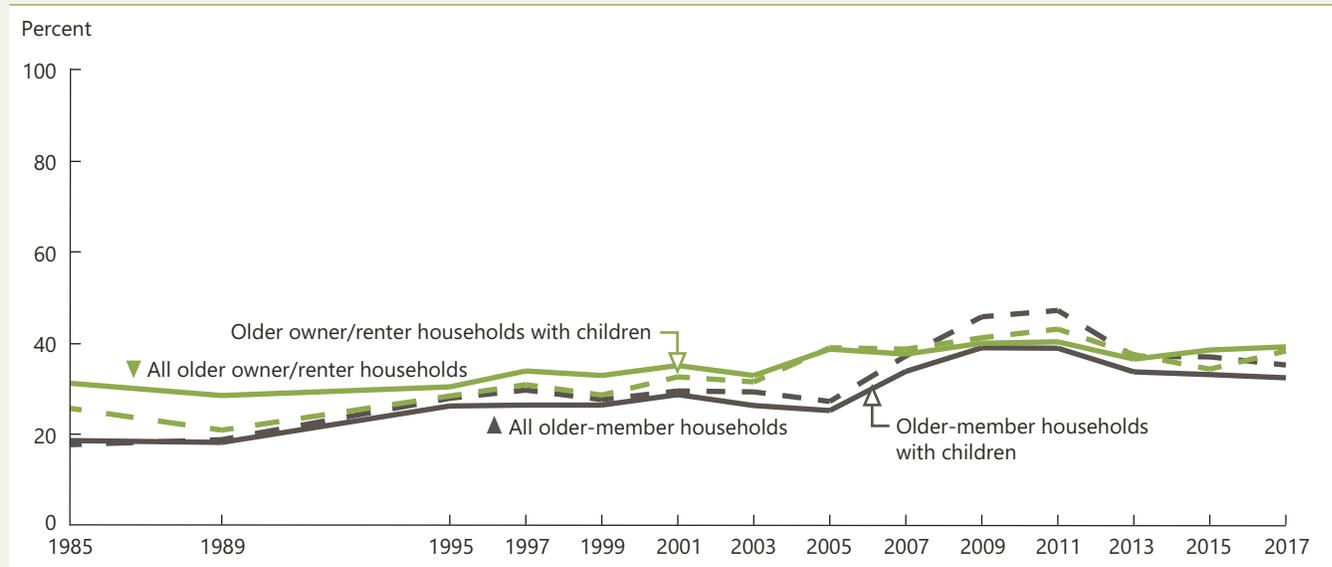
Reference population: These data refer to the resident noninstitutionalized population. People residing in noninstitutional group homes are excluded.

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

- The most prevalent housing problem for older American households remains housing cost burden (expenditures on housing and utilities that exceed 30 percent of household income). In 2017, approximately 39 percent of older-owner/renter households (households with a householder or spouse age 65 and over) and 32 percent of older-member households (households with a member age 65 and over who is not the householder or spouse) had housing cost burden problems.
- Housing cost burden has generally increased over time. Between 2013 and 2017, the prevalence of housing cost burden increased from 36 percent to 39 percent for older-owner/renter households, and there was no significant difference in the prevalence 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 34 percent to 32 percent during the same time period.

Housing cost burden is also the most dominant housing problem for intergenerational households, or households that have both older people (age 65 and over) and children (age 19 or younger) living in the household. Older owner/renter and older-member intergenerational households are likely to represent households in which grandparents are helping raise their grandchildren or in which three generations are living within the same household.

### Percentage of older American households and intergenerational households that report housing cost burden, selected years 1985–2017



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).

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.

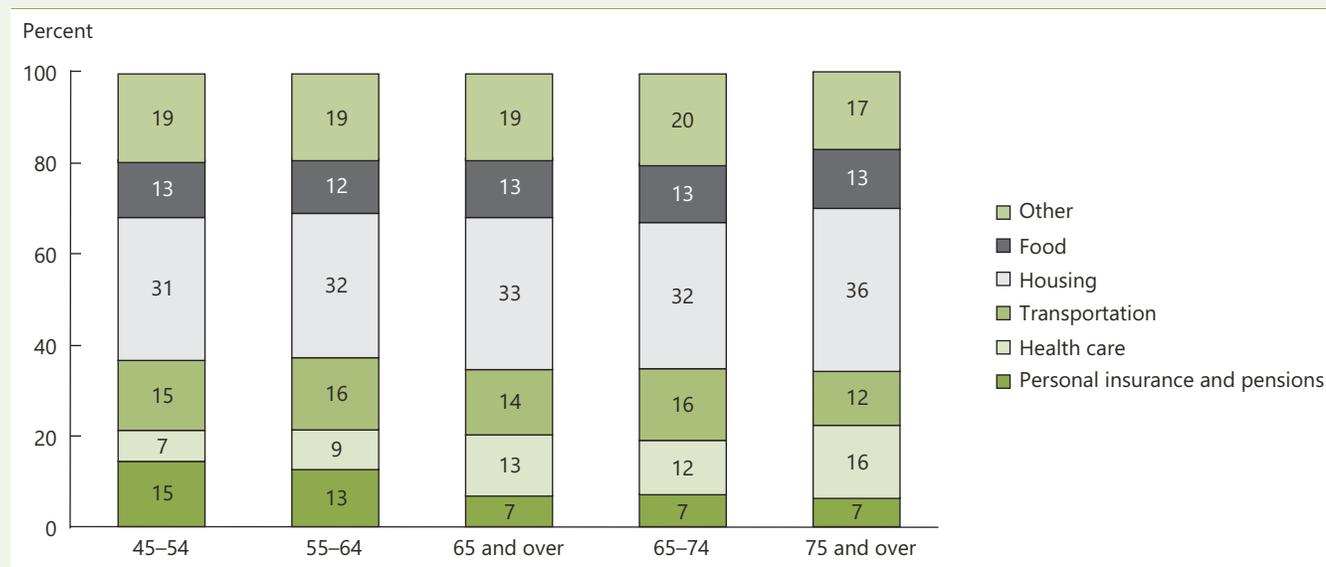
- In 2017, approximately 38 percent of older owner/renter intergenerational households had housing cost burden compared with 39 percent for all older owner/renter households. Approximately 35 percent of older-member intergenerational households had housing cost burden compared with 32 percent for all older-member households for the same time period.
- Although housing cost burden has typically increased over time, there was no significant difference in the prevalence of housing cost burden for older American intergenerational households between 2013 and 2017.
- From 2013 to 2017, the prevalence of housing cost burden remained at approximately 38 percent among older-renter/owner intergenerational households and approximately 36 percent among older-member intergenerational households.

*Data for this indicator's charts and bullets can be found in Tables 12a through 12f on pages 94–96.*

## INDICATOR 13: Total Expenditures

Household expenditures are another indicator of economic well-being, showing 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, 2018**



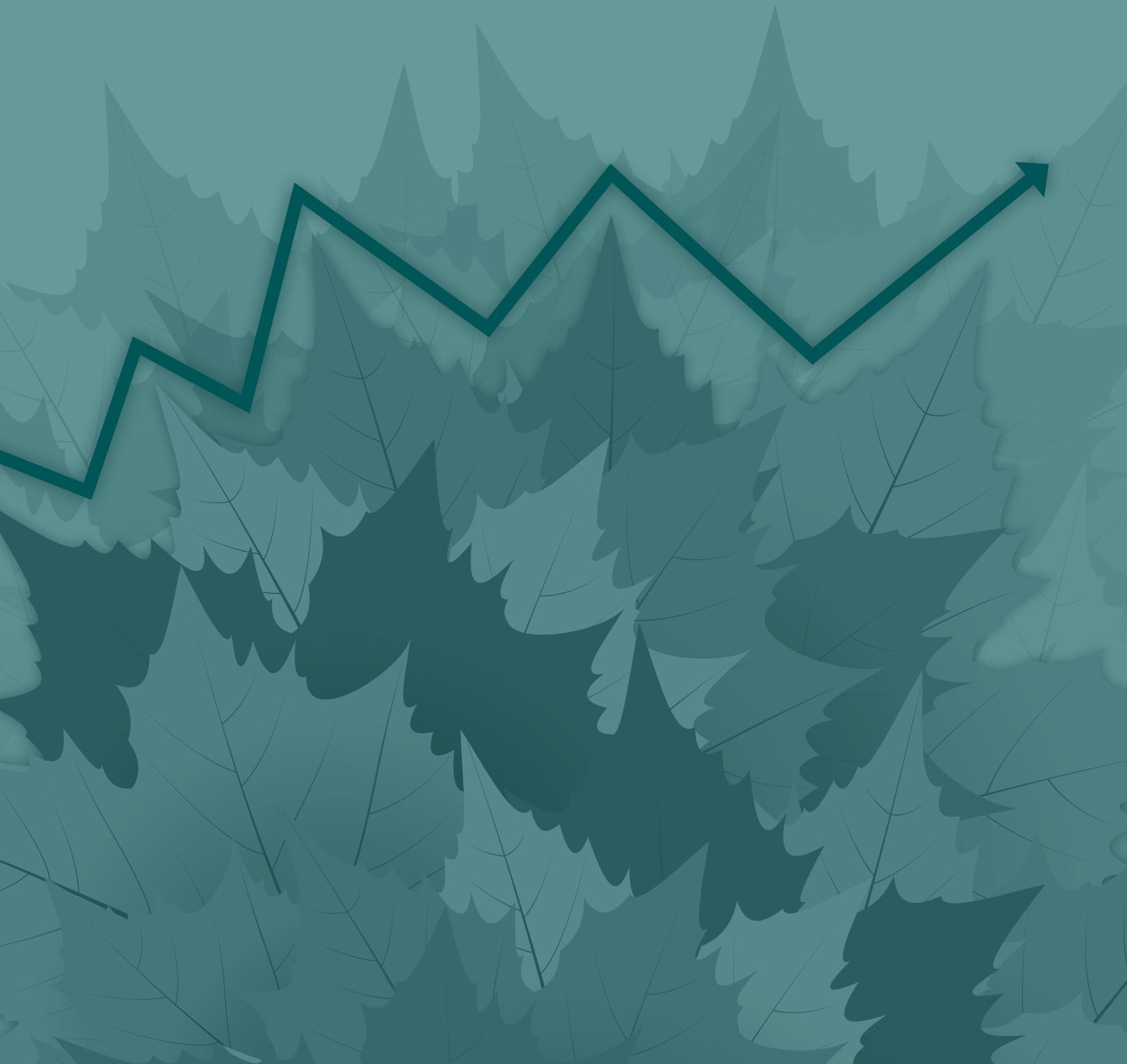
NOTE: Other expenditures include apparel, personal care, entertainment, reading, education, alcohol, tobacco, cash contributions, and miscellaneous expenditures. Data from the Consumer Expenditure Survey by age group represent average annual expenditures for consumer units by the age of the reference 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 the term "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 45 and over. In 2018, the share was 36 percent for households with a reference person age 75 and over.
- As a share of total expenditures, health care expenditures increased with age. For the group age 75 and over, the share (16 percent) was more than twice as high as it was for the group ages 45–54 (7 percent); in addition, the share that those age 75 and over allocated to health care was higher than this group allocated to food (13 percent) or transportation (12 percent). In contrast, for all three younger groups depicted (ages 45–54, 55–64, and 65–74), the health care share was smaller than either the food or transportation share.
- Among the age groups studied, the share of total expenditures allocated to food at home was higher than the share allocated to food away from home. However, for the oldest group (age 75 and over), the food at home share (8 percent) was nearly double the food away from home share (5 percent).

*Data for this indicator's charts and bullets can be found in Table 13 on page 97.*

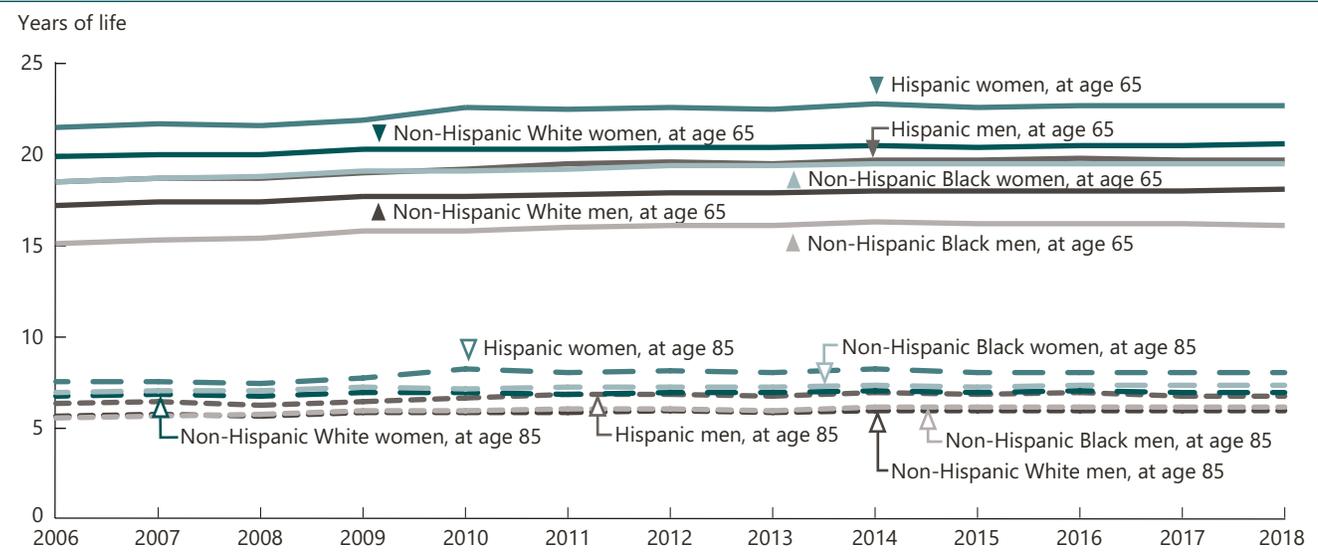


# Health Status

## INDICATOR 14: 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.<sup>9</sup> Life expectancy in the United States is lower than in many other industrialized countries.<sup>10</sup>

**Life expectancy at ages 65 and 85, by race and Hispanic origin and sex, 2006–2018**



NOTE: Starting with 2018 data, race-specific estimates are tabulated according to the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity and are not completely comparable with estimates for earlier years. Persons of Hispanic origin may be of any race.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

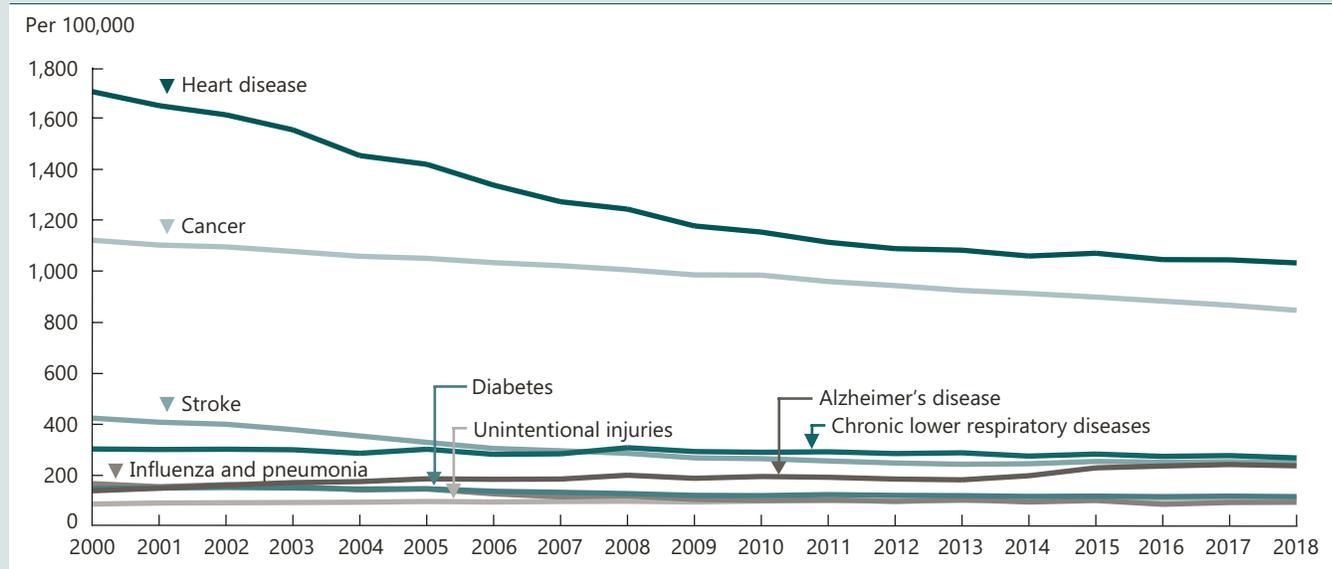
- Under current mortality conditions, people who survive to age 65 can expect to live an average of 19.5 more years overall, 18.1 years for men and 20.7 years for women. In 2018, the life expectancy of people who survive to age 85 was 7.0 years for women and 6.0 years for men.
- Older Americans are living longer. Life expectancies at both age 65 and age 85 have increased for both sexes and for Hispanics, non-Hispanic Whites, and non-Hispanic Blacks. Overall for men, life expectancy at age 65 increased from 17.2 years to 18.1 years from 2006 to 2018, while the increase for women overall was from 19.9 years to 20.7 years. During the same period, life expectancy at age 85 increased from 5.6 years to 6.0 years for men and from 6.7 years to 7.0 years for women.
- In 2018, life expectancy at age 65 was higher among Hispanics than among non-Hispanic Whites and non-Hispanic Blacks for both men and women (19.7, 18.1, and 16.1 years, respectively, for men and 22.7, 20.6, and 19.5 years, respectively, for women). Life expectancy at age 85 was highest among Hispanics (6.7 years for men and 8.0 years for women), but non-Hispanic Blacks had higher life expectancy than non-Hispanic Whites (6.1 years versus 5.9 years for men and 7.3 years versus 6.9 years for women).

*Data for this indicator's charts and bullets can be found in Table 14 on page 98.*

## INDICATOR 15: 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.<sup>11</sup>

**Death rates among people age 65 and over, by selected leading causes of death, 2000–2018**



NOTE: Rates are age adjusted using the 2000 U.S. standard population.  
Reference population: These data refer to the resident population.  
SOURCE: National Center for Health Statistics, National Vital Statistics System.

- In 2018, the leading cause of death among people age 65 and over was heart disease (1,035 deaths per 100,000 U.S. standard population), followed by cancer (849), chronic lower respiratory diseases (270), stroke (252), Alzheimer's disease (239), diabetes (118), unintentional injuries (112), and influenza and pneumonia (96).
- Between 2000 and 2018, the age-adjusted death rate for people age 65 and over declined by 20 percent. Death rates declined for heart disease, cancer, chronic lower respiratory diseases, stroke, diabetes, and influenza and pneumonia. Death rates for Alzheimer's disease and unintentional injuries increased during the same period.
- Heart disease and cancer were the top two leading causes of death in 2018 among all people age 65 and

over. They were also the top two leading causes of death for both men and women with men having higher rates of both causes (1,273 per 100,000 U.S. standard population compared with 856 for heart disease and 1,052 versus 702 for cancer).

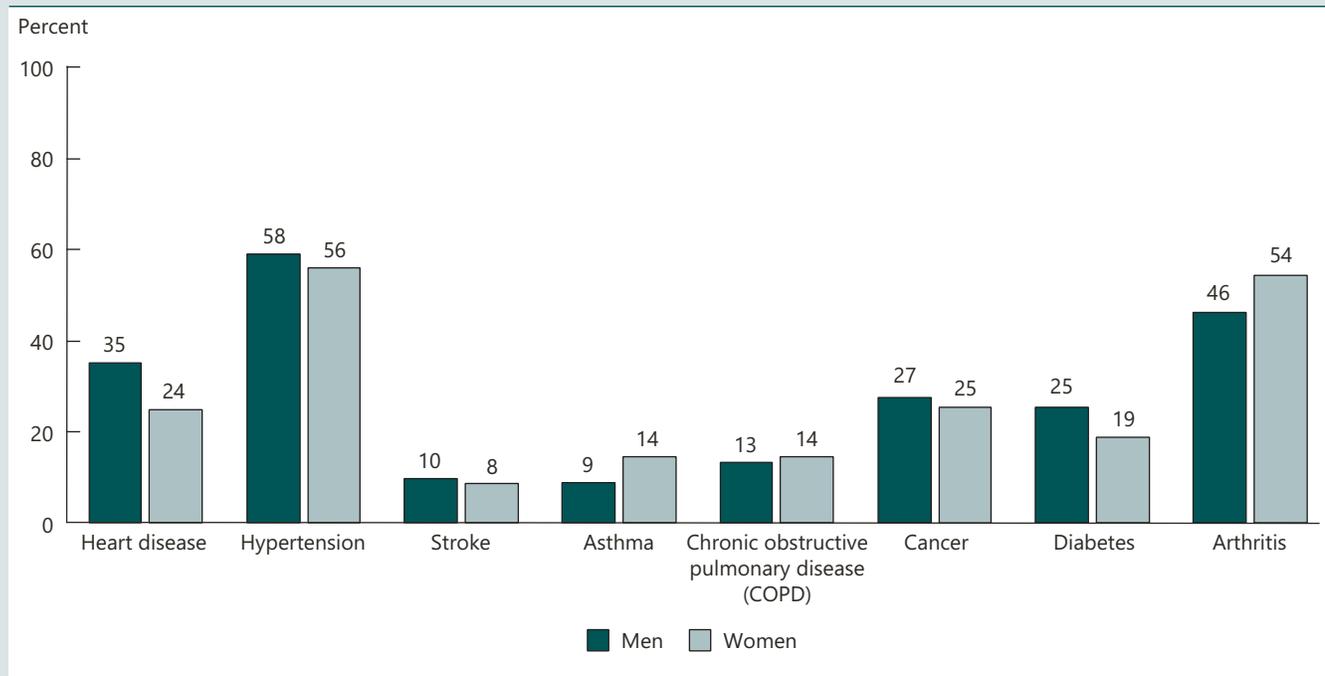
- Other causes of death also varied among older Americans by sex. For example, in 2018, women had higher age-adjusted death rates from Alzheimer's disease than men (268 per 100,000 U.S. standard population compared with 192), while men had higher age-adjusted rates of death from unintentional injuries (141 per 100,000 U.S. standard population compared with 90).

*Data for this indicator's charts and bullets can be found in Tables 15a and 15b on pages 99–100.*

## INDICATOR 16: Chronic Health Conditions

The risk of chronic diseases increases with age.<sup>12</sup> Chronic conditions usually require ongoing medical care and are major contributors to health care costs.<sup>13</sup> The majority of older adults have multiple chronic conditions, which contribute to frailty and disability.<sup>14</sup> Many of the negative effects of chronic conditions are caused by health risk behaviors that can be changed.<sup>13</sup> The six leading causes of death among older Americans in 2018 were chronic diseases (see Indicator 15: Mortality).

**Percentage of people age 65 and over who reported having selected chronic health conditions, by sex, 2018**



NOTE: Chronic obstructive pulmonary disease (COPD) is defined as responding yes to questions on ever having emphysema, COPD, or having chronic bronchitis in the past 12 months. This definition has changed from previous editions of *Older Americans*.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey.

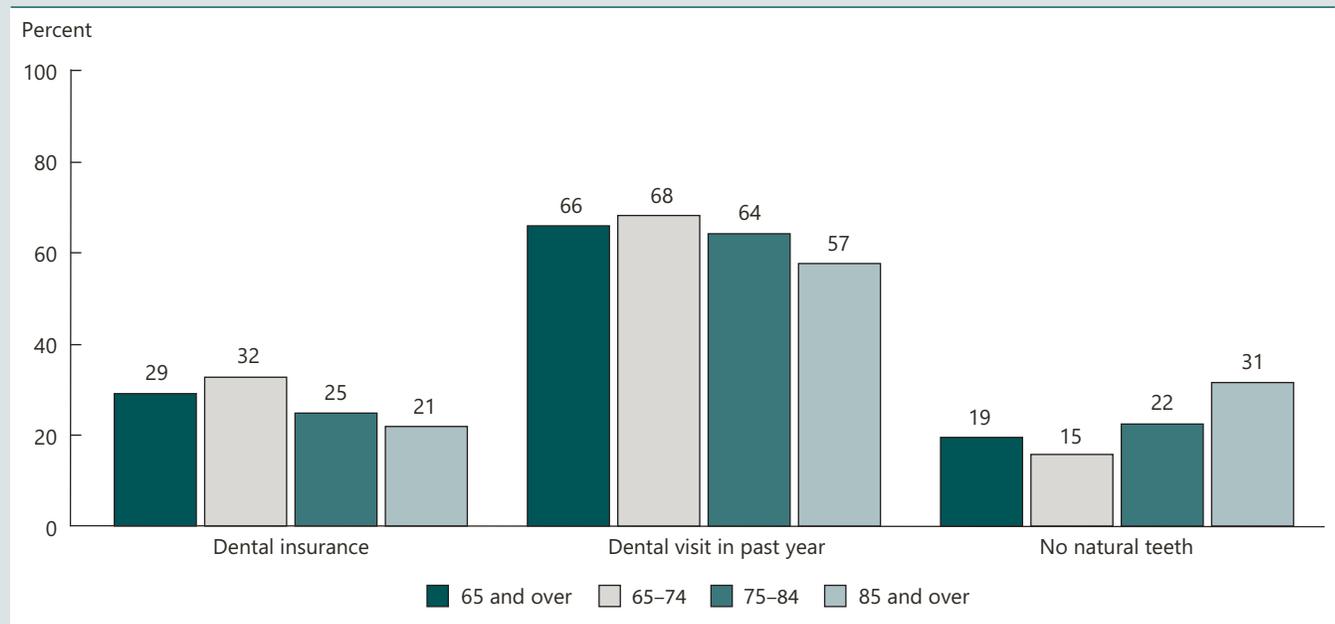
- In 2018, the prevalence of certain chronic health conditions differed by sex. Women reported higher levels of asthma and arthritis than men (14 percent and 54 percent versus 9 percent and 46 percent, respectively). Men reported higher levels of heart disease (35 percent), hypertension (58 percent), cancer (27 percent), and diabetes (25 percent) than women (24 percent, 56 percent, 25 percent, and 19 percent, respectively).
- There were differences by race and ethnicity in the prevalence of certain chronic health conditions. In 2018, among people age 65 and over, non-Hispanic Blacks reported higher levels of hypertension and diabetes than non-Hispanic Whites (68 percent versus 55 percent for hypertension, and 34 percent versus 18 percent for diabetes). Hispanics also reported higher levels of diabetes (33 percent) than non-Hispanic Whites, but lower levels of arthritis than non-Hispanic Whites (44 percent versus 52 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, chronic obstructive pulmonary disease (COPD), cancer, and diabetes was higher in 2018 compared with 1997. Also, the prevalence of arthritis was higher in 2018 compared with 2002.

*Data for this indicator's charts and bullets can be found in Tables 16a and 16b on page 101.*

## INDICATOR 17: 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.<sup>15</sup> 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, or had no natural teeth, by age group, 2018**



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: National Center for Health Statistics, National Health Interview Survey.

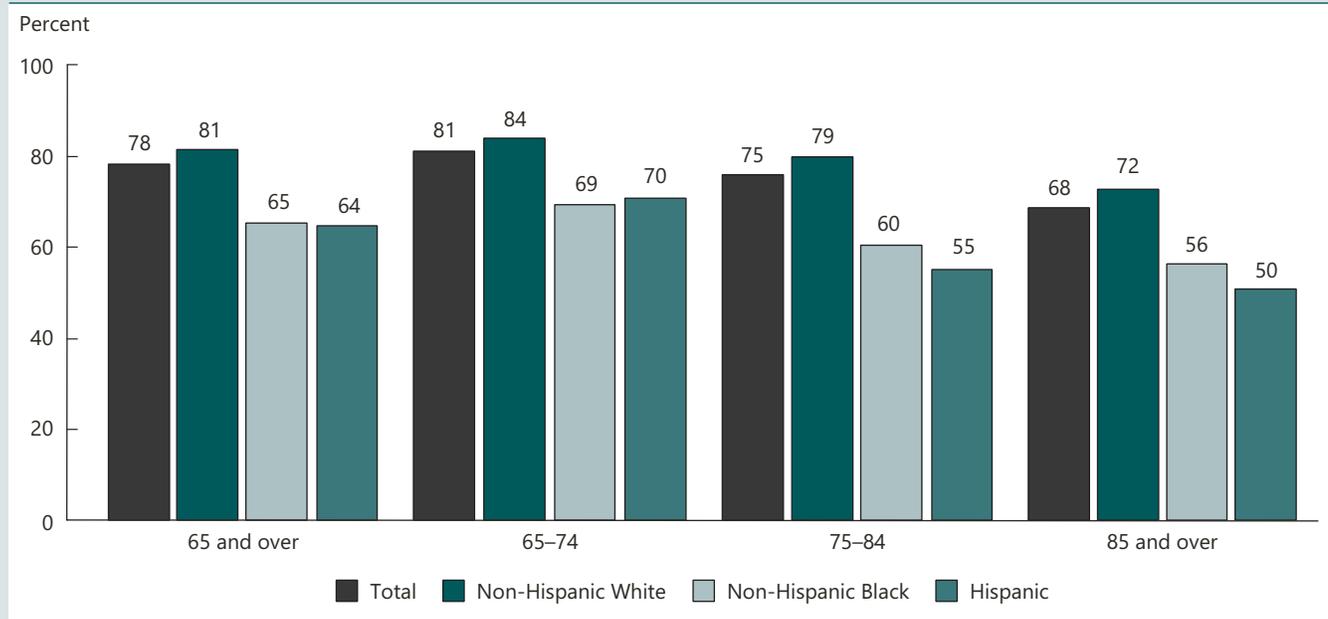
- About 29 percent of people age 65 and over reported having dental insurance in 2018. The percentage with dental insurance declines with age, from 32 percent among people ages 65–74 to 21 percent among people age 85 and over.
- In 2018, about 66 percent of people age 65 and over had a dental visit in the past year. The percentage visiting a dentist was higher among people ages 65–74 than among people age 85 and over (68 percent versus 57 percent).
- The prevalence of edentulism, having no natural teeth, was about twice as high among people age 85 and over (31 percent) as among people ages 65–74 (15 percent).
- Similar percentages of men and women age 65 and over in 2018 had dental insurance, had a dental visit in the past year, and had no natural teeth.
- Non-Hispanic White people age 65 and over had lower levels of edentulism than non-Hispanic Blacks and Hispanics (18 percent versus 28 percent and 23 percent, respectively) and higher levels of dental visits than non-Hispanic Blacks and Hispanics.

*Data for this indicator's charts and bullets can be found in Tables 17a and 17b on page 102.*

## INDICATOR 18: 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.<sup>16,17</sup>

**Percentage of people age 65 and over with respondent-assessed good to excellent health status, by age group and race and Hispanic origin, 2018**



NOTE: 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: National Center for Health Statistics, National Health Interview Survey.

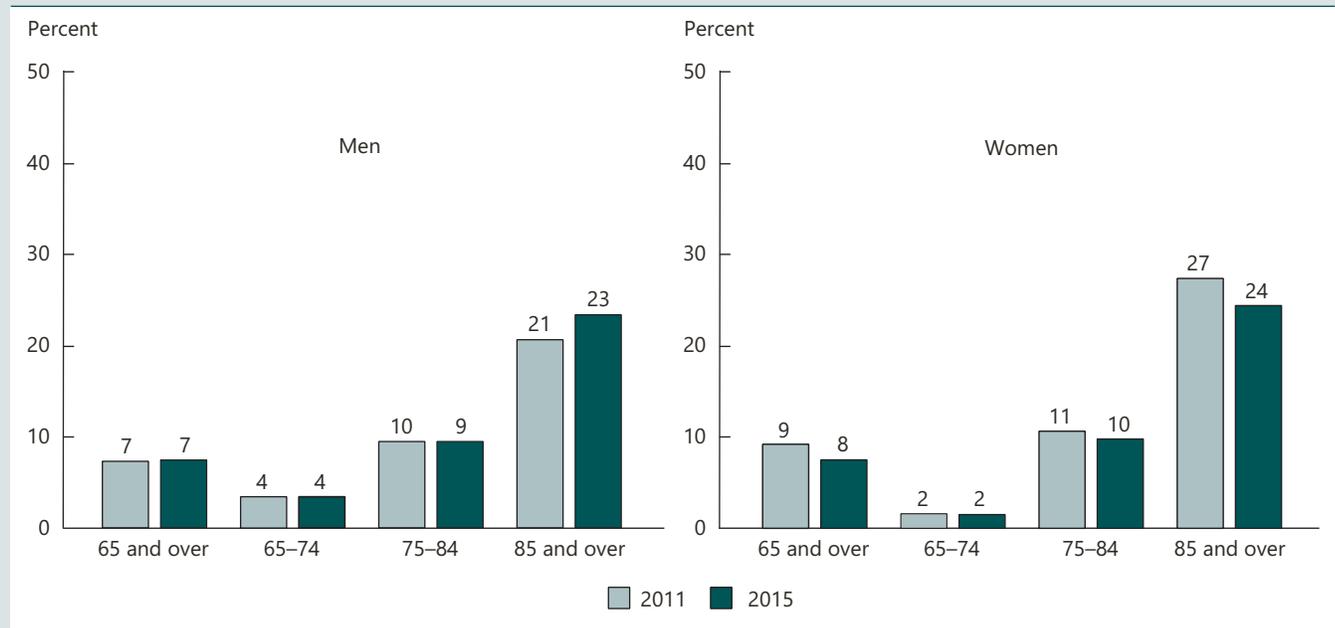
- In 2018, 78 percent of people age 65 and over rated their health as good, very good, or excellent. The levels of health reported by older men and older women were similar.
- The proportion of people reporting good to excellent health was lower among the oldest age groups. Eighty-one percent of those ages 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. Eighty-two percent of non-Hispanic White women age 65 and over reported good to excellent health compared with 65 percent of non-Hispanic Blacks and 61 percent of Hispanics. Among men, the percentages were 80 percent for non-Hispanic White men and 66 percent and 68 percent for non-Hispanic Black and Hispanic men, respectively.

*Data for this indicator's charts and bullets can be found in Table 18 on page 103.*

## INDICATOR 19: 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 15: Mortality). Dementia is a condition overwhelmingly faced by older adults, although it sometimes affects 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 and 2015**



NOTE: The estimate of dementia includes Alzheimer's disease and other related dementias such as frontotemporal, Lewy body, mixed, and vascular dementia. 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. To minimize potential learning bias and to be classified as having dementia, participants must meet criteria for dementia in two subsequent NHATS rounds, or meet dementia criteria in one round followed by death or loss to follow up in the next round, as described in Freedman, Kaspar, Spillman, and Plassman (2018).<sup>18</sup> Data from 2011 have been revised with the two-round dementia criteria and differ from Indicator 20: Dementia in *Older Americans* 2016.

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

SOURCE: Office of the Assistant Secretary for Planning and Evaluation, National Health and Aging Trends Study.

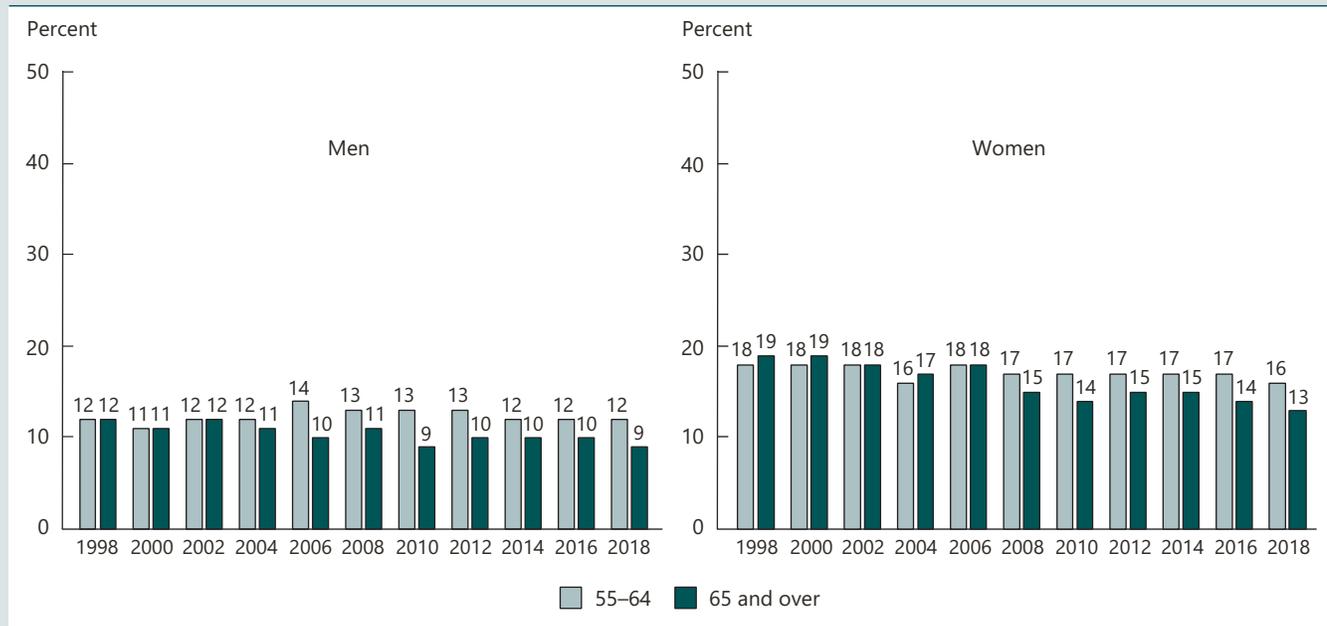
- In 2015, 7.4 percent of men (1.4 million) and 7.5 percent of women (1.7 million) age 65 and over not living in nursing homes had dementia. Despite similar overall percentages with dementia in 2015 among women and men, the size of the population of women in these age groups was larger than that of men. As a result, far more women than men had dementia at older ages. Among those age 85 and over, 24.4 percent of women (830,000) and 23.4 percent of men (440,000) had dementia.
- The prevalence of dementia among people age 65 and over remained largely unchanged for men between 2011 and 2015 but declined for women from 9.2 percent to 7.5 percent. Declines in prevalence were observed for women in all age groups, while prevalence among men was unchanged at younger ages and rose slightly in those age 85 and over (from 20.8 percent in 2011 to 23.4 percent in 2015).
- The prevalence of dementia decreases with educational level. In both 2011 and 2015, among people age 65 and over, approximately 16 percent with less than a high school education had dementia compared with 4 percent of people who had a bachelor's degree or more. These differences by educational level were similar for both men and women and across age groups.

*Data for this indicator's charts and bullets can be found in Tables 19a through 19e on pages 104–105.*

## INDICATOR 20: 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,<sup>19</sup> and dementia.<sup>20</sup>

**Percentage of people age 55 and over with clinically relevant depressive symptoms, by sex and age group, selected years, 1998–2018**



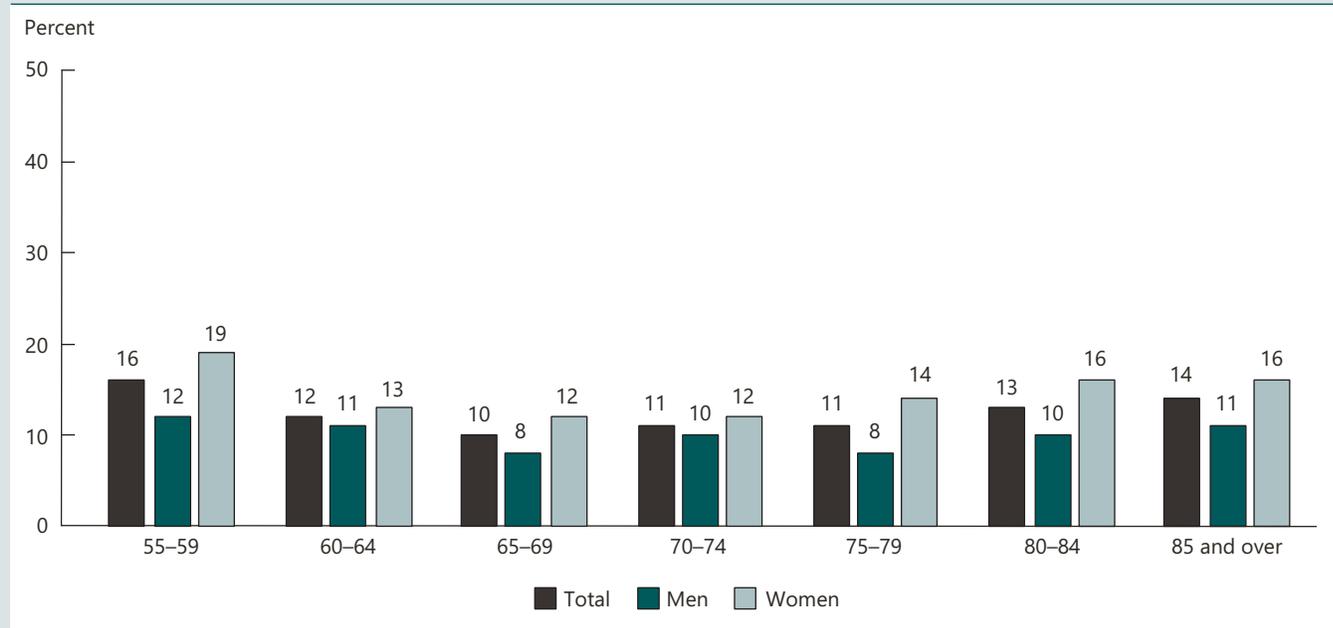
NOTE: The definition of “clinically relevant depressive symptoms” is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D), adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the “four or more symptoms” cutoff can be found at <https://hrs.isr.umich.edu/publications/biblio/5411>. Percentages are based on weighted data using the respondent weights from the HRS Tracker file. Age ranges used in previous versions of *Older Americans* were updated.

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

SOURCE: National Institute on Aging, Health and Retirement Study.

- Older women were more likely to report clinically relevant depressive symptoms than older men. In 2018, 13 percent of women age 65 and over reported clinically relevant depressive symptoms compared with 9 percent of men. There was no significant change between the sexes in this difference from 1998 to 2018. A slight downward trend is apparent for women in this age group, going from 19 percent in 1998 to 13 percent in 2018.
- The percentage of people ages 55–64 reporting clinically relevant symptoms remained relatively stable during the period. Between 1998 and 2018, the percentage of men in this age group who reported clinically relevant depressive symptoms ranged between 11 percent and 14 percent. For women in this age group, the percentage reporting these symptoms ranged between 16 percent and 18 percent.

## Percentage of people age 55 and over with clinically relevant depressive symptoms, by age group and sex, 2018



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” cutoff can be found at <https://hrs.isr.umich.edu/publications/biblio/5411>. Percentages are based on weighted data using the respondent weights from the HRS Tracker file. Age ranges used in previous versions of *Older Americans* were updated.

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

SOURCE: National Institute on Aging, Health and Retirement Study.

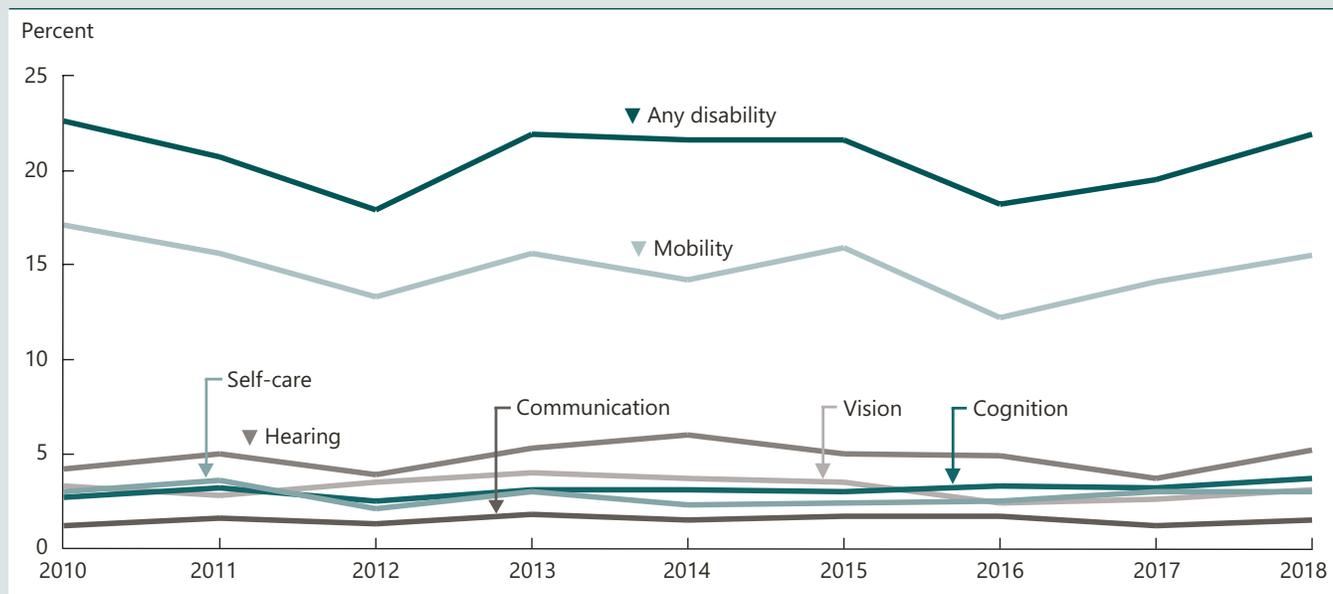
- The prevalence of depressive symptoms varies by age. In 2018, the percentage of people with clinically relevant depressive symptoms was higher for the youngest age group (16 percent among those ages 55–59) and the oldest age group (14 percent for those age 85 and over) than for people ages 65–69 (14 percent).
- In 2018, for both sexes, a U-shaped pattern is apparent in the prevalence of clinically relevant depressive symptoms. It is especially pronounced for women, with the highest prevalence for those ages 55–59 (19 percent) and those ages 80–84 and 85 and over (both 16 percent) and lowest for women in their late 60s and early 70s (both 12 percent).

*Data for this indicator's charts and bullets can be found in Tables 20a and 20b on page 106.*

## INDICATOR 21: 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 functional domain, 2010–2018**



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 a lot of difficulty or being unable to do at least one of these activities.

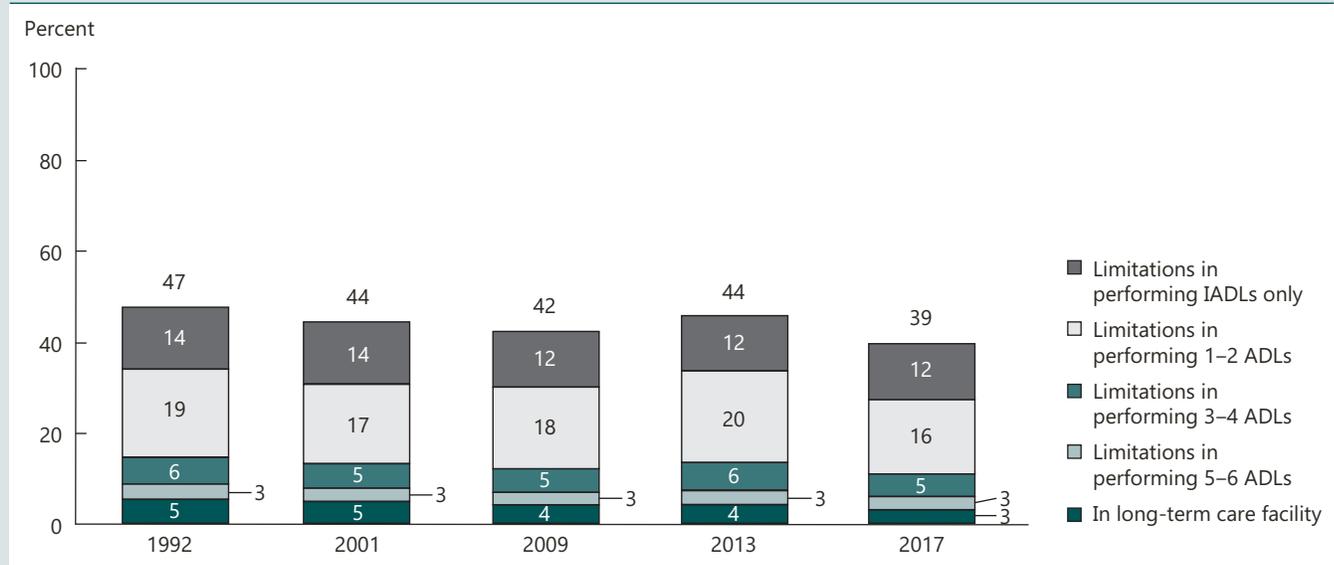
Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health Interview Survey.

- In 2018, 22 percent of the population age 65 and over reported having a disability as defined by having a lot of difficulty or being unable to do at least one of the following functioning domains: vision, hearing, mobility, communication, cognition, or self-care.
- Between 2010 and 2018, the percentage of people age 65 and over who had any disability was stable.
- Difficulties with mobility (walking or climbing stairs) were the most commonly reported disability for those age 65 and over in 2018 (16 percent), followed by hearing (5 percent), cognition (4 percent), and vision and self-care (3 percent each).
- Women were more likely to report any disability than men (24 percent versus 20 percent). Levels of disability in vision and mobility were also higher for women than men (4 percent and 18 percent versus 3 percent and 13 percent, respectively). Men reported higher levels of hearing disability than women (7 percent versus 4 percent).
- Disability increases with age. In 2018, 46 percent of people age 85 and over reported any disability, compared with 16 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 Whites age 65 and over were less likely to report having any disability than non-Hispanic Blacks or Hispanics (21 percent versus 29 percent and 27 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 for planning 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 1992–2017**



NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; 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 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. Some estimates 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 Medicare beneficiaries who were continuously enrolled during the year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1992–2013) and Survey File (2015–2017).

- In 2017, 39 percent of people age 65 and over enrolled in Medicare reported limitations in ADLs, IADLs, 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 24 percent had difficulty performing at least one ADL, and 3 percent were in a facility.
- The proportion of people age 65 and over with limitations in ADLs, IADLs, or who were living in a long-term care facility, was lower in 2017 than in 1992 (39 percent versus 47 percent).
- Women reported higher levels of limitations than men. In 2017, about 46 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 31 percent of male Medicare beneficiaries in this age group.
- Levels of limitation varied by age. Among Medicare beneficiaries age 85 and over, 70 percent had difficulty performing ADLs or IADLs or were in a long-term care facility compared with 44 percent of people ages 75–84 and 30 percent of people ages 65–74.

Data for this indicator's charts and bullets can be found in Tables 21a through 21e on pages 107–109.



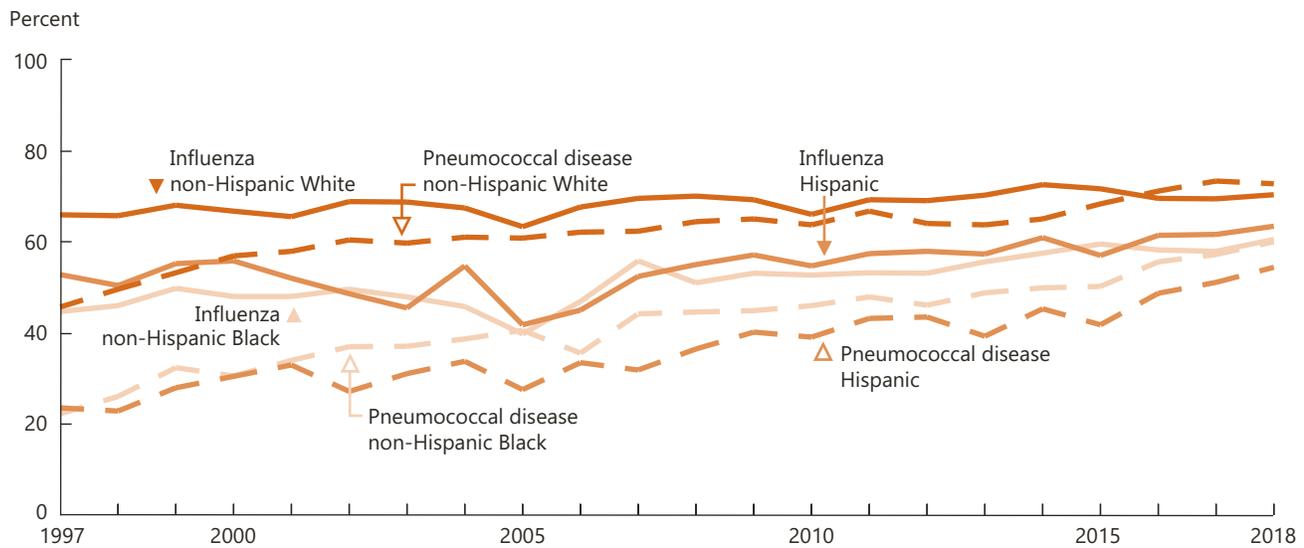


# Health Risks and Behaviors

## INDICATOR 22: 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.<sup>21,22,23</sup> 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, 1997–2018**



NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu vaccination 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 shot; some people receive more than one pneumonia vaccination in their lifetime. Questions concerning the use of influenza and pneumonia vaccination differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States, 2017*, Appendix II. 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: National Center for Health Statistics, National Health Interview Survey.

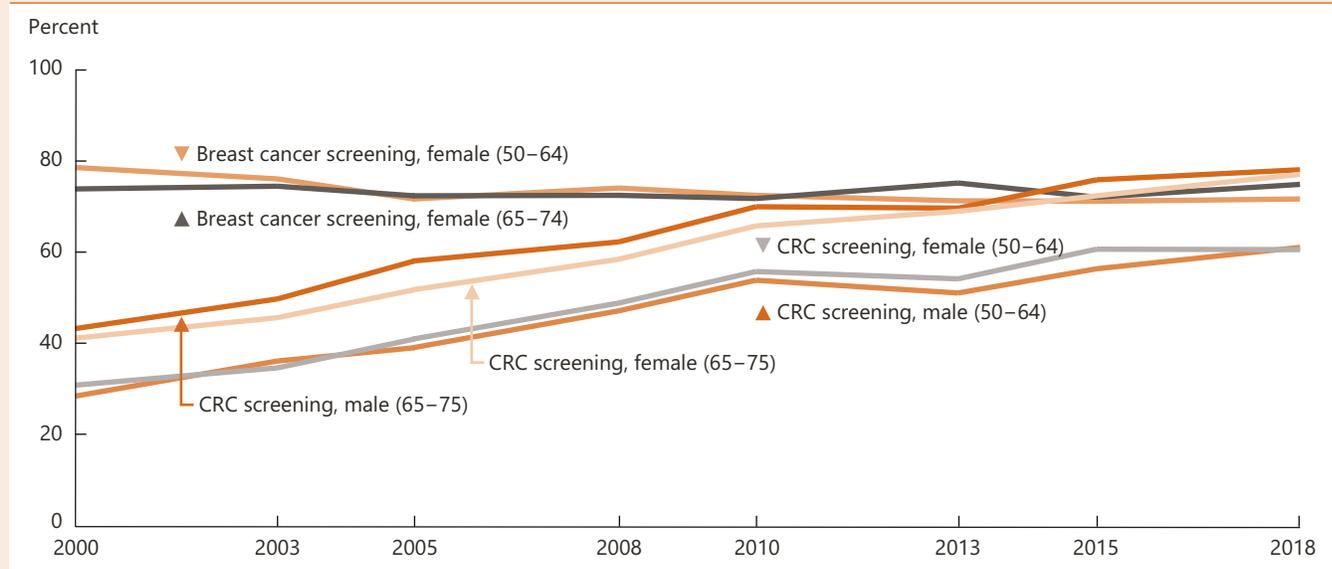
- In 2018, 69 percent of people age 65 and over reported receiving a flu vaccination in the past 12 months; however, there were differences by race and ethnicity. About 70 percent of non-Hispanic Whites reported receiving a flu vaccination compared with 60 percent of non-Hispanic Blacks and 63 percent of Hispanics.
- In 2018, 69 percent of people age 65 and over had ever received a pneumonia vaccination. Non-Hispanic Whites (73 percent) were more likely to have ever received a pneumonia vaccination than non-Hispanic Blacks (60 percent) or Hispanics (54 percent).
- The percentage of people age 65 and over who received a flu vaccination in the past 12 months increased during the past two decades. Increases were seen among non-Hispanic Whites, non-Hispanic Blacks, and Hispanics. Similarly, increases were observed among these groups in the percentage ever having received a pneumonia vaccination.
- The percentage of older people receiving vaccinations increased with age. In 2018, about 77 percent of persons age 85 and over had received a flu vaccination compared with 65 percent of persons ages 65–74. In that same year, 76 percent of persons age 85 and over had ever received a pneumonia vaccination compared with 65 percent of persons ages 65–74.
- In 2018, people age 65 and over who had not graduated from high school were less likely to be vaccinated against pneumonia than were people who had more than a high school education (60 percent versus 71 percent).

*Data for this indicator's charts and bullets can be found in Tables 22a and 22b on page 110.*

## INDICATOR 23: 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.<sup>24,25</sup>

**Percentage of women ages 50–74 who had breast cancer screening and percentage of people ages 50–75 who had colorectal cancer (CRC) screening, by sex and age group, selected years, 2000–2018**



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 the 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, 2017*, 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: National Center for Health Statistics, National Health Interview Survey.

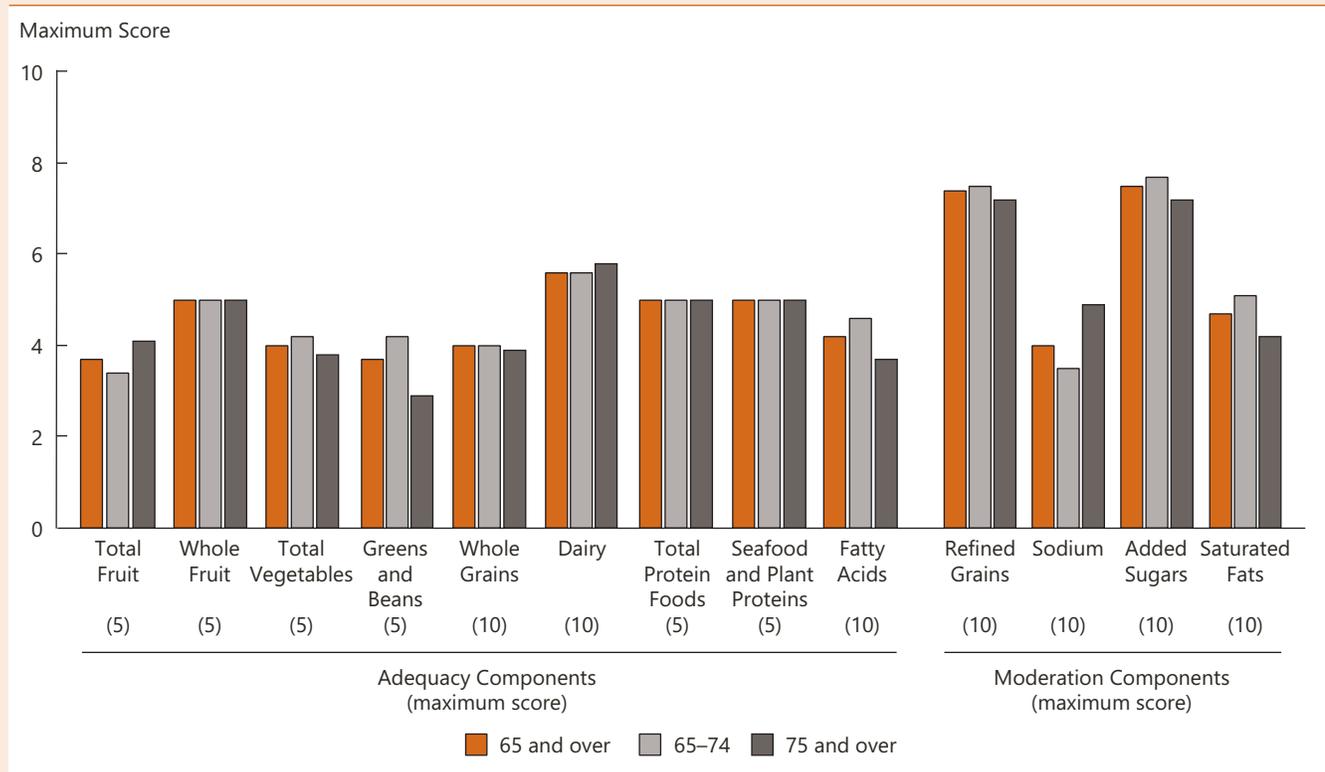
- In 2018, the percentage receiving colorectal cancer screening was higher among people ages 65–75 than among people ages 50–64 (78 percent versus 61 percent for men and 77 percent versus 61 percent for women).
- A higher proportion of women ages 65–74 in 2018 received a mammogram in the past 2 years compared with women ages 50–64 (75 percent versus 72 percent).
- The percentage of people ages 50–75 who received colorectal cancer screening increased from 2000 to 2018. The percentage increased for both men and women.
- The percentage of women ages 50–64 who received a mammogram in the past 2 years was lower in 2018 compared with 2000 (72 percent versus 79 percent). There was no significant difference between 2000 and 2018 in the percentage of women ages 65–74 receiving a mammogram.
- In 2018, there were no significant differences by sex among people ages 50–64 and ages 65–75 in the percentage who received colorectal cancer screening.

*Data for this indicator's charts and bullets can be found in Table 23 on page 111.*

## INDICATOR 24: Diet Quality

The Healthy Eating Index-2015 (HEI-2015) is a measure of diet quality used to assess how well a set of foods aligns with key recommendations of the *2015–2020 Dietary Guidelines for Americans*.<sup>26,27</sup> The HEI-2015 total and component scores in this analysis are averages across older Americans and reflect usual dietary intakes. The diet quality of older Americans can improve by shifting choices across and within food groups<sup>28</sup> and making nutrient dense food choices. Diet quality focuses on the totality of what people eat and drink on multiple eating occasions over time, both at home and away from home.

### Average diet quality scores<sup>a</sup> using the Healthy Eating Index-2015 for the population age 65 and over, by age group, 2015–2016



<sup>a</sup> Calculated using the population ratio method.

NOTE: The Healthy Eating Index-2015 (HEI-2015) is a measure of diet quality with 13 components used to assess how well a set of foods aligns with the key recommendations of the *2015–2020 Dietary Guidelines for Americans*.<sup>27</sup> Intakes equal to or better than the standards set for each component are assigned a maximum score. Maximum HEI-2015 component scores range from 5 to 10 points. Scores for intakes between the minimum and maximum standards are scored proportionately. Scores for each component are summed to create a total maximum HEI-2015 score of 100 points. Nine of the 13 components assess adequacy components. The remaining four components assess dietary components that should be consumed in moderation. For the adequacy components, higher scores reflect higher intakes. For the moderation components, higher scores reflect lower intakes because lower intakes are more desirable. A higher total score indicates a diet that aligns better with the *Dietary Guidelines*. HEI-2015 total and component scores reflect usual dietary intakes among older adults in the United States. This tool was developed by the U.S. Department of Agriculture, Center for Nutrition Policy and Promotion and the U.S. Department of Health and Human Services, National Cancer Institute. The bars represent the actual scores obtained for each component. The maximum scores possible for each component are included in parentheses under each category. Total HEI scores are available in Table 24.

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

SOURCE: National Center for Health Statistics, What We Eat in America, National Health and Nutrition Examination Survey (2015–2016).

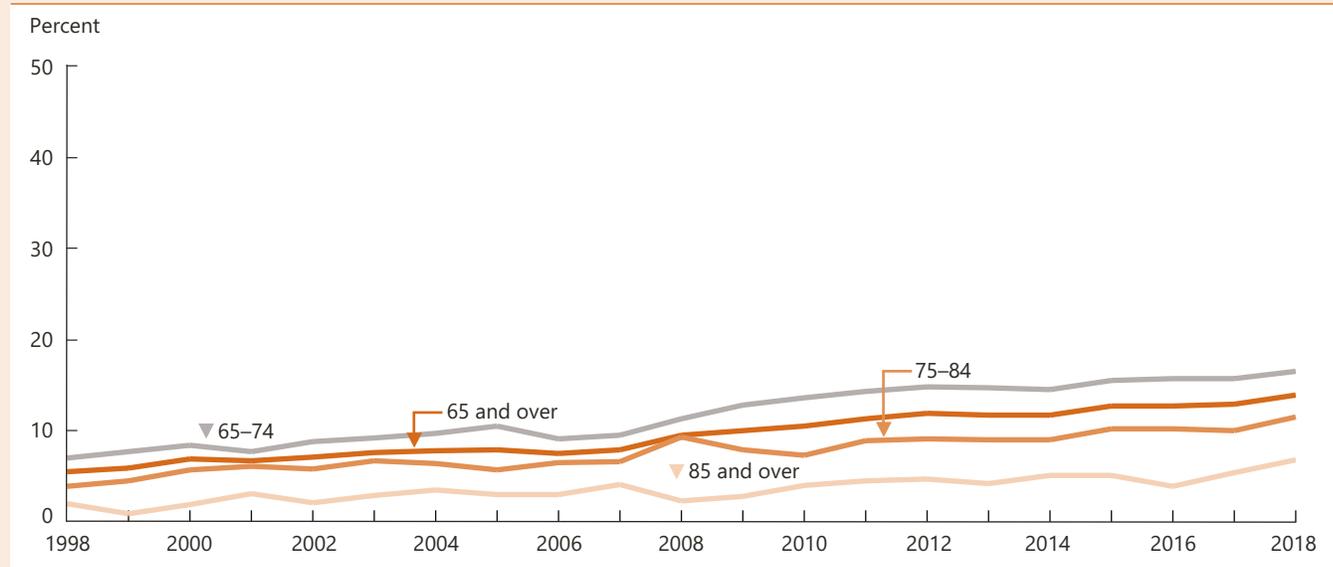
- During 2015–2016, total HEI-2015 scores for age groups 65 and over, 65–74, and 75 and over were 64, 65, and 63, respectively, out of 100.
- Among older Americans age 65 and over, component scores were highest for Whole Fruits, Total Protein Foods, and Seafood and Plant Proteins.
- Maximum scores were not achieved, and component scores were furthest from the maximum for Whole Grains, Dairy, Fatty Acids, Sodium, and Saturated Fats, among older Americans age 65 and over.

*Data for this indicator's charts and bullets can be found in Table 24 on page 112.*

## INDICATOR 25: Physical Activity

Physical activity is important for people of all ages. It improves overall health and reduces the risk of many chronic conditions. Exercise may also reduce the risk of depression and dementia. For older adults, physical activity can lower the risk of falls and fall-related injuries.<sup>29</sup>

### Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the *Physical Activity Guidelines for Americans*, by age group, 1998–2018



NOTE: This measure of physical activity reflects the *Physical Activity Guidelines for Americans* (<https://health.gov/our-work/physical-activity/current-guidelines>). The guidelines recommend that adults age 65 and over 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 preferably should be spread throughout the week. In addition, older adults should perform muscle-strengthening activities that are moderate or greater intensity and involve all major muscle groups on two or more days a week. When older adults cannot do 150 minutes of moderate-intensity aerobic activity a week because of chronic conditions, they should be as physically active as their abilities and conditions allow. 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: National Center for Health Statistics, National Health Interview Survey.

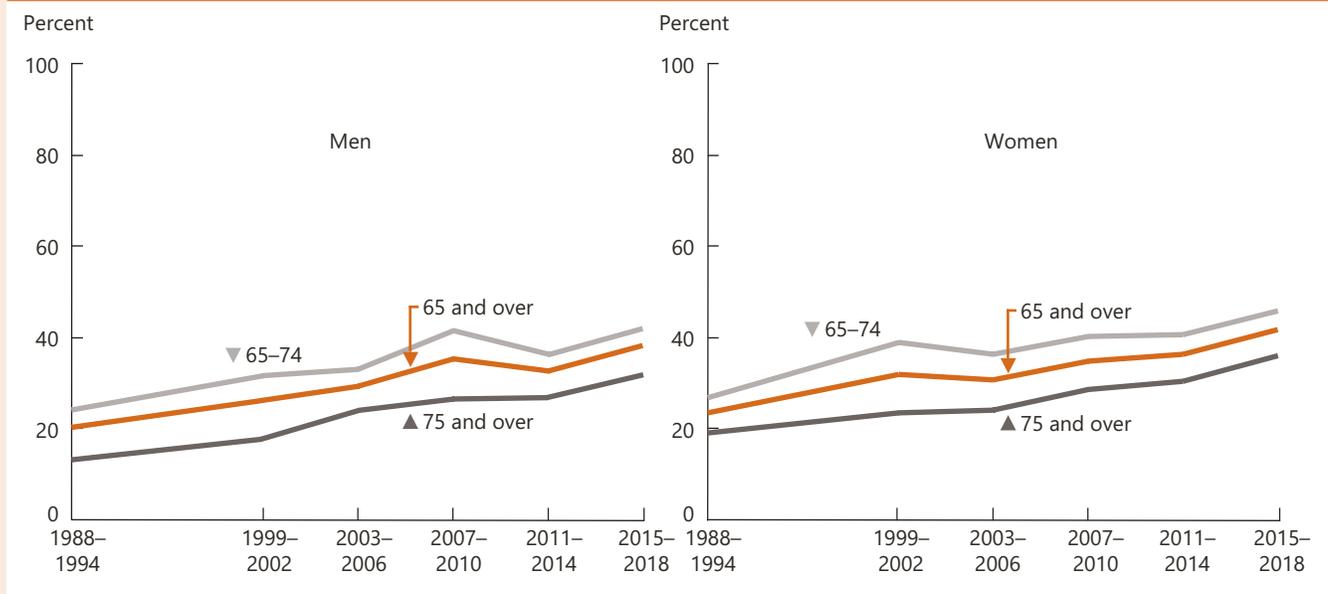
- In 2018, about 14 percent of people age 65 and over reported participating in leisure-time aerobic and muscle-strengthening activities that met the *Physical Activity Guidelines for Americans*. The percentage of older people meeting the physical activity guidelines decreased with age, ranging from 16 percent among people ages 65–74 to 7 percent among people age 85 and over.
- The percentage of older Americans meeting the *Physical Activity Guidelines for Americans* increased over time. In 1998, about 6 percent of people age 65 and over met the guidelines compared with 14 percent in 2018.
- Men age 65 and over were more likely than women in the same age group to meet the *Physical Activity Guidelines for Americans* in 2018 (16 percent versus 12 percent). Non-Hispanic Whites age 65 and over reported higher levels of physical activity than their non-Hispanic Black counterparts (15 percent versus 9 percent).

Data for this indicator's charts and bullets can be found in Tables 25a and 25b on page 113.

## INDICATOR 26: Obesity

Obesity is a major cause of preventable disease and premature death.<sup>30</sup> It is associated with increased risk of coronary heart disease, Type 2 diabetes, various types of cancer, gallstones, and disability.<sup>31</sup>

**Percentage of the population age 65 and over with obesity, by sex and age group, selected years, 1988–2018**



NOTE: Data are based on measured height and weight. Height was measured without shoes. Obesity is defined by a body mass index (BMI) of 30 kilograms/meter<sup>2</sup> 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 often are combined to create increased sample size, especially for subgroup estimates. Reference population: These data refer to the civilian noninstitutionalized population.

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey.

- During 2015–2018, about 40 percent of people age 65 and over had obesity, 38 percent of men and 42 percent of women.
- The percentage of people age 65 and over with obesity has increased from 22 percent in 1988–1994 to 30 percent in 2003–2006 to 40 percent in 2015–2018.
- During 2015–2018, approximately 46 percent of women ages 65–74 and 36 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.

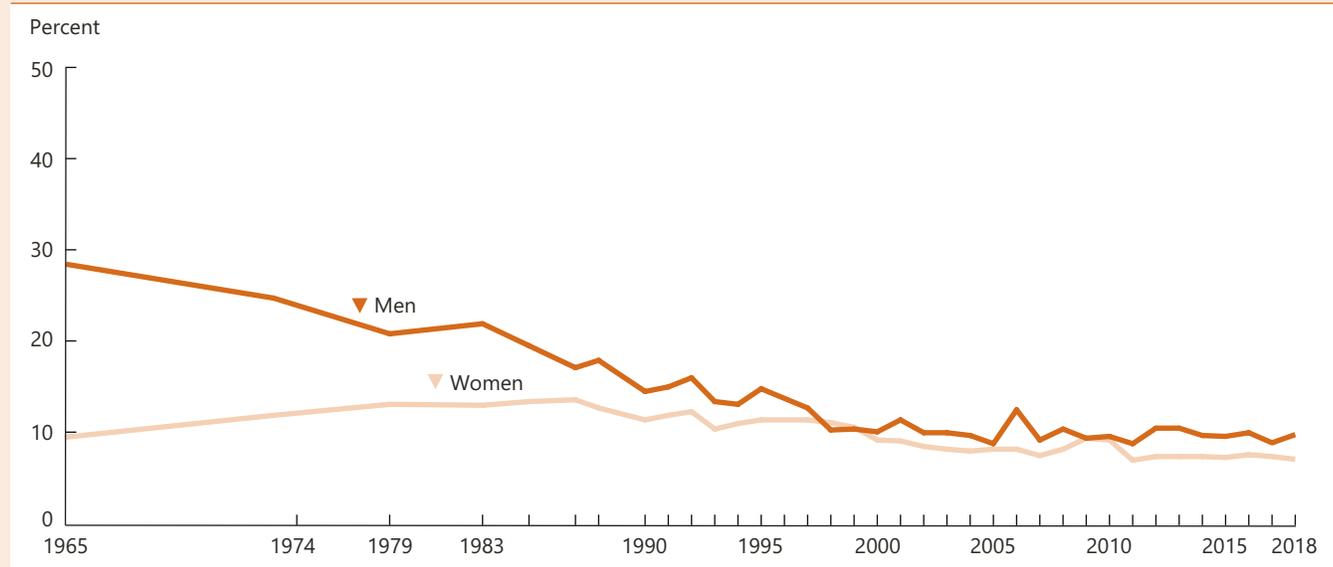
- Older men followed similar trends. Some 24 percent of men ages 65–74 and 13 percent of men age 75 and over had obesity in 1988–1994 compared with 42 percent of men ages 65–74 and 32 percent of men age 75 and over in 2015–2018.

*Data for this indicator's charts and bullets can be found in Table 26 on page 114.*

## INDICATOR 27: Cigarette Smoking

Cigarette smoking affects nearly every organ of the body; it causes diminished health status and raises the risk of many diseases, such as cancer, cardiovascular disease, and chronic obstructive lung diseases.<sup>32</sup>

**Percentage of people age 65 and over who are current cigarette smokers, by sex, selected years, 1965–2018**



NOTE: Questions concerning cigarette smoking differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States, 2018*, Appendix II.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey.

- In 2018, 10 percent of men and 7 percent of women age 65 and over were current cigarette smokers.
- The percentage of people age 65 and over who were current cigarette smokers declined between 1965 and 2018, with larger declines among men than women. Levels of cigarette smoking have been generally stable in the past decade.
- In 2018, the percentage of older men who were current smokers was higher among Non-Hispanic Blacks than Non-Hispanic Whites (16 percent versus 9 percent). The percentages for older women were not statistically different between Non-Hispanic Whites and Non-Hispanic Blacks.
- The percentage of people age 65 and over who were current smokers was higher among those who lived below the poverty threshold than among those with incomes above the poverty threshold. In 2018, 13 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 27a and 27b on pages 115–116.*





**Health Care**

## INDICATOR 28: 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, 1992–2017



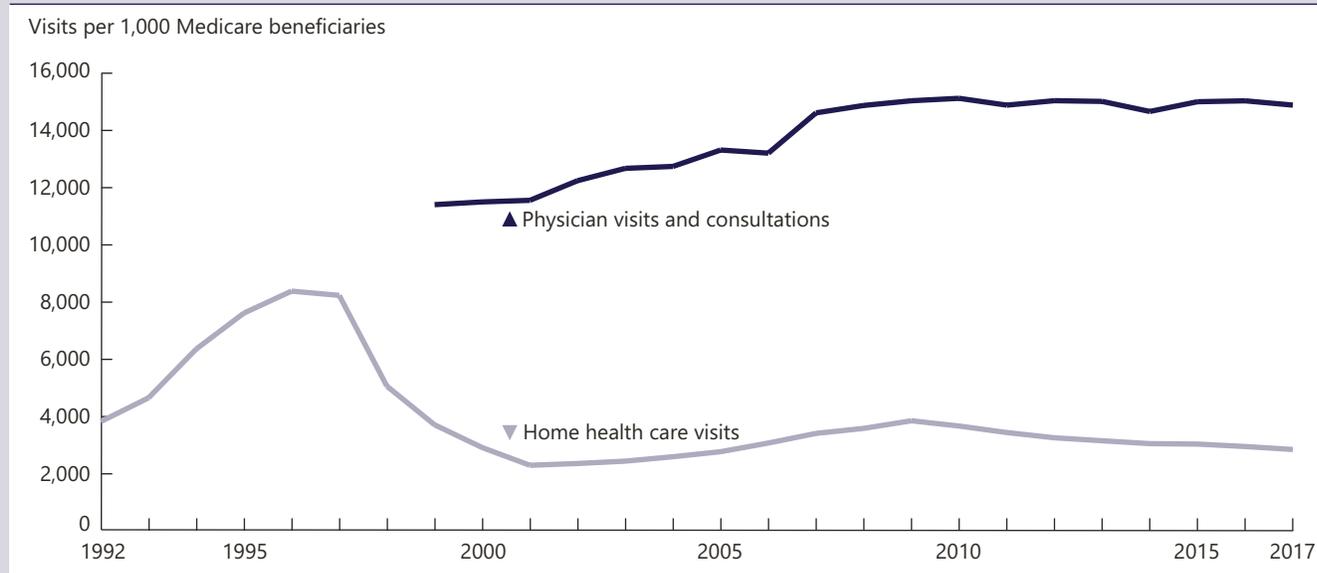
NOTE: Data are for Medicare beneficiaries in fee-for-service only. Beginning in 1994, managed care beneficiaries were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care beneficiaries were included in the denominators; 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.

- In 2017, Medicare beneficiaries had 245 hospital stays and 68 skilled nursing facility stays per 1,000 Medicare beneficiaries.
- Between 1992 and 1999, the hospitalization rate increased from 306 hospital stays per 1,000 Medicare beneficiaries to 365 per 1,000 Medicare beneficiaries. After 1999, the rate began to decrease, reaching 245 per 1,000 Medicare beneficiaries in 2017.
- The number of skilled nursing facility stays increased from 28 per 1,000 Medicare beneficiaries in 1992 to 81 per 1,000 Medicare beneficiaries in 2010. Much of the increase occurred from 1992 to 1997. The number of skilled nursing facility stays has dropped slightly since 2011, decreasing to 68 per 1,000 Medicare beneficiaries in 2017.

## Medicare-covered physician and home health care visits per 1,000 Medicare beneficiaries age 65 and over in fee-for-service, 1992–2017



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 prior to 2016 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, data for 2007–2013 have been revised and differ from editions of *Older Americans* prior to 2016. 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.

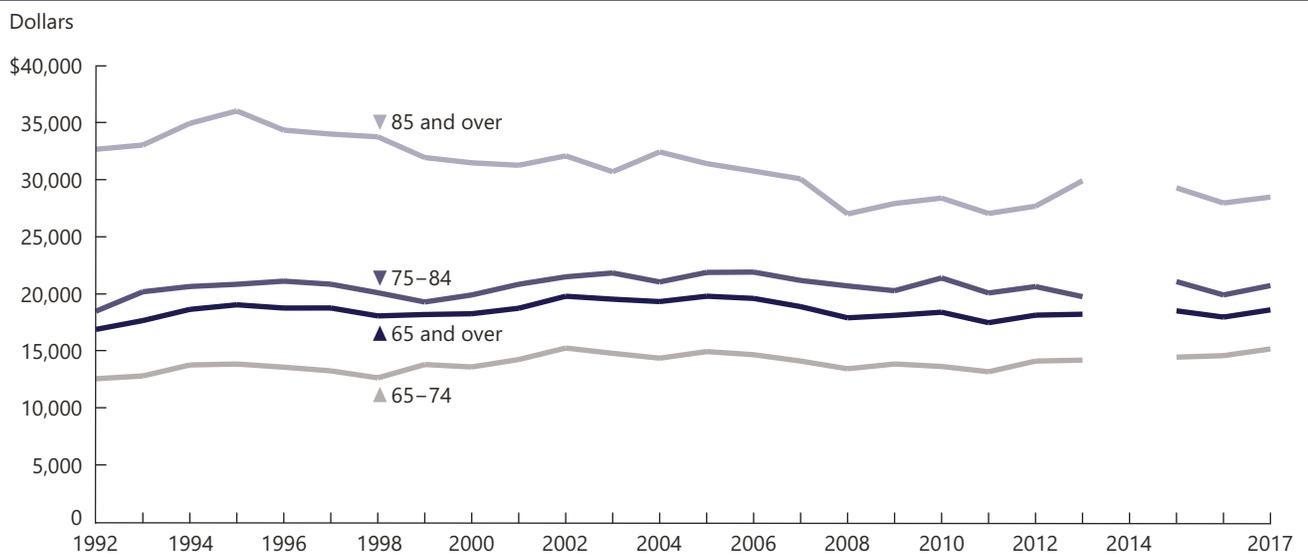
- The number of physician visits and consultations was 14,870 per 1,000 Medicare beneficiaries in 2017—an increase from 11,395 per 1,000 Medicare beneficiaries in 1999.
- Following expansion in the coverage criteria for the Medicare home health care benefit, the number of home health care visits increased from 3,822 per 1,000 Medicare beneficiaries in 1992 to 8,376 per 1,000 Medicare beneficiaries in 1996. Home health care 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 3,850 per 1,000 Medicare beneficiaries in 2009 and has declined since that time to 2,847 per 1,000 Medicare beneficiaries in 2017.
- Use of home health care increases with age. In 2017, home health care agencies made 1,327 visits per 1,000 Medicare beneficiaries ages 65–74 compared with 7,868 visits per 1,000 Medicare beneficiaries for those age 85 and over.

*Data for this indicator's charts and bullets can be found in Tables 28a and 28b on page 117.*

## INDICATOR 29: Health Care Expenditures

Health care costs pose 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 2017 dollars, for Medicare beneficiaries age 65 and over by age group, 1992–2017**



NOTE: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation adjusted to 2017 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. To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

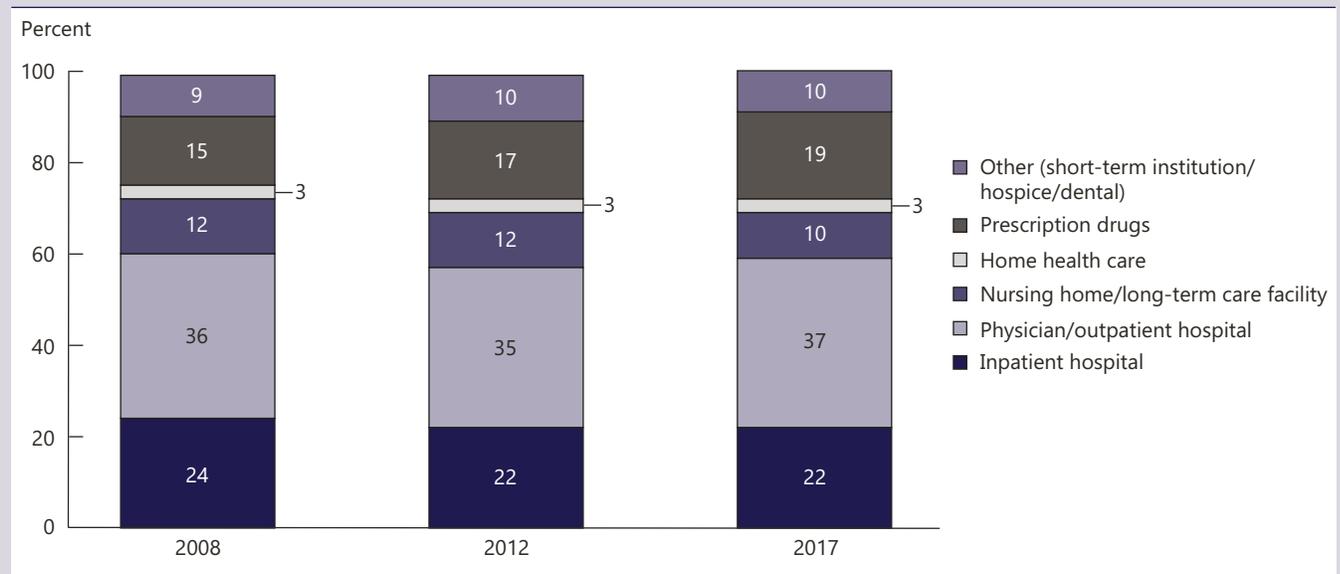
Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use (1992–2013) and Cost Supplement (2015–2017).

- Annual health care costs per capita among Medicare beneficiaries age 65 and over were \$18,620 in 2017.
- After adjusting for inflation, annual health care costs per capita increased between 1992 and 2017—from \$16,906 to \$18,620.
- 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 2017, low-income individuals incurred higher health care costs; those with incomes less than \$10,000 and \$10,000 to \$19,999 in income averaged \$25,577 and \$23,052 in health care costs, respectively, while those with \$30,000 or more in income averaged \$16,403.

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, 2012, and 2017**



NOTE: Data include both out-of-pocket costs and costs covered by insurance. 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 (2008, 2012) and Cost Supplement (2017).

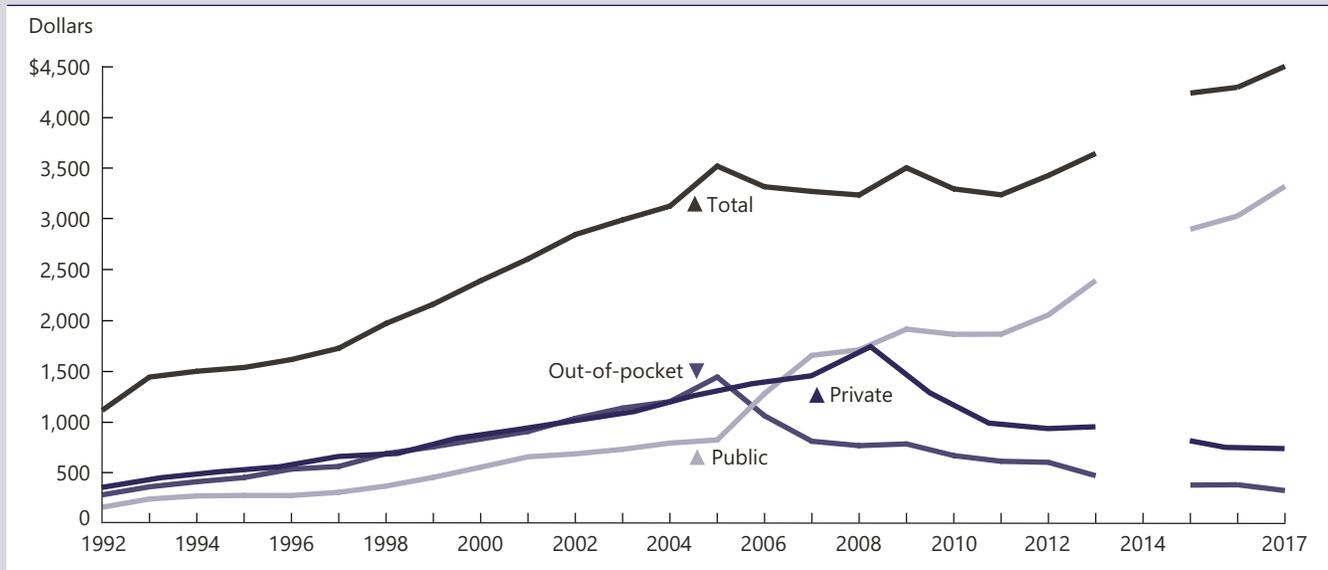
- Outpatient hospital and physician services were the largest components of health care costs, accounting for 37 percent of total health care costs in 2017.
- In 2017, nursing homes and long-term care facilities accounted for 10 percent of total costs, and prescription drugs accounted for 19 percent of health care costs.
- Inpatient hospital care accounted for 22 percent of total costs in 2017. “Other” costs (short-term institutions, hospice, and dental care) constituted 10 percent of total costs.
- The percentage distribution of health care services remained relatively constant between 2008 and 2017.

*Data for this indicator’s charts and bullets can be found in Tables 29a through 29c on pages 118–119.*

## INDICATOR 30: Prescription Drugs

Prescription drug costs have increased rapidly in recent years as more new drugs have 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 2017 dollars, among noninstitutionalized Medicare beneficiaries age 65 and over, by sources of payment, 1992–2017**



NOTE: Dollars have been inflation adjusted to 2017 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. To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

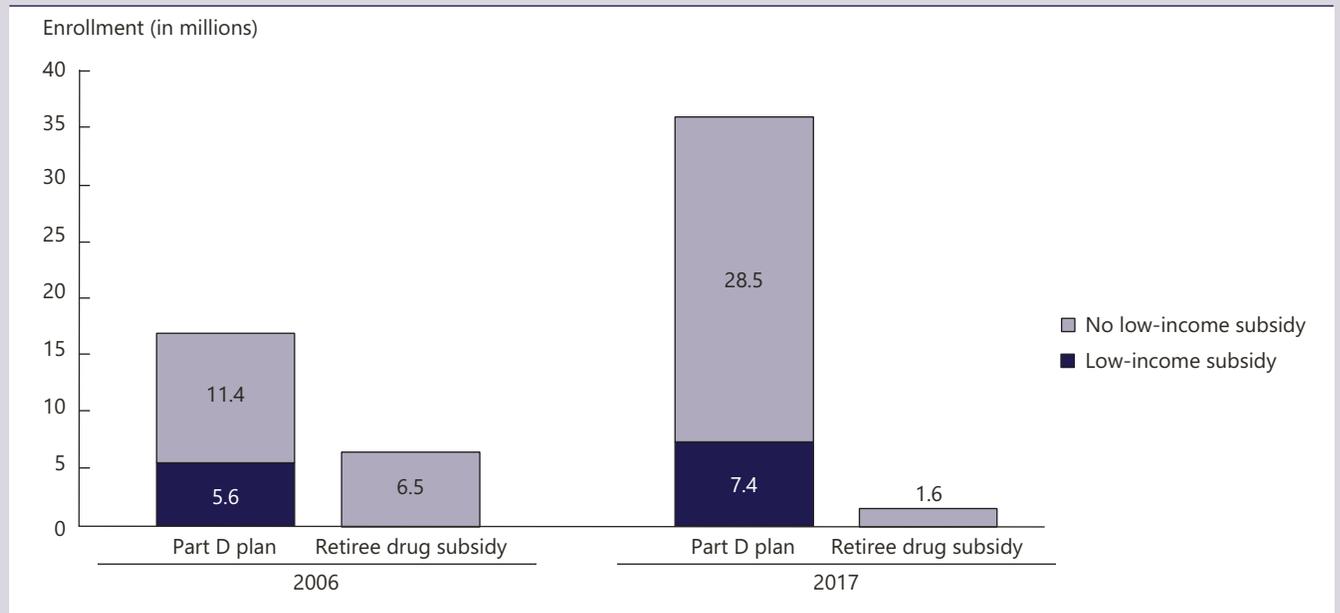
Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use (1992–2013) and Cost Supplement (2015–2017).

- Average prescription drug costs for noninstitutionalized Americans age 65 and over were \$4,499 in 2017.
- After adjusting for inflation, average prescription drug costs for noninstitutionalized Americans age 65 and over increased from \$1,114 in 1992 to \$3,517 in 2005. The increase between 2005 and 2017 was smaller—average prescription drug costs were \$4,499 in 2017.
- 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 19 percent in 2017. Private insurance covered 7 percent of prescription drug costs for noninstitutionalized older Americans in 2017, and public programs covered about 74 percent of those costs.

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 2017**



Reference population: These data refer to Medicare beneficiaries.  
 SOURCE: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

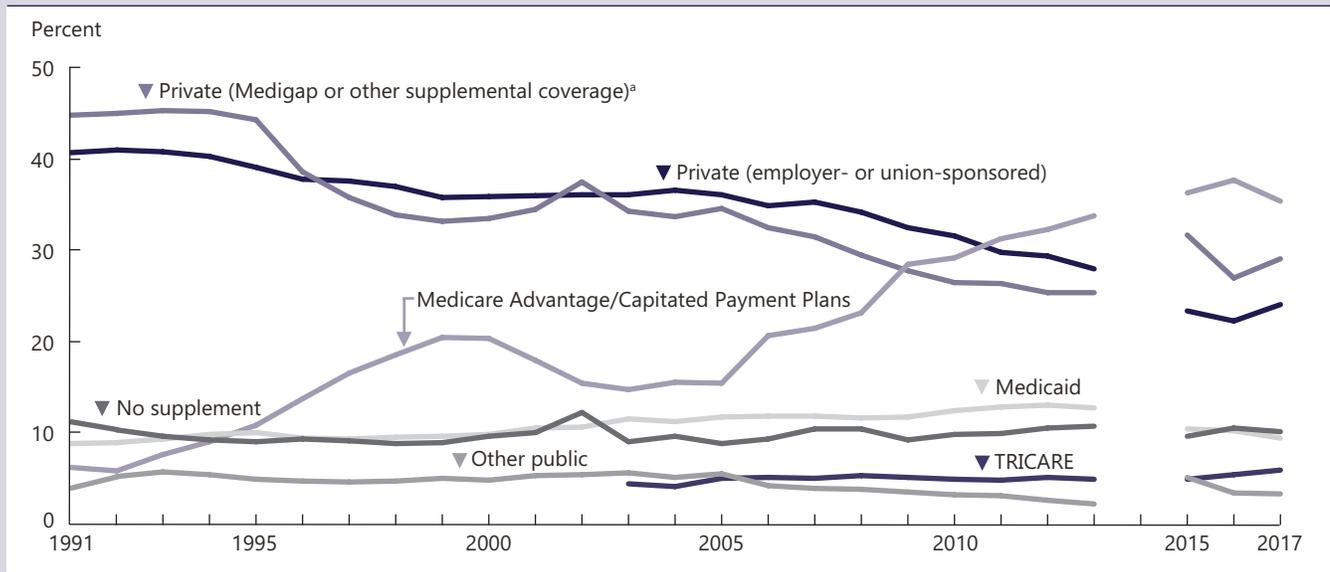
- In 2017, 7.4 million Part D beneficiaries were receiving low-income subsidies. Many of these beneficiaries had drug coverage through the Medicaid program prior to enrollment in Part D.
- Approximately 1.6 million beneficiaries age 65 and over were covered by the retiree drug subsidy in 2017.
- The 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 35.9 million (72 percent of beneficiaries) in 2017.

*Data for this indicator's charts and bullets can be found in Tables 30a through 30c on pages 120–121.*

# INDICATOR 31: Sources of Health Insurance

Medicare is the primary insurance provider for all eligible beneficiaries age 65 and over. 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 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, 1991–2017**



<sup>a</sup> Includes people with a private supplement of unknown sponsorship.

NOTE: 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 percent to 3 percent of beneficiaries). Prior to 2015, supplemental policy estimates were calculated using the first five policies reported only. Estimates for 2015 and later were calculated using all available policy information. 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. Prior to 2015, Medicaid coverage was determined from both survey responses and Medicare administrative records. Starting with 2015, Medicaid coverage is determined from administrative records only. TRICARE coverage was added to Medicare Current Beneficiary Survey Access to Care files beginning in 2003. Adding TRICARE coverage to the table changes the percentage of beneficiaries in the "No supplement" group. The weighting process in the 2017 Survey File was improved to reflect the distribution of enrollment in Medicare Advantage. All 2017 estimates are based on enhanced survey weights. To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who were continuously enrolled during the calendar year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1991–2013) and Survey File (2015–2017).

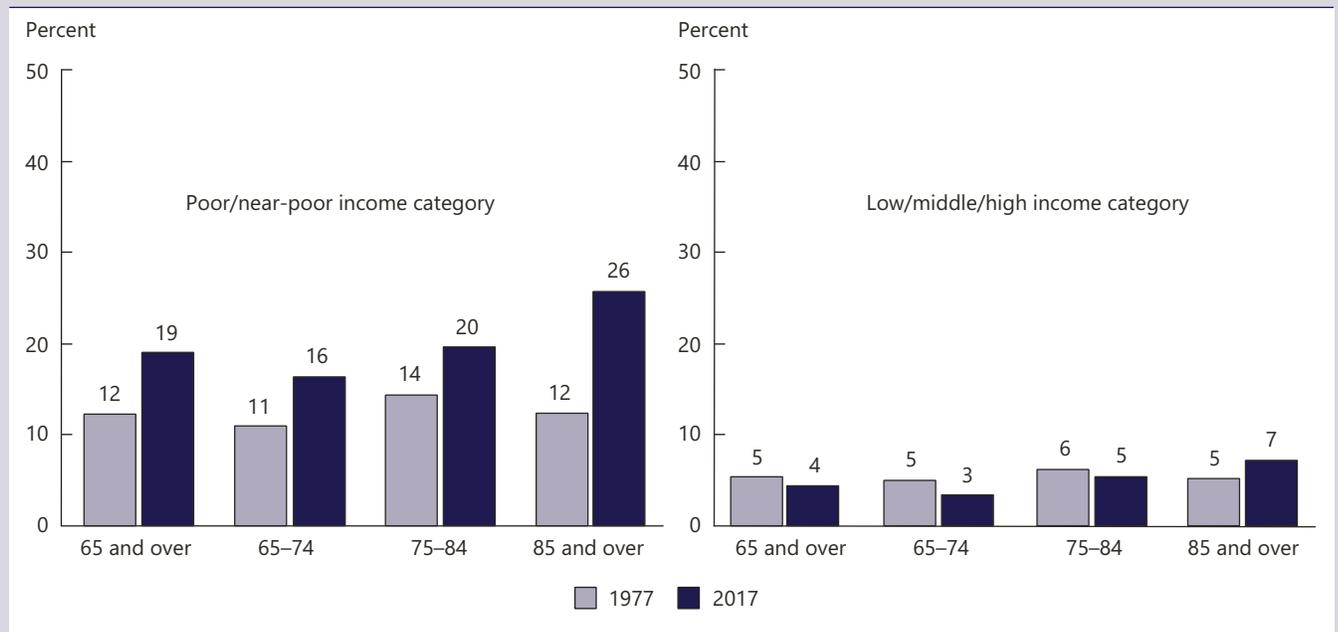
- In 2017, about 53 percent of Medicare beneficiaries had a private insurance supplement, either provided by a former employer or union or purchased as a supplemental policy.
- In 2017, 35 percent of Medicare beneficiaries age 65 and over were enrolled in Medicare Advantage/ Capitated Payment Plans.
- About 10 percent of Medicare beneficiaries reported having no health insurance supplement in 2017.
- The percentage of Medicare beneficiaries age 65 and over who were enrolled in Medicare Advantage/ Capitated Payment Plans increased from 6 percent in 1991 to 35 percent in 2017.

*Data for this indicator's charts and bullets can be found in Tables 31a and 31b on page 122.*

# INDICATOR 32: 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.<sup>33,34</sup> The percentage of household income that is allocated to health care expenditures is a measure of health care expense burden placed on older people.

**Percentage of household income per person attributable to out-of-pocket health care expenditures among people age 65 and over, by income category and age group, 1977 and 2017**



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.

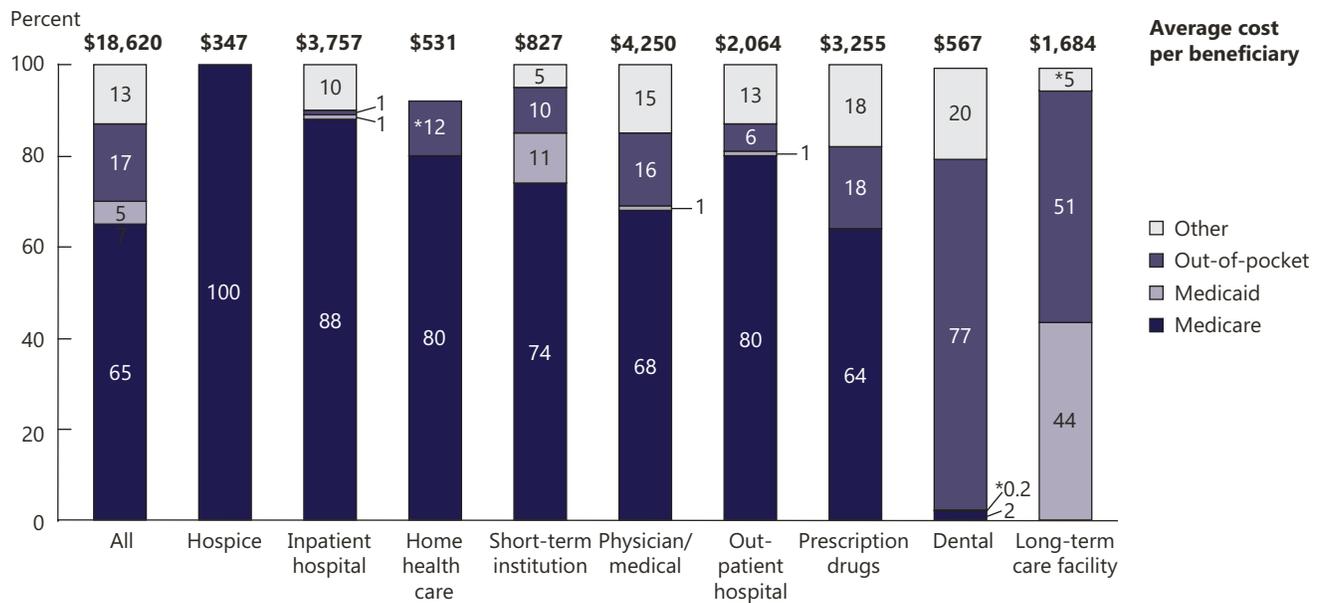
- In 2017, the average per-person percentage of household income attributable to out-of-pocket spending for health care services for poor/near-poor persons age 65 and over was 19 percent. The average percentage for persons age 65 and over in the low/middle/high income category was lower, at 4 percent in 2017.
- 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. The average percentage for persons age 65 and over in the low/middle/high income category was 5 percent 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 ages 65–74 in 2017 was 16 percent, an increase from 11 percent in 1977. For low/middle/high income persons of the same age group, the trend was reversed: 3 percent in 2017 versus 5 percent in 1977.
- For persons age 85 and over, there was an increase in the average per-person percentage of household income attributable to out-of-pocket spending for health care services over time for the poor/near-poor income group. The percentage for poor/near-poor persons in 1977 was 12 percent, increasing to 26 percent in 2017.

*Data for this indicator’s charts and bullets can be found in Tables 32a through 32c on pages 123–127.*

## INDICATOR 33: 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, 2017**



\* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error of 20 percent 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 resulting from high relative standard errors.

Reference population: These data refer to Medicare beneficiaries.

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

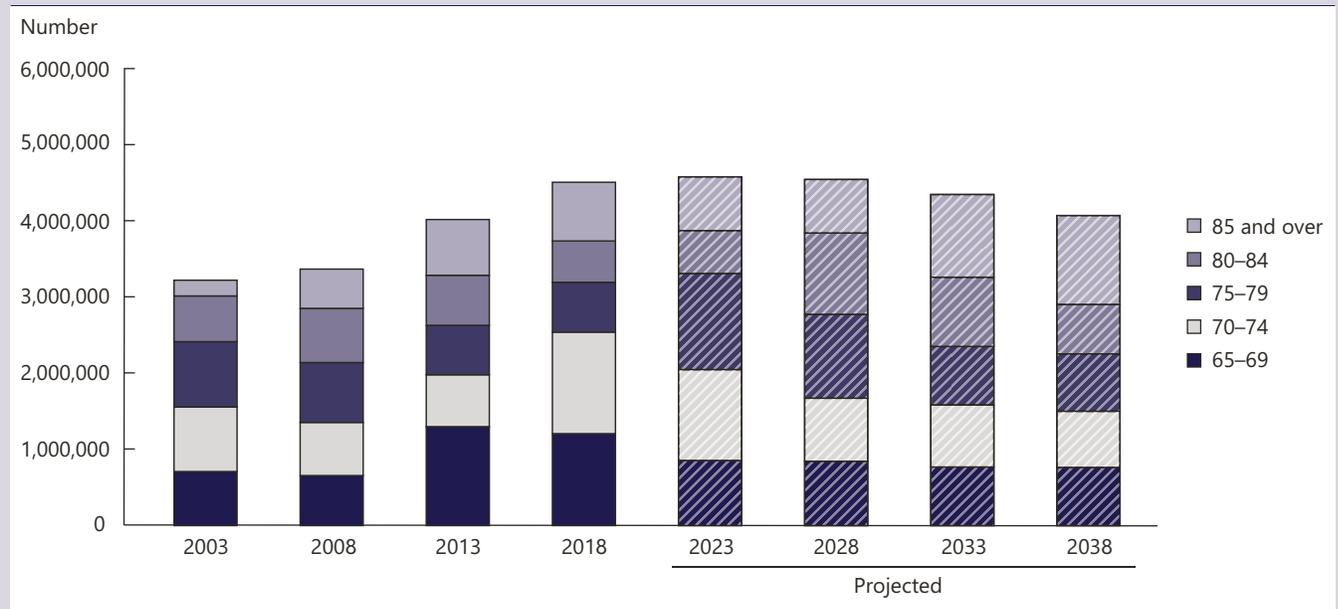
- Total health care costs for Medicare beneficiary age 65 and over averaged \$18,620 in 2017. The largest components of this cost were physician/medical services (\$4,250), inpatient hospital services (\$3,757), prescription drugs (\$3,255), outpatient hospital services (\$2,064), and long-term care facilities (\$1,684).
- Medicare paid for approximately 65 percent of all health care costs of Medicare beneficiaries age 65 and over in 2017. Medicare financed all hospice costs and most hospital, physician, home health care, and short-term institution costs.
- Medicaid covered 5 percent of all health care costs of Medicare beneficiaries age 65 and over, and other payers (primarily private insurers) covered another 13 percent. Medicare beneficiaries age 65 and over paid 17 percent of their health care costs out of pocket (not including insurance premiums).
- In 2017, about 44 percent of long-term care facility costs for Medicare beneficiaries age 65 and over were covered by Medicaid; another 51 percent of these costs were paid out of pocket. About 64 percent of prescription drug costs for Medicare beneficiaries age 65 and over were covered by Medicare, 18 percent were covered by third-party payers other than Medicare and Medicaid (consisting mostly of private insurers), and 18 percent were paid out of pocket. About 77 percent of dental care received by older Americans was paid out of pocket.

*Data for this indicator's charts and bullets can be found in Table 33 on page 128.*

## INDICATOR 34: 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 the health care needs for older veterans that are 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 Veterans Health Administration, by age group, selected years 2003–2018 and projected 2023–2038**



NOTE: Department of Veterans Affairs (VA) enrollees are veterans who have signed up to receive health care from Veterans Health Administration (VHA). Counts for 2023, 2028, 2033, and 2038 are projections from the 2019 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, Chief Strategy Office, 2019 VA Enrollee Health Care Projection Model.

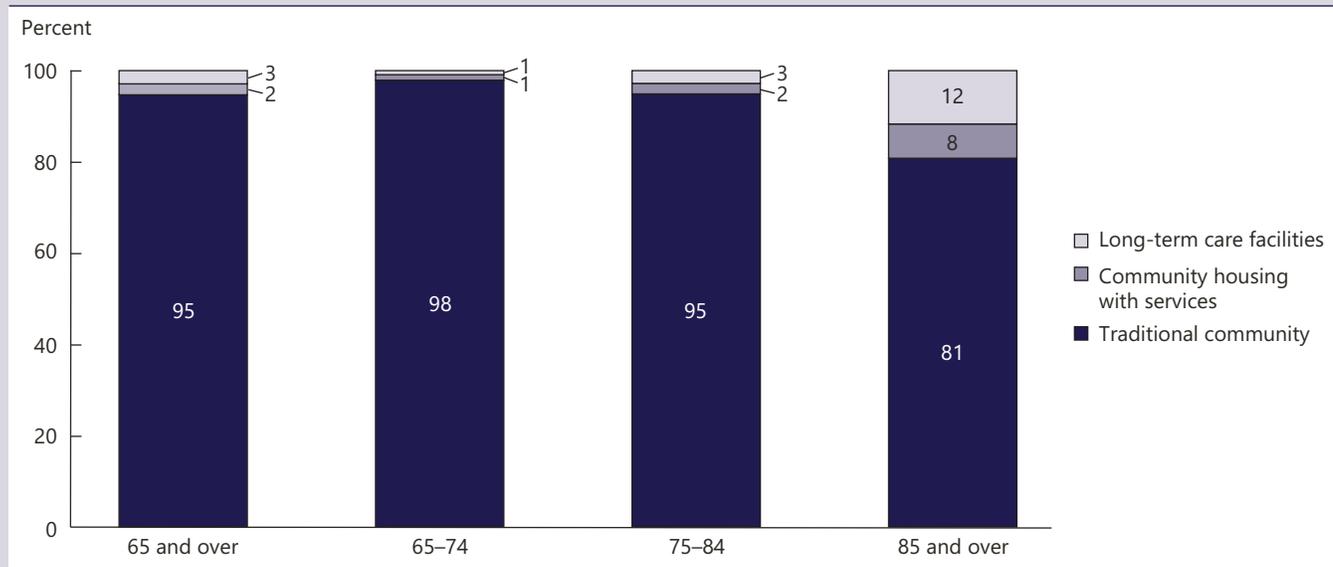
- In 2018, approximately 4.5 million of the 9.1 million veterans enrolled with VHA were age 65 and over (49 percent).
- The percentages of older veterans among the enrollee population are expected to increase as the Vietnam-era enrollee cohort gets older. In 2018, approximately 21 percent of enrollees were age 75 and over; by 2038, approximately 30 percent of enrollees are projected to be age 75 and over.
- In 2018, the largest number of enrollees in the older veteran cohort (age 65 and over) were in the age group 70–74 (1.33 million). By 2038, those in the age group 85 and over will comprise the largest number of enrollees in the older veteran cohort (1.16 million).

*Data for this indicator's charts and bullets can be found in Table 34 on page 128.*

## INDICATOR 35: 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, 2017**



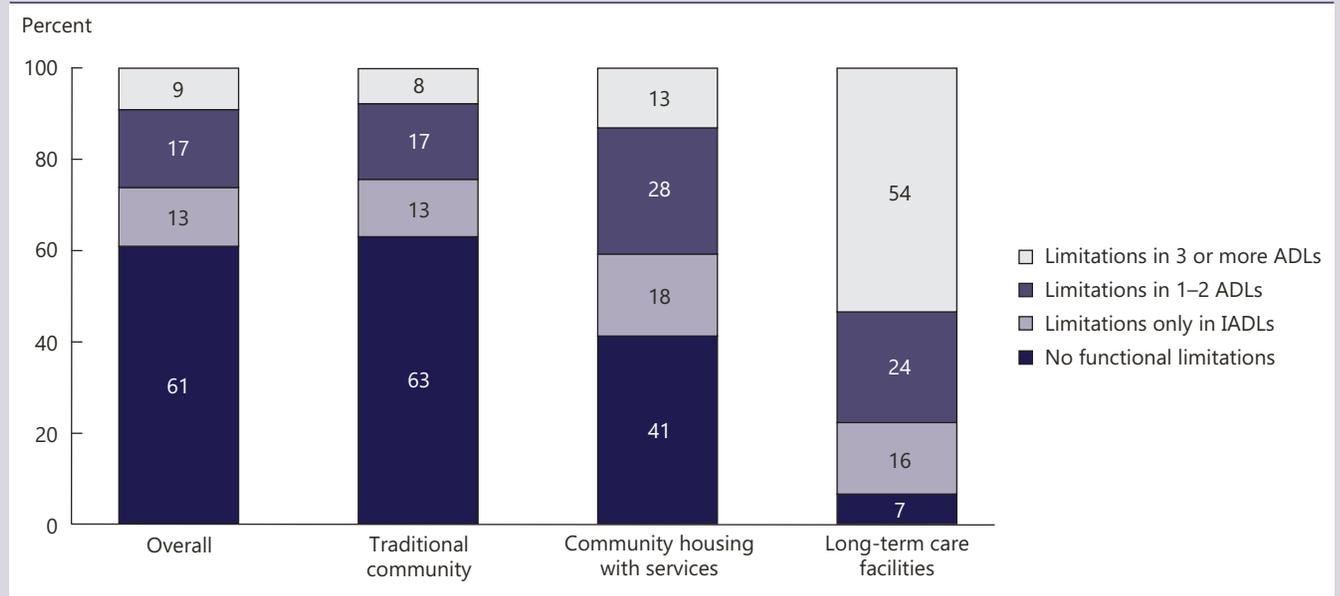
NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations and 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 nonfamily, paid caregiver.

Reference population: These data refer to Medicare beneficiaries who were continuously enrolled during the calendar year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.

- In 2017, about 2 percent of the Medicare population age 65 and over resided in community housing with at least one service available. About 3 percent resided in long-term care facilities, and 95 percent resided in traditional community settings.
- 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, and 12 percent resided in long-term care facilities. Among individuals ages 65–74, about 98 percent resided in traditional community settings.

**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, 2017**



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 nonfamily, 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 who were continuously enrolled during the calendar year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.

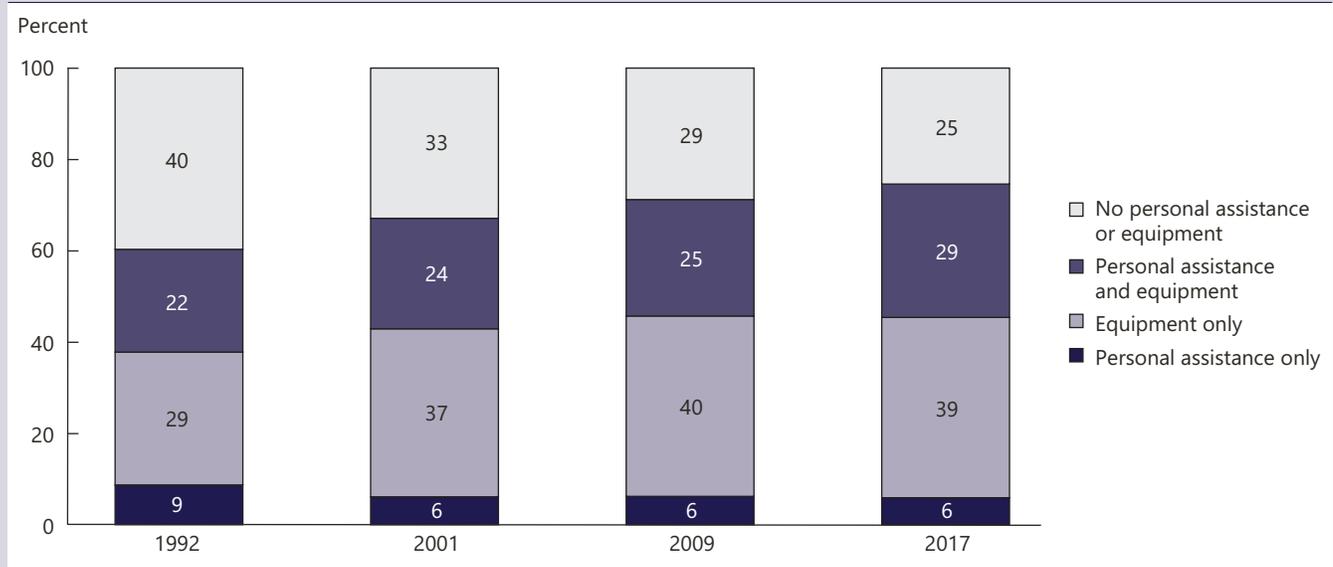
- In 2017, among the Medicare beneficiaries age 65 and over, 39 percent reported at least one limitation with an activity of daily living (ADL) or an instrumental activity of daily living (IADL), regardless of setting.
- People living in community housing with services had more limitations in performing ADLs and IADLs than traditional community residents but not as many as those living in long-term care facilities. About 40 percent of individuals living in community housing with services had at least one ADL limitation compared with 24 percent of traditional community residents and 78 percent of long-term care facility residents in 2017.
- Approximately 63 percent of traditional community residents had no ADL or IADL limitations compared with 41 percent of those living in community housing with services and 7 percent in long-term care facilities.

*Data for this indicator's charts and bullets can be found in Tables 35a and 35b on page 129.*

## INDICATOR 36: 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 1992–2017**



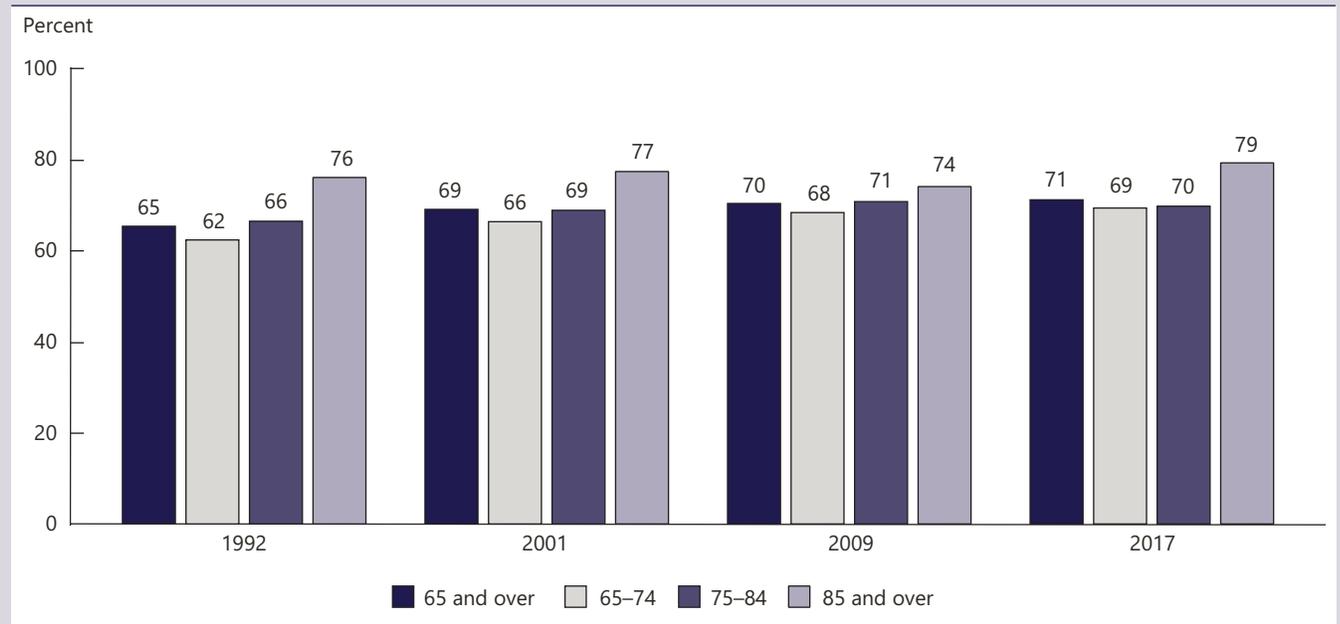
NOTE: Some data have been revised and differ from previous editions of *Older Americans*. Limitations in performing activities of daily living (ADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Personal assistance is defined as assistance with performing the task. In this chart, personal assistance does not include supervision. 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 and are continuously enrolled during the year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1992–2013) and Survey File (2015–2017).

- In 2017, about three quarters of people who had difficulty with one or more activities of daily living (ADLs) received personal assistance or used special equipment: 6 percent received personal assistance only, 39 percent used equipment only, and 29 percent used both personal assistance and equipment.
- Between 1992 and 2017, the proportion of people age 65 and over who had difficulty with one or more ADLs and who did not receive personal assistance or use special equipment for these activities decreased from 40 percent to 25 percent. During the same period, the percentage of people using equipment only increased from 29 percent to 39 percent, while the percentage of people who used personal assistance only decreased from 9 percent to 6 percent.
- In 2017, men age 65 and over were more likely than women to have received no assistance with their limitations (31 percent versus 22 percent). Women were more likely than men to have received personal assistance and used equipment (32 percent versus 24 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 2017, only 13 percent of people age 85 and over with limitations in performing ADLs did not receive assistance or use equipment compared with 35 percent of people ages 65–74. In addition, people age 85 and over were more likely to receive both personal assistance and use equipment compared with younger age groups.

**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 1992–2017**



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

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more IADLs and are continuously enrolled during the year. The population excludes beneficiaries who also have limitations in performing activities of daily living (ADLs).

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1992–2013) and Survey File (2015–2017).

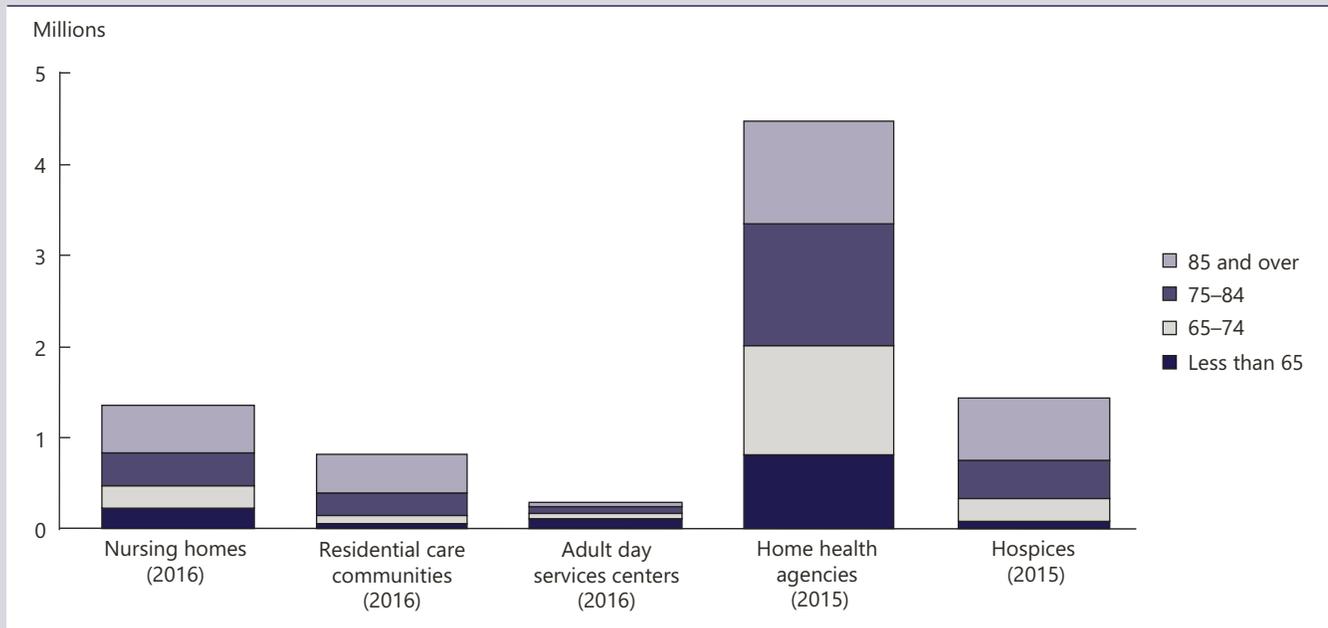
- In 2017, slightly more than two-thirds of people age 65 and over who had difficulty with one or more instrumental activities of daily living (IADLs) received personal assistance.
- In 2017, people age 85 and over were more likely to receive assistance with IADLs compared with people ages 65–74 and ages 75–84.
- Between 1992 and 2017, there were increases in the percentages of people ages 65–74 who received assistance with IADLs. Among people ages 75–84 and age 85 and over, there was no significant increase.
- Men age 85 and over were less likely than women of the same age group to receive personal assistance with their IADLs in 2017.

*Data for this indicator's charts and bullets can be found in Tables 36a through 36d on pages 130–131.*

## INDICATOR 37: Long-Term Care Providers

Long-term care refers to a broad range of 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, disability, or other health-related conditions. 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.<sup>35,36</sup>

**Number of users of long-term care services, by sector and age group, 2015 and 2016**



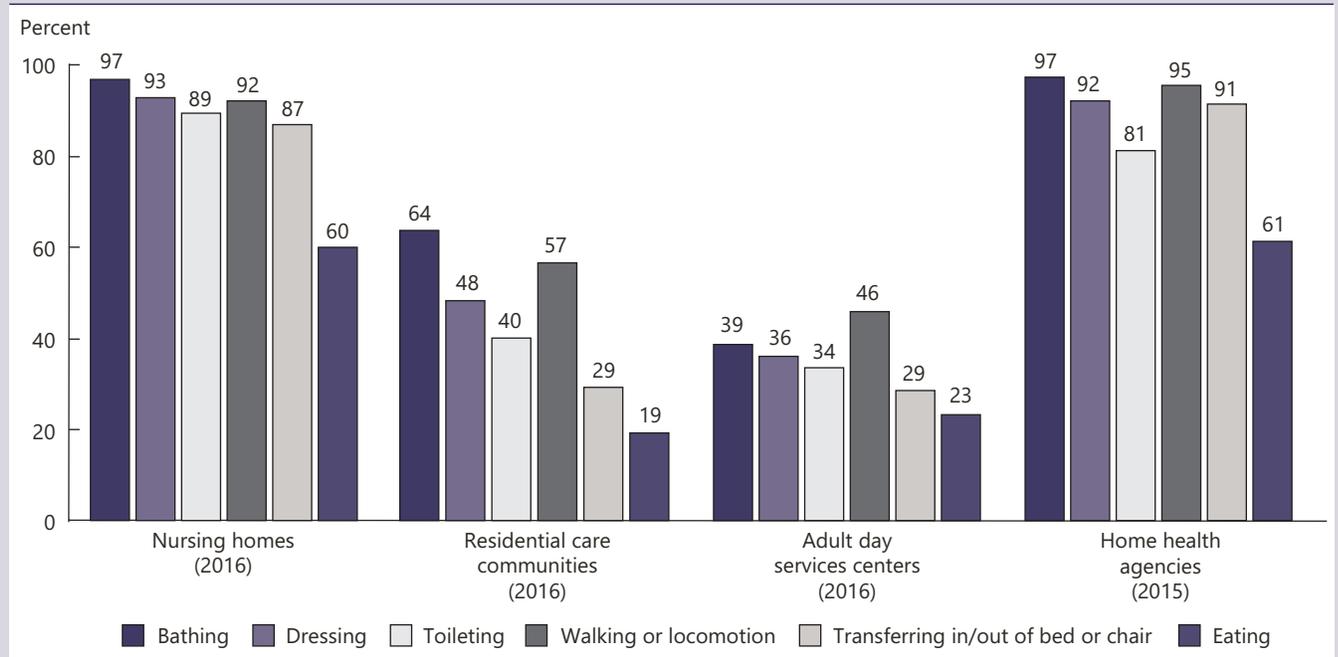
NOTE: The long-term care services described here are provided by paid, regulated providers. They comprise both health care-related and non-health care-related services, including postacute care and rehabilitation. People can receive more than one type of service. The estimated number of nursing home residents represents current residents in 2016. The estimated number of residential care community residents represents current residents in 2016. The estimated number of adult day services center participants represents current participants in 2016. The estimated number of home health patients represents patients who ended care in 2015 (i.e., discharges). The estimated number of hospice patients represents patients who received care at any time in 2015. The number in each age group is calculated by applying the percentage distribution by age to the estimated total number of users and may differ slightly from other published estimates because of rounding. See [https://www.cdc.gov/nchs/data/series/sr\\_03/sr03\\_43-508.pdf](https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf) for definitions.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Study of Long-Term Care Providers.

- In 2016, about 1.1 million people age 65 and over were residents of nursing homes. In the same year, nearly 760,000 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 2016, approximately 290,000 participants received care in adult day services centers. Nearly two-thirds of the participants (180,000) were age 65 and over.
- About 4.5 million people received care from a home health agency in 2015. People ages 75–84 (about 1.3 million) made up the largest share by age group of people receiving care from a home health agency. About 1.2 million people ages 65–74 and 1.1 million age 85 and over received home health care.
- In 2015, 1.4 million people received hospice care. About 48 percent 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, 2015 and 2016



NOTE: The long-term care services described here are provided by paid, regulated providers. They comprise both health care-related and non-health care-related services, including postacute 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, 84 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, 63 percent of participants were age 65 and over. Among home health care patients, 82 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 assistive devices to perform the activity. See [https://www.cdc.gov/nchs/data/series/sr\\_03/sr03\\_43-508.pdf](https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf) for definitions.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Study of Long-Term Care Providers.

- In 2016, most residents of nursing homes needed help with activities of daily living (ADLs). Nearly all (97 percent) needed help with bathing, and almost as many needed help with dressing, toileting, and walking (93 percent, 89 percent, and 92 percent, respectively).
- In 2016, 64 percent of residents of residential care communities needed assistance with bathing. About 57 percent needed help with walking, and 29 percent needed assistance transferring in or out of beds or chairs.
- In 2016, less than half of adult day center participants needed assistance with ADLs. About 39 percent needed help with bathing, and 46 percent needed help with walking.
- The majority of home health care patients in 2015 needed assistance with all six ADLs. Nearly all (97 percent) needed help with bathing.
- Assistance with bathing was the most common need across all sectors except adult day services centers, while assistance with eating was the least common.

*Data for this indicator's charts and bullets can be found in Tables 37a and 37b on page 132.*



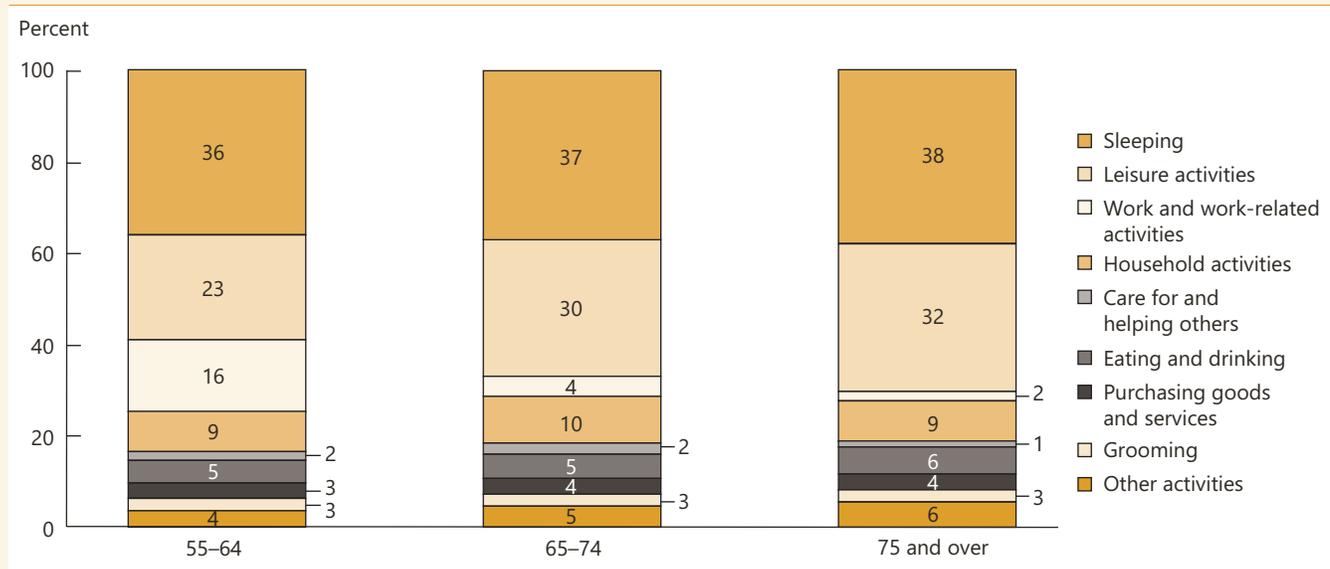


# Environment

## INDICATOR 38: 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 2018, a majority (63 percent) of people ages 55–64 were employed compared with 26 percent of those ages 65–74 and 8 percent of those age 75 and over.<sup>37</sup> 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, 2018**



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.

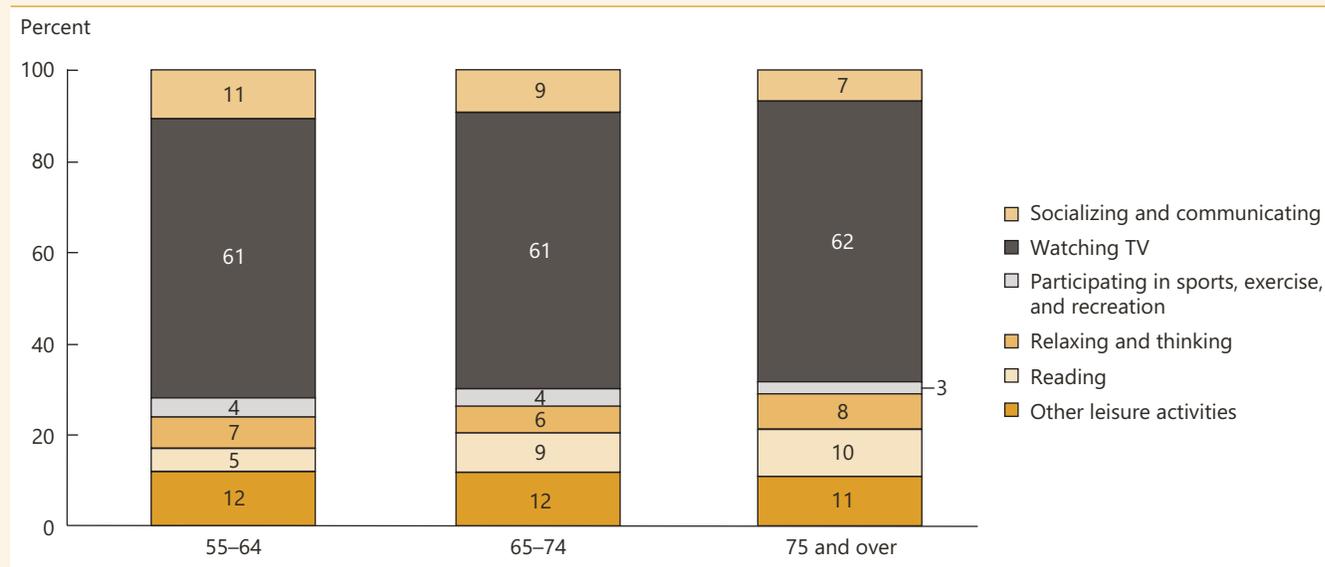
Reference population: These data refer to the civilian noninstitutionalized population.

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

- On an average day, people ages 55–64 spent 16 percent of their time (3 hours and 47 minutes) working or doing work-related activities compared with 4 percent (about 1 hour) for people ages 65–74 and 2 percent (about 30 minutes) for people age 75 and over.
- 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 32 percent of their time in leisure activities compared with 23 percent for those ages 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, 2018



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.

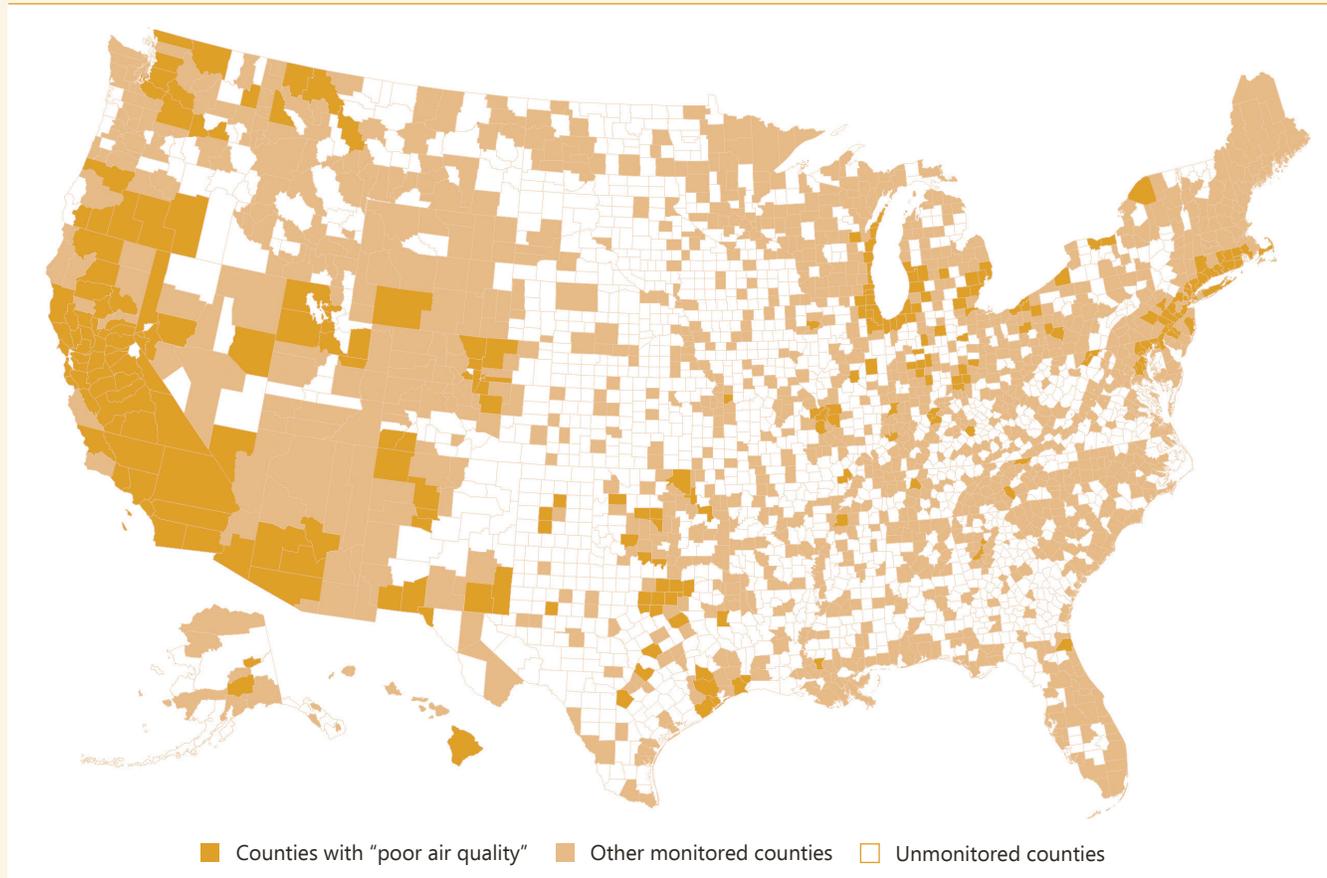
- Watching TV was the activity that occupied the most leisure activity time—more than one-half of the total—for Americans age 55 and over.
- Americans age 75 and over spent a higher percentage of their leisure time reading than did Americans ages 55–64 (10 percent versus 5 percent). Americans age 75 and over spent 48 minutes per day reading compared with 16 minutes per day for Americans ages 55–64.
- 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 7 percent for those age 75 and over.

*Data for this indicator's charts and bullets can be found in Tables 38a and 38b on page 133.*

## INDICATOR 39: 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 set by the Environmental Protection Agency (EPA).

### Counties with instances of “poor air quality” for any standard in 2018



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.

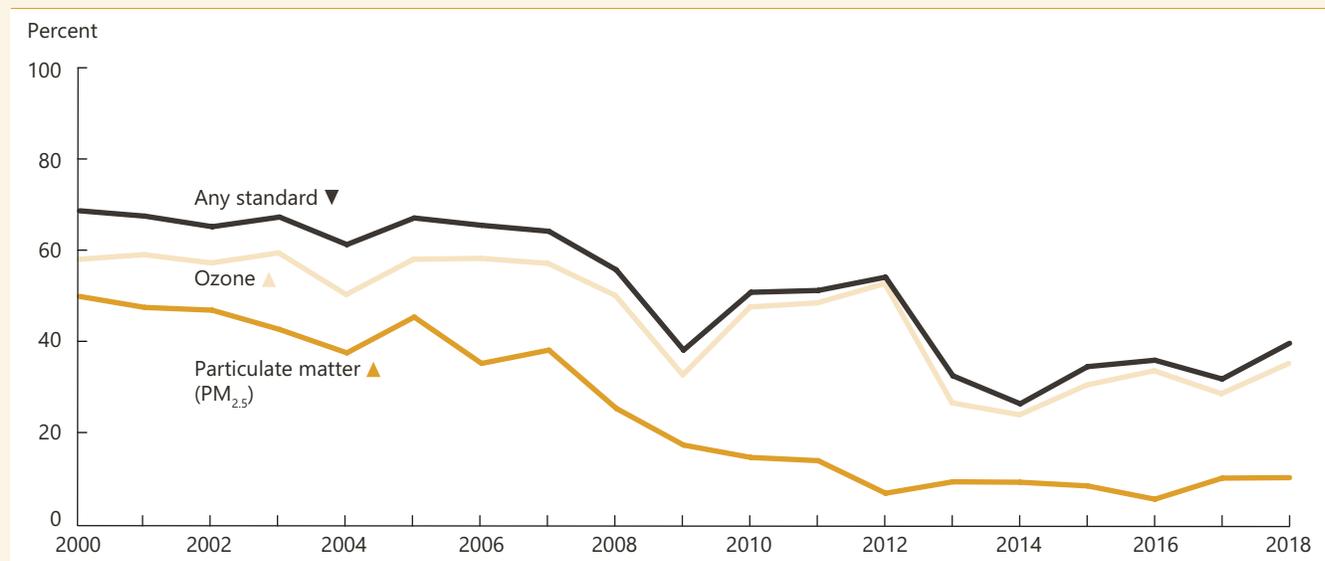
SOURCE: U.S. Environmental Protection Agency, Office of Air Quality Planning and Standards, Air Quality System; U.S. Census Bureau, 2010 Population.

- In 2018, approximately 137 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, particulate matter (PM), nitrogen dioxide, sulfur dioxide, carbon monoxide, and lead. About 12 percent, or nearly

16 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<sub>2.5</sub>.

Ozone and PM, especially fine particle pollution called PM<sub>2.5</sub>, 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.<sup>38–42</sup>

### Percentage of people age 65 and over living in counties with instances of “poor air quality,” by selected pollutant measures, 2000–2018



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 (PM), nitrogen dioxide, sulfur dioxide, carbon monoxide, or lead. PM<sub>2.5</sub> refers to fine inhalable particles with diameters that are generally 2.5 micrometers and smaller. Data for previous years have been computed using the standards in effect as of August 2019 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.

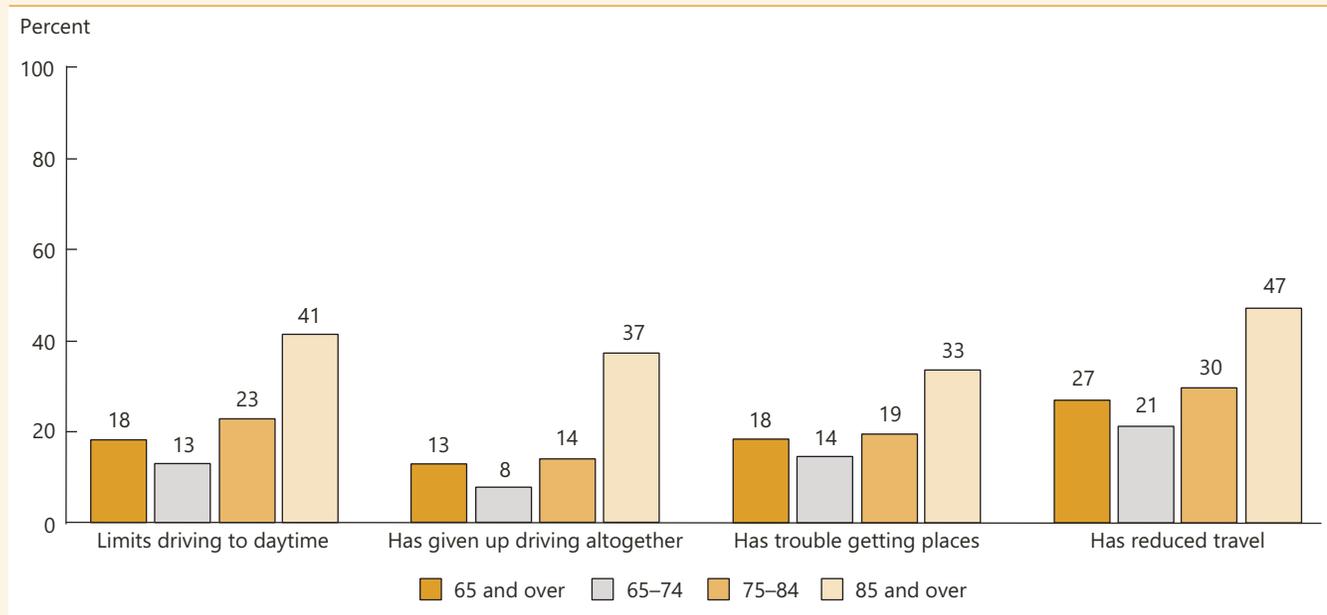
- In 2018, 40 percent of people age 65 and over lived in counties that experienced poor air quality for any standard.
- The percentage of people age 65 and over living in counties that experienced poor air quality for any standard decreased from 69 percent in 2000 to 40 percent in 2018. About 36 percent of people age 65 and over lived in counties with poor air quality for ozone in 2018 compared with 58 percent in 2000.
- A comparison of 2000 and 2018 showed a reduction in PM<sub>2.5</sub> pollution. In 2000, about 50 percent of people age 65 and over lived in a county where PM<sub>2.5</sub> concentrations were at times above the EPA standard compared with about 11 percent of people age 65 and over in 2018.

*Data for this indicator's charts and bullets can be found in Tables 39a and 39b on pages 134–140.*

## INDICATOR 40: 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 because of 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 because of a health or physical problem, by type of change and age group, 2017**



Reference population: These data refer to noninstitutionalized Medicare beneficiaries who were continuously enrolled during the year.  
 SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.

- In 2017, 18 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 (41 percent) than for those ages 65–74 (13 percent).
- Furthermore, 13 percent of the noninstitutionalized Medicare population age 65 and over had given up driving altogether, about 18 percent had trouble getting places, and 27 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 40 on page 140.*



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# 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, 1900–2018, 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
2015	47.7	6.3
2016	49.2	6.4
2017	50.8	6.5
2018	52.4	6.5
Projections		
2020	56.1	6.7
2030	73.1	9.1
2040	80.8	14.4
2050	85.7	18.6
2060	94.7	19.0

NOTE: Some data for 2020–2060 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, 1900–1940, 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, 2018 (PEPAGESEX); U.S. Census Bureau, Table 3: Projections of the Population by Sex and Selected Age Groups for the United States: 2017 to 2060 (NP2017-T3).

## INDICATOR 1: Number of Older Americans

**Table 1b. Percentage of people age 65 and over and age 85 and over, selected years, 1900–2018, 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
2015	14.9	2.0
2016	15.2	2.0
2017	15.6	2.0
2018	16.0	2.0
Projections		
2020	16.9	2.0
2030	20.6	2.6
2040	21.6	3.9
2050	22.0	4.8
2060	23.4	4.7

NOTE: Some data for 2020–2060 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, 1900–1940, 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, 2018 (PEPAGESEX); U.S. Census Bureau, Table 3: Projections of the Population by Sex and Selected Age Groups for the United States: 2017 to 2060 (NP2017-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, 2019**

Country or area	Population (number in thousands)		Percent
	Total	65 and over	65 and over
Japan	125,853	36,241	28.8
Germany	80,313	18,204	22.7
Finland	5,555	1,216	21.9
Italy	62,335	13,634	21.9
Greece	10,753	2,298	21.4
Puerto Rico	3,240	680	21.0
Slovenia	2,103	435	20.7
Portugal	10,328	2,126	20.6
Estonia	1,237	254	20.6
Sweden	10,122	2,072	20.5
Croatia	4,249	869	20.5
Lithuania	2,762	557	20.1
France	67,611	13,619	20.1
Latvia	1,902	383	20.1
Hungary	9,799	1,968	20.1
Czechia	10,696	2,121	19.8
Bulgaria	7,013	1,388	19.8
Denmark	5,842	1,149	19.7
Austria	8,828	1,734	19.6
Canada	36,136	7,071	19.6
Serbia	7,045	1,372	19.5
Netherlands	17,216	3,350	19.5
Belgium	11,647	2,211	19.0
Switzerland	8,349	1,547	18.5
United Kingdom	65,437	11,999	18.3
Spain	49,683	9,097	18.3
Poland	38,356	6,937	18.1
Hong Kong	7,233	1,286	17.8
Norway	5,421	931	17.2
Romania	21,381	3,664	17.1
Ukraine	43,965	7,374	16.8
Australia	23,706	3,964	16.7
Georgia	4,927	814	16.5
Slovakia	5,443	898	16.5
United States	331,884	54,557	16.4
New Zealand	4,580	727	15.9
Bosnia and Herzegovina	3,843	599	15.6
Belarus	9,504	1,477	15.5
Cuba	11,087	1,719	15.5
Korea, South	51,636	7,821	15.1
Russia	141,945	21,353	15.0
Taiwan	23,577	3,542	15.0
Uruguay	3,378	491	14.5
Macedonia	2,123	292	13.8
Ireland	5,123	695	13.6
Moldova	3,401	461	13.5
Cyprus	1,252	159	12.7
Albania	3,066	387	12.6

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, 2019—continued**

Country or area	Population (number in thousands)		Percent 65 and over
	Total	65 and over	
Armenia	3,030	367	12.1
Argentina	45,089	5,392	12.0
China	1,389,619	163,775	11.8
Israel	8,550	1,006	11.8
Trinidad and Tobago	1,212	140	11.6
Chile	18,058	2,069	11.5
Thailand	68,804	7,836	11.4
Mauritius	1,372	146	10.6
Singapore	6,103	639	10.5
Sri Lanka	22,737	2,341	10.3

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, 2019.

## INDICATOR 1: Number of Older Americans

**Table 1d. Percentage of the population age 65 and over, by state, 2018**

State (listed alphabetically)	Percent	State (ranked by percentage)	Percent
United States	16.0	United States	16.0
Alabama	16.9	Puerto Rico	20.7
Alaska	11.8	Maine	20.6
Arizona	17.5	Florida	20.5
Arkansas	17.0	West Virginia	19.9
California	14.3	Vermont	19.4
Colorado	14.2	Montana	18.7
Connecticut	17.2	Delaware	18.7
Delaware	18.7	Hawaii	18.4
District of Columbia	12.1	Pennsylvania	18.2
Florida	20.5	New Hampshire	18.1
Georgia	13.9	South Carolina	17.7
Hawaii	18.4	Oregon	17.6
Idaho	15.9	Arizona	17.5
Illinois	15.6	New Mexico	17.5
Indiana	15.8	Rhode Island	17.2
Iowa	17.1	Connecticut	17.2
Kansas	15.9	Michigan	17.2
Kentucky	16.4	Iowa	17.1
Louisiana	15.4	Ohio	17.1
Maine	20.6	Arkansas	17.0
Maryland	15.4	Wisconsin	17.0
Massachusetts	16.5	Alabama	16.9
Michigan	17.2	Missouri	16.9
Minnesota	15.9	South Dakota	16.6
Mississippi	15.9	Wyoming	16.5
Missouri	16.9	Massachusetts	16.5
Montana	18.7	New York	16.4
Nebraska	15.7	Tennessee	16.4
Nevada	15.7	Kentucky	16.4
New Hampshire	18.1	North Carolina	16.3
New Jersey	16.1	New Jersey	16.1
New Mexico	17.5	Mississippi	15.9
New York	16.4	Kansas	15.9
North Carolina	16.3	Idaho	15.9
North Dakota	15.3	Minnesota	15.9
Ohio	17.1	Indiana	15.8
Oklahoma	15.7	Nebraska	15.7
Oregon	17.6	Oklahoma	15.7

See notes at end of table.

## INDICATOR 1: Number of Older Americans

**Table 1d. Percentage of the population age 65 and over, by state, 2018—continued**

State (listed alphabetically)	Percent	State (ranked by percentage)	Percent
Pennsylvania	18.2	Nevada	15.7
Rhode Island	17.2	Illinois	15.6
South Carolina	17.7	Washington	15.4
South Dakota	16.6	Virginia	15.4
Tennessee	16.4	Louisiana	15.4
Texas	12.6	Maryland	15.4
Utah	11.1	North Dakota	15.3
Vermont	19.4	California	14.3
Virginia	15.4	Colorado	14.2
Washington	15.4	Georgia	13.9
West Virginia	19.9	Texas	12.6
Wisconsin	17.0	District of Columbia	12.1
Wyoming	16.5	Alaska	11.8
Puerto Rico	20.7	Utah	11.1

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, 2018 (PEPAGESEX).

**Table 1e. Percentage of the population age 65 and over, by county, 2018**

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, 2018 (PEPAGESEX).

Data for this table can be found at <https://www.agingstats.gov>.

**Table 1f. Number and percentage of people age 65 and over and age 85 and over, by sex, 2018**

Age and sex	Number (in thousands)	Percent
65 and over	52,431	100.0
Men	23,307	44.5
Women	29,124	55.5
85 and over	6,545	100.0
Men	2,326	35.5
Women	4,219	64.5

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, 2018 (PEPAGESEX).

## INDICATOR 2: Racial and Ethnic Composition

**Table 2. Population age 65 and over, by race and Hispanic origin, 2018 and projected 2060**

Race and Hispanic or Latino origin	2018		2060 projections	
	Number (in thousands)	Percent	Number (in thousands)	Percent
Total	52,431	100.0	94,676	100.0
Non-Hispanic or Latino				
White alone	40,124	76.5	52,156	55.1
Black alone	4,771	9.1	12,144	12.8
Asian alone	2,369	4.5	7,859	8.3
All other races alone or in combination	749	1.4	2,628	2.8
Hispanic or Latino (any race)	4,418	8.4	19,889	21.0

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 or Alaska Native alone who are not Hispanic; people who reported Native Hawaiian or 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, 2018 (PEPASR6H); U.S. Census Bureau, Table 1. Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2017 to 2060 (NP2017\_D1).

## INDICATOR 3: Marital Status

**Table 3. Marital status of the population age 65 and over, by age group and sex, 2018**

Sex and marital status	65 and over	65–74	75–84	85 and over
	Percent			
Total	100.0	100.0	100.0	100.0
Married	57.1	64.1	54.3	29.8
Widowed	22.9	12.6	29.0	57.9
Divorced	14.2	16.5	12.2	8.0
Never married	5.8	6.8	4.5	4.4
Men	100.0	100.0	100.0	100.0
Married	70.6	72.5	71.8	54.7
Widowed	11.1	6.1	13.9	34.9
Divorced	12.3	14.4	10.1	6.5
Never married	5.9	7.0	4.3	3.9
Women	100.0	100.0	100.0	100.0
Married	46.3	56.8	40.7	16.2
Widowed	32.3	18.3	40.7	70.4
Divorced	15.7	18.4	13.9	8.8
Never married	5.7	6.6	4.6	4.7

NOTE: Married includes separated.

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, American Community Survey.

## INDICATOR 4: Educational Attainment

**Table 4a. Educational attainment of the population age 65 and over, selected years 1965–2018**

Educational attainment	1965	1970	1975	1980	1985	1990	1995	2000	2001	2002	2003	2004	2005
	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	74.0
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	18.9
	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
High school graduate or more	75.2	76.1	77.4	78.3	79.5	80.7	81.1	82.6	83.7	84.3	85.4	86.1	86.4
Bachelor's degree or more	19.5	19.2	20.5	21.7	22.5	23.2	24.3	25.3	26.3	26.7	28.1	29.7	29.3

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, 2018**

Sex and race and Hispanic origin	High school graduate or more	Bachelor's degree or more
	Percent	
Total	85.1	28.2
Sex		
Men	85.8	33.2
Women	84.6	24.2
Race and Hispanic origin		
Non-Hispanic White alone	90.3	30.8
Black alone	76.3	17.4
Asian alone	74.3	37.5
Hispanic (any race)	54.0	12.2

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 resident population.

SOURCE: U.S. Census Bureau, American Community Survey.

## INDICATOR 5: Living Arrangements

**Table 5a. Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2018**

Sex and race and Hispanic origin	Total	With spouse	With other relatives	With nonrelatives	Alone	Living in group quarters
Percent						
Men	100.0	67.4	7.4	4.2	18.5	2.5
Non-Hispanic White alone	100.0	69.4	5.5	4.2	18.7	2.3
Black alone	100.0	50.0	14.4	5.0	25.5	5.2
Asian alone	100.0	75.8	12.6	2.4	7.9	1.3
Hispanic (any race)	100.0	63.3	15.7	4.2	14.5	2.3
Women	100.0	47.3	15.0	3.2	31.3	3.2
Non-Hispanic White alone	100.0	49.4	11.1	3.3	32.8	3.4
Black alone	100.0	28.2	30.7	2.5	35.0	3.6
Asian alone	100.0	60.0	19.1	2.8	16.4	1.7
Hispanic (any race)	100.0	45.0	28.1	3.0	21.9	2.0

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 resident population.

SOURCE: U.S. Census Bureau, American Community Survey.

**Table 5b. Percentage of population age 65 and over living alone, by sex and age group, selected years, 1970–2019**

Year	Men		Women	
	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
2016	18.0	23.8	27.5	45.5
2017	17.9	24.1	26.9	44.6
2018	18.5	24.2	26.2	44.3
2019	19.4	23.9	25.8	44.3

— 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, selected years 2000–2018, and projected 2020 and 2030**

Year	65 and over		65–74		75–84		85 and over	
	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
2018	38.1	1.2	31.8	1.2	40.8	0.9	70.7	1.4
Projections								
2020	34.1	1.3	27.0	1.4	39.7	1.0	61.9	1.3
2030	20.7	1.6	14.4	1.9	25.2	1.4	39.8	1.5

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 *2017 Census Summary File 1*; Department of Veterans Affairs, VetPop2014.

**Table 6b. Number of veterans age 65 and over, by age group and sex, selected years 2000–2018, and projected, 2020 and 2030**

Age group and sex	Estimates				Projections	
	2000	2010	2015	2018	2020	2030
Number (in thousands)						
65 and over	9,723	9,169	9,934	9,224	8,907	7,466
Men	9,374	8,866	9,591	8,881	8,519	6,831
Women	349	303	343	344	389	635
65–74	5,628	4,377	5,360	4,743	4,382	3,008
Men	5,516	4,253	5,174	4,541	4,136	2,618
Women	112	124	186	202	246	390
75–84	3,667	3,403	3,060	2,851	2,976	3,029
Men	3,460	3,321	2,972	2,766	2,887	2,836
Women	207	82	88	85	89	193
85 and over	427	1,389	1,513	1,631	1,549	1,429
Men	398	1,292	1,444	1,573	1,496	1,377
Women	30	97	69	57	53	52

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 *2017 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, 1966–2018**

Year	Under 18	18–64	65 and over			
			Total	65–74	75–84	85 and over
Percent						
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
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

See notes at end of table.

## INDICATOR 7: Poverty

**Table 7a. Poverty rate by age, by official poverty measure and Supplemental Poverty Measure, 1966–2018—continued**

Year	Under 18	18–64	65 and over			
			Total	65–74	75–84	85 and over
Percent						
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
2015	19.7	12.4	8.8	8.0	9.1	12.4
2016	18.0	11.6	9.3	8.6	9.5	12.1
2017 (legacy)	17.5	11.2	9.2	8.2	10.0	12.1
2017 (updated)	17.4	11.1	9.6	8.4	10.5	13.3
2018	16.2	10.7	9.7	8.7	10.3	14.0
Supplemental Poverty Measure						
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	17.2	20.1
2013 (redesign)	18.1	15.1	15.6	13.6	17.0	22.0
2014	17.1	15.3	14.4	12.5	16.1	19.6
2015	16.2	14.1	13.7	12.2	14.3	19.6
2016	15.2	13.3	14.5	12.6	16.0	20.7
2017 (legacy)	15.6	13.2	14.1	12.4	15.7	19.0
2017 (updated)	14.2	12.4	13.6	12.1	14.7	18.9
2018	13.7	12.2	13.6	12.2	14.3	19.0

— 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) 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) that received the redesigned income questions. The redesigned income questions were used for the entire 2015 CPS ASEC sample. A new processing system was implemented starting in 2017. The “2017 (legacy)” data reflect estimates using the previous system. “2017 (updated)” reflect estimates using the new processing system. The official 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. The Supplemental Poverty Measure extends the official poverty measure by taking account of many of the government programs designed to assist low-income families and individuals who 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.

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

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

## INDICATOR 7: Poverty

**Table 7b. Percentage of the population age 65 and over living in poverty, by selected characteristics, 2018**

Selected characteristic	65 and over			65–74	75 and over
	Total	Living alone	Married couples		
<b>Both Sexes</b>					
Total	9.7	17.6	5.2	8.7	11.3
Non-Hispanic White alone	7.3	13.4	4.0	6.2	8.9
Black alone	18.9	31.1	8.3	18.1	20.2
Asian alone	11.7	23.5	9.5	10.1	14.2
Hispanic (any race)	19.5	37.3	11.9	17.2	23.1
<b>Men</b>					
Total	8.1	15.6	5.3	7.7	8.8
Non-Hispanic White alone	6.0	12.1	3.9	5.5	6.8
Black alone	17.7	30.9	9.5	18.4	16.3
Asian alone	10.1	15.6	9.3	8.8	12.2
Hispanic (any race)	15.6	27.2	12.3	14.3	17.9
<b>Women</b>					
Total	11.1	18.7	5.2	9.6	13.2
Non-Hispanic White alone	8.4	14.1	4.1	6.8	10.5
Black alone	19.7	31.3	6.8	17.9	22.6
Asian alone	12.8	26.8	9.7	11.2	15.6
Hispanic (any race)	22.4	43.0	11.4	19.5	27.1

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, 1974–2018**

Year	Poverty	Percent		
		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

See notes at end of table.

## INDICATOR 8: Income

**Table 8a. Income distribution of the population age 65 and over, 1974–2018—continued**

Year	Poverty	Low income	Middle income	High income
		Percent		
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
2015	8.8	22.3	31.4	37.5
2016	9.3	21.2	31.4	38.1
2017	9.2	21.0	29.9	40.0
2018	9.7	19.6	30.3	40.4

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. A new processing system was implemented starting in 2017. 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 percent 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 2018 dollars, 1974–2018**

Year	Number (in thousands)	Current dollars	2018 dollars
1974	14,263	\$5,292	\$24,371
1975	14,802	5,585	23,767
1976	14,816	5,962	23,991
1977	15,225	6,347	24,024
1978	15,795	7,081	25,082
1979	16,544	7,879	25,491
1980	16,912	8,781	25,548
1981	17,312	9,903	26,327
1982	17,671	11,041	27,681
1983	17,901	11,718	28,175
1984	18,155	12,799	29,545
1985	18,596	13,254	29,580
1986	18,998	13,845	30,367
1987	19,412	14,443	30,625
1988	19,716	14,923	30,540
1989	20,156	15,771	30,923
1990	20,527	16,855	31,496
1991	20,921	16,975	30,606
1992	20,682	17,135	30,145
1993	20,806	17,751	30,461
1994	21,365	18,095	30,416
1995	21,486	19,096	31,344
1996	21,408	19,448	31,093
1997	21,497	20,761	32,490
1998	21,589	21,729	33,551
1999	22,478	22,797	34,466
2000	22,469	23,083	33,753
2001	22,476	23,118	32,868
2002	22,659	23,152	32,406
2003	23,048	23,787	32,555
2004	23,151	24,516	32,670
2005	23,459	26,036	33,559
2006	23,729	27,798	34,705
2007	24,113	28,305	34,364
2008	24,834	29,744	34,775
2009	25,270	31,354	36,785
2010	25,737	31,461	36,312
2011	26,843	33,118	37,056
2012	27,924	33,848	37,087
2013 (traditional)	28,729	35,611	38,449
2013 (redesign)	29,069	37,297	40,270

See notes at end of table.

## INDICATOR 8: Income

**Table 8b. Median income of householders age 65 and over, in current and in 2018 dollars, 1974–2018—continued**

Year	Number (in thousands)	Current dollars	2018 dollars
2014	29,946	36,895	39,172
2015	30,998	38,515	40,822
2016	31,799	39,823	41,671
2017 (legacy)	32,973	41,125	42,127
2017 (updated)	32,966	41,297	42,304
2018	34,156	43,696	43,696

NOTE: Income distribution from the Current Population Survey Annual and Social Economic Supplement (CPS ASEC) is based income for the year prior. The 2014 CPS 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 and beyond. Implementation of an updated CPS ASEC processing system was used beginning with 2017 data. The "2017 (legacy)" estimates are produced using the legacy processing system. The "2017 (updated)" estimates are produced using the new processing system. 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: Social Security Beneficiaries

**Table 9a. Percentage distribution of people who began receiving Social Security benefits in 2018, by age and sex**

Sex	Total years	Pre-Full Retirement Age				Full Retirement Age		Post-Full Retirement Age		
		Age 62	Age 63	Age 64	Age 65	Age 66	Disabled Worker Conversions <sup>a</sup>	Age 66	Ages 67–69	Age 70 and over
Men	100.0	28.4	6.0	6.1	10.8	18.9	17.7	3.4	4.6	4.1
Women	100.0	32.1	6.5	7.0	10.6	14.1	17.1	2.6	4.1	5.9

<sup>a</sup> 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 2018.

SOURCE: Social Security Administration, Master Beneficiary Record.

**Table 9b. Percentage distribution of female Social Security beneficiaries age 62 and over, by type of benefit received, selected years 1960–2018**

Type of benefit	1960	1970	1975	1980	1985	1990	1995	2000	2005	2010	2015	2016	2017	2018
Worker benefit only <sup>a</sup>	38.7	42.1	42.3	41.0	38.5	36.9	36.2	38.0	41.4	46.3	52.1	53.1	54.2	55.3
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	8.4	8.3	8.0	7.8
Widow only <sup>b</sup>	23.4	26.8	26.1	25.4	24.9	24.3	23.6	21.5	19.3	17.0	13.7	13.2	12.7	12.2
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	11.4	11.2	11.0	10.7
Worker and widow	2.1	5.0	7.4	9.6	11.5	13.0	14.4	15.6	16.0	15.5	14.4	14.2	14.1	13.9

<sup>a</sup> Worker benefits include retired and disabled worker benefits.

<sup>b</sup> 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 10: Net Worth

**Table 10a. Median household net worth, in 2016 dollars, by selected characteristics of head of household, selected years 1989–2016**

Selected characteristic	1989	1992	1995	1998	2001	2004	2007	2010	2013	2016
Age of family head										
45–54	\$204,610	\$150,198	\$170,929	\$174,989	\$209,596	\$199,161	\$247,815	\$160,273	\$142,396	\$160,700
55–64	194,572	211,730	211,880	218,796	267,380	356,099	327,718	241,791	211,789	219,200
65 and over	158,225	165,644	166,623	213,056	242,518	234,517	267,386	257,873	228,802	253,800
65–74	158,225	176,260	186,511	231,499	266,865	258,681	301,084	267,456	263,550	231,800
75 and over	162,423	148,253	152,059	190,187	230,189	214,931	253,721	244,167	213,532	272,400
Marital status, <sup>a</sup> family head age 65 and over										
Married	261,220	261,287	250,874	325,353	400,358	377,211	350,531	375,038	343,152	378,090
Unmarried	87,751	114,145	129,086	146,144	137,382	160,245	208,524	165,059	139,818	176,730
Race, <sup>b</sup> family head age 65 and over										
White	185,280	189,509	196,064	238,877	317,144	285,019	298,884	300,340	278,398	320,920
Nonwhite or Hispanic	56,853	63,058	52,508	78,199	85,220	69,821	115,744	128,218	83,932	102,000
Education, family head age 65 and over										
No high school diploma	83,964	73,271	102,934	98,856	108,388	75,290	141,278	108,256	103,843	82,190
High school diploma only	157,199	183,974	176,802	216,155	234,430	223,579	225,118	198,738	159,966	187,700
Some college or more	463,032	331,775	317,586	358,064	540,044	482,514	602,168	476,728	439,044	460,000

<sup>a</sup> "Married" includes legally married and cohabiting couples. "Unmarried" includes separated, divorced, widowed, and never married.

<sup>b</sup> Race refers to the designated respondent for the household in the Survey of Consumer Finances (SCF).

NOTE: Median net worth is measured in constant 2016 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 2016 SCF (<https://www.federalreserve.gov/data.htm>). The data are for the "primary economic unit" (PEU), which 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. Some estimates have been revised and may differ from previous editions of *Older Americans*. Please note that the format of this indicator has changed from the previous edition. Changes to the indicator are to improve clarity and show trends over time.

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

SOURCE: Survey of Consumer Finances.

**Table 10b. Percent holding and median household financial assets held in retirement investment accounts, in 2016 dollars, by selected characteristics of head of household, selected years 1989–2016**

Selected characteristic	1989		1992		1995		1998		2001	
	In dollars		In dollars		In dollars		In dollars		In dollars	
	Median (among holders)	Percent holding								
Age of family head										
45–54	\$31,720	52.2	\$46,958	51.9	\$43,848	57.4	\$51,641	59.3	\$65,033	63.7
55–64	44,781	47.4	50,312	53.0	50,112	51.0	69,347	58.3	74,517	59.8
65 and over	27,988	20.3	33,541	22.8	42,282	27.3	51,641	32.1	77,227	36.5
65–74	27,988	30.1	33,541	35.1	45,414	36.6	56,067	46.1	81,291	45.1
75 and over	29,854	6.3	46,958	6.3	36,801	15.9	44,264	16.7	65,033	27.7
Marital status, <sup>a</sup> family head age 65 and over										
Married	37,317	32.0	43,604	36.9	59,195	39.0	54,592	46.0	108,388	47.1
Unmarried	18,659	10.5	16,771	11.9	25,056	15.6	41,313	19.8	36,581	24.8

See notes at end of table.

## INDICATOR 10: Net Worth

**Table 10b. Percent holding and median household financial assets held in retirement investment accounts, in 2016 dollars, by selected characteristics of head of household, selected years 1989–2016—continued**

Selected characteristic	1989		1992		1995		1998		2001	
	In dollars		In dollars		In dollars		In dollars		In dollars	
	Median (among holders)	Percent holding								
Race, <sup>b</sup> family head age 65 and over										
White	27,988	23.6	35,218	25.2	42,282	29.8	54,592	35.4	78,852	41.1
Nonwhite or Hispanic	31,720	5.7	23,479	9.7	50,112	11.3	26,558	11.3	27,097	10.0
Education, family head age 65 and over										
No high school diploma	27,988	8.8	15,094	8.0	23,490	13.8	20,952	12.8	27,097	12.9
High school diploma only	18,659	22.4	31,864	28.1	32,886	28.5	48,690	30.1	47,420	33.0
Some college or more	31,720	38.9	41,927	37.0	62,640	40.4	69,347	49.0	132,775	57.5
Selected characteristic	2004		2007		2010		2013		2016	
	In dollars		In dollars		In dollars		In dollars		In dollars	
	Median (among holders)	Percent holding								
Age of family head										
45–54	\$70,584	58.2	\$72,955	65.4	\$66,320	60.1	\$89,706	56.5	\$82,000	59.8
55–64	105,558	63.5	115,802	61.2	110,533	59.8	107,235	59.3	120,000	59.3
65 and over	69,948	36.1	70,407	40.8	78,478	41.1	121,670	39.4	120,000	45.8
65–74	101,743	43.2	89,167	51.7	110,533	48.9	153,635	48.0	126,200	49.8
75 and over	38,154	29.2	40,531	30.0	59,688	32.7	71,146	29.0	120,000	40.8
Marital status, <sup>a</sup> family head age 65 and over										
Married	96,655	49.1	85,693	53.4	103,901	55.3	164,977	50.5	165,000	56.7
Unmarried	38,154	23.7	40,531	28.9	54,161	26.8	70,115	28.7	80,000	34.7
Race, <sup>b</sup> family head age 65 and over										
White	73,763	41.4	75,966	45.3	87,321	45.7	127,857	45.5	131,000	51.5
Nonwhite or Hispanic	13,990	11.8	30,108	16.6	49,740	23.2	51,555	17.1	90,000	28.2
Education, family head age 65 and over										
No high school diploma	13,990	11.7	35,898	19.0	26,528	16.1	22,684	9.1	50,000	18.2
High school diploma only	47,056	38.4	40,531	35.1	50,845	34.0	63,929	31.4	52,000	33.3
Some college or more	108,102	50.2	134,330	59.1	134,850	57.4	175,288	55.5	185,000	60.1

<sup>a</sup> "Married" includes legally married and cohabiting couples. "Unmarried" includes separated, divorced, widowed, and never married.

<sup>b</sup> Race refers to the designated respondent for the household in the Survey of Consumer Finances (SCF).

NOTE: Median values are measured in constant 2016 dollars. Retirement accounts include the total value of investment retirement accounts such as individual retirement accounts, Keoghs, thrift-type plans, and current and future account-type pensions. All observations are weighted for analysis. The term "household" in this indicator is from the codebook of the 2016 SCF (<https://www.federalreserve.gov/data.htm>). The data are for the "primary economic unit" (PEU), which 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 estimates of median levels are calculated only for households with positive values. Some estimates have been revised and may differ from previous editions of *Older Americans*. Please note that the format of this indicator has changed from the previous edition. Changes to the indicator are to improve clarity and show trends over time.

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

SOURCE: Survey of Consumer Finances.

## INDICATOR 10: Net Worth

Table 10c. Amount of funds (in millions of dollars) held in retirement assets, by sector and type of plan, 1975–2018

Year	All sectors			Private only		Public only	
	Individual retirement accounts (IRAs)	Defined contribution	Defined benefit <sup>a</sup>	Defined contribution	Defined benefit <sup>a</sup>	Defined contribution	Defined benefit <sup>a</sup>
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	—	139,717	515,723	136,320	279,781	\$3,397	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	597,129	1,674,304	577,118	812,800	20,011	861,504
1989	546,000	715,195	1,918,853	688,709	921,494	26,486	997,359
1990	637,000	737,196	1,962,358	708,546	899,857	28,650	1,062,501
1991	776,000	890,178	2,274,407	852,773	1,051,654	37,405	1,222,753
1992	873,000	974,094	2,427,769	930,211	1,079,860	43,883	1,347,909
1993	993,000	1,108,998	2,684,968	1,056,833	1,195,109	52,165	1,489,859
1994	1,056,000	1,183,877	2,853,227	1,125,844	1,275,964	58,033	1,577,263
1995	1,288,000	1,465,478	3,299,521	1,388,463	1,466,122	77,015	1,833,399
1996	1,467,000	1,839,785	3,660,841	1,632,519	1,590,232	207,266	2,070,609
1997	1,728,000	2,219,835	4,159,755	1,948,201	1,763,538	271,634	2,396,217
1998	2,150,000	2,581,594	4,581,283	2,238,002	1,907,730	343,592	2,673,553
1999	2,651,000	2,951,009	5,084,432	2,527,758	2,074,645	423,251	3,009,787
2000	2,629,000	2,900,572	4,977,000	2,497,318	1,978,987	403,254	2,998,013
2001	2,619,000	2,631,773	4,782,651	2,249,748	1,810,236	382,025	2,972,415
2002	2,532,000	2,399,859	4,463,024	2,051,380	1,639,303	348,479	2,823,721
2003	2,993,000	2,987,886	5,151,882	2,546,469	1,994,538	441,417	3,157,344
2004	3,299,000	3,321,626	5,671,203	2,816,422	2,132,170	505,204	3,539,033
2005	3,425,000	3,699,198	5,900,406	3,140,097	2,281,326	559,101	3,619,080
2006	4,207,000	4,079,826	6,320,356	3,437,077	2,380,547	642,749	3,939,809
2007	4,748,000	4,367,200	6,660,834	3,662,216	2,523,174	704,984	4,137,660
2008	3,681,000	3,262,335	5,296,372	2,723,349	1,885,268	538,986	3,411,104
2009	4,488,000	3,998,192	5,891,500	3,335,355	2,150,270	662,837	3,741,230
2010	5,029,000	4,514,954	6,406,356	3,768,435	2,398,216	746,519	4,008,140
2011	5,153,000	4,500,367	6,424,613	3,775,363	2,449,294	725,004	3,975,319
2012	5,785,000	5,007,229	6,960,773	4,224,426	2,640,925	782,803	4,319,848
2013	6,819,000	5,877,282	7,607,572	4,983,514	2,822,831	893,768	4,784,741
2014	7,292,000	6,168,885	7,941,740	5,247,662	2,922,939	921,223	5,018,801
2015	7,477,000	6,100,984	7,847,651	5,166,860	2,790,740	934,124	5,056,911
2016	8,015,000	6,515,135	8,162,890	5,619,081	2,850,541	896,054	5,312,349
2017	9,105,000	7,511,118	9,046,813	6,513,763	3,152,754	997,355	5,894,059
2018	8,715,000	7,229,677	8,882,634	6,236,604	2,989,081	993,073	5,893,553

— Not available.

<sup>a</sup> Public and private defined benefit retirement assets do not include claims of pension funds on sponsor.

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

NOTE: Some estimates have been revised and may differ from previous editions of Older Americans.

SOURCE: Federal Reserve Board Z.1 Statistical Release for Dec. 12, 2019.

## INDICATOR 11: Participation in Labor Force

**Table 11. Labor force participation rates (annual averages) of persons age 55 and over, by sex and age group, 1963–2019**

Year	Men				Women			
	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 11: Participation in Labor Force

**Table 11. Labor force participation rates (annual averages) of persons age 55 and over, by sex and age group, 1963–2019—continued**

Year	Men				Women			
	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
2016	75.3	56.1	36.9	16.5	63.5	45.3	28.0	9.3
2017	75.5	57.7	37.3	16.5	63.9	46.2	27.9	9.8
2018	76.3	58.3	37.6	16.9	64.0	46.9	28.9	9.9
2019	76.8	58.2	39.4	17.1	64.6	47.3	29.8	10.3

NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years because of 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 12: Housing Problems

**Table 12a. Prevalence of housing problems among older owner/renter households,<sup>a</sup> by type of problem, selected years, 2013–2017**

	2013				2015				2017			
	Households	%	Persons <sup>b</sup>	%	Households	%	Persons <sup>b</sup>	%	Households	%	Persons <sup>b</sup>	%
Total	28,330	100.0	38,327	100.0	29,734	100.0	40,574	100.0	32,396	100.0	44,248	100.0
Number and percent with	Number (in thousands)											
One or more housing problems	10,905	38.5	13,541	35.3	12,251	41.2	15,447	38.1	13,420	41.4	16,982	38.4
Housing cost burden (>30%)	10,316	36.4	12,809	33.4	11,419	38.4	14,351	35.4	12,663	39.1	15,984	36.1
Physically inadequate housing	1,063	3.8	1,290	3.4	1,372	4.6	1,701	4.2	1,243	3.8	1,553	3.5
Crowded housing	106	0.4	147	0.4	172	0.6	241	0.6	156	0.5	237	0.5

<sup>a</sup> Older owner/renter households are defined as households with a householder or spouse age 65 and over.

<sup>b</sup> Number of persons age 65 and over.

NOTE: Additional data for selected years 1985–2017 are available at [agingstats.gov](http://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 12b. Prevalence of housing problems among older-member households,<sup>a</sup> by type of problem, selected years, 2013–2017**

	2013				2015				2017			
	Households	%	Persons <sup>b</sup>	%	Households	%	Persons <sup>b</sup>	%	Households	%	Persons <sup>b</sup>	%
Total	2,115	100.0	2,366	100.0	2,174	100.0	2,459	100.0	2,533	100.0	2,896	100.0
Number and percent with	Number (in thousands)											
One or more housing problems	818	38.7	940	39.7	842	38.7	955	38.8	997	39.4	1,148	39.6
Housing cost burden (>30%)	711	33.6	820	34.7	717	33.0	813	33.1	818	32.3	933	32.2
Physically inadequate housing	81	3.8	92	3.9	105	4.8	116	4.7	99	3.9	105	3.6
Crowded housing	129	6.1	156	6.6	138	6.4	169	6.9	197	7.8	246	8.5

<sup>a</sup> 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.

<sup>b</sup> Number of persons (excluding householder and spouse) age 65 and over.

NOTE: Additional data for selected years 1985–2017 are available at [agingstats.gov](http://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 12: Housing Problems

**Table 12c. Prevalence of housing problems among all U.S. households except those households<sup>a</sup> with one or more persons age 65 and over, by type of problem, selected years, 2013–2017**

	2013				2015				2017			
	Households	%	Persons	%	Households	%	Persons	%	Households	%	Persons	%
	Number (in thousands)											
Total	85,406	100.0	230,689	100.0	86,382	100.0	229,250	100.0	86,631	100.0	234,250	100.0
Number and percent with												
One or more housing problems	32,285	37.8	87,835	38.1	33,133	38.4	88,830	38.7	31,583	36.5	85,317	36.4
Housing cost burden (>30%)	28,606	33.5	74,587	32.3	29,315	33.9	75,416	32.9	27,861	32.2	71,308	30.4
Physically inadequate housing	4,744	5.6	11,807	5.1	5,202	6.0	14,055	6.1	4,654	5.4	12,387	5.3
Crowded housing	2,262	2.6	14,101	6.1	2,228	2.6	13,399	5.8	2,243	2.6	13,536	5.8

<sup>a</sup> Households with no persons age 65 and over.

NOTE: Additional data for selected years 1985–2017 are available at [agingstats.gov](http://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 12d. Prevalence of housing problems among older owner/renter intergenerational households,<sup>a</sup> by type of problem, selected years, 2013–2017**

	2013				2015				2017			
	Households	%	Persons <sup>b</sup>	%	Households	%	Persons <sup>b</sup>	%	Households	%	Persons <sup>b</sup>	%
	Number (in thousands)											
Total	1,220	100.0	1,494	100.0	1,293	100.0	1,674	100.0	1,435	100.0	1,880	100.0
Number and percent with												
One or more housing problems	532	43.6	630	42.2	572	44.2	745	44.5	641	44.7	823	43.8
Housing cost burden (>30%)	457	37.4	542	36.3	443	34.2	564	33.7	547	38.2	703	37.4
Physically inadequate housing	57	4.7	65	4.4	81	6.3	100	6.0	71	4.9	85	4.5
Crowded housing	89	7.3	121	8.1	129	10.0	179	10.7	114	7.9	172	9.2

<sup>a</sup> Older owner/renter intergenerational households are defined as households with a householder or spouse age 65 and over with children age 19 or younger.

<sup>b</sup> Number of persons age 65 and over.

NOTE: Additional data for selected years 1985–2017 are available at [agingstats.gov](http://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 12: Housing Problems

**Table 12e. Prevalence of housing problems among older-member intergenerational households,<sup>a</sup> by type of problem, selected years, 2013–2017**

	2013				2015				2017			
	House-holds	%	Persons <sup>b</sup>	%	House-holds	%	Persons <sup>b</sup>	%	House-holds	%	Persons <sup>b</sup>	%
	Number (in thousands)											
Total	862	100.0	982	100.0	783	100.0	898	100.0	950	100.0	1,127	100.0
Number and percent with												
One or more housing problems	391	45.3	447	45.5	364	46.5	410	45.7	451	47.5	533	47.3
Housing cost burden (>30%)	319	37.0	364	37.1	288	36.9	325	36.2	333	35.1	390	34.6
Physically inadequate housing	40	4.7	48	4.9	35	4.5	36	4.0	32	3.4	37	3.3
Crowded housing	118	13.7	136	13.9	121	15.4	138	15.4	165	17.4	198	17.6

<sup>a</sup> 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.

<sup>b</sup> Number of persons age 65 and over.

NOTE: Additional data for selected years 1985–2017 are available at [agingstats.gov](http://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 12f. Prevalence of housing problems among all older households: householder, spouse, or member(s) age 65 and over,<sup>a</sup> by type of problem, selected years, 2013–2017**

	2013				2015				2017			
	House-holds	%	Persons <sup>a</sup>	%	House-holds	%	Persons <sup>a</sup>	%	House-holds	%	Persons <sup>a</sup>	%
	Number (in thousands)											
Total	30,446	100.0	40,693	100.0	31,908	100.0	43,033	100.0	34,929	100.0	47,144	100.0
Number and percent with												
One or more housing problems	11,723	38.5	14,481	35.6	13,092	41.0	16,401	38.1	14,416	41.3	18,130	38.5
Housing cost burden (>30%)	11,027	36.2	13,630	33.5	12,136	38.0	15,164	35.2	13,481	38.6	16,917	35.9
Physically inadequate housing	1,145	3.8	1,382	3.4	1,477	4.6	1,816	4.2	1,342	3.8	1,658	3.5
Crowded housing	235	0.8	303	0.7	310	1.0	410	1.0	353	1.0	483	1.0

<sup>a</sup> Number of persons age 65 and over.

NOTE: Additional data for selected years 1985–2017 are available at [agingstats.gov](http://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: Total Expenditures

**Table 13. Percentage distribution of total household annual expenditures, by age of reference person, 2018**

Annual expenditure	45–54	55–64	65 and over		
			Total	65–74	75 and over
Personal insurance and pensions	14.6	12.8	7.0	7.3	6.5
Health care	6.8	8.7	13.4	11.9	16.0
Transportation	15.3	15.8	14.3	15.7	11.8
Housing	31.3	31.6	33.3	32.0	35.7
Food	12.6	12.1	13.0	13.0	12.9
Food at home	6.8	7.2	7.9	7.6	8.4
Food away from home	5.8	4.9	5.1	5.4	4.5
Other	19.4	19.1	19.0	20.1	17.0

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 the term "consumer unit" in this text.

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

SOURCE: Bureau of Labor Statistics, Consumer Expenditure Survey.

## INDICATOR 14: Life Expectancy

Table 14. Life expectancy at ages 65 and 85, by race and Hispanic origin and sex, 2006–2018

Age and year	All races and origins <sup>a</sup>			Hispanic			Non-Hispanic White			Non-Hispanic Black or African American		
	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women	Both sexes	Men	Women
At age 65												
2006	18.7	17.2	19.9	20.2	18.5	21.5	18.7	17.2	19.9	17.1	15.1	18.5
2007	18.8	17.4	20.0	20.5	18.7	21.7	18.8	17.4	20.0	17.2	15.3	18.7
2008	18.8	17.4	20.0	20.4	18.7	21.6	18.8	17.4	20.0	17.4	15.4	18.8
2009	19.1	17.7	20.3	20.7	19.0	21.9	19.1	17.7	20.3	17.7	15.8	19.1
2010	19.1	17.7	20.3	21.2	19.2	22.6	19.1	17.7	20.3	17.7	15.8	19.1
2011	19.2	17.8	20.3	21.2	19.5	22.5	19.1	17.8	20.3	17.9	16.0	19.2
2012	19.3	17.9	20.5	21.4	19.6	22.6	19.2	17.9	20.4	18.0	16.1	19.4
2013	19.3	17.9	20.5	21.3	19.5	22.5	19.3	17.9	20.4	18.0	16.1	19.4
2014	19.4	18.0	20.6	21.5	19.7	22.8	19.3	18.0	20.5	18.1	16.3	19.5
2015	19.3	18.0	20.5	21.4	19.7	22.6	19.3	18.0	20.4	18.1	16.2	19.5
2016	19.4	18.1	20.6	21.5	19.8	22.7	19.4	18.0	20.5	18.1	16.2	19.5
2017	19.4	18.0	20.6	21.4	19.7	22.7	19.3	18.0	20.5	18.1	16.2	19.5
2018 <sup>b</sup>	19.5	18.1	20.7	21.4	19.7	22.7	19.4	18.1	20.6	18.0	16.1	19.5
2018 <sup>c</sup>	—	—	—	—	—	—	19.4	18.1	20.6	18.1	16.2	19.6
At age 85												
2006	6.3	5.6	6.7	7.2	6.3	7.5	6.3	5.6	6.7	6.5	5.5	6.9
2007	6.4	5.7	6.8	7.3	6.4	7.5	6.4	5.7	6.8	6.5	5.6	7.0
2008	6.4	5.7	6.7	7.1	6.2	7.4	6.3	5.6	6.7	6.6	5.7	7.0
2009	6.6	5.8	7.0	7.3	6.4	7.7	6.5	5.8	6.9	6.8	5.9	7.2
2010	6.5	5.8	6.9	7.6	6.6	8.2	6.5	5.8	6.9	6.7	5.9	7.1
2011	6.5	5.9	6.9	7.6	6.8	8.0	6.5	5.8	6.8	6.8	6.0	7.2
2012	6.6	5.9	6.9	7.7	6.8	8.1	6.5	5.9	6.9	6.8	6.0	7.2
2013	6.6	5.9	7.0	7.6	6.7	8.0	6.5	5.8	6.9	6.8	5.9	7.2
2014	6.7	6.0	7.1	7.8	6.9	8.2	6.6	5.9	7.0	6.9	6.1	7.3
2015	6.6	5.9	7.0	7.7	6.8	8.0	6.5	5.9	6.9	6.8	6.1	7.2
2016	6.7	6.0	7.1	7.7	6.9	8.0	6.6	5.9	7.0	6.9	6.1	7.3
2017	6.6	5.9	7.0	7.6	6.7	8.0	6.5	5.9	6.9	6.9	6.1	7.3
2018 <sup>b</sup>	6.6	6.0	7.0	7.6	6.7	8.0	6.5	5.9	6.9	6.9	6.1	7.3
2018 <sup>c</sup>	—	—	—	—	—	—	6.5	5.9	6.9	6.9	6.1	7.3

— Not available.

<sup>a</sup> "All races and origins" includes races not shown separately.

<sup>b</sup> Estimates are calculated using single-race population estimates.

<sup>c</sup> Estimates are calculated using bridged-race population estimates.

NOTE: The race groups, White and Black or African American, include persons of Hispanic and non-Hispanic origin. Persons of Hispanic origin may be of any race. Starting with 2018 data, race on death records is available based on the 1997 Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity and are presented as "single" race estimates. Before 2018, data were tabulated according to the 1977 standards, and race data were "bridged" to retain comparability across states as they transitioned from the 1977 standards to the 1997 standards. Single race estimates for 2018 and beyond are not completely comparable with bridged estimates for earlier years. Bridged race estimates for 2018 are presented for comparison. See *Health, United States, 2018*, Appendix II for a description of changes in life table methodology over time. Estimates for 2018 are found in Arias, E., and Xu, J.Q. (in press, 2020). *United States life tables, 2018* (National Vital Statistics Reports).

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

## INDICATOR 15: Mortality

**Table 15a. Death rates among people age 65 and over, by selected leading causes of death, 2000–2018**

Year	Total <sup>a</sup>	Heart disease	Cancer	Stroke	Chronic lower respiratory diseases	Influenza and pneumonia	Diabetes	Alzheimer's disease	Unintentional injuries
Rate per 100,000 standard population									
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
2015	4,241	1,073	901	256	285	103	120	231	109
2016	4,166	1,048	885	253	276	88	118	238	110
2017	4,188	1,047	869	255	279	95	120	244	113
2018	4,139	1,035	849	252	270	96	118	239	112

<sup>a</sup> Includes other causes of death not shown separately.

NOTE: Rates are age adjusted using the 2000 U.S. standard population.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

## INDICATOR 15: Mortality

**Table 15b. Number of deaths and age-adjusted death rates among people age 65 and over, by selected leading causes of death and sex, 2018**

Sex	Total <sup>a</sup>		Heart disease		Cancer	
	Age-adjusted death rate	Number of deaths	Age-adjusted death rate	Number of deaths	Age-adjusted death rate	Number of deaths
All	4,139	2,099,263	1,035	526,509	849	431,102
Sex						
Men	4,756	997,417	1,273	264,920	1,052	227,938
Women	3,666	1,101,846	856	261,589	702	203,164
Sex	Chronic lower respiratory diseases		Stroke		Alzheimer's disease	
	Age-adjusted death rate	Number of deaths	Age-adjusted death rate	Number of deaths	Age-adjusted death rate	Number of deaths
All	270	135,560	252	127,244	239	120,658
Sex						
Men	300	63,097	249	51,051	192	37,359
Women	249	72,463	250	76,193	268	83,299
Sex	Diabetes		Unintentional injuries		Influenza and pneumonia	
	Age-adjusted death rate	Number of deaths	Age-adjusted death rate	Number of deaths	Age-adjusted death rate	Number of deaths
All	118	60,182	112	57,213	96	48,888
Sex						
Men	148	32,027	141	29,934	112	22,923
Women	96	28,155	90	27,279	85	25,965

<sup>a</sup> Includes other causes of death not shown separately.

NOTE: Rates are age adjusted using the 2000 U.S. standard population. Ranking of causes of death are based on number of deaths.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Vital Statistics System.

## INDICATOR 16: Chronic Health Conditions

**Table 16a. Percentage of people age 65 and over who reported having selected chronic health conditions, by sex and race and Hispanic origin, 2018**

Sex and race and Hispanic origin	Heart disease	Hyper-tension	Stroke	Asthma	Chronic obstructive pulmonary disease (COPD)	Cancer	Diabetes	Arthritis
Total	29.1	57.0	8.9	11.7	13.7	25.8	21.5	50.5
Sex								
Men	34.9	58.5	9.5	8.6	13.1	27.2	25.0	46.0
Women	24.5	55.7	8.3	14.2	14.2	24.7	18.7	54.1
Race and Hispanic origin								
Non-Hispanic White	30.2	55.0	8.4	11.2	14.3	29.1	18.2	52.0
Non-Hispanic Black	27.2	68.1	11.6	14.6	13.4	16.9	33.5	51.9
Hispanic	22.0	60.0	8.5	12.9	11.6	13.4	32.7	44.2

NOTE: Chronic obstructive pulmonary disease (COPD) is defined as responding yes to questions on ever having emphysema, COPD, or chronic bronchitis in the past 12 months. This definition is changed from previous editions of *Older Americans*. 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: National Center for Health Statistics, National Health Interview Survey.

**Table 16b. Percentage of people age 65 and over who reported having selected chronic health conditions, 1997–2018**

Year	Heart disease	Hyper-tension	Stroke	Asthma	Chronic obstructive pulmonary disease (COPD)	Cancer	Diabetes	Arthritis
1997	31.6	46.7	7.8	7.6	10.6	19.4	13.2	—
1998	32.1	46.2	8.3	7.8	9.9	17.8	13.2	—
1999	28.9	45.8	7.8	6.6	9.5	19.5	13.2	—
2000	30.3	48.5	8.3	8.4	10.1	20.1	14.6	—
2001	31.5	49.6	9.0	8.7	10.5	19.8	15.3	—
2002	31.0	50.5	8.6	8.0	9.1	21.7	16.0	47.8
2003	31.5	51.3	9.0	8.1	9.4	19.7	16.6	48.9
2004	32.1	52.4	9.4	9.8	9.8	21.5	17.3	50.9
2005	31.5	52.0	9.2	9.9	9.6	21.8	17.0	50.3
2006	31.0	53.2	9.3	10.6	10.0	21.1	18.1	49.6
2007	31.2	53.9	8.3	9.7	8.6	22.1	18.7	47.7
2008	32.5	57.5	9.4	11.0	9.3	22.8	18.5	51.1
2009	30.8	56.2	9.0	11.3	10.7	24.5	19.5	51.1
2010	30.1	55.5	8.2	11.2	9.9	23.5	21.4	51.3
2011	30.9	56.5	8.3	10.4	9.7	24.8	20.6	49.9
2012	29.8	55.2	8.2	10.4	11.7	24.3	20.0	47.9
2013	29.8	55.0	8.6	10.3	11.7	23.7	21.0	49.3
2014	28.9	56.8	7.2	11.0	12.4	23.1	20.5	48.8
2015	29.5	57.7	7.9	10.3	12.0	25.6	21.7	50.6
2016	28.2	57.1	8.4	10.9	11.9	25.8	20.6	49.4
2017	27.9	56.1	8.7	11.1	12.1	25.5	19.1	51.3
2018	29.1	57.0	8.9	11.7	13.7	25.8	21.5	50.5

— Not available.

NOTE: In 2012–2018, chronic obstructive pulmonary disease (COPD) is defined as responding yes to questions on ever having emphysema, COPD, or chronic bronchitis in the past 12 months. In 1997–2011, the single question on COPD was not included.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 17: Oral Health

**Table 17a. 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, 2018**

Age group	Dental insurance	Dental visit in past year	No natural teeth
65 and over	29.0	65.6	19.2
65–74	32.4	67.9	15.4
75–84	24.7	63.9	22.3
85 and over	21.5	57.3	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: National Center for Health Statistics, National Health Interview Survey.

**Table 17b. 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, 2018**

Sex and race and Hispanic origin	Dental insurance	Dental visit in past year	No natural teeth
Sex			
Men	30.4	64.4	19.4
Women	27.8	66.5	19.0
Race and Hispanic origin			
Non-Hispanic White	30.1	68.8	17.6
Non-Hispanic Black	30.2	54.1	28.2
Hispanic	21.6	55.9	22.5

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: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 18: Respondent-Assessed Health Status

**Table 18. Percentage of people age 65 and over with respondent-assessed health status, by race and Hispanic origin, sex, and age group, 2018**

Selected characteristic	Total	Non-Hispanic White	Non-Hispanic Black	Hispanic
<b>Good to excellent health</b>				
Both sexes				
65 and over	77.8	81.1	65.3	64.3
65–74	80.9	83.7	69.0	70.5
75–84	75.3	79.3	59.9	54.8
85 and over	68.5	72.2	55.9	50.0
Men				
65 and over	77.6	79.9	66.0	68.4
65–74	80.1	82.6	68.5	72.4
75–84	75.0	77.2	61.7	60.4
85 and over	68.7	71.5	*	*
Women				
65 and over	78.0	82.0	64.9	61.1
65–74	81.5	84.7	69.5	68.8
75–84	75.4	81.0	59.0	51.4
85 and over	68.3	72.6	54.2	47.6
<b>Fair or poor health</b>				
Both sexes				
65 and over	22.2	19.0	34.7	35.7
65–74	19.1	16.3	31.0	29.5
75–84	24.8	20.7	40.1	45.3
85 and over	31.5	27.8	44.1	50.0
Men				
65 and over	22.4	20.1	34.0	31.6
65–74	19.9	17.4	31.5	27.6
75–84	25.0	22.8	38.3	39.6
85 and over	31.3	28.5	*	*
Women				
65 and over	22.0	18.0	35.1	38.9
65–74	18.5	15.3	30.5	31.3
75–84	24.6	19.0	41.0	48.6
85 and over	31.7	27.4	45.8	52.4

\* Statistic does not meet National Center for Health Statistics standards of reliability or precision.

NOTE: 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: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 19: Dementia

**Table 19a. Number and percentage of the non-nursing home population age 65 and over with dementia, by age group, 2011 and 2015**

Age group	2011		2015	
	Number	Percent	Number	Percent
65 and over	3,020,000	8.4	3,100,000	7.5
65–74	550,000	2.9	570,000	2.5
75–79	550,000	8.1	530,000	7.1
80–84	670,000	12.9	700,000	13.4
85–89	690,000	21.7	680,000	20.3
90 and over	520,000	32.7	590,000	30.6

NOTE: Population estimates that are representative of Medicare beneficiaries age 65 and over living in settings other than nursing homes were calculated according to the methodology in Freedman, Kaspar, Spillman, and Plassman (2018).<sup>18</sup>

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

SOURCE: Office of the Assistant Secretary for Planning and Evaluation, National Health and Aging Trends Study.

**Table 19b. Number and percentage of the non-nursing home population age 65 and over with dementia, by sex and age group, 2011 and 2015**

Age group	2011				2015			
	Men		Women		Men		Women	
	Number	Percent	Number	Percent	Number	Percent	Number	Percent
65 and over	1,150,000	7.3	1,870,000	9.2	1,370,000	7.4	1,740,000	7.5
65–74	330,000	3.5	240,000	2.4	400,000	3.5	200,000	1.6
75–84	480,000	9.5	730,000	10.7	530,000	9.4	700,000	9.9
85 and over	340,000	20.8	860,000	27.4	440,000	23.4	830,000	24.4

NOTE: Population estimates that are representative of Medicare beneficiaries age 65 and over living in settings other than nursing homes were calculated according to the methodology in Freedman, Kaspar, Spillman, and Plassman (2018).<sup>18</sup>

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

SOURCE: Office of the Assistant Secretary for Planning and Evaluation, National Health and Aging Trends Study.

**Table 19c. Number and percentage of the non-nursing home population age 65 and over with dementia, by sex and educational attainment, 2011 and 2015**

Educational attainment	2011					
	Total		Men		Women	
	Number	Percent	Number	Percent	Number	Percent
Less than high school	1,250,000	16.5	500,000	15.2	750,000	17.6
High school graduate	810,000	8.4	250,000	7.0	570,000	9.3
Some college	450,000	4.9	160,000	4.5	290,000	5.2
Bachelor's degree or more	330,000	3.9	180,000	3.7	160,000	4.2
Beyond high school	780,000	4.4	330,000	4.0	450,000	4.8

See notes at end of table.

## INDICATOR 19: Dementia

**Table 19c. Number and percentage of the non-nursing home population age 65 and over with dementia, by sex and educational attainment, 2011 and 2015—continued**

Educational attainment	2015					
	Total		Men		Women	
	Number	Percent	Number	Percent	Number	Percent
Less than high school	1,080,000	15.9	480,000	15.5	600,000	16.2
High school graduate	860,000	8.4	360,000	9.2	500,000	7.8
Some college	460,000	4.1	190,000	4.4	270,000	4.0
Bachelor's degree or more	440,000	3.9	210,000	3.4	230,000	4.5
Beyond high school	900,000	4.0	410,000	3.8	490,000	4.2

NOTE: The beyond high school category includes trade school and any college education whether or not a degree was completed. In 2011 and 2015, 1.3 percent and 3.0 percent, respectively, of the overall population were missing data on education. These cases were excluded.

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

SOURCE: Office of the Assistant Secretary for Planning and Evaluation, National Health and Aging Trends Study.

**Table 19d. Number and percentage of the non-nursing home population age 65 and over with dementia, by age group and educational attainment, 2011 and 2015**

Educational attainment	2011					
	65–74		75–84		85 and over	
	Number	Percent	Number	Percent	Number	Percent
Less than high school	250,000	7.7	540,000	18.3	460,000	33.9
High school graduate	140,000	2.8	350,000	9.8	330,000	24.5
Beyond high school	150,000	1.5	290,000	5.5	340,000	17.7
Educational attainment	2015					
	65–74		75–84		85 and over	
	Number	Percent	Number	Percent	Number	Percent
Less than high school	190,000	6.7	460,000	17.1	420,000	34.3
High school graduate	190,000	3.6	360,000	10.5	310,000	20.0
Beyond high school	150,000	1.1	320,000	5.1	430,000	19.5

NOTE: The beyond high school category includes trade school and any college education whether or not a degree was completed. In 2011 and 2015, 1.3 percent and 3.0 percent, respectively, of the overall population were missing data on education. These cases were excluded.

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

SOURCE: Office of the Assistant Secretary for Planning and Evaluation, National Health and Aging Trends Study.

**Table 19e. Number and percentage of the non-nursing home population age 65 and over with dementia, by race and Hispanic origin, 2011 and 2015**

Race and Hispanic origin	2011		2015	
	Number	Percent	Number	Percent
White, non-Hispanic	250,000	7.7	190,000	6.7
Black, non-Hispanic	140,000	2.8	190,000	3.6
Other	150,000	1.5	150,000	1.1

NOTE: Population estimates that are representative of Medicare beneficiaries age 65 and over living in settings other than nursing homes were calculated according to the methodology in Freedman, Kaspar, Spillman, and Plassman (2018).<sup>18</sup> The "Other" race/ethnicity category includes people who reported Hispanic ethnicity or reported a race other than White, non-Hispanic or Black, non-Hispanic.

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

SOURCE: Office of the Assistant Secretary for Planning and Evaluation, National Health and Aging Trends Study.

## INDICATOR 20: Depressive Symptoms

**Table 20a. Percentage of people age 55 and over with clinically relevant depressive symptoms, by age group and sex, selected years 1998–2018**

Sex	1998		2000		2002		2004		2006		2008	
	55–64	65 and over										
Both sexes												
Men	12.0	12.0	11.0	11.0	12.0	12.0	12.0	11.0	14.0	10.0	13.0	11.0
Women	18.0	19.0	18.0	19.0	18.0	18.0	16.0	17.0	18.0	18.0	17.0	15.0
Sex	2010		2012		2014		2016		2018			
	55–64	65 and over										
Both sexes												
Men	13.0	9.0	13.0	10.0	12.0	10.0	12.0	10.0	12.0	9.0		
Women	17.0	14.0	17.0	15.0	17.0	15.0	17.0	14.0	16.0	13.0		

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” cutoff can be found at <https://hrs.isr.umich.edu/publications/biblio/5411>. Percentages are based on weighted data using the respondent weights from the HRS Tracker file. Age ranges used in previous versions of *Older Americans* were updated.

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

SOURCE: National Institute on Aging, Health and Retirement Study.

**Table 20b. Percentage of people age 55 and over with clinically relevant depressive symptoms, by age group and sex, 2018**

Age group	Both sexes	Men	Women
55–59	16.0	12.0	19.0
60–64	12.0	11.0	13.0
65–69	10.0	8.0	12.0
70–74	11.0	10.0	12.0
75–79	11.0	8.0	14.0
80–84	13.0	10.0	16.0
85 and over	14.0	11.0	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” cutoff can be found at <https://hrs.isr.umich.edu/publications/biblio/5411>. Percentages are based on weighted data using the respondent weights from the HRS Tracker file. Age ranges used in previous versions of *Older Americans* were updated.

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

SOURCE: National Institute on Aging, Health and Retirement Study.

## INDICATOR 21: Functional Limitations

**Table 21a. Percentage of people age 65 and over with a disability, by sex and functional domain, 2010–2018**

Sex and functional domain	2010	2011	2012	2013	2014	2015	2016	2017	2018
<b>Total</b>									
Any disability	22.6	20.7	17.9	21.9	21.6	21.6	18.2	19.5	21.9
Vision	3.3	2.8	3.5	4.0	3.7	3.5	2.4	2.6	3.1
Hearing	4.2	5.0	3.9	5.3	6.0	5.0	4.9	3.7	5.2
Mobility	17.1	15.6	13.3	15.6	14.2	15.9	12.2	14.1	15.5
Communication	1.2	1.6	1.3	1.8	1.5	1.7	1.7	1.2	1.5
Cognition	2.7	3.2	2.5	3.1	3.1	3.0	3.3	3.2	3.7
Self-care	3.0	3.6	2.1	3.0	2.3	2.4	2.5	3.0	3.0
<b>Men</b>									
Any disability	20.0	16.8	16.9	19.6	19.3	19.6	17.4	16.7	20.1
Vision	2.6	2.0	3.7	3.2	3.4	3.1	2.8	2.4	2.5
Hearing	6.0	6.1	5.2	6.0	8.1	5.9	6.4	4.3	7.2
Mobility	13.7	11.4	10.6	12.0	10.5	12.7	9.6	10.1	12.5
Communication	1.9	1.4	1.7	1.9	1.6	1.2	2.0	1.0	1.5
Cognition	2.8	3.3	2.1	2.8	3.1	3.1	3.2	3.2	3.6
Self-care	2.3	2.0	2.3	2.8	1.8	2.3	1.7	1.8	2.6
<b>Women</b>									
Any disability	24.8	23.7	18.8	23.7	23.5	23.2	18.8	21.7	23.5
Vision	4.0	3.5	3.3	4.6	3.9	3.8	2.1	2.7	3.6
Hearing	2.8	4.2	2.8	4.8	4.4	4.2	3.8	3.1	3.5
Mobility	19.8	18.8	15.5	18.5	17.1	18.5	14.2	17.4	18.1
Communication	0.6	1.8	1.0	1.6	1.4	2.2	1.4	1.4	1.6
Cognition	2.6	3.2	2.7	3.5	3.0	2.9	3.4	3.2	3.9
Self-care	3.5	4.8	2.0	3.3	2.7	2.5	3.1	3.9	3.3

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 a lot of difficulty or being unable to do at least one of these activities.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey.

**Table 21b. Percentage of people age 65 and over with a disability, by age group and functional domain, 2018**

Functional domain	65–74	75–84	85 and over
Any disability	16.2	24.7	45.9
Vision	2.4	3.1	6.6
Hearing	2.9	6.7	13.4
Mobility	11.7	17.3	32.1
Communication	1.0	1.3	5.2
Cognition	2.5	3.6	11.1
Self-care	1.5	3.9	8.8

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 a lot of difficulty or being unable to do at least one of these activities.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 21: Functional Limitations

**Table 21c. Percentage of people age 65 and over with a disability, by race and Hispanic origin and functional domain, 2018**

Functional domain	Non-Hispanic White	Non-Hispanic Black	Hispanic
Any disability	20.5	28.6	26.9
Vision	2.8	4.8	3.9
Hearing	5.3	4.3	5.6
Mobility	14.4	22.9	18.5
Communication	1.3	2.5	2.4
Cognition	3.4	4.5	5.7
Self-care	2.4	4.3	5.6

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 a lot of difficulty or being unable to do at least one of these activities. 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: National Center for Health Statistics, National Health Interview Survey.

**Table 21d. Percentage of Medicare beneficiaries age 65 and over who have limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, 1992–2017**

Year	Total	IADLs only	1–2 ADLs	3–4 ADLs	5–6 ADLs	Long-term care facility
1992	47.3	13.6	19.3	5.9	3.3	5.2
1993	46.1	13.4	18.0	5.8	3.4	5.5
1994	46.2	14.1	17.6	5.6	3.4	5.5
1995	44.8	12.9	17.2	5.7	3.3	5.6
1996	42.8	12.9	16.7	5.0	3.1	5.1
1997	42.4	12.8	16.7	4.9	3.1	4.9
1998	42.6	12.5	17.3	5.2	3.0	4.7
1999	44.0	12.9	18.0	5.1	3.1	4.9
2000	43.9	13.1	17.6	5.6	2.8	4.8
2001	43.9	13.6	17.4	5.3	2.9	4.7
2002	44.6	13.4	18.6	5.2	2.8	4.7
2003	43.6	13.0	17.9	5.6	2.9	4.3
2004	43.3	13.3	18.5	4.6	2.6	4.4
2005	42.7	12.5	18.6	4.8	2.4	4.4

See notes at end of table.

## INDICATOR 21: Functional Limitations

**Table 21d. Percentage of Medicare beneficiaries age 65 and over who have limitations in activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, 1992–2017—continued**

Year	Total	IADLs only	1–2 ADLs	3–4 ADLs	5–6 ADLs	Long-term care facility
2006	42.8	12.5	18.3	5.2	2.6	4.3
2007	42.8	14.0	18.0	4.6	2.2	4.1
2008	42.0	11.9	19.2	4.6	2.3	4.0
2009	42.1	12.2	18.0	5.2	2.7	4.0
2010	42.5	12.0	19.0	5.1	2.8	3.6
2011	44.2	12.3	19.9	5.4	3.0	3.7
2012	47.1	11.9	22.0	6.4	3.0	3.8
2013	44.1	11.7	20.1	5.7	2.8	3.8
2014	*	*	*	*	*	*
2015	43.1	10.3	20.9	5.7	3.0	3.1
2016	39.7	11.2	17.4	5.3	2.8	3.0
2017	39.3	12.3	16.3	4.9	2.9	2.9

\* To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; 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 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. Some estimates have been revised and differ from previous editions of *Older Americans*.

Reference population: These data refer to Medicare beneficiaries who were continuously enrolled during the year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1992–2013) and Survey File (2015–2017).

**Table 21e. 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, 2017**

	Total	IADLs only	1–2 ADLs	3–4 ADLs	5–6 ADLs	Long-term care facility
Total	39.3	12.3	16.3	4.9	2.9	2.9
Sex						
Men	31.5	9.5	14.0	3.8	2.1	2.0
Women	45.6	14.6	18.2	5.8	3.5	3.7
Age group						
65–74	29.9	10.7	12.6	3.7	1.9	0.9
75–84	43.6	13.8	18.9	5.3	2.7	2.9
85 and over	69.6	15.6	26.0	8.9	7.4	11.7

NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; 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 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.

Reference population: These data refer to Medicare beneficiaries who were continuously enrolled during the year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.

## INDICATOR 22: Vaccinations

**Table 22a. Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by race and Hispanic origin, 1997–2018**

Year	Influenza			Pneumococcal disease		
	Non-Hispanic White	Non-Hispanic Black	Hispanic	Non-Hispanic White	Non-Hispanic Black	Hispanic
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
2015	71.5	59.4	56.9	68.2	50.1	41.7
2016	69.4	58.1	61.3	71.0	55.5	48.6
2017	69.3	57.8	61.5	73.2	57.1	51.0
2018	70.2	60.4	63.3	72.6	59.9	54.3

NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu vaccination 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 shot; some people receive more than one pneumonia vaccination in their lifetime. Questions concerning the use of influenza and pneumonia vaccination differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States, 2017*, Appendix II. 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: National Center for Health Statistics, National Health Interview Survey.

**Table 22b. Percentage of people age 65 and over who reported having been vaccinated against influenza and pneumococcal disease, by selected characteristics, 2018**

Selected characteristic	Influenza	Pneumococcal disease
Total	68.8	69.0
Sex		
Men	67.2	66.9
Women	70.0	70.6
Age group		
65–74	65.1	64.8
75–84	73.2	74.9
85 and over	76.9	76.3
Education		
Less than high school graduate	66.3	59.5
High school graduate or higher	69.4	70.8

NOTE: For influenza, the percentage vaccinated consists of people who reported having a flu vaccination 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; some people receive more than one pneumonia vaccination in their lifetime.

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

SOURCE: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 23: Cancer Screenings

**Table 23. 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, 2000–2018**

Selected characteristic	2000	2003	2005	2008	2010	2013	2015	2018
Breast cancer screening								
Women								
50–64	78.7	76.2	71.8	74.2	72.6	71.4	71.3	71.8
65–74	74.0	74.6	72.5	72.6	71.9	75.3	72.2	75.0
Colorectal cancer (CRC) screening								
Men								
50–64	28.6	36.3	39.2	47.3	54.0	51.2	56.5	61.2
65–75	43.4	49.9	58.2	62.4	70.1	69.8	76.0	78.2
Women								
50–64	31.0	34.8	41.1	49.0	55.9	54.3	60.8	60.7
65–75	41.3	45.8	51.9	58.6	65.9	69.1	72.5	77.2

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, 2017*, 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: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 24: Diet Quality

**Table 24. Average diet quality scores<sup>a</sup> using the Healthy Eating Index-2015 for the population age 65 and over, by age group, 2015–2016**

Dietary component	65 and over	65–74	75 and over
Total Healthy Eating Index-2015 Score (maximum score = 100)	63.9	64.7	62.6
Adequacy Components (maximum score)			
Total Fruit (5)	3.7	3.4	4.1
Whole Fruit (5)	5.0	5.0	5.0
Total Vegetables (5)	4.0	4.2	3.8
Greens and Beans (5)	3.7	4.2	2.9
Whole Grains (10)	4.0	4.0	3.9
Dairy (10)	5.6	5.6	5.8
Total Protein Foods (5)	5.0	5.0	5.0
Seafood and Plant Proteins (5)	5.0	5.0	5.0
Fatty Acids (10)	4.2	4.6	3.7
Moderation Components (maximum score)			
Refined Grains (10)	7.4	7.5	7.2
Sodium (10)	4.0	3.5	4.9
Added Sugars (10)	7.5	7.7	7.2
Saturated Fats (10)	4.7	5.1	4.2

<sup>a</sup> Calculated using the population ratio method.

NOTE: The Healthy Eating Index-2015 (HEI-2015) is a measure of diet quality with 13 components used to assess how well a set of foods aligns with the key recommendations of the *2015–2020 Dietary Guidelines for Americans*.<sup>27</sup> Intakes equal to or better than the standards set for each component are assigned a maximum score. Maximum HEI-2015 component scores range from 5 to 10 points. Scores for intakes between the minimum and maximum standards are scored proportionately. Scores for each component are summed to create a total maximum HEI-2015 score of 100 points. Nine of the 13 components assess adequacy components. The remaining four components assess dietary components that should be consumed in moderation. For the adequacy components, higher scores reflect higher intakes. For the moderation components, higher scores reflect lower intakes because lower intakes are more desirable. A higher total score indicates a diet that aligns better with the *Dietary Guidelines*. HEI-2015 total and component scores reflect usual dietary intakes among older adults in the United States. This tool was developed by the U.S. Department of Agriculture, Center for Nutrition Policy and Promotion and the U.S. Department of Health and Human Services, National Cancer Institute.

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

SOURCE: National Center for Health Statistics, What We Eat in America, National Health and Nutrition Examination Survey (2015–2016).

## INDICATOR 25: Physical Activity

**Table 25a. Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the *Physical Activity Guidelines for Americans*, by age group, 1998–2018**

Year	Total	65 and over		
		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
2015	12.7	15.5	10.2	5.1
2016	12.7	15.7	10.2	3.9
2017	12.9	15.7	10.0	5.4
2018	13.9	16.5	11.5	6.8

NOTE: This measure of physical activity reflects the *Physical Activity Guidelines for Americans*. The guidelines recommend that adults age 65 and over 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 preferably should be spread throughout the week. In addition, older adults should perform muscle-strengthening activities that are moderate or greater intensity and involve all major muscle groups on two or more days a week. When older adults cannot do 150 minutes of moderate-intensity aerobic activity a week because of chronic conditions, they should be as physically active as their abilities and conditions allow. 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: National Center for Health Statistics, National Health Interview Survey.

**Table 25b. Percentage of people age 65 and over who reported participating in leisure-time aerobic and muscle-strengthening activities that meet the *Physical Activity Guidelines for Americans*, by sex and race and Hispanic origin, 2018**

Activity and race and Hispanic origin	Total	Men	Women
Aerobic and muscle-strengthening activities			
Total	13.9	16.5	11.9
Non-Hispanic White	14.6	16.9	12.6
Non-Hispanic Black	9.4	11.3	8.2
Hispanic	11.5	16.2	7.7

NOTE: This measure of physical activity reflects the *Physical Activity Guidelines for Americans*. The guidelines recommend that adults age 65 and over 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 preferably should be spread throughout the week. In addition, older adults should perform muscle-strengthening activities that are moderate or greater intensity and involve all major muscle groups on two or more days a week. When older adults cannot do 150 minutes of moderate-intensity aerobic activity a week because of chronic conditions, they should be as physically active as their abilities and conditions allow. 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: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 26: Obesity

**Table 26. Percentage of people age 65 and over overweight and with obesity, by sex and age group, selected years, 1976–2018**

Sex and age group	1976–1980	1988–1994	1999–2002	2003–2006	2007–2010	2011–2014	2015–2018
<b>Overweight</b>							
Both sexes							
65 and over	—	60.1	68.8	69.5	72.0	70.9	77.5
65–74	57.2	64.1	73.3	73.8	75.7	73.5	81.1
75 and over	—	53.9	62.8	63.9	67.2	67.3	71.8
Men							
65 and over	—	64.4	72.8	73.0	75.7	74.2	80.4
65–74	54.2	68.5	76.2	78.0	77.5	76.1	83.7
75 and over	—	56.5	67.4	65.8	73.2	71.0	74.6
Women							
65 and over	—	56.9	65.9	66.7	69.1	68.4	75.1
65–74	59.5	60.3	70.9	70.3	74.2	71.2	78.9
75 and over	—	52.3	59.9	62.6	63.2	64.6	69.9
<b>Obese</b>							
Both sexes							
65 and over	—	22.2	29.6	30.1	35.1	34.7	40.2
65–74	17.9	25.6	35.7	34.8	40.8	38.6	44.0
75 and over	—	17.0	21.3	24.1	27.8	29.0	34.4
Men							
65 and over	—	20.3	26.2	29.3	35.3	32.6	38.2
65–74	13.2	24.1	31.6	33.0	41.5	36.2	41.9
75 and over	—	13.2	17.7	24.0	26.5	26.8	31.8
Women							
65 and over	—	23.6	32.0	30.8	34.9	36.4	41.8
65–74	21.5	26.9	39.0	36.4	40.3	40.7	45.9
75 and over	—	19.2	23.6	24.2	28.7	30.5	36.1

— 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<sup>2</sup>. Obesity is defined by a BMI of 30 kilograms/meter<sup>2</sup> 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 often are combined to create increased sample size, especially for subgroup estimates.

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

SOURCE: National Center for Health Statistics, National Health and Nutrition Examination Survey.

## INDICATOR 27: Cigarette Smoking

**Table 27a. Percentage of people age 65 and over who are current cigarette smokers, by sex and race and Hispanic origin, selected years, 1965–2018**

Year	Men						Women					
	Total	White	Black or African American	Non-Hispanic White	Non-Hispanic Black	Hispanic	Total	White	Black or African American	Non-Hispanic White	Non-Hispanic Black	Hispanic
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	25.7	11.4	24.7	17.0	11.5	11.6	10.7	11.8	10.9	8.5
1998	10.4	9.9	16.3	9.9	16.8	12.6	11.2	11.2	11.6	11.3	11.5	10.2
1999	10.5	10.5	17.3	9.7	16.8	13.1	10.7	10.5	13.5	10.7	13.7	6.1
2000	10.2	9.1	14.2	10.0	14.6	10.8	9.3	9.1	10.2	9.4	10.1	6.4
2001	11.5	10.7	21.2	10.5	21.0	13.7	9.2	9.4	9.3	9.6	9.4	5.1
2002	10.1	9.3	19.4	9.2	19.5	10.6	8.6	8.5	9.4	8.9	9.4	*
2003	10.1	9.6	18.0	9.3	17.7	12.4	8.3	8.4	8.0	8.5	8.7	6.2
2004	9.8	9.4	14.1	9.5	14.0	7.7	8.1	8.2	6.7	8.6	7.4	*
2005	8.9	7.9	16.8	8.0	16.9	7.2	8.3	8.4	10.0	8.6	10.1	5.9
2006	12.6	12.6	16.0	12.7	16.8	10.1	8.3	8.4	9.3	8.6	9.0	*
2007	9.3	8.9	14.3	8.7	14.4	*	7.6	8.0	6.4	8.4	6.6	3.3
2008	10.5	9.9	17.5	10.2	17.6	7.9	8.3	8.6	8.1	8.9	8.0	5.1
2009	9.5	9.3	14.0	9.5	13.8	7.9	9.5	9.6	11.5	9.9	11.8	5.1
2010	9.7	9.6	10.0	9.8	9.9	8.7	9.3	9.4	9.4	9.7	9.5	6.2
2011	8.9	8.7	13.7	8.5	13.9	10.7	7.1	7.0	9.1	7.3	9.3	4.6
2012	10.6	10.3	17.4	10.0	17.3	14.4	7.5	7.5	9.1	7.8	9.0	3.5
2013	10.6	10.0	15.5	10.0	14.6	12.0	7.5	7.9	6.5	8.3	6.5	3.5
2014	9.8	9.4	13.9	9.7	14.7	6.6	7.5	7.6	8.2	8.1	8.0	3.9
2015	9.7	9.3	16.0	9.2	15.5	11.0	7.4	7.5	9.7	7.7	9.9	4.8
2016	10.1	9.1	19.1	9.3	19.7	7.3	7.7	7.6	8.7	7.8	9.8	*
2017	9.0	8.4	15.1	8.1	14.9	12.0	7.5	7.8	7.1	8.2	7.2	4.4
2018	9.9	9.5	16.0	9.3	16.2	11.5	7.2	7.2	8.9	7.6	8.4	*

— Data not available.

\* Estimate does not meet National Center for Health Statistics standards of reliability.

NOTE: Data have been revised and may differ from earlier versions of *Older Americans*. Total includes all other races not shown separately. The value for all women includes other races who may have very low rates of cigarette smoking. Thus, the weighted average for some estimates of all women is lower than that for the race groups shown in the table. Questions concerning cigarette smoking differed slightly on the National Health Interview Survey across the years for which data are shown. For details, see *Health, United States, 2018*, Appendix II. 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: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 27: Cigarette Smoking

**Table 27b. Percentage of people age 65 and over who are current cigarette smokers, by sex and poverty status, 2018**

Sex	All	Poverty threshold		
		Below 100 percent	100 percent to 199 percent	200 percent or more
Both sexes	8.4	13.3	11.7	6.9
Men	9.9	17.9	14.6	8.1
Women	7.2	10.9	9.9	5.7

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: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 28: Use of Health Care Services

**Table 28a. Use of Medicare-covered health care services per 1,000 Medicare beneficiaries age 65 and over, 1992–2017**

Year	Utilization measure				Average length of hospital stay
	Hospital stays	Skilled nursing facility stays	Physician visits and consultations	Home health care visits	
	Number per 1,000 Medicare beneficiaries				
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	320	84	14,858	3,584	5.4
2009	302	82	15,022	3,850	5.2
2010	298	81	15,107	3,666	5.2
2011	291	81	14,869	3,439	5.1
2012	276	77	15,025	3,255	5.0
2013	262	75	14,999	3,152	5.1
2014	252	74	14,648	3,051	5.1
2015	251	74	14,988	3,036	5.0
2016	245	70	15,020	2,951	4.9
2017	245	68	14,870	2,847	4.9

— 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 the 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 2007–2013 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 28b. Use of Medicare-covered home health care and skilled nursing facility services per 1,000 Medicare beneficiaries age 65 and over, by age group, 2017**

Utilization measure	65–74	75–84	85 and over
Number per 1,000 Medicare beneficiaries			
Skilled nursing facility stays	31	85	192
Home health care visits	1,327	3,512	7,868

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 29: Health Care Expenditures

**Table 29a. Average annual health care costs, in 2017 dollars, for Medicare beneficiaries age 65 and over, by age group, 1992–2017**

Age group	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Total	\$16,906	\$17,680	\$18,663	\$19,065	\$18,779	\$18,786	\$18,090	\$18,211	\$18,282	\$18,762	\$19,816	\$19,557	\$19,348
65–74	12,581	12,825	13,789	13,873	13,593	13,273	12,656	13,826	13,614	14,265	15,274	14,810	14,382
75–84	18,501	20,209	20,670	20,863	21,138	20,871	20,124	19,311	19,928	20,864	21,519	21,857	21,070
85 and over	32,701	33,075	34,975	36,065	34,382	34,038	33,797	31,980	31,518	31,302	32,124	30,732	32,473
Age group	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total	\$19,819	\$19,625	\$18,904	\$17,923	\$18,140	\$18,415	\$17,494	\$18,157	\$18,237	*	\$18,536	\$17,985	\$18,620
65–74	14,963	14,687	14,130	13,455	13,874	13,658	13,194	14,130	14,210	*	14,475	14,605	15,194
75–84	21,905	21,933	21,199	20,720	20,299	21,420	20,100	20,662	19,778	*	21,099	19,929	20,750
85 and over	31,449	30,793	30,109	27,033	27,949	28,422	27,074	27,711	29,944	*	29,322	27,992	28,514

\* To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

NOTE: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation adjusted to 2017 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 (1992–2013) and Cost Supplement (2015–2017).

**Table 29b. Total amount and percentage distribution of annual health care costs among Medicare beneficiaries age 65 and over, by major cost component, 2008, 2012, and 2017**

Major cost component	2008		2012		2017	
	Total dollars	Percent	Total dollars	Percent	Total dollars	Percent
Total	\$593,814,582,768	100	\$718,814,057,899	100	\$873,341,235,533	100
Inpatient hospital	144,225,616,200	24	157,288,552,385	22	189,865,172,917	22
Physician/outpatient hospital	214,888,544,309	36	253,728,764,587	35	319,116,789,673	37
Nursing home/long-term care facility	72,458,957,283	12	88,104,428,735	12	85,084,459,745	10
Home health care	19,976,448,445	3	23,853,729,622	3	26,836,027,930	3
Prescription drugs	90,800,824,928	15	121,139,985,089	17	164,481,897,694	19
Other (short-term institution/hospice/dental)	51,464,191,603	9	74,698,597,482	10	87,956,887,574	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 (2008, 2012) and Cost Supplement (2017).

## INDICATOR 29: Health Care Expenditures

**Table 29c. Average annual health care costs among Medicare beneficiaries age 65 and over, by selected characteristics, 2017**

Selected characteristic	Cost
Total	\$18,620
Race and ethnicity	
Non-Hispanic White	18,279
Non-Hispanic Black	20,718
Hispanic	21,128
Other	16,933
Institutional status	
Community only	16,592
Long-term care facility	69,417
Annual income	
Under \$10,000	25,577
\$10,000–\$19,999	23,052
\$20,000–\$29,999	19,008
\$30,000 and over	16,403
Number of chronic conditions	
0	8,077
1–2	9,543
3–4	17,427
5 and over	24,794
Veteran status (men only)	
Yes	17,519
No	18,906

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, respiratory conditions (emphysema/asthma/chronic obstructive pulmonary disease), urinary incontinence, Alzheimer's disease, dementia, mental conditions (depression/mental disorder not depression), osteoporosis/broken hip, and Parkinson's disease. Annual income includes that of respondent and spouse. Long-term care facility includes beneficiaries who resided in a long-term care facility at any point during the calendar year.

Reference population: These data refer to Medicare beneficiaries.

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

## INDICATOR 30: Prescription Drugs

**Table 30a. Average prescription drug costs, in 2017 dollars, among noninstitutionalized Medicare beneficiaries age 65 and over, by sources of payment, 1992–2017**

Sources of payment	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
Total	\$1,114	\$1,442	\$1,499	\$1,536	\$1,614	\$1,725	\$1,969	\$2,159	\$2,389	\$2,604	\$2,844	\$2,988	\$3,123
Out-of-pocket	670	838	815	805	802	854	911	949	1,002	1,041	1,122	1,120	1,131
Private	283	362	412	453	536	562	689	755	832	906	1,036	1,137	1,200
Public	161	242	272	277	276	308	369	455	555	657	686	731	792
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total	\$3,517	\$3,314	\$3,268	\$3,233	\$3,501	\$3,293	\$3,235	\$3,425	\$3,642	*	\$4,236	\$4,293	\$4,499
Out-of-pocket	1,251	974	802	756	804	762	758	769	780	*	962	884	854
Private	1,442	1,061	810	767	784	669	613	603	471	*	379	382	325
Public	823	1,279	1,655	1,710	1,913	1,862	1,864	2,053	2,392	*	2,896	3,027	3,319

\* To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

NOTE: Dollars have been inflation adjusted to 2017 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 (1992–2013) and Cost Supplement (2015–2017).

**Table 30b. Percentage distribution of annual prescription drug costs among noninstitutionalized Medicare beneficiaries age 65 and over, 2017**

Cost in dollars	Percent of beneficiaries
Total	100.0
\$0	6.8
1–499	26.4
500–999	14.6
1,000–1,499	8.4
1,500–1,999	5.5
2,000–2,499	3.8
2,500–2,999	3.3
3,000–3,499	2.6
3,500–3,999	2.7
4,000–4,499	1.9
4,500–4,999	2.3
5,000 or more	21.8

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 Supplement.

## INDICATOR 30: Prescription Drugs

**Table 30c. 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 2017**

Part D benefit categories	2006	2017
All Medicare beneficiaries age 65 and over	36,454,840	49,678,033
Enrollees in prescription drug plans	16,935,231	35,934,242
Type of plan		
Stand-alone plan	11,345,012	20,940,252
Medicare Advantage plan	5,590,219	14,993,990
Low-income subsidy		
Yes	5,560,171	7,397,405
No	11,375,060	28,536,838
Retiree drug subsidy	6,548,138	1,610,847
Other	12,971,471	12,132,944

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.

## INDICATOR 31: Sources of Health Insurance

**Table 31a. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over with supplemental health insurance, by type of insurance, 1991–2017**

Type of insurance	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004
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	36.1	36.6
Private (Medigap or other supplemental coverage) <sup>a</sup>	44.8	45.0	45.3	45.2	44.3	38.6	35.8	33.9	33.2	33.5	34.5	37.5	34.3	33.7
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	14.8	15.6
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	11.6	11.3
TRICARE	—	—	—	—	—	—	—	—	—	—	—	—	4.5	4.2
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	5.7	5.2
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	9.1	9.7
	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	
Private (employer- or union-sponsored)	36.1	34.9	35.3	34.2	32.5	31.6	29.8	29.4	28.0	*	23.4	22.3	24.1	
Private (Medigap or other supplemental coverage) <sup>a</sup>	34.6	32.5	31.5	29.5	27.8	26.5	26.4	25.4	25.4	*	31.7	27.0	29.1	
Medicare Advantage/ Capitated Payment Plans	15.5	20.7	21.5	23.2	28.5	29.2	31.3	32.3	33.8	*	36.3	37.7	35.4	
Medicaid	11.8	11.9	11.9	11.7	11.8	12.5	12.9	13.1	12.8	*	10.5	10.3	9.5	
TRICARE	5.1	5.2	5.1	5.4	5.2	5.0	4.9	5.2	5.0	*	5.0	5.5	6.0	
Other public	5.6	4.3	4.0	3.9	3.6	3.3	3.2	2.7	2.3	*	5.2	3.5	3.4	
No supplement	8.9	9.4	10.5	10.5	9.3	9.9	10.0	10.6	10.8	*	9.7	10.6	10.2	

\* To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

— Not available.

<sup>a</sup> Includes people with a private supplement of unknown sponsorship.

NOTE: 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 percent to 3 percent of beneficiaries). Prior to 2015, supplemental policy estimates were calculated using the first five policies only. Estimates for 2015 and later were calculated using all available policy information. 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. Prior to 2015, Medicaid coverage was determined from both survey responses and Medicare administrative records. Starting with 2015, Medicaid coverage is determined from administrative records only. 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. The weighting process in the 2017 Survey File was improved to reflect the distribution of enrollment in Medicare Advantage. All 2017 estimates are based on enhanced survey weights.

Reference population: These estimates refer to noninstitutionalized Medicare beneficiaries who were continuously enrolled during the calendar year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1992–2013) and Survey File (2015–2017).

**Table 31b. Percentage of people ages 55–64 with health insurance coverage, by poverty status and type of insurance, 2018**

Type of insurance	Total	Poverty threshold		
		Below 100 percent	100 percent to 199 percent	200 percent or more
Private	72.3	17.2	40.8	85.2
Medicaid	10.8	48.1	26.0	3.2
Medicare	4.9	10.2	13.2	2.7
Other coverage	3.5	3.5	3.6	3.5
Uninsured	8.5	21.1	16.5	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 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: National Center for Health Statistics, National Health Interview Survey.

## INDICATOR 32: Out-of-Pocket Health Care Expenditures

**Table 32a. Percentage of people age 55 and over with out-of-pocket expenditures for health care service use, by age group, 1977, 1987, 1996, and 2000–2017**

Age group	1977	1987	1996	2000	2001	2002	2003	2004	2005	2006	2007
55–64	81.9	84.0	89.6	90.2	90.4	90.9	90.4	90.0	90.5	88.9	89.5
55–61	81.6	83.9	89.5	89.4	90.2	90.7	89.6	89.5	89.6	88.4	88.7
62–64	82.6	84.3	89.7	92.4	91.1	91.3	92.7	91.6	93.3	90.6	91.9
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
65–74	83.4	87.9	91.8	93.3	94.1	94.4	93.7	95.1	94.2	94.1	93.2
75–84	83.8	90.0	92.9	93.5	95.6	94.6	95.7	95.8	96.1	96.2	95.3
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
Age group	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	
55–64	90.1	88.5	89.4	89.1	90.0	88.2	87.3	87.6	86.0	86.9	
55–61	89.0	88.6	88.3	87.9	89.4	87.1	86.1	86.6	85.2	86.2	
62–64	93.0	88.3	92.2	92.0	91.6	91.3	90.5	90.0	87.9	88.5	
65 and over	95.0	94.3	93.7	94.0	94.3	92.7	93.5	92.8	92.5	92.7	
65–74	94.3	93.8	93.4	93.7	93.6	92.2	92.6	91.7	92.1	92.5	
75–84	95.7	94.8	94.1	94.9	95.9	94.7	95.4	95.2	93.7	93.2	
85 and over	95.8	95.1	93.9	93.1	93.7	89.9	93.0	92.4	91.8	92.2	

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 (2002).<sup>43</sup>

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 32b. Percentage of household income per person attributable to out-of-pocket health care expenditures among people age 55 and over, by selected characteristics, 1977, 1987, 1996, 2000, and 2005–2017**

Selected characteristic	1977	1987	1996	2000	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Total																	
55–64	5.2	5.8	7.1	7.0	7.1	7.1	6.0	6.2	6.2	6.1	6.5	5.6	5.6	4.9	4.6	4.7	5.0
55–61	5.1	5.7	6.2	6.1	6.7	6.6	5.8	5.8	5.8	5.8	6.1	5.7	5.7	4.5	4.2	4.4	4.7
62–64	5.5	5.9	9.5	9.3	8.2	8.5	6.6	7.3	7.4	7.1	7.6	5.4	5.5	6.2	5.5	5.6	5.8
65 and over	7.2	8.8	8.4	9.1	10.9	10.0	8.6	8.4	8.1	7.8	7.1	7.0	6.5	7.1	6.2	4.7	5.0
65–74	6.4	7.2	7.7	8.1	9.2	9.1	7.2	7.0	7.0	7.4	6.3	5.9	5.3	5.6	4.7	5.1	5.0
75–84	8.8	11.0	9.0	10.4	12.5	10.5	10.0	9.5	9.3	7.5	7.7	7.2	6.9	8.8	7.5	6.6	7.8
85 and over	7.9	12.0	9.8	10.1	13.0	12.2	10.1	10.7	9.4	10.2	8.9	10.5	11.0	10.1	9.6	8.4	11.1
Income category																	
Poor/near-poor																	
55–64	16.1	18.1	30.0	29.9	27.7	28.8	23.3	24.3	26.1	24.8	25.3	21.7	20.2	17.0	14.1	17.5	17.5
55–61	17.5	19.8	27.6	28.1	27.9	27.7	24.1	24.2	25.1	24.3	23.8	23.2	21.1	16.0	12.8	16.5	16.6
62–64	13.3	14.0	34.3	*	27.3	31.5	21.2	24.4	28.5	26.1	28.6	18.2	17.4	19.6	17.3	20.1	19.5
65 and over	12.3	15.8	19.2	22.6	27.6	28.1	21.9	19.4	22.4	21.4	20.5	20.0	17.5	20.1	16.1	16.1	19.1
65–74	11.0	13.7	21.6	24.4	26.2	29.4	20.2	19.4	23.3	27.1	21.0	19.5	15.3	18.8	12.6	15.1	16.4
75–84	14.4	19.0	18.3	22.9	28.6	27.9	24.5	18.3	21.5	15.3	20.2	17.5	15.9	23.6	18.3	15.9	19.7
85 and over	12.4	14.7	*	17.6	28.6	24.9	20.0	21.6	22.5	19.9	20.1	25.2	25.1	17.6	19.9	19.4	25.8

See notes at end of table.

## INDICATOR 32: Out-of-Pocket Health Care Expenditures

**Table 32b. Percentage of household income per person attributable to out-of-pocket health care expenditures among people age 55 and over, by selected characteristics, 1977, 1987, 1996, 2000, and 2005–2017—continued**

Selected characteristic	1977	1987	1996	2000	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Low/middle/high																	
55–64	3.9	3.7	3.2	3.4	4.2	4.0	3.8	3.8	3.4	3.4	3.4	3.2	3.3	3.1	3.2	2.7	3.0
55–61	3.7	3.4	2.9	3.1	3.9	3.8	3.5	3.4	3.2	3.0	3.3	3.1	3.1	2.7	3.0	2.5	2.9
62–64	4.2	4.6	3.8	4.3	5.3	4.8	4.5	4.9	4.0	4.3	3.6	3.3	3.7	4.0	3.8	3.4	3.2
65 and over	5.4	7.0	5.6	6.3	7.4	6.0	5.6	5.9	5.2	5.2	4.7	4.5	4.5	4.5	4.5	4.1	4.4
65–74	5.0	5.9	4.9	5.6	6.2	5.2	4.9	4.8	4.3	4.3	4.1	3.9	3.8	3.6	3.8	3.7	3.4
75–84	6.2	8.4	6.3	6.9	8.8	6.5	6.1	7.2	6.2	5.8	5.2	5.0	5.1	5.3	5.2	4.6	5.4
85 and over	5.2	10.9	7.8	7.6	8.2	8.2	7.2	7.4	6.4	7.8	5.7	5.8	6.6	7.0	6.4	5.4	7.2
Health status category																	
Poor or fair health																	
55–64	8.7	8.5	13.0	14.1	12.7	13.2	10.0	11.3	9.8	10.9	12.0	9.5	10.0	10.6	9.7	8.5	9.9
55–61	8.8	9.0	11.8	12.8	11.8	12.9	9.8	10.9	10.2	10.9	11.3	10.0	11.1	10.4	8.8	7.8	10.1
62–64	8.6	7.6	15.9	17.4	15.3	14.0	10.5	12.2	8.8	11.1	13.6	8.1	7.3	11.2	12.2	10.4	9.5
65 and over	9.5	11.0	11.7	13.1	15.5	12.9	11.3	11.8	10.5	10.9	9.0	9.7	8.7	10.3	8.4	8.1	10.6
65–74	8.7	10.0	10.7	11.8	14.3	13.1	11.3	11.4	9.6	11.0	8.3	8.8	6.9	9.3	6.0	7.5	8.3
75–84	11.3	12.4	11.8	14.6	17.1	13.0	11.3	11.2	11.9	9.8	9.9	9.7	8.6	10.2	11.6	8.1	12.0
85 and over	8.9	12.2	*	13.8	14.5	12.2	11.2	14.4	10.0	13.2	9.2	11.9	13.5	13.8	11.0	10.6	15.2
Excellent, very good, or good health																	
55–64	3.9	4.6	5.0	4.0	4.9	4.8	4.4	4.1	4.8	4.3	4.3	4.1	3.9	3.7	3.5	3.9	4.1
55–61	3.9	4.5	4.1	3.5	4.6	4.3	4.3	3.9	4.1	4.0	3.9	4.0	3.7	3.3	3.2	3.6	3.7
62–64	4.1	4.9	7.3	5.6	5.6	6.3	5.0	4.8	6.8	5.3	5.2	4.3	4.7	4.9	4.2	4.6	5.0
65 and over	6.1	7.1	6.6	6.7	8.1	8.2	7.0	6.4	6.8	6.1	6.1	5.6	5.5	6.2	5.6	5.4	5.6
65–74	5.3	5.4	6.3	6.2	6.6	7.1	5.3	5.0	5.7	5.8	5.5	4.7	4.7	4.6	4.4	4.5	4.4
75–84	7.5	9.7	7.2	7.5	9.2	8.8	9.2	8.3	7.8	6.0	6.3	5.9	6.0	8.3	6.5	6.2	6.6
85 and over	7.6	11.8	6.4	7.1	11.9	12.2	9.2	7.9	9.0	7.8	8.7	9.2	8.8	8.8	9.2	7.9	9.9

\* 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 what was 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 (2002).<sup>43</sup>

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.

## INDICATOR 32: Out-of-Pocket Health Care Expenditures

**Table 32c. 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, 2000–2017**

Year and type of health care service	65 and over	55–64	55–61	62–64	65–74	75–84	85 and over
2000							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	6.4	8.5	7.5	*	7.3	4.6	8.6
Office-based medical provider services	9.8	18.9	19.8	16.7	11.6	9.0	6.0
Dental services	15.8	20.0	21.3	17.0	17.5	15.9	9.6
Prescription drugs	53.6	44.7	44.0	46.5	57.1	51.5	48.0
Other health care	14.3	7.8	7.5	8.7	6.6	19.0	27.9
2001							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	5.4	9.8	9.4	10.7	5.2	5.8	*
Office-based medical provider services	9.4	19.8	19.9	19.7	10.5	9.6	6.0
Dental services	13.0	18.6	20.0	15.2	15.6	11.9	8.3
Prescription drugs	56.0	45.7	44.3	48.9	57.2	58.9	45.1
Other health care	16.2	6.1	6.4	5.5	11.5	13.8	*
2002							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	5.0	10.2	9.2	13.1	4.6	5.5	5.1
Office-based medical provider services	10.5	21.3	21.6	20.3	12.3	9.3	7.8
Dental services	14.0	18.1	18.3	17.7	17.6	12.3	6.2
Prescription drugs	58.2	43.8	43.5	44.7	57.9	56.6	65.5
Other health care	12.3	6.6	7.4	4.3	7.7	16.3	15.4
2003							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	5.2	9.2	8.8	10.1	5.9	4.5	5.1
Office-based medical provider services	8.7	18.8	18.3	19.9	9.4	9.1	5.4
Dental services	11.8	16.7	16.7	16.9	14.5	9.5	9.5
Prescription drugs	58.3	48.5	49.0	47.5	61.3	54.5	59.8
Other health care	16.0	6.8	7.3	5.6	8.9	22.4	20.2
2004							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	5.0	9.2	10.1	6.9	5.1	4.5	*
Office-based medical provider services	10.1	20.1	18.7	23.6	12.4	9.2	5.3
Dental services	11.8	16.9	18.5	12.8	13.2	12.0	7.5
Prescription drugs	61.4	46.0	45.0	48.7	61.9	64.8	51.9
Other health care	11.8	7.8	7.7	8.1	7.4	9.5	29.5
2005							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	5.4	12.2	12.8	10.8	5.1	5.7	5.4
Office-based medical provider services	11.4	19.6	19.6	19.9	11.4	12.3	8.7
Dental services	15.3	15.7	16.3	14.3	19.4	12.6	9.8
Prescription drugs	57.8	45.9	44.7	49.0	57.9	59.1	53.3
Other health care	10.1	6.5	6.7	6.1	6.2	10.4	22.7
2006							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	7.2	*	9.4	*	6.6	5.9	12.2
Office-based medical provider services	12.3	19.8	20.9	17.4	14.1	11.0	9.5
Dental services	16.2	13.9	15.4	10.6	19.7	15.3	7.6
Prescription drugs	51.1	43.2	48.5	32.0	51.5	53.2	45.2
Other health care	13.2	5.5	5.8	4.9	8.1	14.7	25.5

See notes at end of table.

## INDICATOR 32: Out-of-Pocket Health Care Expenditures

**Table 32c. 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, 2000–2017—continued**

Year and type of health care service	65 and over	55–64	55–61	62–64	65–74	75–84	85 and over
2007							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	*	12.4	12.6	11.9	4.4	*	*
Office-based medical provider services	13.7	22.1	21.7	23.1	15.5	12.7	10.4
Dental services	18.5	21.1	21.3	20.7	21.4	16.4	14.9
Prescription drugs	47.3	38.8	38.8	38.7	49.5	45.4	45.3
Other health care	11.6	5.6	5.7	5.5	9.2	10.2	21.6
2008							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	6.3	14.2	14.7	13.3	7.3	5.9	4.5
Office-based medical provider services	15.0	23.1	24.0	21.4	17.3	14.9	9.3
Dental services	19.6	19.9	19.8	20.2	21.4	19.8	14.2
Prescription drugs	42.0	35.9	35.8	36.3	44.8	41.2	35.9
Other health care	17.1	6.8	5.8	8.8	9.2	18.2	36.1
2009							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	10.6	16.0	13.3	*	6.4	14.5	12.7
Office-based medical provider services	15.8	23.2	24.6	20.3	18.8	14.0	11.8
Dental services	18.7	21.6	23.0	18.6	23.0	15.4	15.0
Prescription drugs	41.3	32.2	32.2	32.1	44.2	40.2	36.1
Other health care	13.6	7.0	6.9	7.1	7.7	15.9	24.4
2010							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	7.9	12.2	12.6	11.4	7.8	6.8	10.8
Office-based medical provider services	15.8	24.7	24.4	25.4	17.5	14.6	13.0
Dental services	20.4	20.6	19.2	23.4	21.4	22.2	13.4
Prescription drugs	44.4	36.3	37.6	33.9	46.3	44.0	39.3
Other health care	11.4	6.2	6.4	5.8	7.0	12.4	23.5
2011							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	7.8	16.6	15.5	19.1	8.6	7.4	6.0
Office-based medical provider services	15.9	24.1	23.7	24.9	18.0	14.8	12.0
Dental services	20.0	18.3	18.5	18.1	20.2	24.3	11.4
Prescription drugs	40.2	34.6	35.0	33.7	42.4	41.5	30.7
Other health care	16.1	6.4	7.3	4.2	10.9	11.9	39.9
2012							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	9.2	18.0	15.5	*	10.0	8.2	*
Office-based medical provider services	15.6	23.7	24.3	22.4	19.7	13.5	8.6
Dental services	22.1	17.3	18.1	15.6	23.0	26.7	*
Prescription drugs	34.2	34.9	36.2	32.1	37.7	39.4	18.4
Other health care	18.8	6.2	6.0	6.5	9.5	12.2	50.8
2013							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	7.7	16.0	18.4	10.9	7.4	9.6	5.6
Office-based medical provider services	19.2	27.2	25.5	30.8	22.1	16.9	14.5
Dental services	21.0	18.5	17.7	20.0	23.2	23.6	10.5
Prescription drugs	33.3	30.5	29.9	31.7	35.7	35.5	22.6
Other health care	18.8	7.9	8.5	6.7	11.7	14.3	46.9

See notes at end of table.

## INDICATOR 32: Out-of-Pocket Health Care Expenditures

**Table 32c. 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, 2000–2017—continued**

Year and type of health care service	65 and over	55–64	55–61	62–64	65–74	75–84	85 and over
2014							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	8.8	15.0	14.9	15.1	8.5	9.6	8.1
Office-based medical provider services	20.7	28.4	28.0	29.3	24.7	17.9	14.7
Dental services	21.1	16.9	17.9	14.9	22.3	22.5	15.2
Prescription drugs	32.1	31.0	30.7	31.7	34.0	33.9	24.2
Other health care	17.3	8.7	8.5	9.1	10.4	16.2	37.7
2015							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	7.6	12.7	12.3	13.4	8.3	7.6	5.4
Office-based medical provider services	20.0	29.3	30.1	27.6	26.2	15.8	9.5
Dental services	22.0	18.5	17.5	20.5	23.4	22.8	16.0
Prescription drugs	30.0	31.5	32.2	30.3	33.0	30.0	20.3
Other health care	20.4	8.0	8.0	8.2	9.1	23.8	48.8
2016							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	8.7	13.7	13.1	14.9	9.6	8.3	6.0
Office-based medical provider services	20.7	32.5	32.9	31.8	24.0	18.1	13.7
Dental services	22.5	20.0	19.3	21.4	23.2	23.9	16.5
Prescription drugs	29.3	26.0	26.9	24.3	32.8	27.0	21.1
Other health care	18.8	7.8	7.8	7.6	10.4	22.7	42.6
2017							
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Hospital care	5.8	12.9	14.1	10.4	6.9	6.1	3.0
Office-based medical provider services	20.5	30.5	29.8	32.1	22.8	23.2	11.2
Dental services	19.8	21.8	19.8	25.8	24.3	20.6	8.6
Prescription drugs	26.6	25.2	27.8	20.1	33.3	24.2	15.2
Other health care	27.2	9.6	8.6	11.6	12.6	25.9	62.0

\* Estimate not shown because of a relative standard error greater than 30 percent.

NOTE: Percentages in this table might not sum to 100 percent because of rounding. 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.

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

SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

## INDICATOR 33: Sources of Payment for Health Care Services

**Table 33. 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, 2017**

Type of service	Average cost per beneficiary	Sources of payment				
		Total	Medicare	Medicaid	Out-of-pocket	Other
All	\$18,620	100.0	65.4	5.5	16.6	12.5
Hospice	347	100.0	100.0			
Inpatient hospital	3,757	100.0	87.8	0.9	1.2	10.2
Home health care	531	100.0	79.8	**	*11.9	**
Short-term institution	827	100.0	73.7	11.4	10.4	4.5
Physician/medical	4,250	100.0	67.7	1.1	15.7	15.5
Outpatient hospital	2,064	100.0	80.3	1.2	5.9	12.6
Prescription drugs	3,255	100.0	63.6	**	18.3	18.0
Dental	567	100.0	2.3	*0.2	77.2	20.3
Long-term care facility	1,684	100.0	**	43.8	50.6	*4.9

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

\*\* Estimates are not shown because of 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 because of high relative standard errors.

Reference population: These data refer to Medicare beneficiaries.

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

## INDICATOR 34: Veterans' Health Care

**Table 34. Total number of veterans age 65 and over who are enrolled in Veterans Health Administration, by age group, 2003–2018 and projected 2023–2038**

Year	All ages	65 and over					
		Total	65–69	70–74	75–79	80–84	85 and over
<b>Actual</b>							
2003	6,986,958	3,218,901	709,240	845,958	857,769	599,645	206,289
2008	7,760,502	3,365,055	656,428	697,441	785,151	711,054	514,981
2013	8,748,718	4,015,045	1,298,196	680,450	648,932	656,241	731,226
2018	9,157,881	4,503,786	1,206,186	1,331,767	654,024	541,464	770,345
<b>Projected</b>							
2023	9,223,000	4,575,000	853,000	1,194,000	1,259,000	564,000	705,000
2028	9,070,000	4,540,000	843,000	828,000	1,099,000	1,067,000	703,000
2033	8,806,000	4,343,000	768,000	815,000	766,000	909,000	1,085,000
2038	8,453,000	4,067,000	762,000	738,000	753,000	647,000	1,167,000

NOTE: Department of Veterans Affairs (VA) enrollees are veterans who have signed up to receive health care from Veterans Health Administration (VHA). Counts for 2023–2038 are projections from the 2019 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, Chief Strategy Office, 2019 VA Enrollee Health Care Projection Model.

## INDICATOR 35: Residential Services

**Table 35a. Percentage distribution of Medicare beneficiaries age 65 and over residing in selected residential settings, by age group, 2017**

Residential setting	Total	65 and over		
		65–74	75–84	85 and over
Total	100.0	100.0	100.0	100.0
Traditional community	94.7	97.9	94.9	80.8
Community housing with services	2.4	1.2	2.3	7.5
Long-term care facilities	2.9	0.9	2.9	11.7
Number (in thousands)	46,150	25,777	14,325	6,048

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 nonfamily, paid caregiver.

Reference population: These estimates refer to Medicare beneficiaries who were continuously enrolled during the calendar year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.

**Table 35b. 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, 2017**

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	60.9	63.0	41.2	6.5
IADL limitation(s) only	12.9	12.6	18.0	15.7
1–2 ADL limitations	17.1	16.6	27.7	24.3
3 or more ADL limitations	9.2	7.7	13.1	53.5

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 nonfamily, 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 estimates refer to Medicare beneficiaries who were continuously enrolled during the calendar year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.

## INDICATOR 36: Personal Assistance and Equipment

**Table 36a. Percentage distribution of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs), by type of assistance, 1992–2017**

Year	Total	Personal assistance only	Equipment only	Personal assistance and equipment	No personal assistance or equipment
1992	100.0	8.7	29.1	22.5	39.7
1993	100.0	8.6	29.7	22.9	38.8
1994	100.0	7.7	32.5	24.0	35.8
1995	100.0	7.8	32.8	24.2	35.2
1996	100.0	7.2	33.4	24.3	35.1
1997	100.0	5.7	35.2	23.8	35.4
1998	100.0	6.1	32.2	25.2	36.5
1999	100.0	6.2	36.2	21.5	36.1
2000	100.0	6.3	36.8	22.8	34.1
2001	100.0	6.1	36.8	24.2	32.9
2002	100.0	6.3	36.9	23.7	33.1
2003	100.0	5.7	36.5	24.0	33.7
2004	100.0	6.7	35.9	23.9	33.5
2005	100.0	6.5	37.7	23.6	32.2
2006	100.0	6.5	37.6	24.9	31.0
2007	100.0	6.0	39.2	24.3	30.5
2008	100.0	5.0	39.8	23.2	32.0
2009	100.0	6.2	39.5	25.5	28.9
2010	100.0	6.5	38.5	24.8	30.2
2011	100.0	5.8	39.3	25.2	29.8
2012	100.0	7.4	34.4	26.3	32.0
2013	100.0	6.8	36.3	27.3	29.6
2014	*	*	*	*	*
2015	100.0	7.3	35.0	28.1	29.6
2016	100.0	5.6	37.8	28.8	27.8
2017	100.0	5.9	39.5	29.2	25.4

\* To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

NOTE: 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. Personal assistance is defined as assistance with performing the task. In this table, personal assistance does not include supervision. 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 and are continuously enrolled during the year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1992–2013) and Survey File (2015–2017).

**Table 36b. 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, 2017**

Age group and sex	Total	Personal assistance only	Equipment only	Personal assistance and equipment	No personal assistance or equipment
65 and over	100.0	5.9	39.5	29.2	25.4
Men	100.0	5.6	39.2	24.3	30.9
Women	100.0	6.1	39.7	32.0	22.2
65–74	100.0	6.4	36.3	22.6	34.7
75–84	100.0	5.6	43.1	29.1	22.2
85 and over	100.0	5.4	40.0	41.3	13.3

NOTE: 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. Personal assistance is defined as assistance with performing the task. In this table, personal assistance does not include supervision. 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 and are continuously enrolled during the year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.

## INDICATOR 36: Personal Assistance and Equipment

**Table 36c. 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, 1992–2017**

Year	Total	65 and over		
		65–74	75–84	85 and over
1992	65.3	62.3	66.4	76.0
1993	64.3	60.0	65.4	78.9
1994	65.2	64.0	64.1	73.8
1995	66.3	63.0	67.6	75.4
1996	66.2	64.1	66.2	74.5
1997	67.1	64.3	67.7	74.9
1998	69.1	66.9	68.9	76.8
1999	67.9	65.6	67.8	76.1
2000	65.4	59.1	67.3	78.5
2001	69.0	66.3	68.8	77.3
2002	70.8	69.7	70.5	75.4
2003	70.9	69.6	69.5	78.1
2004	69.0	65.1	70.3	75.4
2005	69.5	65.2	70.6	77.3
2006	67.6	66.1	66.5	74.0
2007	71.0	68.7	71.4	75.7
2008	70.9	71.0	70.5	71.5
2009	70.3	68.3	70.7	74.0
2010	70.0	67.8	68.9	77.8
2011	72.5	69.7	71.9	79.7
2012	73.0	71.2	71.8	80.3
2013	71.1	65.7	74.2	79.5
2014	*	*	*	*
2015	70.7	66.4	74.0	75.0
2016	71.7	69.9	71.4	77.9
2017	71.1	69.3	69.7	79.2

\* To accommodate changes in sampling and data collection methodologies, the 2014 Medicare Current Beneficiary Survey data are not being released.

NOTE: 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.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more IADLs and are continuously enrolled during the year. The population excludes beneficiaries who also have limitations in performing activities of daily living.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1992–2013) and Survey File (2015–2017).

**Table 36d. 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, 2017**

Age group	Men	Women
65–74	68.2	70.7
75–84	70.8	71.8
85 and over	71.9	81.5

NOTE: 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.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more IADLs and are continuously enrolled during the year. The population excludes beneficiaries who also have limitations in performing activities of daily living.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.

## INDICATOR 37: Long-Term Care Providers

**Table 37a. Number of users of long-term care services, by sector and age group, 2015 and 2016**

Age group	Nursing homes (2016)	Residential care communities (2016)	Adult day services centers (2016)	Home health agencies (2015)	Hospices (2015)
Less than 65	222,400	53,600	107,100	806,500	78,400
65–74	245,300	89,300	58,100	1,194,100	249,600
75–84	359,800	245,900	74,200	1,332,300	417,800
85 and over	520,200	422,800	46,700	1,122,800	681,600

NOTE: The long-term care services described here are provided by paid, regulated providers. They comprise both health care-related and non-health care-related services, including postacute care and rehabilitation. People can receive more than one type of service. The estimated number of nursing home residents represents current residents in 2016. The estimated number of residential care community residents represents current residents in 2016. The estimated number of adult day services center participants represents current participants in 2016. The estimated number of home health patients represents patients who ended care in 2015 (i.e., discharges). The estimated number of hospice patients represents patients who received care at any time in 2015. The number in each age group is calculated by applying the percentage distribution by age to the estimated total number of users and may differ slightly from other published estimates because of rounding. See [https://www.cdc.gov/nchs/data/series/sr\\_03/sr03\\_43-508.pdf](https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf) for definitions.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Study of Long-Term Care Providers.

**Table 37b. Percentage of users of long-term care services needing any assistance with activities of daily living (ADLs), by sector and activity, 2015 and 2016**

Activity	Nursing homes (2016)	Residential care communities (2016)	Adult day services centers (2016)	Home health agencies (2015)
Bathing	96.7	63.6	38.6	97.2
Dressing	92.7	48.2	36.0	92.0
Toileting	89.3	40.0	33.5	81.1
Walking or locomotion	92.0	56.5	45.8	95.4
Transferring in/out of bed or chair	86.8	29.2	28.5	91.3
Eating	59.9	19.2	23.2	61.2

NOTE: The long-term care services described here are provided by paid, regulated providers. They comprise both health care-related and non-health care-related services, including postacute 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, 84 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, 63 percent of participants were age 65 and over. Among home health care patients, 82 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 assistive devices to perform the activity. See [https://www.cdc.gov/nchs/data/series/sr\\_03/sr03\\_43-508.pdf](https://www.cdc.gov/nchs/data/series/sr_03/sr03_43-508.pdf) for definitions.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Study of Long-Term Care Providers.

## INDICATOR 38: Use of Time

**Table 38a. 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, 2018**

	55 and over		55-64		65-74		75 and over	
	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	8.83	36.8	8.66	36.1	8.88	37.0	9.12	38.0
Leisure activities	6.54	27.3	5.49	22.9	7.17	29.9	7.75	32.3
Work and work-related activities	2.16	9.0	3.79	15.8	1.05	4.4	0.49	2.0
Household activities	2.22	9.3	2.10	8.8	2.45	10.2	2.14	8.9
Caring for and helping others	0.47	2.0	0.47	1.9	0.58	2.4	0.31	1.3
Eating and drinking	1.26	5.3	1.18	4.9	1.28	5.3	1.41	5.9
Purchasing goods and services	0.82	3.4	0.79	3.3	0.85	3.5	0.83	3.5
Grooming	0.64	2.7	0.65	2.7	0.63	2.6	0.63	2.6
Other activities	1.05	4.4	0.86	3.6	1.12	4.6	1.31	5.5

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 38b. 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, 2018**

	55 and over		55-64		65-74		75 and over	
	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	0.60	9.2	0.59	10.7	0.67	9.3	0.53	6.8
Watching TV	4.00	61.1	3.36	61.3	4.34	60.6	4.78	61.7
Participation in sports, exercise, and recreation	0.24	3.7	0.23	4.2	0.28	3.9	0.21	2.7
Relaxing and thinking	0.44	6.7	0.37	6.8	0.42	5.9	0.59	7.7
Reading	0.50	7.7	0.27	5.0	0.61	8.6	0.80	10.3
Other leisure activities	0.76	11.6	0.67	12.1	0.84	11.7	0.84	10.8

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 39: Air Quality

**Table 39a. Percentage of people age 65 and over living in counties with “poor air quality,” by selected pollutant measures, 2000–2018**

Pollutant measures	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2018
Particulate matter (PM <sub>2.5</sub> )	50.1	47.7	47.1	42.9	37.8	45.6	35.5	38.4	25.7	17.7	15.0	14.3	7.2	9.7	9.6	8.8	5.9	10.5	10.6
Ozone	58.2	59.2	57.4	59.6	50.5	58.2	58.4	57.3	50.3	33.0	47.8	48.7	52.9	26.9	24.3	30.8	33.9	28.9	35.5
Any standard	68.7	67.6	65.3	67.4	61.4	67.2	65.6	64.3	55.9	38.4	51.0	51.4	54.3	32.8	26.7	34.8	36.2	32.1	39.9

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. PM<sub>2.5</sub> refers to fine inhalable particles with diameters that are generally 2.5 micrometers and smaller. Data for previous years have been computed using the standards in effect as of August 2019 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 39b. Counties with “poor air quality” for any standard in 2018**

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
Alaska	Fairbanks North Star Borough	97,581	6,375
Alaska	Matanuska-Susitna Borough	88,995	7,069
Arizona	Gila County	53,597	12,450
Arizona	Maricopa County	3,817,117	462,641
Arizona	Pima County	980,263	151,293
Arizona	Pinal County	375,770	52,071
Arizona	Yuma County	195,751	30,646
California	Alameda County	1,510,271	167,746
California	Amador County	38,091	7,865
California	Butte County	220,000	33,817
California	Calaveras County	45,578	9,565
California	Colusa County	21,419	2,495
California	Contra Costa County	1,049,025	130,438
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	Lake County	64,665	11,440
California	Los Angeles County	9,818,605	1,065,699
California	Madera County	150,865	17,262
California	Marin County	252,409	42,192
California	Mariposa County	18,251	3,821
California	Mendocino County	87,841	13,493
California	Merced County	255,793	23,960
California	Mono County	14,202	1,377
California	Napa County	136,484	20,594
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
California	Riverside County	2,189,641	258,586
California	Sacramento County	1,418,788	158,551
California	San Benito County	55,269	5,360

See notes at end of table.

## INDICATOR 39: Air Quality

**Table 39b. Counties with “poor air quality” for any standard in 2018—continued**

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
California	San Bernardino County	2,035,210	181,348
California	San Diego County	3,095,313	351,425
California	San Francisco County	805,235	109,842
California	San Joaquin County	685,306	71,181
California	San Luis Obispo County	269,637	41,022
California	San Mateo County	718,451	96,262
California	Santa Clara County	1,781,642	196,944
California	Santa Cruz County	262,382	29,158
California	Shasta County	177,223	29,967
California	Siskiyou County	44,900	8,782
California	Solano County	413,344	46,847
California	Sonoma County	483,878	67,364
California	Stanislaus County	514,453	54,831
California	Sutter County	94,737	11,990
California	Tehama County	63,463	10,071
California	Tulare County	442,179	41,779
California	Tuolumne County	55,365	11,294
California	Ventura County	823,318	96,309
California	Yolo County	200,849	19,771
Colorado	Arapahoe County	572,003	57,580
Colorado	Boulder County	294,567	29,521
Colorado	Clear Creek County	9,088	1,132
Colorado	Denver County	600,158	62,132
Colorado	Douglas County	285,465	20,343
Colorado	El Paso County	622,263	62,051
Colorado	Jefferson County	534,543	67,411
Colorado	La Plata County	51,334	5,979
Colorado	Larimer County	299,630	35,541
Colorado	Montezuma County	25,535	4,269
Colorado	Weld County	252,825	24,235
Connecticut	Fairfield County	916,829	124,075
Connecticut	Litchfield County	189,927	30,342
Connecticut	Middlesex County	165,676	25,621
Connecticut	New Haven County	862,477	123,972
Connecticut	New London County	274,055	38,995
Connecticut	Tolland County	152,691	18,220
Connecticut	Windham County	118,428	15,215
Delaware	New Castle County	538,479	66,222
District of Columbia	District of Columbia	601,723	68,809
Florida	Duval County	864,263	96,169
Georgia	Fulton County	920,581	83,424
Hawaii	Hawaii County	185,079	26,834
Idaho	Shoshone County	12,765	2,537
Illinois	Champaign County	201,081	20,066
Illinois	Cook County	5,194,675	620,329
Illinois	DuPage County	916,924	106,398
Illinois	Kane County	515,269	49,690

See notes at end of table.

## INDICATOR 39: Air Quality

Table 39b. Counties with “poor air quality” for any standard in 2018—continued

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
Illinois	Lake County	703,462	73,093
Illinois	McHenry County	308,760	31,320
Illinois	Macon County	110,768	18,142
Illinois	Madison County	269,282	38,428
Illinois	St. Clair County	270,056	33,810
Illinois	Will County	677,560	62,814
Indiana	Allen County	355,329	42,137
Indiana	Boone County	56,640	6,644
Indiana	Clark County	110,232	14,055
Indiana	Floyd County	74,578	9,660
Indiana	Hamilton County	274,569	23,689
Indiana	Howard County	82,752	13,441
Indiana	Knox County	38,440	6,062
Indiana	Lake County	496,005	65,870
Indiana	LaPorte County	111,467	15,867
Indiana	Madison County	131,636	20,234
Indiana	Marion County	903,393	96,102
Indiana	Porter County	164,343	20,363
Indiana	St. Joseph County	266,931	35,565
Indiana	Shelby County	44,436	6,188
Indiana	Wabash County	32,888	5,952
Iowa	Scott County	165,224	21,605
Kentucky	Henderson County	46,250	6,551
Kentucky	Jefferson County	741,096	99,095
Kentucky	Madison County	82,916	9,312
Louisiana	East Baton Rouge Parish	440,171	48,030
Maryland	Allegany County	75,087	13,402
Maryland	Anne Arundel County	537,656	63,664
Maryland	Baltimore County	805,029	117,476
Maryland	Cecil County	101,108	11,875
Maryland	Harford County	244,826	30,564
Maryland	Prince George's County	863,420	81,513
Maryland	Baltimore City	620,961	72,812
Massachusetts	Barnstable County	215,888	53,879
Massachusetts	Bristol County	548,285	77,879
Michigan	Allegan County	111,408	14,438
Michigan	Berrien County	156,813	25,549
Michigan	Cass County	52,293	8,355
Michigan	Clinton County	75,382	9,705
Michigan	Kalamazoo County	250,331	30,780
Michigan	Kent County	602,622	67,104
Michigan	Lenawee County	99,892	14,580
Michigan	Macomb County	840,978	120,180
Michigan	Muskegon County	172,188	23,352
Michigan	Oakland County	1,202,362	159,124
Michigan	Ottawa County	263,801	31,023
Michigan	St. Clair County	163,040	23,671

See notes at end of table.

## INDICATOR 39: Air Quality

**Table 39b. Counties with “poor air quality” for any standard in 2018—continued**

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
Michigan	Washtenaw County	344,791	34,951
Michigan	Wayne County	1,820,584	230,703
Missouri	Clay County	221,939	24,964
Missouri	Jefferson County	218,733	24,394
Missouri	New Madrid County	18,956	3,045
Missouri	St. Charles County	360,485	40,378
Missouri	St. Louis County	998,954	149,493
Missouri	St. Louis city	319,294	35,175
Montana	Flathead County	90,928	13,103
Montana	Lewis and Clark County	63,395	8,757
Montana	Lincoln County	19,687	4,040
Nevada	Churchill County	24,877	3,781
Nevada	Clark County	1,951,269	220,445
Nevada	Douglas County	46,997	9,479
Nevada	Lyon County	51,980	8,215
Nevada	Washoe County	421,407	50,879
Nevada	White Pine County	10,030	1,494
Nevada	Carson City	55,274	9,133
New Jersey	Bergen County	905,116	137,103
New Jersey	Camden County	513,657	65,725
New Jersey	Essex County	783,969	90,287
New Jersey	Gloucester County	288,288	35,699
New Jersey	Hudson County	634,266	66,066
New Jersey	Hunterdon County	128,349	16,344
New Jersey	Mercer County	366,513	46,347
New Jersey	Middlesex County	809,858	99,462
New Jersey	Morris County	492,276	68,155
New Jersey	Ocean County	576,567	121,104
New Mexico	Bernalillo County	662,564	81,014
New Mexico	Doña Ana County	209,233	25,881
New Mexico	Eddy County	53,829	7,541
New Mexico	Lea County	64,727	6,991
New Mexico	Luna County	25,095	4,907
New Mexico	Sandoval County	131,561	15,880
New Mexico	San Juan County	130,044	14,083
New Mexico	Valencia County	76,569	9,742
New York	Bronx County	1,385,108	145,882
New York	Chautauqua County	134,905	22,381
New York	Monroe County	744,344	103,594
New York	New York County	1,585,873	214,153
New York	Queens County	2,230,722	286,146
New York	Richmond County	468,730	59,344
New York	Rockland County	311,687	41,841
New York	St. Lawrence County	111,944	15,553
New York	Suffolk County	1,493,350	201,793
New York	Wayne County	93,772	13,363
New York	Westchester County	949,113	139,122

See notes at end of table.

## INDICATOR 39: Air Quality

Table 39b. Counties with "poor air quality" for any standard in 2018—continued

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
North Carolina	Haywood County	59,036	12,416
Ohio	Allen County	106,331	15,697
Ohio	Butler County	368,130	42,484
Ohio	Clark County	138,333	22,422
Ohio	Cuyahoga County	1,280,122	198,541
Ohio	Geauga County	93,389	14,474
Ohio	Hamilton County	802,374	106,863
Ohio	Lake County	230,041	36,965
Ohio	Lucas County	441,815	57,809
Ohio	Montgomery County	535,153	81,041
Ohio	Stark County	375,586	60,978
Ohio	Trumbull County	210,312	36,617
Ohio	Warren County	212,693	22,936
Oklahoma	Canadian County	115,541	12,576
Oklahoma	Cleveland County	255,755	26,177
Oklahoma	Comanche County	124,098	12,702
Oklahoma	Dewey County	4,810	958
Oklahoma	Jefferson County	6,472	1,239
Oklahoma	Love County	9,423	1,618
Oklahoma	Muskogee County	70,990	10,408
Oklahoma	Oklahoma County	718,633	86,357
Oklahoma	Osage County	47,472	7,278
Oklahoma	Tulsa County	603,403	72,856
Oregon	Harney County	7,422	1,402
Oregon	Jackson County	203,206	35,834
Oregon	Josephine County	82,713	18,438
Oregon	Klamath County	66,380	11,351
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	Berks County	411,442	59,558
Pennsylvania	Bucks County	625,249	91,219
Pennsylvania	Delaware County	558,979	79,726
Pennsylvania	Montgomery County	799,874	120,727
Pennsylvania	Northampton County	297,735	46,606
Pennsylvania	Philadelphia County	1,526,006	185,309
Rhode Island	Kent County	166,158	26,069
Rhode Island	Providence County	626,667	84,389
Rhode Island	Washington County	126,979	19,017
Tennessee	Davidson County	626,681	65,403
Tennessee	Shelby County	927,644	95,224
Tennessee	Sullivan County	156,823	29,215
Texas	Bell County	310,235	27,003
Texas	Bexar County	1,714,773	175,883
Texas	Brazoria County	313,166	29,923
Texas	Collin County	782,341	60,048
Texas	Dallas County	2,368,139	207,972

See notes at end of table.

# INDICATOR 39: Air Quality

**Table 39b. Counties with “poor air quality” for any standard in 2018—continued**

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
Texas	Denton County	662,614	46,043
Texas	El Paso County	800,647	82,223
Texas	Galveston County	291,309	32,804
Texas	Harris County	4,092,459	333,487
Texas	Hood County	51,182	10,892
Texas	Howard County	35,012	4,615
Texas	Hunt County	86,129	12,001
Texas	Hutchinson County	22,150	3,266
Texas	Jefferson County	252,273	32,002
Texas	Johnson County	150,934	17,331
Texas	Montgomery County	455,746	47,404
Texas	Navarro County	47,735	6,863
Texas	Orange County	81,837	11,473
Texas	Parker County	116,927	14,283
Texas	Potter County	121,073	13,142
Texas	Randall County	120,725	15,079
Texas	Rockwall County	78,337	7,540
Texas	Rusk County	53,330	7,487
Texas	Tarrant County	1,809,034	161,385
Texas	Travis County	1,024,266	74,759
Utah	Box Elder County	49,975	5,563
Utah	Carbon County	21,403	2,903
Utah	Davis County	306,479	24,992
Utah	Duchesne County	18,607	1,984
Utah	Salt Lake County	1,029,655	89,367
Utah	Tooele County	58,218	4,379
Utah	Utah County	516,564	33,457
Utah	Weber County	231,236	23,388
Washington	Benton County	175,177	20,586
Washington	King County	1,931,249	210,679
Washington	Kittitas County	40,915	5,212
Washington	Okanogan County	41,120	7,070
Washington	Pierce County	795,225	87,785
Washington	Snohomish County	713,335	73,544
Washington	Spokane County	471,221	60,969
Washington	Walla Walla County	58,781	8,778
Washington	Whatcom County	201,140	26,640
Washington	Yakima County	243,231	28,122
West Virginia	Mineral County	28,212	4,893
Wisconsin	Door County	27,785	6,245
Wisconsin	Kenosha County	166,426	18,679
Wisconsin	Kewaunee County	20,574	3,393
Wisconsin	Manitowoc County	81,442	13,714
Wisconsin	Milwaukee County	947,735	109,133
Wisconsin	Outagamie County	176,695	20,834
Wisconsin	Ozaukee County	86,395	13,208
Wisconsin	Racine County	195,408	25,739
Wisconsin	Sheboygan County	115,507	16,821

See notes at end of table.

## INDICATOR 39: Air Quality

**Table 39b. Counties with “poor air quality” for any standard in 2018—continued**

State	County	Total population (in Census 2010)	Population 65 and over (in Census 2010)
Wyoming	Sweetwater County	43,806	3,643
Puerto Rico	Arecibo Municipio, Puerto Rico	96,440	15,727
Puerto Rico	Bayamón Municipio, Puerto Rico	208,116	34,335
Puerto Rico	Guaynabo Municipio, Puerto Rico	97,924	15,811
Puerto Rico	Ponce Municipio, Puerto Rico	166,327	25,178

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 40: Transportation

**Table 40. Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who made a change in transportation mode because of a health or physical problem, by age group and type of change, 2017**

Type of change	Total	65 and over		
		65–74	75–84	85 and over
Limits driving to daytime	18.1	12.9	22.7	41.2
Has given up driving altogether	12.8	7.7	13.9	37.1
Has trouble getting places	18.3	14.5	19.4	33.4
Has reduced travel	26.8	21.1	29.5	46.9

Reference population: These data refer to noninstitutionalized Medicare beneficiaries who were continuously enrolled during the year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Survey File.



# Data Sources

# Data Sources

## American Community Survey

The American Community Survey (ACS) is a nationwide survey designed to provide communities with reliable and timely demographic, social, economic, and housing data for the nation, states, congressional districts, counties, places, and other localities every year. It has an annual sample size of about 3.5 million addresses across the United States and Puerto Rico and includes both housing units and group quarters (e.g., nursing facilities, prisons). The ACS is conducted in every county throughout the nation, and every municipio in Puerto Rico, where it is called the Puerto Rico Community Survey. ACS 1-year estimates have been released annually for geographic areas with populations of 65,000 and more since 2006. ACS 5-year estimates have been released annually for all geographic areas down to the block group level, regardless of population size, since 2010. Data included in this report come from 1-year estimates. For information on the ACS sample design and other topics, visit <https://www.census.gov/programs-surveys/acs/>.

For more information, contact:  
U.S. Census Bureau Customer Service Center  
Phone: 800-923-8282  
Website: <https://ask.census.gov>

## 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 the EPA's 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: <https://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 (HUD) by the U.S. Census Bureau. The AHS encompasses a national survey and 35 metropolitan surveys and is designed to collect data from the same housing units for each survey. The integrated national sample, a representative sample of approximately 66,000 housing units as of 2017, is conducted biennially in odd-numbered years. This includes a representative national sample, representative samples of the 15 largest metropolitan areas, and an oversample of HUD-assisted housing units. Two sets of 10 metropolitan samples of 3,000 housing units per metropolitan area alternate 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:  
George Carter  
U.S. Department of Housing and Urban Development  
Office of Policy Development and Research  
Phone: 202-402-5873  
Website: <https://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  
Email: [atusinfo@bls.gov](mailto:atusinfo@bls.gov)  
Phone: 202-691-6339  
Website: <https://www.bls.gov/tus/>

### Consumer Expenditure Survey

The Consumer Expenditure (CE) Survey 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 Survey. Data are integrated before publication. The data presented in this report 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 that respondents can recall for a period of three 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 one-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  
Email: [CEXINFO@bls.gov](mailto:CEXINFO@bls.gov)  
Phone: 202-691-6900  
Website: <https://www.bls.gov/ce/>

### 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 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 or Alaska Native, Asian, and Native Hawaiian or 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

## Data Sources

ethnicity (such as Mexican, Puerto Rican, or Cuban). People of Hispanic origin may be of any race.

For more information, contact:

Bureau of Labor Statistics  
U.S. Department of Labor

Email: [cpsinfo@bls.gov](mailto:cpsinfo@bls.gov)

Phone: 202-691-6378

Website: <http://www.bls.gov/cps>

Additional website: <https://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 U.S. Census 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, and more was replaced by the American Community Survey, 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 the 2000 Census, 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 or Alaska Native, Asian, Native Hawaiian or 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 the 2000 Census 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, publishes 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 resulting from 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

Comment form: <https://www.federalreserve.gov/apps/contactus/feedback.aspx>

Website: <https://www.federalreserve.gov/apps/fof/>

## 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). The HRS is based on core interviews every two years of over 20,000 individuals representing the U.S. population over age 50. Respondents are followed longitudinally until death (including following people who move into a nursing home or other institutionalized setting). In 1992, the study began with an initial sample of more than 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 every 6 years of a new 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) were added in 2016. The Early GenX cohort (1966–1971) will be added in 2022. The 2010 wave also included an expansion of the minority sample of Early and Mid-Baby Boomers. The minority sample will be expanded again in 2022. 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 performance measures and biomarker data. The Aging, Demographics, and Memory Study (ADAMS) and Harmonized Cognitive Assessment Protocol (HCAP) supplement the HRS with data to support population-based research on Alzheimer's Disease and Alzheimer's Disease-Related Dementias. Data from a genome-wide scan on saliva samples collected from approximately 19,000 respondents from 2006–2016 supports genetic and genomic studies. Venous blood samples collected in 2016 and 2018 provided new biomarker data and a repository of serum, plasma, and cryo-preserved cells.

The HRS is designed to support research on aging, and the health and well-being of the older population. Survey content includes physical/psychological health and well-being, disabilities, blood-based biomarkers, health services,

labor force, economic status, family structure, and early life experiences. Linkages are available to a variety of administrative and contextual data.

*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  
 Email: [hqsquestions@umich.edu](mailto:hqsquestions@umich.edu)  
 Phone: 734-936-0314  
 Website: <https://hrs.isr.umich.edu/about>

## 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 the 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 <https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/intercensal/2000-2010-intercensal-estimates-methodology.pdf>.

For more information, contact:  
 Population Estimates Branch  
 Phone: 301-763-2385  
 Website: <https://www.census.gov/programs-surveys/popest.html>

## International Data Base

The U.S. Census Bureau produces the International Data Base (IDB), which includes regularly updated population estimates and projections for more than 200 countries

## Data Sources

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 online at <https://www.census.gov/programs-surveys/international-programs/about/idb.html>.

For more information, contact:

Demographic and Economic Studies Branch  
International Programs Population Division

Phone: 301-763-1360

Website: <https://www.census.gov/programs-surveys/international-programs.html>

### 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 semiannually, and is used to support a variety of research and statistical projects.

The data in Indicator 9 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 9 include 5A.1.2, 5A1.6, 5A5, 5A.6, 5A, and 6B5.t1.

For more information, contact:

Social Security Administration

Email: [statistics@ssa.gov](mailto: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 (CCW). The Centers for Medicare & Medicaid Services (CMS) launched the 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 on 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

Email: [resdac@umn.edu](mailto:resdac@umn.edu)

Phone: 1-888-973-7322

Website: <https://www.resdac.org>

Chronic Conditions Data Warehouse

Email: [CCWHelp@gdit.com](mailto: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 noncovered services; develop reliable and current information on the use and cost of services not covered by Medicare (such as long-term care and dental, vision, and hearing services); 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 on the beneficiaries. 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 residing in the community and in institutions.

The survey is conducted in 3 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 11 interviews. In-person interviews are conducted using computer-assisted personal interviewing. A sample of approximately 16,000 people is interviewed in each round. However, because of the rotating panel design, only 12,000 people receive all 3 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 Survey file and the Cost Supplement file. The Survey file contains information on beneficiaries' access to health care, satisfaction with care, usual source of care, health insurance coverage, and social determinants of health. The sample for this file is the "ever enrolled" population, including those who entered the Medicare program, and those who died during the benefit year. Medicare claims are linked to survey-reported events to produce the Cost Supplement file, which provides complete expenditure and source of payment data on all health care services, including those not covered by Medicare. The sample for the Cost Supplement is a subset of those in the Survey file who met criteria for having enough covered days of reporting their expenditures. Both files have weights that also allow for analysis of the continually (always) enrolled Medicare population as well—those who participated in the Medicare program for the entire 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 29c 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

Email: [MCBS@cms.hhs.gov](mailto:MCBS@cms.hhs.gov)

Website: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/MCBS/index>

## 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 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 the billing mechanism for medical services has grown more complex as a result of increasing penetration of managed care and Health Maintenance Organizations (HMOs) 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.<sup>44</sup> 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

## Data Sources

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 (2002).<sup>43</sup> 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 VR-12 physical and mental health assessment tool starting in 2018, 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: <https://meps.ahrq.gov/mepsweb>

### National Health and Aging Trends Study

The National Health and Aging Trends Study (NHATS) is a scientific study of how Americans function in later life. The study is led by investigators from the Johns Hopkins University Bloomberg School of Public Health and the Institute for Social Research at the University of Michigan, with data collection by Westat and support from the National Institute on Aging. 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, 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 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, 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.

For more information, contact:

National Health and Aging Trends Study

Email: [NHATSdata@westat.com](mailto:NHATSdata@westat.com)

Website: <https://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 and is one of the major data collection programs of the National Center for Health Statistics (NCHS).

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 is a cross-sectional household interview survey. The target population for the NHIS is the civilian noninstitutionalized population residing in the United States at the time of the interview. Excluded from the survey are persons in long-term care institutions (e.g., nursing homes for the elderly, hospitals for the chronically ill or physically or intellectually disabled, wards for abused or neglected children), correctional facilities (e.g., prisons or jails, juvenile detention centers, halfway houses), and U.S. nationals living in foreign countries. Active-duty Armed Forces personnel are also excluded from the survey, unless at least one other family member is a civilian eligible for the survey (e.g., a child whose parents are both active-duty military). In that case, data for these Armed Forces members (259 persons in 2018) are collected and included in all relevant files in order to aid any analyses pertaining to the family (e.g., family structure, relationships, income), but these persons are given a final

weight of zero so that their individual characteristics will not be counted when making national (i.e., weighted) estimates. Weighted estimates cover only the civilian noninstitutionalized household population.

*Race and Hispanic origin:* Starting with data year 1999, race-specific estimates in the NHIS were collected according to 1997 standards for Federal data on race and ethnicity, which specify five single-race categories and multiple race categories and are not strictly comparable with estimates for earlier years. In *Older Americans 2020*, estimates presented by race and Hispanic origin calculated from the NHIS include persons of multiple race. See *Health, United States, 2018, Appendix II* for details on race and ethnicity in the NHIS.

For more information, contact:

Division of Health Interview Statistics

Email: [nhis@cdc.gov](mailto:nhis@cdc.gov)

Phone: 301-458-4901

Website: <https://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).

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

Email: [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov)

Phone: 1-800-232-4636

Website: <https://www.cdc.gov/nchs/nhanes/index.htm>

## National Study of Long-Term Care Providers

The biennial National Study of Long-Term Care Providers (NSLTCP) monitors trends in the supply, provision, and use of the major sectors of paid, regulated long-term care services. NSLTCP uses survey data on the residential care community and adult day services sectors and administrative data on the home health, nursing home, and hospice sectors.

The main goals of NSLTCP are to

1. estimate the supply and use of paid, regulated long-term care services providers.
2. estimate key policy-relevant characteristics and practices.
3. produce national and state-level estimates, where feasible.
4. compare estimates among sectors.
5. monitor trends over time.

NSLTCP replaces NCHS' previous National Nursing Home Survey, National Home and Hospice Care Survey, and National Survey of Residential Care Facilities.

*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

Email: [ltcsbfeedback@cdc.gov](mailto:ltcsbfeedback@cdc.gov)

Phone: 301-458-4747

Website: <https://www.cdc.gov/nchs/nsltcp/index.htm>

## National Vital Statistics System

The National Vital Statistics System (NVSS) collects and disseminates official vital statistics. These data are provided through contracts between the National Center for Health Statistics (NCHS) and vital registration systems operated in the various jurisdictions legally responsible for the registration of vital events—births, deaths, marriages, divorces, and fetal deaths.

## Data Sources

In the United States, legal authority for the registration of these events resides individually with the 50 States, 2 cities (Washington, DC, and New York City), and 5 territories (Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Commonwealth of the Northern Mariana Islands). These jurisdictions are responsible for maintaining registries of vital events and for issuing copies of birth, marriage, divorce, and death certificates.

Mortality data from the NVSS are a fundamental source of demographic, geographic, and cause-of-death information. The NVSS is one of the few sources of health-related data that are comparable for small geographic areas and available for a long time period in the United States. The data are also used to present the characteristics of those dying in the United States, determine life expectancy, and compare mortality trends with other countries.

*Race and Hispanic origin:* Race and Hispanic origin are reported separately on the death certificate. Beginning in 2018, all states reported deaths using the 2003 revision of the U.S. Standard Certificate of Death, which allows the reporting of more than one race. The race categories on the 2003 version of the certificate are consistent with the 1997 Office of Management and Budget standard. See *Health, United States 2018*, Appendix II for more information on race and Hispanic origin in the mortality files of the NVSS.

For more information, contact:  
Division of Vital Statistics  
Email: [cdcinfo@cdc.gov](mailto:cdcinfo@cdc.gov)  
Phone: 1-800-232-4636  
Website: <https://www.cdc.gov/nchs/nvss/index.htm>

### Population Projections

The 2017 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 U.S. Census Bureau recommends the use of the population estimates. The following is a general description of the methods used to produce the 2017 National Population Projections.

The 2017 National Population Projections start with the Vintage July 1, 2016, 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 ages 14–54 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/programs-surveys/popproj.html>

### Postcensal Population Estimates

Each year, the U.S. Census Bureau produces and publishes population estimates of the nation, states, counties, state/county equivalents, and Puerto Rico.<sup>45</sup> 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.<sup>46</sup>

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).<sup>47</sup> 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: <https://www.census.gov/programs-surveys/popest/technical-documentation/methodology.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 spring 1995.<sup>48</sup>

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.<sup>48</sup>

Since 2011, the Census Bureau has published poverty estimates using the new measure based on these suggestions.<sup>49</sup> 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.<sup>50</sup>

For more information, contact:

Dr. Trudi J. Renwick

U.S. Census Bureau

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Website: <https://www.census.gov/topics/income-poverty/supplemental-poverty-measure.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.<sup>51,52</sup> 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 underrepresentation 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

## Data Sources

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.<sup>53</sup> The Indicator 10 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 PEU are shown for White and Black. Data are not shown by Hispanic origin.

For more information, contact:  
Chris Tamborini  
Social Security Administration  
Email: [chris.tamborini@ssa.gov](mailto:chris.tamborini@ssa.gov)  
Phone: 202-358-6109

### VA Enrollee Health Care Projection Model

The Department of Veterans Affairs (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 approximately 140 categories of health care services. First, VA uses the Model to determine how many veterans will be enrolled each year and their age, priority, and geographic location. Next, 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 VA.

The Model accounts for the unique demographic characteristics of the enrolled veteran population, including Post-9/11 Era Combat Veteran and other enrollee cohorts, as well as other factors that impact a veteran's decision to enroll in 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 Post-9/11 Era Combat Veteran, female, and new enrollees, and other enrollee cohorts with unique utilization patterns for particular services
- New policies, regulations, and legislation, including the Choice Act and MISSION Act
- VA health care initiatives, such as the mental health capacity improvement initiative
- A continually evolving VA health care system (e.g., quality and efficiency initiatives)
- Changes in health care practice and technology, such as new diagnostics, drugs, and treatments

For more information, contact:  
Maggie Heimann  
Veterans Health Administration  
Chief Strategy Office  
Email: [margaret.heimann@va.gov](mailto:margaret.heimann@va.gov)  
Phone: 202-461-4194  
Website: <https://www.va.gov/HEALTHPOLICYPLANNING/planning.asp>

### Veteran Population Estimates and Projections

The VA Analytics Service provided veteran population projection by key demographic characteristics such as age and gender as well as geographic areas. VetPop2016 was last updated using 2000 Census data, VA administrative data, and Department of Defense data. VetPop2018 was released in spring 2020.

*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  
Email: [VANCVAS@va.gov](mailto:VANCVAS@va.gov)  
Website: [https://va.gov/vetdata/veteran\\_population.asp](https://va.gov/vetdata/veteran_population.asp)



# Glossary

# Glossary

**Activities of daily living (ADLs):** Basic activities that support survival, including eating, bathing, and toileting. *See also 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.

**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<sup>2</sup> or kilograms/meters<sup>2</sup>. The categories used in this report are consistent with those set by the World Health Organization. For adults age 20 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 [https://www.nhlbi.nih.gov/health/educational/lose\\_wt/BMI/bmicalc.htm](https://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*.<sup>54</sup>

**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, coded, and 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 10th Revision of the ICD (ICD-10).<sup>55</sup>

**Civilian noninstitutionalized population:** *See Population.*

**Civilian population:** *See Population.*

**Crowded housing:** 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 29 and 33), the Medical Expenditure Panel Survey (MEPS), and the data used from the MEPS predecessor surveys used in this report (Indicator 32), 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 29, dental services are included as part of the "Other" category; in Indicator 33, 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.

**Emergency room services:** In the Medical Expenditure Panel Survey (MEPS) and the data used from the MEPS predecessor surveys used in this report (Indicator 32), 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 29 and 33), 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:** 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 per 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 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 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. Group quarters are 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: <https://www.census.gov/prod/cen2010/doc/sf1.pdf>.

**Head of household:** The Survey of Consumer Finances estimates wealth for the “primary economic unit” (PEU), which is similar to the U.S. Census Bureau’s Household. The PEU 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 13), 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 29 and 33), 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 32), 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 [2002].<sup>45</sup>) 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):** 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 one year).

**Health Eating Index-2015 (HEI-2015):** A dietary assessment tool with 13 components designed to measure quality in terms of how well a set of foods aligns with the key recommendations of the *2015–2020 Dietary Guidelines for Americans*. Intakes equal to or better than the standards set for each component are assigned a maximum score. Maximum HEI-2015 component scores range from 5 to 10 points. Scores for intakes between the minimum and maximum standards are scored proportionately. Scores for each component are summed to create a total maximum HEI-2015 score of 100 points. Nine of the 13 components assess adequacy components. The remaining four components assess dietary components that should be consumed in moderation. For the adequacy components, higher scores reflect higher intakes that meet or exceed the standards. For the moderation components, higher scores reflect lower intakes because lower intakes are more desirable. A higher total score indicates a diet that aligns better with the *Dietary Guidelines*. HEI-2015 total and component scores in this report reflect usual dietary intakes among older adults in the United States.

# Glossary

**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 28, 29, and 33), 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 32), 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 (Indicators 29 and 33), hospice care includes only those services provided as part of a Medicare benefit. In Indicator 29, hospice services are part of the “Other” category. In Indicator 33, hospice services are a separate category. In the Medical Expenditure Panel Survey (MEPS; Indicator 32), 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:** In the Medical Expenditure Panel Survey (Indicator 32), hospital care 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 29 and 33), 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 separately billed physician inpatient services are excluded. In the Medical Expenditure Panel Survey (Indicator 32), 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 29 and 33) 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:** In the Medicare claims data (Indicator 28), hospital stays refer 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 Medicare Current Beneficiary Survey, 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 Veterans Administration 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 also Poverty, Indicator 32: Out-of-Pocket Health Care Expenditures.*

**Inpatient hospital:** *See Hospital inpatient services.*

**Institutionalized population:** *See Population.*

**Institutions:** For the 2010 Census, the U.S. 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 also Population.*

**Instrumental activities of daily living (IADLs):** Indicators of functional well-being that measure the ability to perform more complex tasks than the related activities of daily living. *See also 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 21 and 35), a residence (or unit) is considered a long-term care facility if it is certified by Medicare or Medicaid; 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 nonfamily, paid caregiver. In the MCBS (Indicators 29 and 33), a long-term care facility excludes “short-term institutions” (e.g., subacute care) stays. *See also Short-term institution (Indicators 29 and 33), and Skilled nursing facility (Indicator 28).*

**Mammography:** An X-ray image of the breast used to detect irregularities in breast tissue.

**Mean:** An average of  $n$  numbers computed by adding the numbers and dividing by  $n$ .

**Median:** 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 postacute 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:** Also known as Hospital Insurance, Medicare Part A covers inpatient care in hospitals, critical access hospitals, skilled nursing facilities, and other postacute care settings, such as rehabilitation and long-term care hospitals. It also covers hospice and some home health care.

**Medicare Part B:** Also known as Medical Insurance, Medicare Part B 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

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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:** This program 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 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 for drug coverage only or they can join a Medicare Advantage plan that covers both medical services and prescription drugs. 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*.

**Noninstitutional group quarters:** For the 2010 Census, the U.S. 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 residents. 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 <https://www.census.gov/prod/cen2010/doc/sf1.pdf>.

**Obesity:** See *Body mass index (BMI)*.

**Office-based medical provider services:** In the Medical Expenditure Panel Survey (Indicator 32), 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 33), this category includes short-term institution, hospice, and dental services. In the Medical

Expenditure Panel Survey (Indicator 32), 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.

**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 (BMI)*.

**Physician/medical services:** In the Medicare Current Beneficiary Survey (Indicator 33), 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 29), this term refers to “physician/medical services” combined with “hospital outpatient services.”

**Physician visits and consultations:** In Medicare claims data (Indicator 28), 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 residing 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 States sovereignty or jurisdiction (principally American Samoa, Guam, U.S. Virgin Islands, 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 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 population residing in noninstitutional group quarters. *See also Resident population and Noninstitutional group quarters.*

**Civilian population:** 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 Noninstitutional group quarters.*

**Institutionalized population:** For the 2010 Census, the U.S. 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 residents. 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 <https://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., \$12,043 for one person age 65 and over in 2018).<sup>56</sup> Poverty thresholds are the dollar amounts used to determine poverty status. Each family (including single-person households) is assigned a poverty threshold based on the family's size and the ages of the family members. All family members have the same poverty status. Several indicators included in this report include a poverty status measure. Poverty status (less than 100 percent of the poverty threshold) was computed for Indicators 7, 8, 27, 31, and 32 using the official 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 \$12,043 and \$24,085 for one person age 65 and over in 2018). Middle income is income between 200 percent and 399 percent of the poverty threshold (i.e., between \$24,086 and \$36,128 for one person age 65 and over in 2018). High income is income 400 percent or more of the poverty threshold.

**Indicator 27: 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 31: 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 32: 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 also Income, household.*

**Prescription drugs/medicines:** In the Medicare Current Beneficiary Survey (Indicators 29, 30, 33) and in the Medical Expenditure Panel Survey (Indicator 32), 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.

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**Prevalence:** 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.

**Race:** See *specific data source descriptions*.

**Rate:** 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 also *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:** This 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 29 and 33) includes skilled nursing facility stays and other short-term (e.g., subacute care) facility stays (e.g., a rehabilitation facility stay). Payments for these services include Medicare and other payment sources. See also *Skilled nursing facility (Indicator 28)*, *Nursing facility (Indicator 35)*, and *Long-term care facility (Indicators 21, 29, 33, and 36)*.

**Skilled nursing facility:** As defined by Medicare (Indicator 28), a skilled nursing facility 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 29 and 33), “skilled nursing facilities” are classified as a type of “short-term institution.” See also *Short-term institution (Indicators 29 and 33)*, and *Long-term care facility (Indicators 21, 29, 33, and 35)*.

**Skilled nursing facility stays:** In the Medicare claims data (Indicator 28), skilled nursing facility stays refer to admission to and discharge from a skilled nursing facility, regardless of the length of stay. See also *Skilled nursing facility (Indicator 28)*.

**Standard population:** 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:** 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 that 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 Health Maintenance Organizations (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 U.S. 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:** 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's Medicare wraparound coverage (similar to traditional Medigap coverage) for Medicare-eligible uniformed services beneficiaries and their eligible family members and survivors.

**Veteran:** People 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 34) 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 1935–2020

			Year	Historical Events	Legislative Events	
		1935 Cohort	Born	1935		1935—Social Security Act passed
				.		
				.		
			5 years old	1940		1937—U.S. Housing Act passed, establishing Public Housing
				.		
				.		
	1945 Cohort		Born	1945	1941—Pearl Harbor; United States enters WWII	
				.		
				.		
			5 years old	1945	1944—D-Day landings in Normandy	
				.	1945—Yalta Conference; Cold War begins; Atomic bombings of Hiroshima and Nagasaki; 1946—Baby boom begins	
				.		
			5 years old	1950	1950—United States enters Korean War	
				.		
				.		
1955 Cohort			Born	1955	1953—Korean Armistice Agreement signed	
				.		
				.		
			5 years old	1955	1955—Nationwide polio vaccination program begins	1956—Women ages 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
				.		
				.		
			5 years old	1960	1962—Cuban Missile Crisis	1961—Men ages 62–64 eligible for reduced Social Security benefits; 1962—Self-Employed Individual Retirement Act (Keogh Act) passed; 1964—Civil Rights Act passed
				.	1963—March on Washington; Assassination of President John F. Kennedy; 1964—baby boom ends; New York World's Fair	
				.		
			5 years old	1965	1965—Medicare and Medicaid established; Older Americans Act passed	1965—Medicare and Medicaid established; Older Americans Act passed
				.		1967—Age Discrimination in Employment Act passed
				.		
			5 years old	1965	1968—Assassination of Martin Luther King, Jr.	
				.	1969—First man on the moon; Stonewall uprising	
				.	1970—Kent State shootings	
			5 years old	1970		1972—Formula for Social Security cost-of-living adjustment established; Social Security Supplemental Security Income legislation passed; 1974—Employee Retirement Income Security Act passed; IRAs established; 1975—Age Discrimination Act passed
				.		
				.		
			5 years old	1975	1973— <i>Roe v. Wade</i>	
				.		
				.		
			5 years old	1980	1980—First AIDS case is reported to the Centers for Disease Control and Prevention	1978—401(k)s established
				.		
				.		
			5 years old	1985	1987—Development of HyperText Markup Language (HTML), giving rise to the World Wide Web	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
				.	1989—Berlin Wall falls	1987—Reverse mortgage market created by the HUD Home Equity Conversion Program
				.		
			5 years old	1990	1990—United States enters Persian Gulf War	1990—Americans with Disabilities Act passed
				.	1992—Maastricht Treaty creates European Union	
				.		
				.		
			5 years old	1995	1997—WiFi first released for consumers	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
				.	1998—Launch of International Space Station	2000—Social Security earnings test eliminated for full retirement age
				.		
			5 years old	2000	2001—September 11: Terrorists attack United States; War on Terror declared and invasion of Afghanistan	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
				.	2003—United States enters Iraq War	
				.		
				.		
			5 years old	2005	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;	
				.		
			5 years old	2010	2010—Offshore explosion on the Deepwater Horizon drilling rig causes the largest oil spill in U.S. history;	2010—Patient Protection and Affordable Care Act passed;
				.	2011—World population reaches 7 billion, 0.9 billion age 60 and over; United States formally ends the Iraq War;	
				.	2012—First Baby Boomers reach Social Security full-retirement age; 2013— <i>United States v. Windsor</i> ruling	
				.	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; 2019—Setting Every Community Up for Retirement Enhancement Act passed; 2020—Supporting Older Americans Act passed	
				.	2015— <i>Obergefell v. Hodges</i> ruling legalizes same-sex marriage across all 50 states	
				.		
			5 years old	2020	2020—First reported case of COVID-19 in United States	

