2024

Older Americans
Key Indicators of Well-Being

FEDERAL INTERAGENCY FORUM ON AGING RELATED STATISTICS

Federal Interagency Forum on Aging-Related Statistics

The Federal Interagency Forum on Aging-Related Statistics (Forum) was founded in 1986 to foster collaboration among Federal agencies that produce or use statistical data on the older population. Forum agencies as of October 2024 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 2024

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 2024: Key Indicators of Well-Being (*Older Americans 2024*) provides a comprehensive, easy-to-understand picture of our older population. *Older Americans 2024* is the ninth 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.

At the beginning of the COVID-19 pandemic, changes to Medicare expanded the use of telehealth among older adults. Although levels of telehealth are currently lower than the peak in 2020, they have remained higher than before the pandemic. This year's report highlights these findings in a special feature using three Forum agency data sources: 1) visit-based data from fee-for-service Medicare claims; 2) person-level data from the National Health Interview Survey; and 3) visit-based data from the Medical Expenditure Panel Survey.

The Forum has also conducted an Inventory of Cognitive Functioning data sets and resources and expects to release the online tool in 2025 on agingstats.gov.

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://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.

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

About This Report

Introduction

Older Americans 2024 marks 24 years since the Forum first released key indicators describing the overall condition of the U.S. population age 65 and over. It is the ninth in this 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 2024* complements other more technical and comprehensive reports from the individual Forum agencies. The report includes indicators grouped into 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; and

- Bulleted data highlights.

The data used in the indicators are presented in tables at https://agingstats.gov/reports-and-tables.html. Data source descriptions, a glossary, and a timeline of selected historical events are included in the back matter. 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, nationally representative 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; and

- Representative of large segments of the aging population, rather than one particular group.

Considerations When Examining the Indicators

The data in *Older Americans 2024* 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 2022, 9 percent of the population age 85 and over was not included in the civilian noninstitutionalized population as estimated by the American Community Survey. For example, the reference population for Indicator 20: 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.

The labels for specific race and ethnic groups used in this report vary according to the standards adopted by each reporting agency. In addition, on March 28, 2024, the Office of Management and Budget released new standards for the collection of race and ethnicity data (spd15revision. gov). These new standards include updated categories and require that detailed data be collected. These standards have not yet been adopted for the indicators presented in this report. When the new standards have been adopted by data collection systems, they will be incorporated into future *Older Americans* reports.

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 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 may 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 can be found in tables on the Forum's website at https://agingstats.gov. Data are also described in the bullets below each 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

Recent evidence increasingly points to a substantial underestimation of the incomes of older Americans in official government statistics. Individually linked administrative data revealed widespread underreporting of several sources of income that are disproportionately important in old age: interest, dividends, and private retirement income.[1] Because of this underreporting, using administrative records yielded a median income estimate for households headed by someone aged 65 or over that was 30 percent higher than the official survey-based estimate, as well as an estimated poverty rate for those aged 65 or over that was 23 percent lower. Research into income underreporting has continued. For example, the ongoing National Experimental Wellbeing Statistics program (NEWS)[2] reports income and poverty statistics that are corrected not only for misreporting, but also for many other forms of error (such as nonresponse bias), with similar results for those 65 and over. Other teams at Census and SSA have continued to investigate this phenomenon in other surveys.

Some options may become available for future statistical products describing the incomes of older Americans. First, analysts have adjusted statistics generated from public-use microdata using published estimates of underreporting.[3] Second, future iterations of NEWS and other administrative-record-based statistical programs may include the desired statistical tabulations.

The Forum continues to research topics of interest and relevance to older Americans. This section focuses on current issues.

Emerging Topic for Older Americans

In 2023, the United States Surgeon General declared an epidemic of loneliness and isolation with the release of *The U.S. Surgeon General's Advisory on the Healing Effects of Social Connection and Community*. Research demonstrates that social connection is a significant driver of health, including for older adults. The health risks associated with loneliness and social isolation include cardiovascular disease, hypertension, cancer, diabetes, cognitive decline, depression, anxiety, suicidality, and self-harm.[4] There is robust evidence that loneliness and isolation are associated with a significantly increased risk for early death from all causes. A 2023 meta-analysis of 90 studies with over 2.2 million participants found that social isolation is associated with increased risk for earlier death by 32 percent and loneliness by 14 percent.[5]

Although there is much evidence of the impacts of social connection on health and well-being, there is inconsistency in how it has been defined and measured over time. Incorporating standardized measures into surveillance systems to track the prevalence rates of social connection in older adults to identify and address health disparities in populations at risk in the older adult population.

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; and

- Address concerns regarding collection, access, and dissemination of data.

For Further Information

The Forum's website (https://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 X (formerly Twitter) @agingstats for selected highlights from *Older Americans 2024*.

For more information about *Older Americans 2024* or other Forum activities, contact the Forum:

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Website: https://agingstats.gov

Additional Online Resources

Administration for Community Living

ACL Program Evaluations and Related Reports
https://acl.gov/programs/program-evaluations-and-reports

AGing, Independence, and Disability (AGID) Program
Data Portal
https://agid.acl.gov

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

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

Longitudinal Employer-Household Dynamics
https://lehd.ces.census.gov

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

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, Research Reports, and
Information Services
https://www.huduser.gov

Department of Veterans Affairs

National Center for Veterans Analysis and Statistics
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/index.htm

NCHS Data Query System
https://www.cdc.gov/nchs/dataquery/index.htm

Washington Group on Disability Statistics
http://www.washingtongroup-disability.com/

National Institute on Aging

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

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

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.gov
https://www.data.gov

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

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HEALTH CARE

ENVIRONMENT

SPECIAL FEATURE

Highlights

Older Americans 2024 is one in a series of periodic reports to the Nation on the condition of older adults in the United States. In this report, 41 indicators depict the well-being of older Americans in the areas of Population, Economics, Health Status, Health Risks and Behaviors, Health Care, and Environment. A special feature is also included. Selected highlights from each section of the report follow.

Population

- In 2022, 57.8 million people age 65 and over lived in the United States, accounting for 17.3 percent of the total population. By 2100, the older population is projected to nearly double to 106.3 million people, representing 29.1 percent of the population (Indicator 1: Number of Older Americans).

- The older Hispanic population is projected to grow the fastest of all racial and ethnic groups, which will affect the broader racial and ethnic composition of the older population. For example, in 2022, the older Hispanic population was slightly smaller than the older non-Hispanic Black alone population (5.3 million versus 5.5 million respectively). However, by 2060, it is projected to be much larger—18.1 million compared to 11.3 million (Indicator 2: Racial and Ethnic Composition).

- People are less likely to be married and more likely to be widowed as they age. In 2022, nearly two-thirds of people aged 65–74 were married, whereas approximately one-tenth of people in this age group were widowed. Conversely, slightly less than a third of people age 85 and over were married, but just over half were widowed. Marital status also varies by sex, such that men age 65 and over were more likely than women to be married (69.8 percent versus 47.3 percent) and less likely to be widowed (10.3 percent versus 29.5 percent) (Indicator 3: Marital Status).

- In 2022, 88.2 percent of older men and 87.5 percent of older women had at least a high school diploma. More older men than older women had attained at least a bachelor's degree (34.7 percent versus 27.7 percent, respectively) (Indicator 4: Educational Attainment).

- The percentage of older men living alone has increased over time; 11.3 percent of men aged 65–74 lived alone in 1970, and this percentage rose to 20.8 percent in 2023. Further, 19.1 percent of men age 75 and over lived alone in 1970, whereas 23.0 percent lived alone in 2023. The percentage of women age 75 and over living alone also

rose, increasing from 37.0 percent in 1970 to 41.8 percent in 2023. In contrast, the percentage of women aged 65–74 living alone decreased from 31.7 percent in 1970 to 27.1 in 2023 (Indicator 5: Living Arrangements).

- In 2022, there were 8.5 million Veterans age 65 and over in the United States. This number is projected to drop to 6.0 million by 2040, a decrease of 30.0 percent (Indicator 6: Veterans).

Economics

- The poverty rate for the population age 65 and over was 10.2 percent in 2022. Older women experienced higher poverty rates than older men; 11.2 percent of women were in poverty in comparison to 9.0 percent of men. Additionally, poverty rates varied by race and ethnicity in the older population. The non-Hispanic White alone population had the lowest poverty rate (8.2 percent); the non-Hispanic Black alone population had one of the highest rates (17.6 percent), though not significantly different from the rate of 16.9 percent among the Hispanic (any race) population; the non-Hispanic Asian alone population had a poverty rate of 12.9 percent (Indicator 7: Poverty).

- In 2022, 10.2 percent of the older population lived in poverty, and 19.2 percent was in the low-income group. However, 39.6 percent of the older population was in the high-income group, which made up the largest share of older people by income category. Correspondingly, 31.0 percent of older Americans were in the middle-income group (Indicator 8: Income).

- The type of Social Security benefits received by older women changed between 1960 and 2022. The percentage receiving spouse-only benefits decreased from 33 percent to 6 percent, and the percentage of widow-only benefits fell from 23 percent to 11 percent. In contrast, the percentage who received earned worker benefits rose from 43 percent to 83 percent (Indicator 9: Social Security Beneficiaries).

- Between 1989 and 2022, the median net worth, in 2022 dollars, of households headed by people age 65 and over increased by about 108 percent, from $195,514 to $406,750 (Indicator 10: Net Worth).

- Labor force participation rates for men and women age 55 and over declined from 2019 to 2023, reflecting effects from the pandemic and continued aging of Baby

Boomers. In 2023, the labor force participation rate for women age 55 and over was 34 percent, which was lower than the recent high of 35 percent in 2019 but still higher than historical rates after rising steadily starting in the early 1990s. Among men age 55 and over, labor force participation increased in the mid-1990s and early 2000s, following a declining rate over the previous three decades. From 2008 to 2019, men's labor force participation held steady around 46 percent but fell to 44 percent in 2023 (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 2021, 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 2022, for the group age 75 and over, the share (over 14 percent) was more than double the share for the ages 45–54 group (nearly 7 percent) and larger than the share the oldest group allocated to transportation (12 percent) or the share allocated to food (11 percent; Indicator 13: Total Expenditures).

- In 2022, 9 percent of U.S. households with people age 65 and over (3.9 million households) were food insecure at some time during the year (Indicator 14: Food Insecurity).

Health Status

- Under mortality conditions present in 2022, people who survive to age 65 can expect to live an average of 18.9 more years overall: 17.5 years for men and 20.2 years for women. In 2022, the life expectancy of people who survive to age 85 was 6.4 years overall: 5.8 years for men and 6.8 years for women. (Indicator 15: Life Expectancy).

- Age-adjusted death rates for people age 65 and over were 14 percent lower in 2022 than 2000. Most leading causes of death declined over this period, but death rates for Alzheimer's disease, unintentional injuries, and Parkinson's disease increased. COVID-19 was the third leading cause of death for people age 65 and over in 2022 (Indicator 16: Mortality).

- In 2022, the prevalence of certain chronic health conditions among people age 65 and over differed by sex. Women reported higher levels than men of arthritis and asthma. Men reported higher levels than women of cancer, diabetes, heart disease, and high cholesterol (Indicator 17: Chronic Health Conditions).

- In 2021, 61 percent of people age 65 and over had a dental visit in the past year. This percentage was higher among people ages 65–74 than among people age 85 and over (62 percent versus 47 percent) (Indicator 18: Oral Health).

- In 2022, among people age 65 and over, 80 percent of those who were White, non-Hispanic reported good to excellent health, which was similar to the percentage for those who were Asian, non-Hispanic (75 percent) but higher than the percentage for those who were Black, non-Hispanic (68 percent) and Hispanic (62 percent) (Indicator 19: Respondent-Assessed Health Status).

- In 2022, 5.1 percent of men (1.2 million) and 6.6 percent of women (1.9 million) age 65 and over not living in nursing homes had dementia (Indicator 20: Dementia).

- Older women were more likely to report clinically relevant depressive symptoms than older men. In 2020, 15 percent of women age 65 and over reported clinically relevant depressive symptoms compared with 10 percent of men (Indicator 21: Depressive Symptoms).

- In 2022, 18.5 percent of the population age 65 and over reported having a disability, defined as having a lot of difficulty or being unable to do one of the following six functional activities: vision, hearing, mobility, communication, cognition, and self-care (Indicator 22: Functional Limitations).

Health Risks and Behaviors

- In 2022, 71 percent of people age 65 and over reported receiving a flu vaccination in the past 12 months. Those who were Asian, non-Hispanic and White, non-Hispanic were more likely to report receiving a flu vaccination (74 percent and 73 percent, respectively) compared with those who were Black, non-Hispanic and Hispanic (63 percent and 61 percent, respectively; Indicator 23: Vaccinations).

- In 2021, the percentage of people receiving colorectal cancer screening was higher among those ages 65–75 than among those ages 50–64 (84 percent versus 65 percent for men and 83 percent versus 68 percent for women. The percentage of women receiving breast cancer screening with a mammogram was similar for those ages 50–64 (76 percent) and ages 65–75 (77 percent; Indicator 24: Cancer Screenings).

- The USDA Dietary Patterns take the unique needs of older adults into account and provide a framework to help older adults follow a healthy dietary pattern and meet the Dietary Guidelines for Americans. When the

intakes of older Americans are compared with their recommendations, results show that several food group intakes fall below recommendations including Total Vegetables, Total Fruits, Total Dairy and Whole Grains (Indicator 25: Diet Quality).

- In 2022, 14.4 percent of people age 65 and over reported participating in aerobic and muscle-strengthening activities that met the Physical Activity Guidelines for Americans (Indicator 26: Physical Activity).

- During August 2021-August 2023, about 38 percent of people age 65 and over had obesity, 38 percent of men and 39 percent of women. The percentage with obesity was similar in 2015–2018 and August 2021–August 2023 (Indicator 27: Obesity).

- In 2022, 9 percent of people age 65 and over were current cigarette smokers, 10 percent of men and 8 percent of women (Indicator 28: Cigarette Smoking).

Health Care

- Between 1992 and 2021, the hospitalization rate decreased from 306 hospital stays per 1,000 Medicare beneficiaries to 197 per 1,000 beneficiaries (Indicator 29: Use of Health Care Services).

- After adjusting for inflation, annual health care costs per capita increased slightly among those age 65 and over between 1992 and 2021. In all years during that time period, average annual costs were substantially higher for those age 85 and over compared with those in the younger age groups (Indicator 30: Health Care Expenditures).

- After adjusting for inflation, average annual prescription drug costs for noninstitutionalized Medicare beneficiaries age 65 and over increased between 1992 and 2021—from $1,235 to $6,432 (Indicator 31: Prescription Drug Costs).

- Enrollment in Medicare Advantage (MA)/Capitated Payment Plans has grown rapidly in recent years. In 2005, 16 percent of Medicare beneficiaries age 65 and over were enrolled in an MA plan, compared with 46 percent in 2021 (Indicator 32: Sources of Health Insurance).

- From 1977 to 2021, 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 22 percent (Indicator 33: Out-of-Pocket Health Care Expenditures).

- Medicare paid for approximately 67 percent of all health care costs of Medicare beneficiaries age 65 and over in 2021. Medicare financed all hospice costs and most

hospital, physician, home health care, prescription drug, and short-term institution costs (Indicator 34: 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 health benefits was reformed. Enrollment is now steadily declining and will continue through the projection years. However, the number of Veterans age 85 and over enrolled, the oldest and frailest enrollees, is projected to increase significantly until it exceeds 1.1 million by 2037 (Indicator 35: Veterans' Health Care).

- In 2021, about 4 percent of Medicare beneficiaries age 65 and over resided in community housing with at least one service available or in long-term care facilities (Indicator 36: Residential Services).

- In 2021, about three-quarters of noninstitutionalized Medicare beneficiaries age 65 and over who had difficulty with one or more activities of daily living (ADLs) received personal assistance or used special equipment: 7 percent received personal assistance only, 42 percent used equipment only, and 28 percent used both personal assistance and equipment (Indicator 37: Personal Assistance and Equipment).

- In 2020, about 1.1 million people age 65 and over were residents of nursing homes. In 2022, about 1 million people age 65 and over lived in residential care communities such as assisted living facilities. In both settings, people age 85 and over comprised the largest share of residents (Indicator 38: Long-Term Care Providers).

Environment

- The proportion of leisure time that people age 55 and over spent socializing and communicating—such as visiting friends or attending or hosting social events— declined with age. In 2022, the percentage of leisure time spent socializing and communicating was about 9 percent for those ages 55–64 and 7 percent for those age 75 and over (Indicator 39: Use of Time).

- The percentage of people age 65 and over living in counties that experienced poor air quality decreased from 69 percent in 2000 to 23 percent in 2022 (Indicator 40: Air Quality).

- In 2021, about 16 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 (36 percent)

than for those ages 65–74 (12 percent) (Indicator 41: Transportation).

Special Feature

- Telehealth visits among older Americans increased in 2020, the first year of the COVID-19 pandemic. Rates of telehealth have declined since 2020 but remain higher than in 2019. There is variation in the use of telehealth by region, age, race and ethnicity, and education and income level. Among people aged 65 and over, visits to psychiatrists were the most frequent telehealth doctor visits in 2022. (Special Feature).
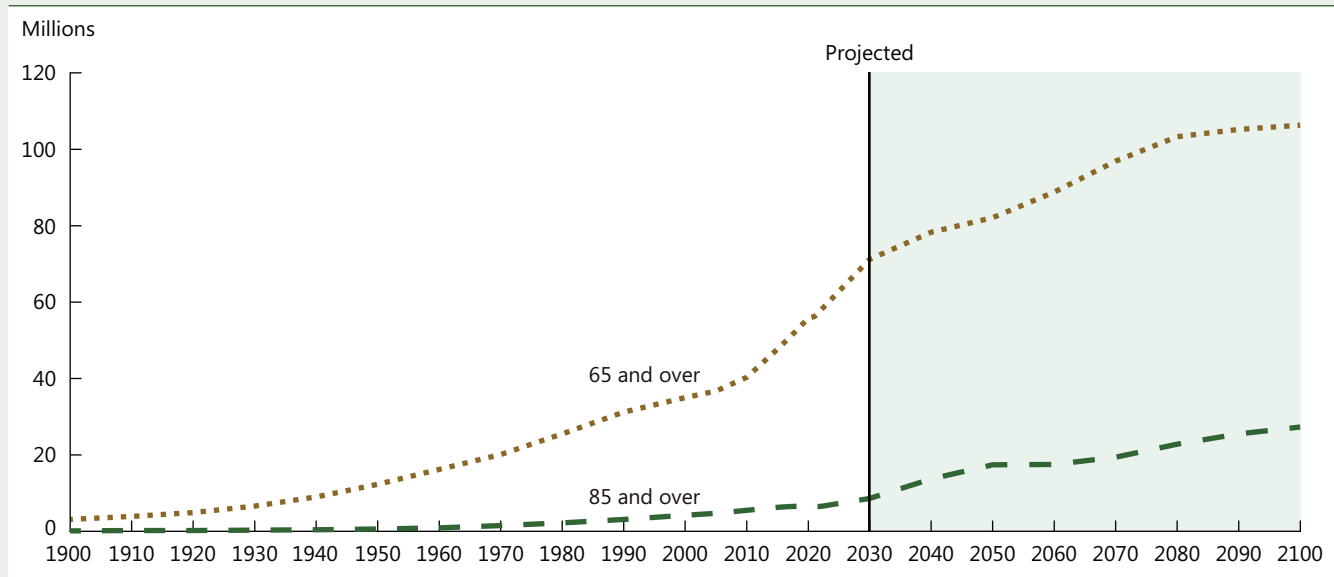
Population

Indicator 1: **Number of Older Americans**

The growth of the population age 65 and over affects many aspects of our society. These changes present challenges to those seeking to meet the needs of aging individuals, including families, businesses, health care providers, and policymakers.[6]

Population age 65 and over and age 85 and over, selected years, 1900–2022, and projected years, 2030–2100

Millions

Projected

65 and over

85 and over

NOTE: Some data for 2020–2050 have been revised and differ from previous editions of *Older Americans*.
Reference population: These data refer to the resident population.
SOURCE: U.S. Census Bureau, 1900–1940, 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). Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2010 to July 1, 2019 (NC-EST2019-AGESEX); U.S. Census Bureau, 2023. 2020 Census Demographic and Housing Characteristics; Annual Estimates of the Resident Population for Selected Age Groups by Sex for the United States: April 1, 2020 to July 1, 2022 (NC-EST2022-AGESEX); U.S. Census Bureau, Table 2. Projected Population by Age Group and Sex (NP2023-T2).

- In 2022, 57.8 million people age 65 and over lived in the United States, accounting for 17.3 percent of the total population. Further, 6.5 million people were age 85 and over, accounting for 1.9 percent of the overall population. In comparison, in 1920, 4.7 percent of people were age 65 and over (4.9 million) and 0.2 percent were age 85 and over (200,000).

- In 2022, roughly 1 in 6 Americans was age 65 and over, and this is projected to rise to 1 in 5 as soon as 2030. This change in the age composition reflects the large increase in the number of older Americans. The older population is expected to continue increasing from 57.8 million in 2022 to a projected 71.2 million in 2030, a difference of approximately 15 million people. Projecting further into the future, the population age 65 and over is expected to rise to 106.3 million (29.1 percent) in 2100.

- People age 85 and over comprised 1.9 percent of the population in 2022, and this is expected to rise to 2.5 percent in 2030 and eventually to 4.8 percent in 2060. Thus, by 2060, the number of people age 85 or over will have increased by roughly 11 million since 2022, from 6.3 million to an expected 17.5 million. Looking further ahead, the population age 85 and over is expected to increase to 7.5 percent of the total population in 2100 (27.3 million).

Indicator 1: **Number of Older Americans** (cont.)

Percentage of population age 65 and over, by county and state, 2022
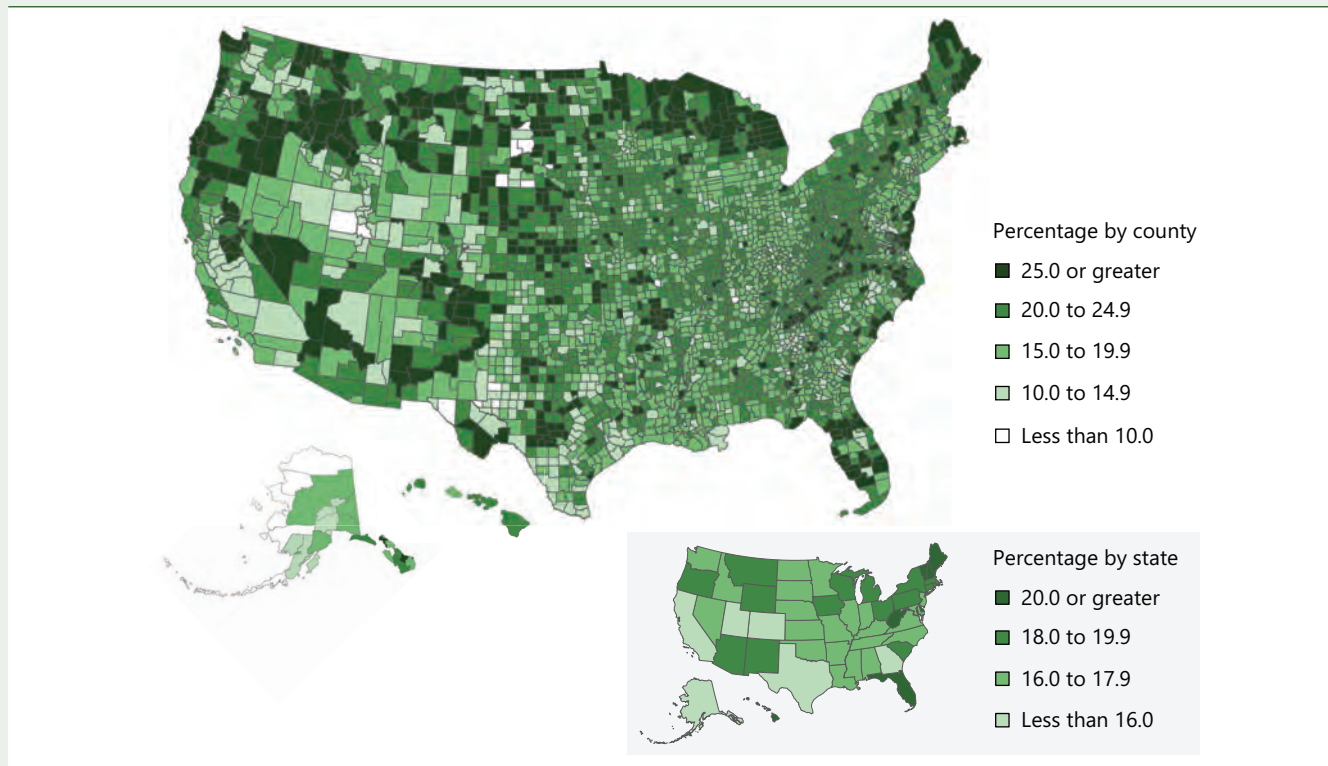
Percentage by county
- ◼ 25.0 or greater
- ◼ 20.0 to 24.9
- ◼ 15.0 to 19.9
- ◻ 10.0 to 14.9
- ◻ Less than 10.0

Percentage by state
- ◼ 20.0 or greater
- ◼ 18.0 to 19.9
- ◼ 16.0 to 17.9
- ◻ Less than 16.0

Reference population: These data refer to the resident population.

SOURCE: U.S. Census Bureau, Annual County Resident Population Estimates by Age, Sex, Race, and Hispanic Origin: April 1, 2020 to July 1, 2022 (CC-EST2022-ALLDATA) Annual State Resident Population Estimates for 6 Race Groups (5 Race Alone Groups and Two or More Races) by Age, Sex, and Hispanic Origin: April 1, 2020 to July 1, 2022 (SC-EST2022-ALLDATA6); Annual Estimates of the Resident Population for Selected Age Groups by Sex for Puerto Rico Commonwealth: April 1, 2020 to July 1, 2022 (PRC-EST2022-AGESEX).

- The percentage of the population age 65 and over varies by states and territories. Differences in this population share are affected by factors such as state fertility and mortality levels and the number of older and younger people who migrate in and out of the state. In 2022, the greatest percentages of people in this age group were found in Puerto Rico (23.5 percent), Maine (22.5 percent), and Florida (21.6 percent). Conversely, Utah and the District of Columbia had the smallest percentage of people age 65 and over (12.0 percent and 13.0 percent, respectively).

- The proportion of the population age 65 and over varies more noticeably by county. In 2022, Sumter County, Florida, had the highest percentage of people age 65 and over in the country, with over half (57.5 percent) of its population in this age group. Further, Chattahoochee County, Georgia, had the lowest percentage of people age 65 and over, with only 5.4 percent of its population in this age group.

- Consistent with past years, there were more older women than older men in the United States, and the percentage of the older female population increased with age. Women accounted for 55.1 percent of the population age 65 and over and for 64.8 percent of the population age 85 and over in 2022.

- Although the United States, like many other developed nations, has an aging population, the share of older adults remains lower in the United States than in many other countries, with 18.1 percent of its population age 65 and over in 2023. In comparison, among countries with a population of at least 1 million, Japan had the highest percentage of individuals age 65 and over (29.2 percent). Twenty-two of the 26 countries and areas with a population greater than 1 million and over 20 percent of their population age 65 and over are in Europe, with Greece, Italy, and Germany having the highest percentages, all over 23.3 percent.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 2: **Racial and Ethnic Composition**

The older population becomes more racially and ethnically diverse as it grows. This trend reflects broader demographic changes in the U.S. population in recent decades. Programs and services for older people will need to meet the needs of an increasingly diverse population.

Population age 65 and over, by race and Hispanic origin, 2022 and 2060 (projected)

Percent

	NH White alone	NH Black alone	NH Asian alone	NH all other races alone or in combination	Hispanic (any race)
2022	74.9	9.4	4.9	1.6	9.1
2060	55.6	12.7	8.5	2.9	20.4

■ 2022 ■ 2060
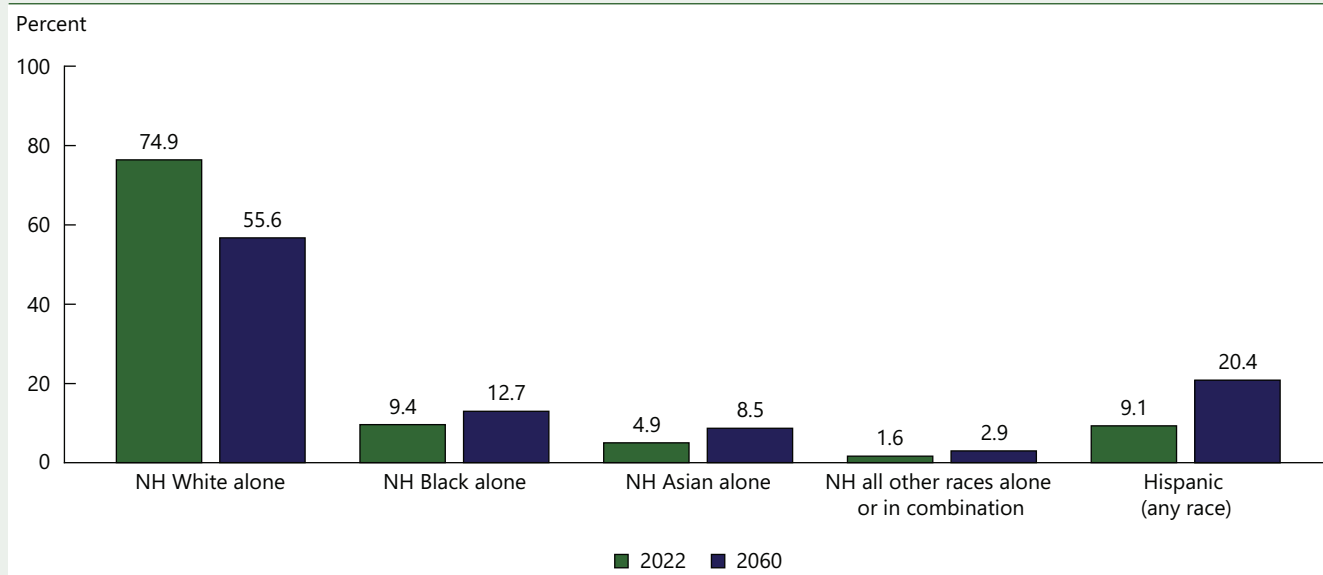
NH = Non-Hispanic.

NOTE: The presentation of racial and ethnic composition data in this table has changed from previous editions of *Older Americans*. Unlike in previous editions, Hispanic people are not counted in any race group. The term "non-Hispanic White alone" is used to refer to people who reported being White and no other race and who are not Hispanic. The term "non-Hispanic Black alone" is used to refer to people who reported being Black or African American and no other race and who are not Hispanic, and the term "non-Hispanic Asian alone" is used to refer to people who reported only Asian as their race and who are not Hispanic. The use of single-race populations in this chart does not imply that this is the preferred method of presenting or analyzing data. The U.S. Census Bureau uses a variety of approaches. The race group "non-Hispanic All other races alone or in combination" includes people who reported American Indian 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; Hispanic people 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: April 1, 2020 to July 1, 2022 (NC-EST2022-ASR6H); Projected Population by Single Year of Age, Sex, Race, and Hispanic Origin for the United States: 2022 to 2100 (NP2023-D1-MID).

- Racial and ethnic diversity is projected to increase in the older population. Of the population age 65 and over, 74.9 percent is non-Hispanic White alone, 9.4 percent is non-Hispanic Black alone, 4.9 percent is non-Hispanic Asian alone, and 9.1 percent is Hispanic (any race). By 2060, these percentages are projected to change to 55.6 percent for non-Hispanic White alone, 12.7 percent for non-Hispanic Black alone, 8.5 percent for non-Hispanic Asian alone, and 20.4 percent for Hispanic (any race).

- The older Hispanic population is projected to grow the fastest of all racial and ethnic groups, which will affect the broader racial and ethnic composition of the older population. For example, in 2022, the older Hispanic population was slightly smaller than the older non-Hispanic Black alone population (5.3 million versus 5.5 million respectively). However, by 2060, it is projected to be much larger—18.1 million compared to 11.3 million.

- The number of people age 65 and over who identify as non-Hispanic, all other races alone or in combination is projected to increase to 2.5 million in 2060. However, in 2022, with approximately 930,000 people, this group currently represents a small percentage (1.6 percent) of the older population.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 3: **Marital Status**

Marital status is highly influential for individuals' psychological, physical, and economic well-being. It influences factors such as living arrangements and support systems for older Americans, which is especially relevant for those with an illness or disability.

Marital status of the population age 65 and over, by sex and age group, 2022
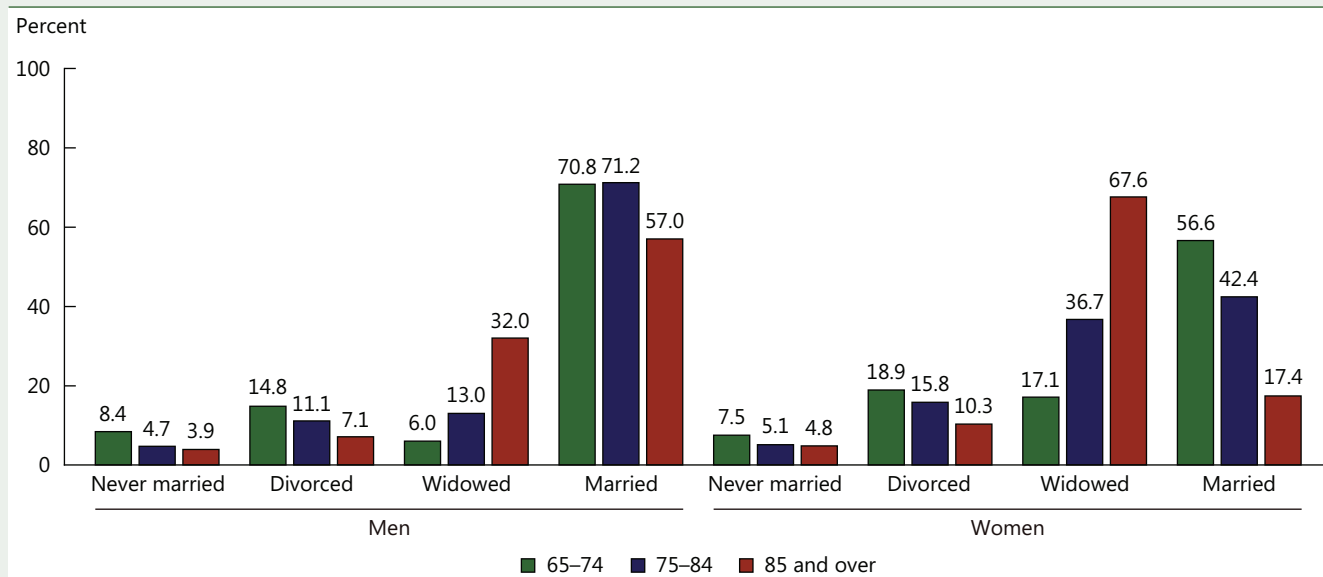
NOTE: Married includes separated. The Census Bureau has reviewed this data product, 2022 American Community Survey 1-year estimates (Project No.: D-0000000918, Approval CBDRB-FY24-0137).
Reference population: These data refer to the resident population.
SOURCE: U.S. Census Bureau, American Community Survey.

- People are less likely to be married and more likely to be widowed as they age. In 2022, nearly two-thirds of people ages 65–74 were married, whereas approximately one-tenth of people in this age group were widowed. Conversely, slightly less than one-third of people age 85 and over were married, but just over half were widowed.

- Within the older population, marital status varied by sex. Broadly, men age 65 and over were more likely to be married than women in this age group (69.8 percent versus 47.3 percent) and less likely to be widowed (10.3 percent versus 29.5 percent). This difference is more substantial among those age 85 and over, where 67.6 percent of women were widowed—approximately

double the estimate for men (32.0 percent). Relatedly, just over half of men age 85 and over were married, compared to less than one-fifth of women in the same age group.

- Compared to those who were married or widowed, relatively few men and women age 65 and over were divorced in 2022 (13.1 percent and 16.8 percent, respectively) and even fewer were never married (6.9 percent and 6.4 percent, respectively).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 4: **Educational Attainment**

Educational attainment has meaningful impacts throughout people's lives, which, in turn, affects 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.[7,8,9]

Educational attainment of the population age 65 and over, selected years, 1965–2023
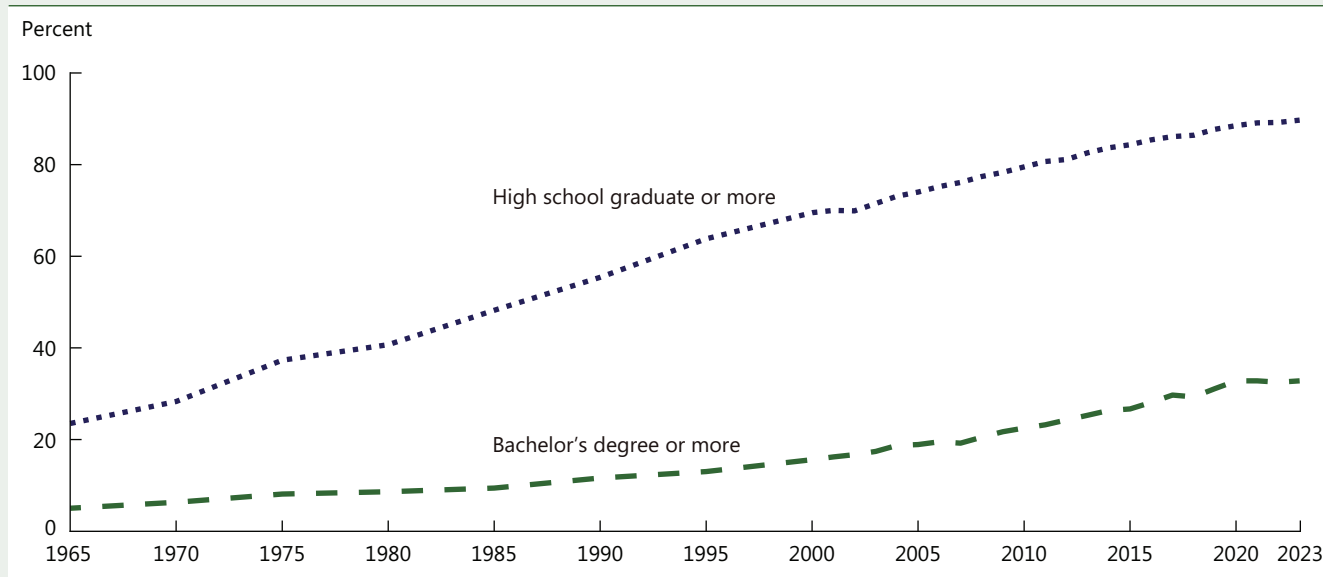
NOTE: A single question that asks for the highest grade or degree completed is used to determine educational attainment. Prior to 1995, educational attainment was measured using data on years of school completed. The Census Bureau has reviewed this data product, 1965–2023 Current Population Survey, Annual Social and Economic Supplement (Project Nos.: D-0000009574, D-0000009972, D-0000010797, D-0000012591, D-0000013193/Approval CBDRB-FY24-0137).

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

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

- In 1975, 37.3 percent of the older population had graduated from high school and 8.1 percent had at least a bachelor's degree. Nearly 50 years later, in 2023, 89.7 percent of those age 65 and over were high school graduates, and 32.8 percent had a bachelor's degree or higher.

- In 2022, 88.2 percent of older men and 87.5 percent of older women had at least a high school diploma. A higher percentage of men than women had a bachelor's degree or higher (34.7 versus 27.7 percent, respectively).

- Overall, older Americans have seen an increase in educational attainment in the past decade. In 2013, 82.6 percent of people age 65 and over were high school graduates; this rose to 89.7 percent in 2023. Also, the percentage of the older population with a bachelor's degree or higher rose from 25.3 percent in 2013 to 32.8 percent in 2023.

Indicator 4: **Educational Attainment** (cont.)

Educational attainment of the population age 65 and over, by race and Hispanic origin, 2022

Percent

NH = Non-Hispanic.

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. The Census Bureau has reviewed this data product, 2022 American Community Survey 1-year estimates (Project No.: D-0000000918, Approval CBDRB-FY24-0137).

Reference population: These data refer to the resident population.

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

- In 2022, among non-Hispanic White alone people, 92.7 percent had graduated from high school, and 33.6 percent had received a bachelor's degree or more.

- Among persons age 65 and over, Hispanic people (of any race) had the lowest levels of formal education. In 2022, 59.9 percent of this population had graduated from high school, and 15.0 percent had received a bachelor's degree or more.

- Among the older non-Hispanic Black alone population, 81.7 percent graduated from high school, but only 20.3 percent had a bachelor's degree or more.

- Among the older non-Hispanic Asian alone population, 76.6 percent were high school graduates, and 40.0 percent had a bachelor's degree or more.

- Of these four racial and Hispanic origin groups, the older non-Hispanic White alone population had the highest percentage of people who had graduated from high school (92.7 percent), while the older non-Hispanic Asian alone population had the highest percentage of individuals with a bachelor's degree or higher (40.0 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 5: **Living Arrangements**

The living arrangements of America's older population are linked to multiple factors, including income, health, marital status, and caregiver availability. For example, living alone can contribute to social isolation and loneliness, which, in turn, are linked to higher risks of physical and mental conditions such as high blood pressure, heart disease, obesity, a weakened immune system, anxiety, depression, cognitive decline, Alzheimer's disease, and even death.[10]

Living arrangements of the population age 65 and over, by sex and race and Hispanic origin, 2022

NH = Non-Hispanic.
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. The Census Bureau has reviewed this data product, 2022 American Community Survey 1-year estimates (Project No.: D-0000000918, Approval CBDRB-FY24-0137).
Reference population: These data refer to the resident population.
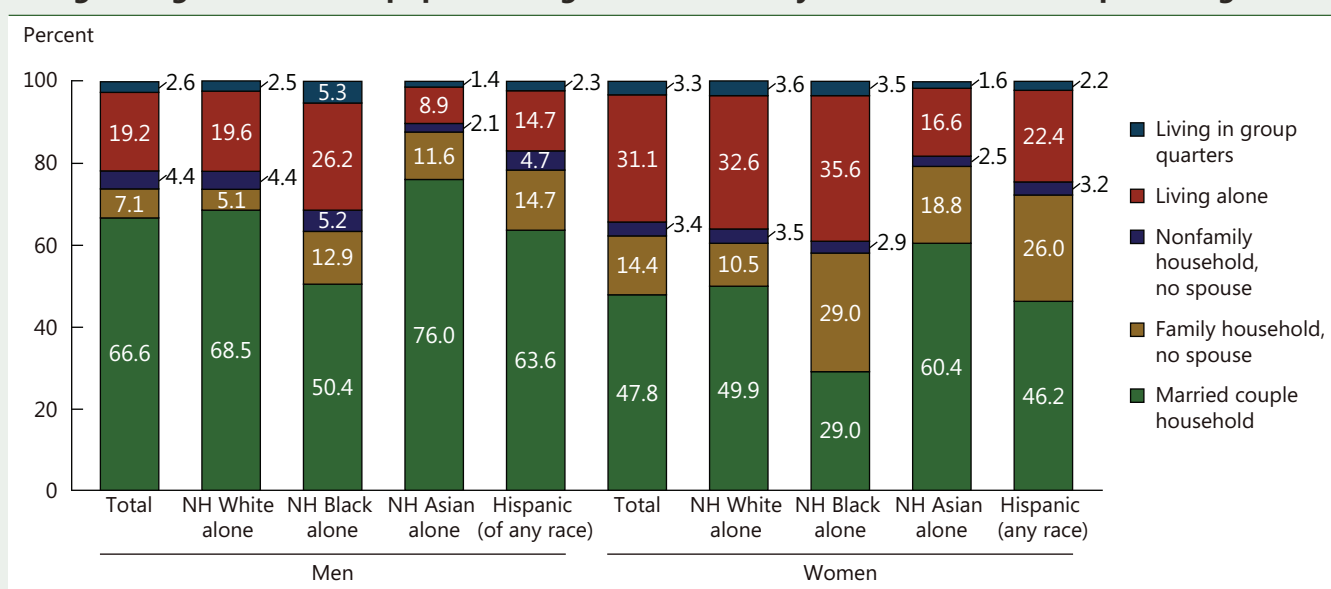SOURCE: U.S. Census Bureau, American Community Survey.

- In 2022, older women were less likely to live in a married couple household than were older men. Of men age 65 and over, 66.6 percent lived in a married couple household, whereas 47.8 percent of women in this age group did so. Similarly, older women were more likely to live alone than older men (31.1 percent versus 19.2 percent).

- The percentage of older men living alone has increased over time; 11.3 percent of men ages 65–74 lived alone in 1970, and that percentage rose to 20.8 percent in 2023. Further, 19.1 percent of men age 75 and over lived alone in 1970, whereas 23.0 percent lived alone in 2023. The percentage of women age 75 and over living alone also rose, increasing from 37.0 percent in 1970 to 41.8 percent in 2023. In contrast, the percentage of women ages 65–74 living alone decreased from 31.7 percent in 1970 to 27.1 in 2023.

- In 2022, at least 50 percent of older men of all race and Hispanic groups lived in a married couple household, ranging from 50.4 percent of non-Hispanic Black alone older men to 76.0 percent of non-Hispanic Asian alone older

men. For older women, about half of non-Hispanic White alone women and Hispanic (of any race) women lived in a married couple household. However, only 29.0 percent of older non-Hispanic Black alone women lived in a married couple household, while 60.4 percent of older non-Hispanic Asian alone women lived in a married couple household.

- In 2022, older non-Hispanic Asian alone men and women were least likely to live alone (8.9 percent and 16.6 percent, respectively). In comparison, older non-Hispanic Black alone individuals were most likely to live alone, with 26.2 percent of older non-Hispanic Black men and 35.6 percent of older non-Hispanic Black alone women living alone. Similarly, in the older non-Hispanic White population, 32.6 percent of women and 19.6 percent men live alone. Further, among older Hispanic people of any race, 22.4 percent of women and 14.7 percent of men live alone.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 6: **Veterans**

Nearly half of the Veteran population is age 65 and older.[11] Compared with the overall older American population, older Veterans generally have a higher median family income, are more likely to have functional limitations in daily activities and/ or a disability, and are less likely to be uninsured or covered by Medicaid and/or rate their general health as good or better.[12] The oldest Veterans will continue to have significant demand for health care services, particularly long-term care.[12] Those with chronic conditions, such as diabetes and high blood pressure, or disabilities are more likely to require comprehensive care and long-term support services.[11]

Percentage of population age 65 and over who are Veterans, by sex and age group, 2010 and 2020 (estimated) and 2030 and 2040 (projected)
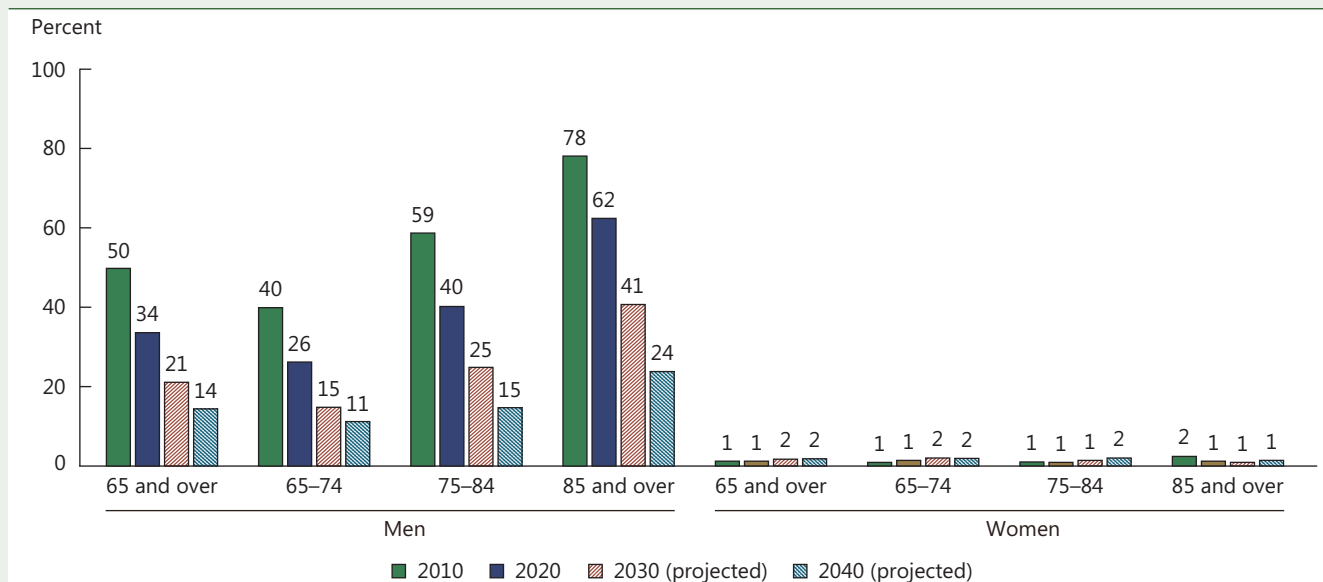
Percent

Men: 65 and over — 50, 34, 21, 14; 65–74 — 40, 26, 15, 11; 75–84 — 59, 40, 25, 15; 85 and over — 78, 62, 41, 24

Women: 65 and over — 1, 1, 2, 2; 65–74 — 1, 1, 2, 2; 75–84 — 1, 1, 1, 2; 85 and over — 2, 1, 1, 1

Legend: 2010 | 2020 | 2030 (projected) | 2040 (projected)

Reference population: These data refer to the resident population of the United States and Puerto Rico.
SOURCE: U.S. Census Bureau, Population Projections 2023, and *2010, 2020 Census Summary File 1*; Department of Veterans Affairs, VetPop2020.

- In 2020, 34 percent of men and 1 percent of women age 65 and over in the United States and Puerto Rico were Veterans. In addition, 26 percent of men ages 65–74, 40 percent of men ages 75–84, and 62 percent of men age 85 and over were Veterans. About 1 percent of women in each of the age groups 65–74, 75–84, and 85 and over were Veterans.

- The percentage of men age 65 and over who are Veterans is projected to decrease from 34 percent (8.5 million) in 2020 to 21 percent (6.9 million) in 2030. This percentage is projected to further decrease to 14 percent (5.2 million) in 2040.

- The percentage of women age 65 and over who are Veterans is projected to increase from 1 percent (389,000) in 2020 to 2 percent (657,000) in 2030 and 2 percent (797,000) in 2040.

- By 2040, it is projected that the percentage of men age 85 and over who are Veterans will have decreased to 24 percent from 62 percent in 2020 and 41 percent in 2030.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.
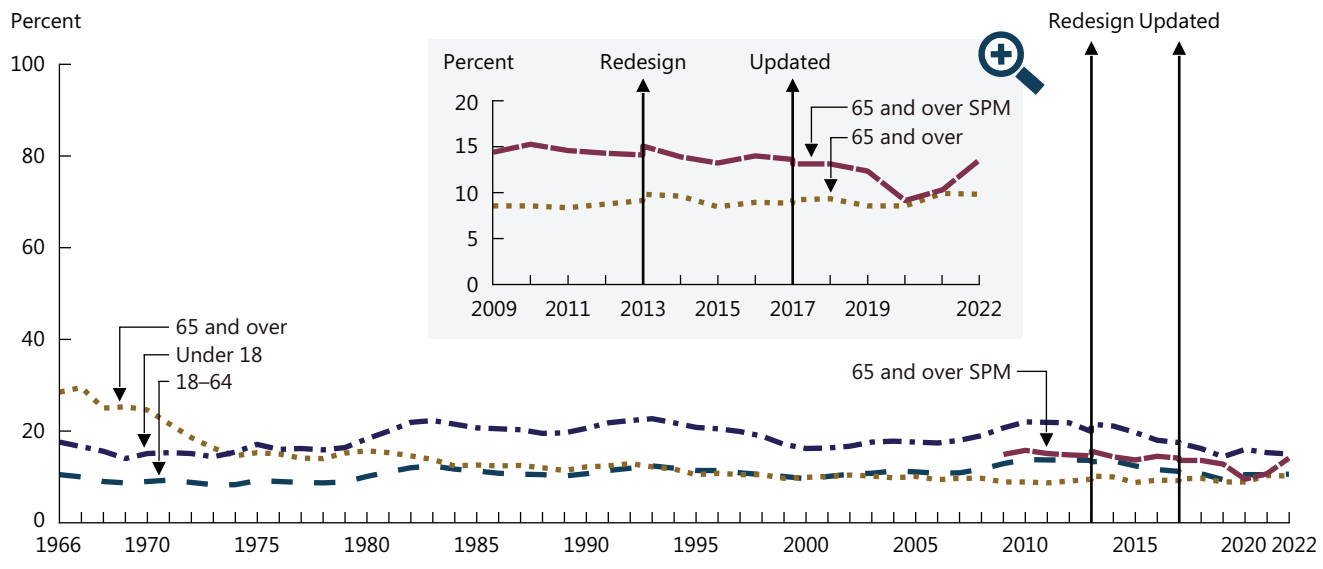
9

Economics

Indicator 7: **Poverty**

Poverty rates are useful for evaluating the economic well-being of the population. People identified as living in poverty are at risk of having inadequate resources for many needs, including food, housing, and health care.

Poverty rate using the Official Poverty Measure and the Supplemental Poverty Measure (SPM), by age
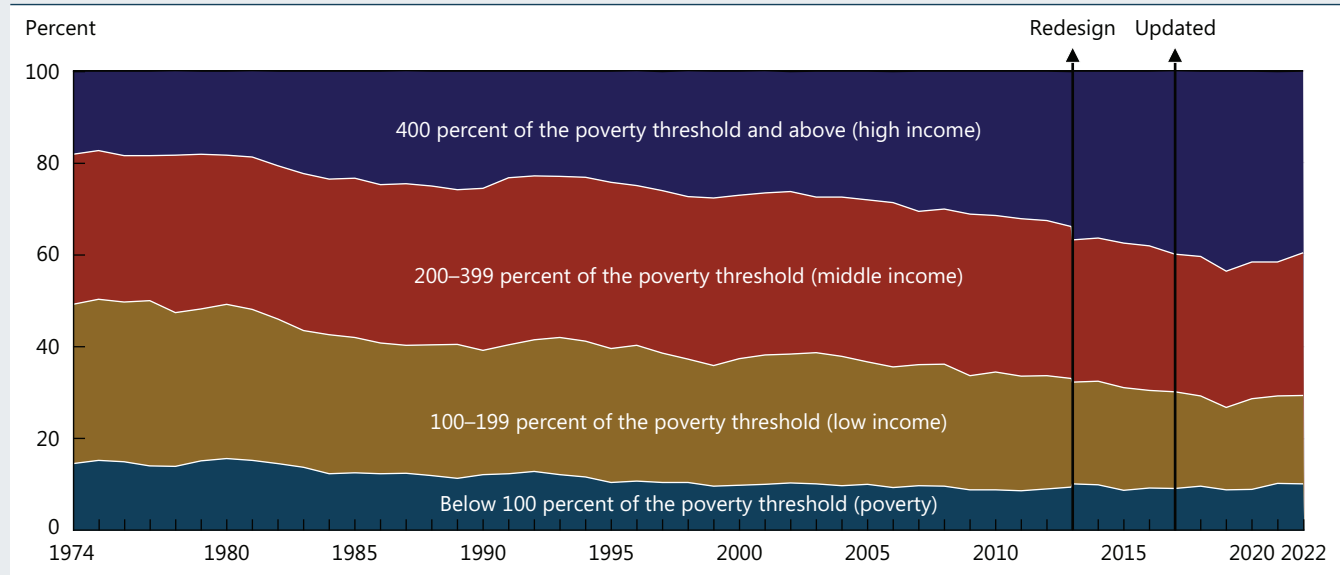

NOTE: Poverty status in the Current Population Survey (CPS) is based on prior year income. The 2014 CPS Annual Social and Economic Supplement (ASEC) included redesigned questions for income that were administered to a subsample of the 98,000 addresses using a probability split panel design. The source 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. The Supplemental Poverty Measure (SPM) estimates for 2019 and beyond reflect the implementation of revised SPM methodology. "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. SPM extends the official poverty measure by taking account of many of the government programs designed to assist low income families and individuals that are not included in the current official poverty measure and by using thresholds derived from the Consumer Expenditure Survey by the Bureau of Labor Statistics. For more detail, see U.S. Census Bureau Series P-60, No. 252. Information on confidentiality protection, methodology, sampling and nonsampling error, and definitions is available at www2.census.gov/programs-surveys/cps/techdocs/cpsmar23.pdf. The Census Bureau has reviewed this data product, 1967–2023 Current Population Survey, Annual Social and Economic Supplement (Project No. D-0000009574, D-0000009972, D-0000010797, D-0000012591, D-0000013193, Approval CBDRB-FY24-0137. Table B-2. Number and Percentage of People in Poverty Using the Supplemental Poverty Measure by Age, Race, and Hispanic Origin: 2009 to 2022 (Table B-2)).

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

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

- The poverty rate for the population age 65 and over was 10.2 percent in 2022.

- Among the older population, poverty rates have remained relatively stable since 2000. During these 22 years, the rate was at its lowest in 2011 (8.7 percent) and at its highest in 2002 (10.4 percent).

- Older women experienced higher poverty rates than older men in 2022. Specifically, 11.2 percent of women were in poverty compared to 9.0 percent of men.

- Within the older population, increasing age is associated with higher rates of poverty. In 2022, 9.4 percent of people ages 65–74 were in poverty compared with 13.9 percent of people age 85 and over. Significant differences were not found between people under age 18 and over age 85, people ages 18–64 and 75–84, people ages 18–64 and 65 and over, and people ages 75–84 and 65 and over.

- Children have had higher poverty rates over time than both the older population and the working-age population. Since the mid-1970s, children under age 18 have had higher rates of poverty than adults age 65 and over. In 2022, 15.0 percent of children lived in poverty compared to 10.2 percent of people age 65 and over and 10.6 percent of people ages 18–64.

- In 2022, the non-Hispanic White alone population had the lowest poverty rate (8.2 percent); the non-Hispanic Black alone population had one of the highest (17.6 percent), though not significantly different from the rate of 16.9 percent among the Hispanic (any race) population; the non-Hispanic Asian alone population had a poverty rate of 12.9 percent.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 8: **Income**

The percentage of Americans age 65 and over living below the poverty line provides an incomplete picture of the economic situation of these individuals. Deeper insights into the economic well-being of the older population can be gained by examining their income distribution and median income.

Income distribution of the population age 65 and over, 1974–2022

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 administered to a subsample of the 98,000 addresses using a probability split panel design. The source for "2013 (traditional)" in this table is the portion of the sample (68,000 addresses) that received a set of income questions similar to those used in 2013; the source for "2013 (redesign)" is the portion of the 2014 CPS ASEC sample (30,000 addresses) that received the redesigned income questions. The redesigned income questions were used for the entire 2015 CPS ASEC sample. The income categories are derived from the ratio of the family's income (or an unrelated individual's income) to the corresponding official poverty threshold. Being in poverty is measured as income less than 100 percent of the poverty threshold. Low income is between 100 and 199 percent of the poverty threshold. Middle income is between 200 percent and 399 percent of the poverty threshold. High income is 400 percent or more of the poverty threshold. Some data have been revised and differ from previous versions of *Older Americans*. Information on confidentiality protection, methodology, sampling and nonsampling error, and definitions is available at www2.census.gov/ programs-surveys/cps/techdocs/cpsmar23.pdf. The Census Bureau has reviewed this data product, 1975–2023 Current Population Survey, Annual Social and Economic Supplement (Project No. D-0000009574, D-0000009972, D-0000010797, D-0000012591, D-0000013193, Approval CBDRB-FY24-0137).

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

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

- In 2022, 10.2 percent of the older population lived in poverty, and 19.2 percent was in the low-income group. However, 39.6 percent of the older population was in the high-income group, which made up the largest share of older people by income category.

- Between 1975 and 2022, the percentage of the older population living in poverty decreased by approximately 5 percentage points, from 15.3 percent to 10.2 percent. The relative size of the low-income group decreased even more, from 35.0 percent to 19.2 percent of the older population. Correspondingly, the share of older people in the high-income group more than doubled, from 17.4 percent to 39.6 percent. The share of older people of middle income slightly decreased from 32.3 percent to 31.0 percent.

- The median income of householders age 65 and over has been steadily trending upward. In 1975, householders' median income was $26,080 (in 2022 dollars); by 2010, the median income of this population had increased to $41,060 (in 2022 dollars), and in 2022, their median income was $50,290.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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 older adults. Social Security provides retired worker benefits to those 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 2022, by age and sex
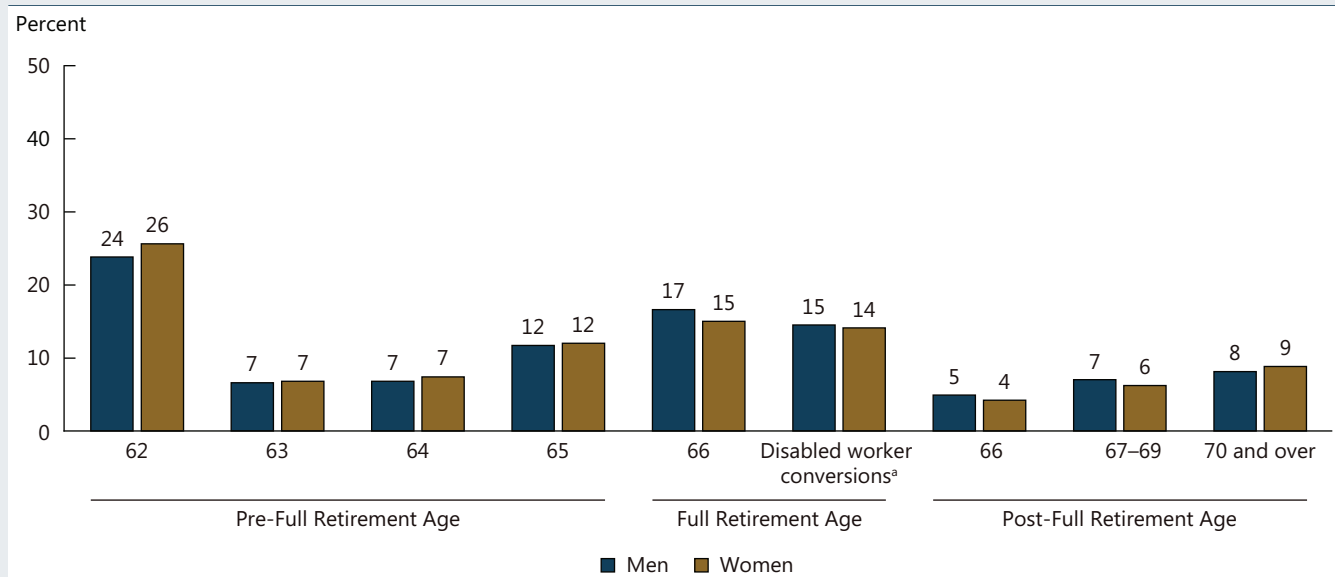
ᵃ At Full Retirement Age (FRA), persons formerly receiving disabled worker benefits are reclassified and begin receiving retired worker benefits.

NOTE: FRA is 65 for workers born before 1938. It increases in 2-month increments for workers born in each of the years 1938 through 1943. It is 66 for workers born in the years 1943 through 1954. It again increases in 2-month increments for workers born in the years 1955 through 1960. It is 67 for workers born in 1960 or later. It increases in 2-month increments for workers attaining age 65 in each of the years 2003 through 2008. It is 66 for workers attaining age 65 in the years 2008 through 2019. It again increases in 2-month increments for workers attaining age 65 in the years 2020 through 2025. It is 67 for workers attaining age 65 in 2025 or later. The percentages are not probabilities of a birth cohort claiming at a particular age. A person begins receiving Social Security benefits the month after entitlement. 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 2022.

SOURCE: Social Security Administration, Master Beneficiary Record.

- In 2022, half (50 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. Around one-fifth of new worker beneficiaries received a greater amount of benefits by waiting to claim benefits until after reaching FRA. A person begins receiving benefits the month after entitlement.

- Of new Social Security retired worker beneficiaries in 2022, 24 percent of men and 26 percent of women became entitled at age 62, and about one-quarter of men and women became entitled at ages 63–65. In contrast, 17 percent of men and 15 percent of women became entitled at FRA, and 20 percent of men and 19 percent of women became entitled post-FRA.

- Of new Social Security retired worker beneficiaries in 2022, 15 percent of men and 14 percent of women converted from receiving disabled worker benefits at FRA.

Indicator 9: **Social Security Beneficiaries** (cont.)

Percentage distribution of female Social Security beneficiaries age 62 and over, by type of benefit received, selected years 1960–2022

Percent

Worker benefits[a]

- ■ Dually entitled widow
- ■ Dually entitled spouse
- ■ Worker only

Spouse or widow benefits only

- ■ Widow only[b]
- ■ Spouse only
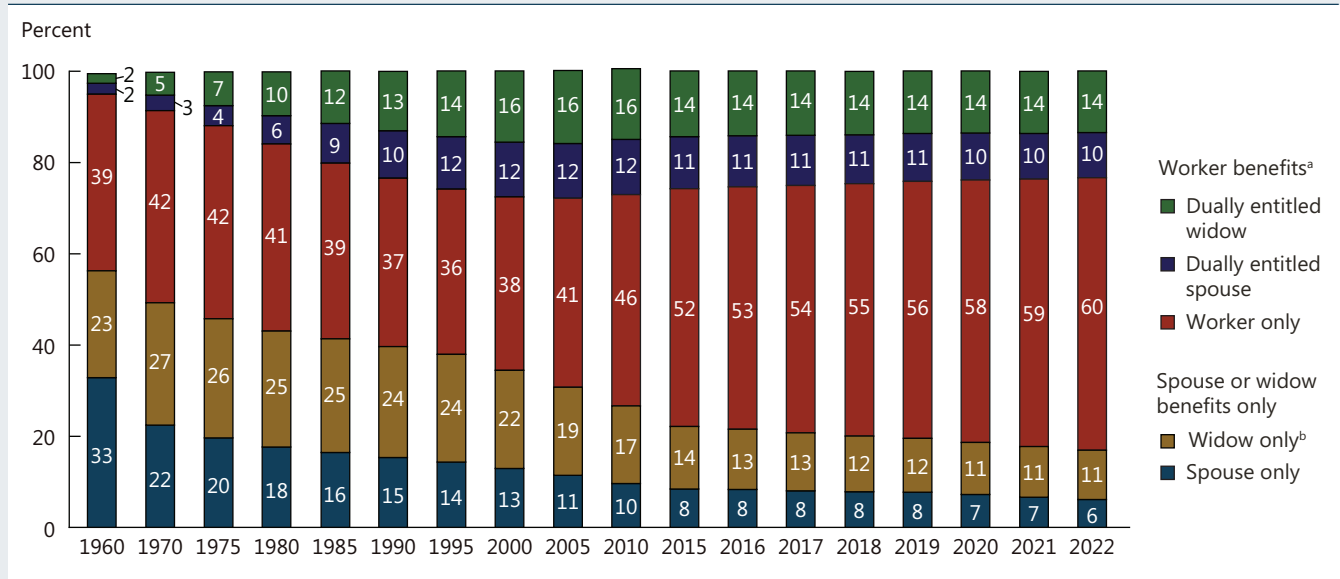
[a] Worker benefits include retired and disabled worker benefits.

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

NOTE: All data for 2005 and dual-entitlement data for 1995 and 2000 are based on a 10 percent sample of administrative records. All other estimates are based on 100 percent 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 2022, 83 percent of women beneficiaries age 62 and over received earned worker benefits. The remaining portion of women (17 percent) received benefits only as the spouse or surviving widow of an entitled worker. In 2022, 6 percent of women received spouse-only benefits, and 11 percent received widow-only benefits.

- The type of benefits received by women age 62 and over dramatically changed between 1960 and 2022. The percentage of female Social Security beneficiaries who received spouse-only benefits decreased from 33 percent to 6 percent, and the percentage receiving widow-only benefits decreased from 23 percent to 11 percent. In contrast, the percentage of female Social Security

beneficiaries who received earned worker benefits increased from 43 percent in 1960 to 83 percent in 2022.

- 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 2022, 60 percent received only earned worker benefits, 10 percent received both earned worker and spouse benefits, and 14 percent received both earned worker and widow benefits.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/ reports-and-tables.html.

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 due to job loss, health problems, or family changes such as divorce.

Median household net worth, in 2022 dollars, by race and educational attainment of head of household age 65 and over, selected years, 1989–2022
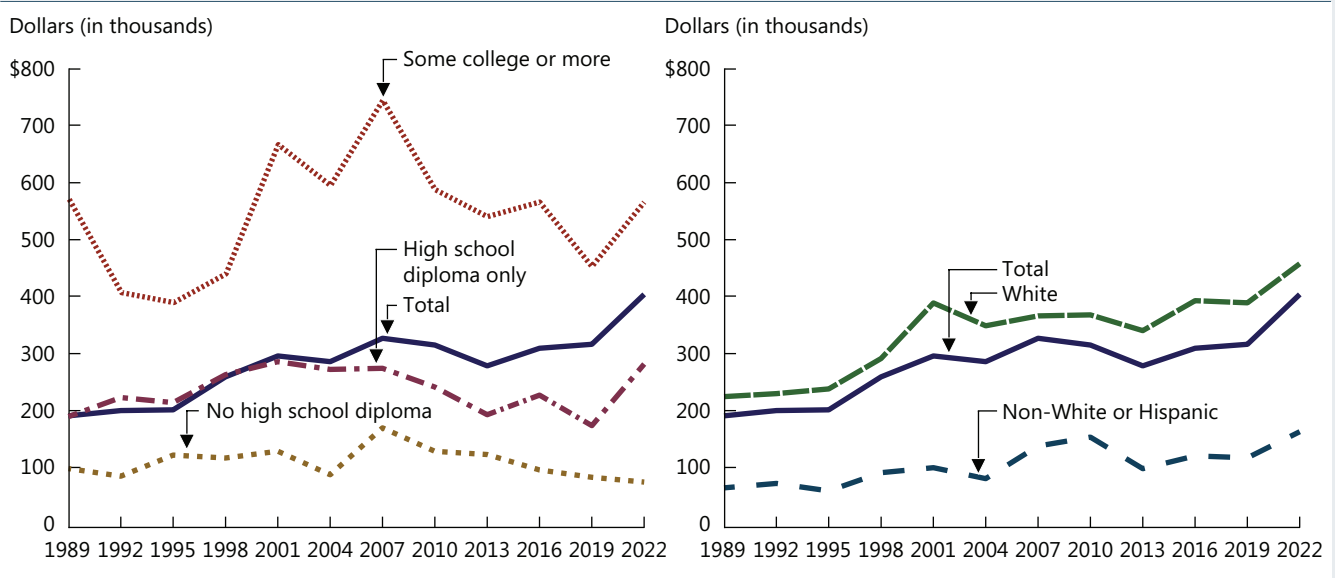
NOTE: Median household net worth is measured in constant 2022 dollars. Net worth includes assets held in investment retirement accounts such as individual retirement accounts, Keoghs, and 401(k)-type plans. All observations are weighted for analysis. The term "household" in this indicator is from the codebook of the 2022 Survey of Consumer Finance (www.federalreserve.gov/econresdata/). The data are for the "primary economic unit" (PEU). The PEU consists of an economically dominant single individual or couple (married or living partners) in a household and all other members of the household who are financially interdependent with the individual or couple. In the majority of cases, the PEU and household are identical. Some estimates have been revised and may differ from previous editions of *Older Americans*.

Reference population: These data refer to U.S. households.

SOURCE: Survey of Consumer Finances.

- In 2022, the median net worth, in 2022 dollars (including the value of retirement investment accounts), of households headed by people age 65 and over was $406,750.

- Between 1989 and 2022, the median net worth of households headed by people age 65 and over increased by about 108 percent, from $195,514 to $406,750. The rate of change was quite variable over this time period. The largest percentage increase was between 1995 and 1998. In addition, there was a decrease between 2001 and 2004 and between 2007 and 2013.

- Between 1989 and 2022, the median net worth of households headed by White people age 65 and over increased by nearly 101 percent, from $228,945 to $460,110. The median net worth of households headed by non-White or Hispanic people age 65 and over increased by nearly 140 percent over the same period, from $70,251 to $167,930.

- 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 non-White or Hispanic people age 65 and over. In 2022, the median net worth of households headed by White people age 65 and over was about 2.7 times that of households headed by older non-White or Hispanic people age 65 and over.

- Between 1989 and 2022, the median net worth of people age 65 and over without a high school diploma decreased by about 23 percent. In 2022, households headed by people age 65 and over who attended college had a median net worth about seven times greater than those without a high school diploma.

Indicator 10: **Net Worth** (cont.)

Amount of funds held in retirement assets, by sector and type of plan, 1975–2022

Dollars (in trillions)
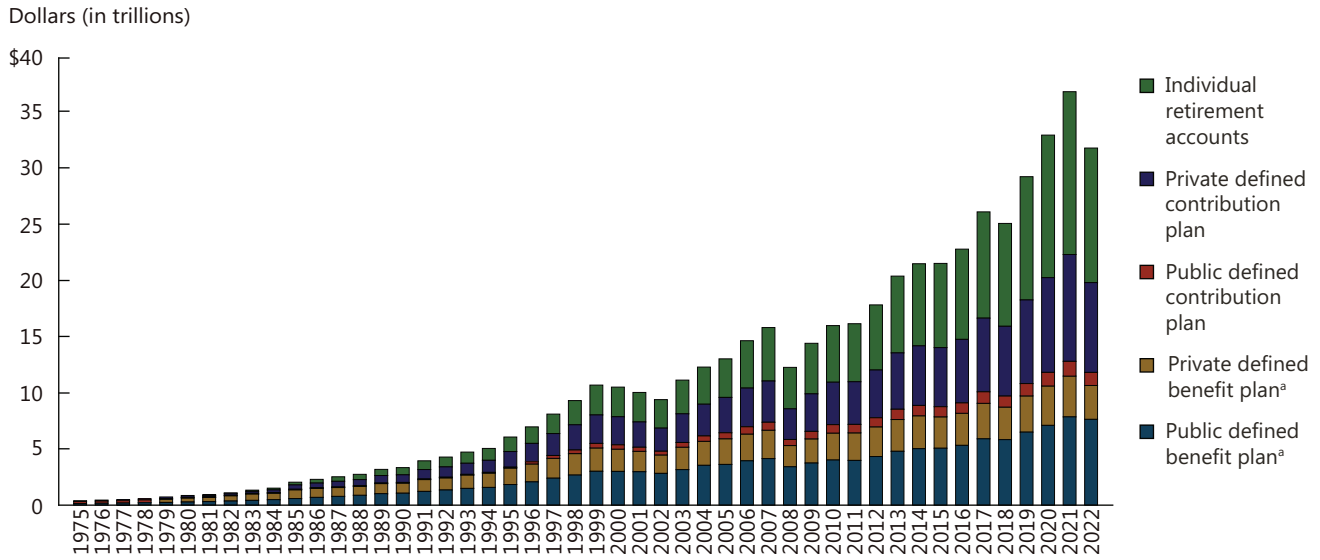
ᵃ Public and private defined benefit retirement assets do not include claims of pension funds on sponsor.
NOTE: Some estimates have been revised and may differ from previous editions of *Older Americans*.
Reference population: Public and private retirement assets for total population.
SOURCE: Federal Reserve Board Z.1 Statistical Release for June 7, 2024.

- 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 2022, about $12.0 trillion in assets were held in IRAs, about $9.1 trillion were held in public and private defined contribution plans, and about $10.6 trillion were held in public and private defined benefit plans.

- Between 1975 and 2022, an increasing proportion of retirement assets shifted from traditional defined benefit plans to individual account-based retirement vehicles like 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.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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 participate in the job market or stay employed because of the social contact, intellectual challenges, or sense of value that work often provides. By the early 2020s, Baby Boomers constituted a large share of older workers, and they were participating in the labor force at higher rates than in previous generations.

Labor force participation rates (annual averages) of men age 55 and over, by age group, 1963–2023
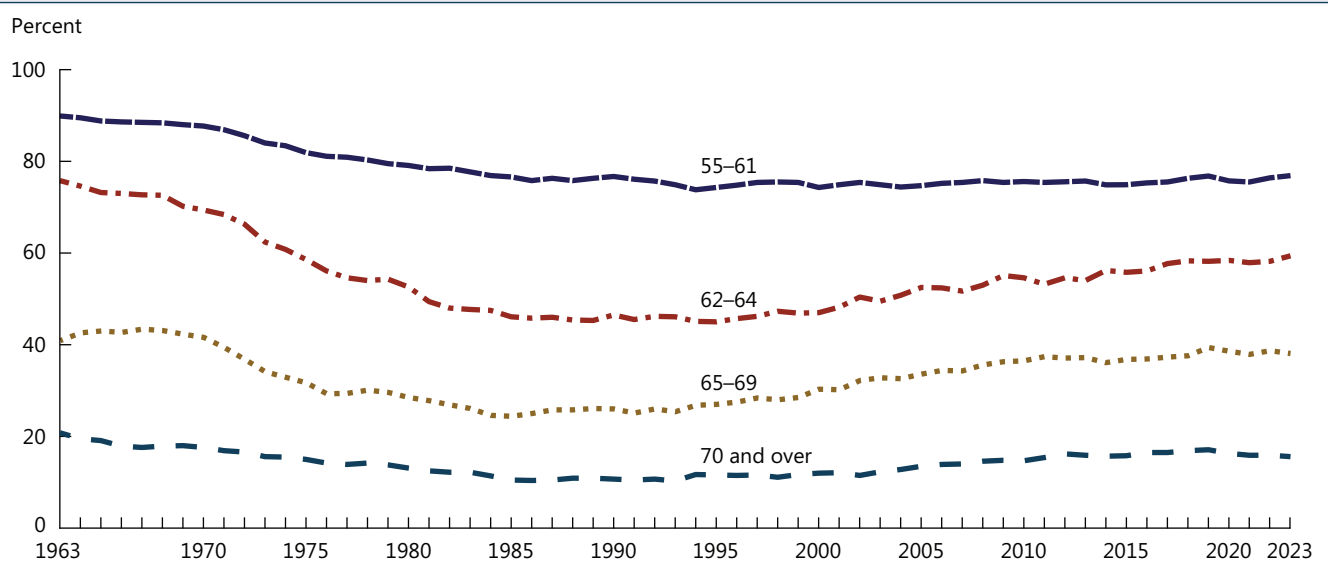
NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, Current Population Survey.

- The labor force participation rate for men age 55 and over fell following the COVID-19 pandemic, from 46 percent in 2019 to 44 percent in 2023. This decline also partially reflects the continued aging of Baby Boomers. Prior to 2019, the labor force participation rate for men age 55 and over held steady around 46 percent for about a decade.

- In 2023, the labor force participation rate for men ages 55–61 was 77 percent, higher than the recent low of 76 percent in 2021 following the COVID-19 pandemic, but 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 2023, the participation rate for men ages 62–64 had increased to 59 percent.

- Men ages 65–69 experienced a gradual rise in labor force participation following a period of decline in the late 1960s and 1970s. The labor force participation rate for men ages 65–69 declined from a high of 43 percent in 1967 to 24 percent in 1985. Their participation rate from the mid-1980s to the early 1990s remained in the range of 24 to 26 percent. In the mid-1990s, the labor force participation rate for men in this age group began to increase until reaching a high of 39 percent in 2019. Since 2019, the labor force participation rate for men ages 65–69 has remained in the range of 38 to 39 percent.

- 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. The participation rate for men age 70 and over trended higher from its low in 1993 until reaching 17 percent in 2019. The labor force participation rate for this group fell to 16 percent in 2020 and remained at this rate through 2023.

Indicator 11: **Participation in Labor Force** (cont.)

Labor force participation rates (annual averages) of women age 55 and over, by age group, annual averages, 1963–2023

Percent

NOTE: Data for 1994 and later years are not strictly comparable with data for 1993 and earlier years due to a redesign of the survey and methodology of the Current Population Survey.
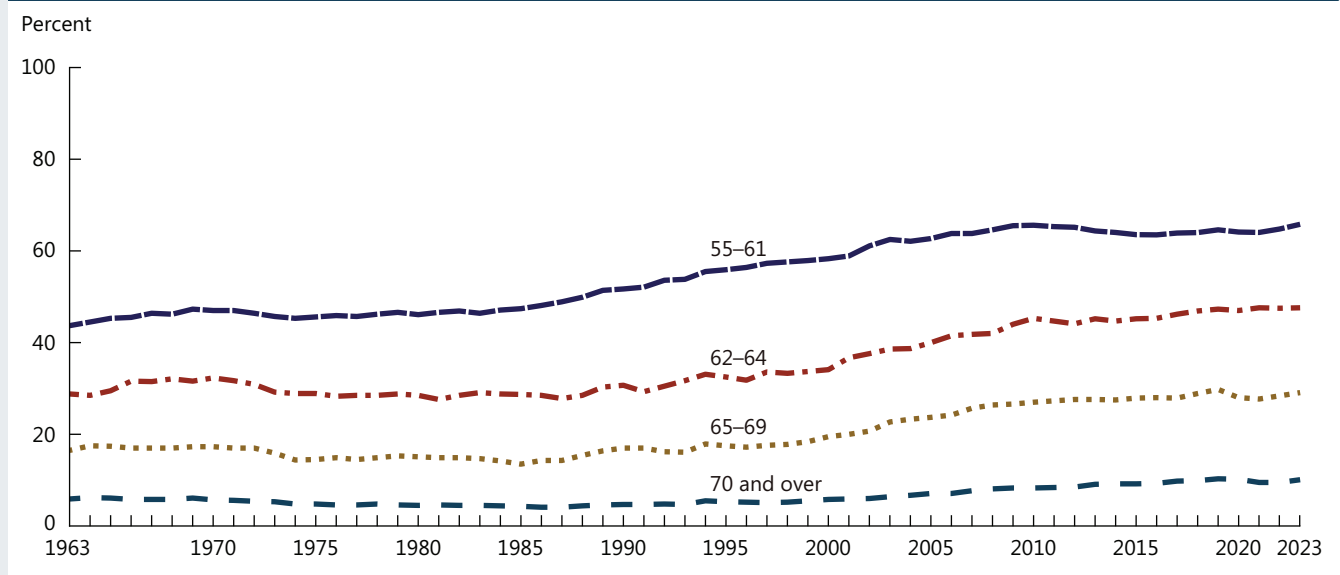Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, Current Population Survey.

- Among women age 55 and over, the labor force participation rate had been fairly stable at 35 percent from about 2009 until 2019, after rising steadily starting in the early 1990s. Their labor force participation dropped during the COVID-19 pandemic and ranged between 33 and 34 percent from 2020 to 2023. This decline also partially reflects the continued aging of Baby Boomers.

- In 2023, 66 percent of women ages 55–61 were in the labor force, compared with 44 percent in 1963. Among women ages 62–64, the labor force participation rate increased from 28 percent in 1981 to 48 percent in 2021. Their participation rate remained at 48 percent through 2023.

- The participation rate for women ages 65–69 increased from around 14 percent in the mid-1980s to a high of 30 percent in 2019. Their participation rate dropped to 28 percent in 2020 and remained at this level until it rose

to 29 percent in 2023. The labor force participation rate of women age 70 and over rose from around 4 percent in the mid-1980s to 10 percent in 2019, where it remained through 2023.

- The difference between labor force participation rates for men and women has narrowed over time, especially for those ages 55–61 and those ages 62–64. Among those ages 55–61, the gap between men's and women's rates in 2019 was 12 percentage points, compared with a 46-percentage-point gap in 1963. For those ages 62–64, the gap between men's and women's rates in 2019 was 11 percentage points, compared with a 47-percentage-point gap in 1963.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on aggingstats.gov/reports-and-tables.html.

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 2009–2021
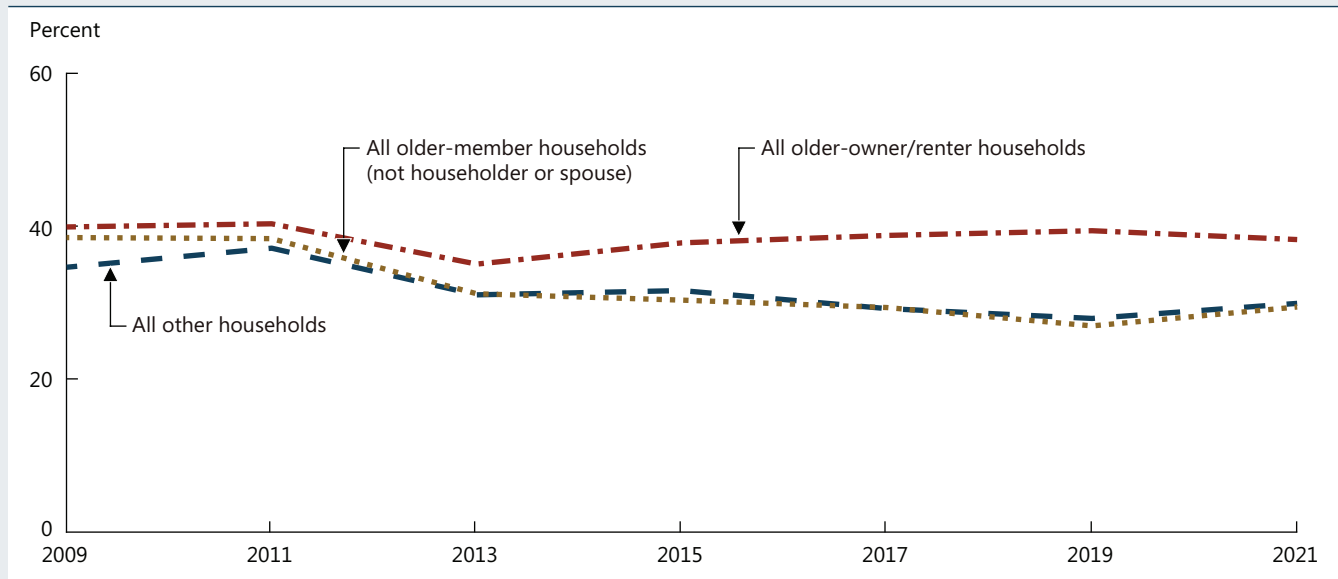
NOTE: Housing cost burden refers to expenditures on housing and utilities that exceed 30 percent of household income. Older-owner/renter households are households with a householder or spouse age 65 and over; older-member households are households with a member age 65 and over who is not the householder 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 2021, 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.

- Although housing cost burden has generally increased over time, between 2019 and 2021 the prevalence of cost burden among older-owner/renter households remained about the same at 40 percent. Among older-member households the prevalence significantly increased from 31 percent in 2019 to 32 percent in 2021. In comparison, the prevalence of housing cost burden for all other U.S. households (households without one or more persons age 65 and over) increased from 31 to 33 percent over the same time period.

Indicator 12: **Housing Problems** (cont.)

Housing cost burden is also the most dominant housing problem for intergenerational households—that is, households that have both older people (age 65 and over) and children (age 17 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 2009–2021
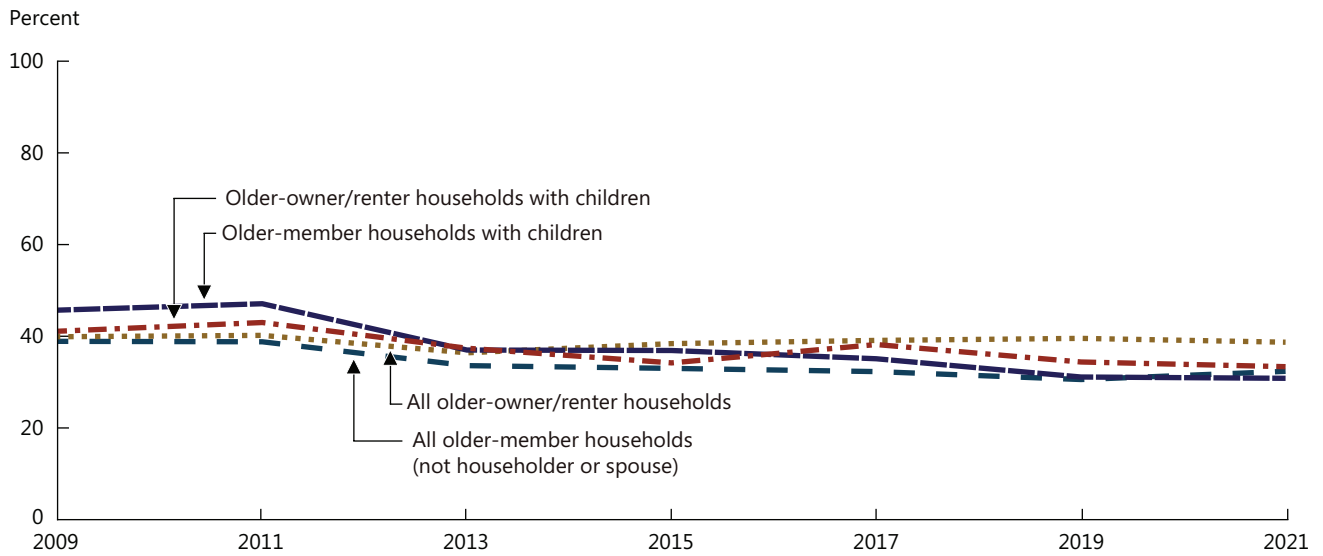
NOTE: Housing cost burden refers to expenditures on housing and utilities that exceed 30 percent of household income. Older-owner/renter households are households with a householder or spouse age 65 and over; older-member households are households with a member age 65 and over who is not the householder or spouse; older-owner/renter households with children are households with a householder or spouse age 65 and over and children (age 17 or younger); and older-member households with children are households with a member age 65 and over and children (age 17 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 2021, approximately 33 percent of older-owner/renter intergenerational households had housing cost burden compared with 39 percent of all older-owner/renter households. Approximately 31 percent of older-member intergenerational households had housing cost burden compared with 32 percent of all older-member households.

- Although housing cost burden has typically increased over time, there was a significant decrease in the prevalence of housing cost burden for older American intergenerational households between 2019 and 2021.

- From 2019 to 2021, the prevalence of housing cost burden decreased from 34 percent to 33 percent among older-owner/renter intergenerational households and remained at 31 percent among older-member intergenerational households.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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, 2022

Percent

Category	45–54	55–64	65 and over	65–74	75 and over
Other	18	17	19	17	22
Food	13	13	13	13	11
Housing	31	31	35	35	36
Transportation	17	17	14	16	12
Health care	7	9	13	12	14
Personal insurance and pensions	15	13	6	7	4
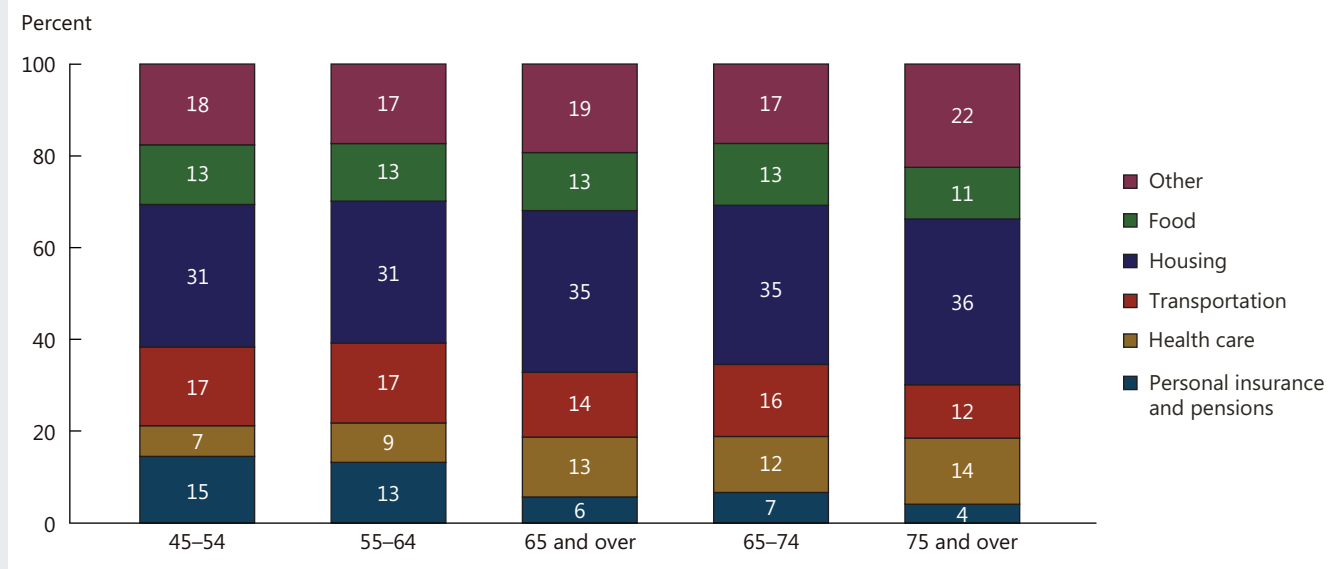
NOTE: Other expenditures include apparel, personal care, entertainment, reading, education, alcohol, tobacco, cash contributions, and miscellaneous expenditures. Data from the Consumer Expenditure Surveys by age group represent average annual expenditures for consumer units by the age of the reference 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 Bureau of Labor Statistics publishes information from consumer units, which are generally defined as a person or group of people who live in the same household and are related by blood, marriage, or other legal arrangement (i.e., a family) or people who live in the same household who are unrelated but make financial decisions together. A household usually refers to a physical dwelling and may contain more than one consumer unit (e.g., roommates who are sharing an apartment but who are financially independent from each other). However, for convenience, the term "household" is substituted for "consumer unit" in this indicator.

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

SOURCE: Bureau of Labor Statistics, Consumer Expenditure Surveys.

- 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 2022, the largest share was 36 percent, for households with a reference person age 75 and over.

- As a share of total expenditures, health care expenditures increased dramatically with age. For the group age 75 and over, the share (over 14 percent) was more than twice as high as it was for the group ages 45–54 (nearly 7 percent); in addition, the share that those age 75 and over allocated to health care was higher than this group allocated to food (11 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, expenditures for food at home as a share of total expenditures were higher than the share allocated to food away from home. However, for the oldest group (age 75 and over), the food at home share (nearly 8 percent) was more than double the food away from home share (less than 4 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 14: **Food Insecurity**

Food insecurity means that households were, at times, unable to acquire adequate food for one or more household members because they had insufficient money and other resources for food. Very low food security, a subset of food-insecure households in the severe range of food insecurity, means that households were food insecure to the extent that eating patterns of one or more household members were disrupted and their food intake reduced, at least some time during the year, because they could not afford enough food.

Trends in the prevalence of food insecurity in households with people age 65 and over, by household composition, 2001–2022
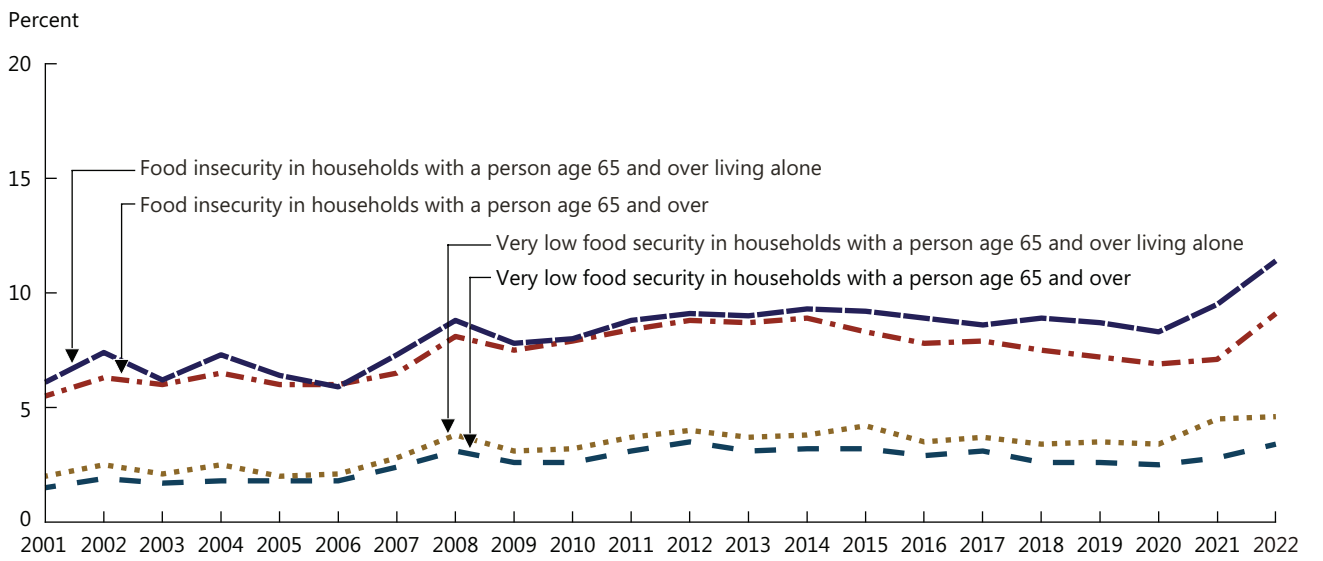
NOTE: Food insecurity includes low and very low food security. Households with people age 65 and over includes all households with at least one older adult. Households with a person age 65 and over living alone are households with only one older adult in the household and no other household members.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: The data is collected by the U.S. Department of Commerce, Bureau of the Census and the USDA, Economic Research Service sponsors the annual Food Security Supplement and analyzes the responses.

- In 2022, 9.1 percent of U.S. households with people age 65 and over (3.9 million households) were estimated to be food insecure at some time during the year, meaning they had difficulty providing enough food for all their members because of a lack of resources. The prevalence of food insecurity in households with people age 65 and over in 2022 was higher than the 7.1 percent recorded in 2021.

- In 2022, an estimated 11.4 percent of households with a person age 65 and over living alone were food insecure, which is higher than the 9.5 percent in 2021.

- Very low food security is a more severe form of food insecurity in which the food intake of some household members was reduced and normal eating patterns were disrupted at times during the year. The 2022 prevalence of very low food security in households with people age 65 and over was an estimated 3.4 percent, higher than the 2.8 percent in 2021.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.
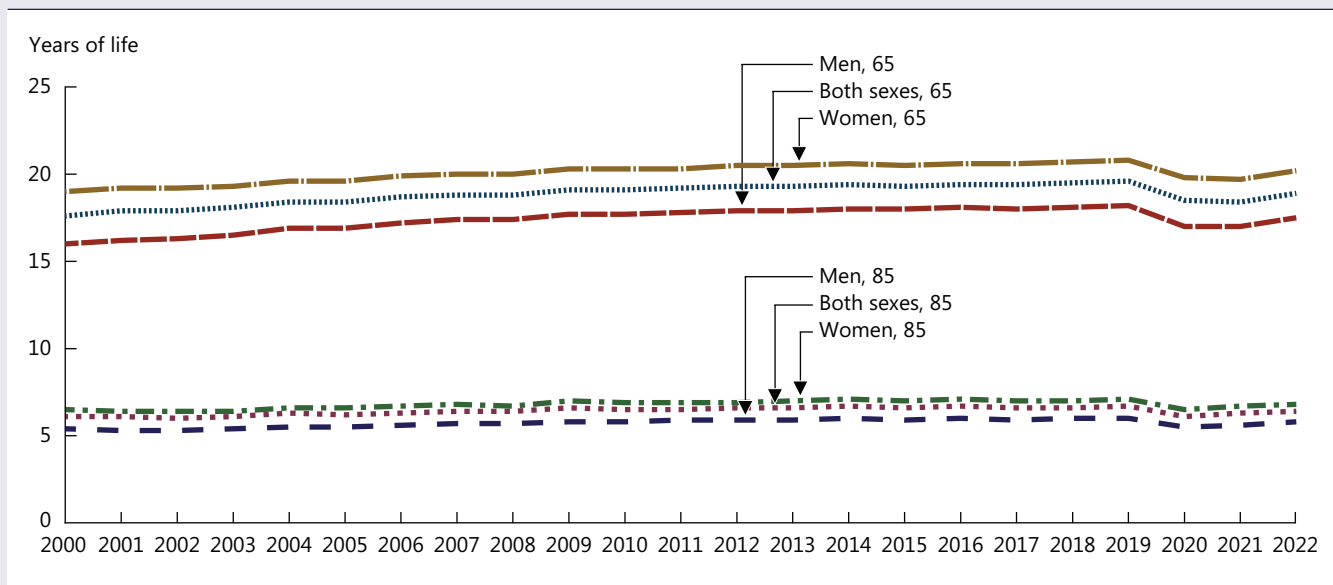
Health Status

Indicator 15: **Life Expectancy**

Life expectancy is a summary measure of the overall health of a population. It represents the average number of years of life remaining to a person at a given age if death rates remain constant. Improvements in health have resulted in generally rising life expectancy over time. Changes in life expectancy reflect the positive and negative contributions of death rates from individual causes of death.[13] Beginning in 2020, life expectancy estimates include the effect of COVID-19 mortality.

Life expectancy at ages 65 and 85, by sex, 2000–2022

NOTE: Life expectancy estimates are from annual life tables produced by the National Center for Health Statistics found at https://www.cdc.gov/nchs/products/life_tables.htm. Estimates for 2022 are based on provisional mortality data.[13]
Reference population: These data refer to the resident population.
SOURCE: National Center for Health Statistics, National Vital Statistics System.

- Under mortality conditions present in 2022, people who survive to age 65 can expect to live an average of 18.9 more years overall, 17.5 years for men and 20.2 years for women. In 2022, the life expectancy of people who survive to age 85 was 6.4 years overall: 5.8 years for men and 6.8 years for women.

- Life expectancy for the older population was generally increasing until 2020, the first year of the COVID-19 pandemic. Life expectancy for people age 65 and over increased from 17.6 years in 2000 to 19.6 years in 2019. Life expectancy fell to 18.5 years in 2020 and to 18.4 years in 2021. Life expectancy in 2022 rose to 18.9 years.

- Life expectancy for people age 85 and over increased from 6.1 years in 2000 to 6.7 years in 2019. In 2020, life expectancy fell to 6.1 years and then rose to 6.3 years in 2021 and 6.4 years in 2022.

- Women had higher life expectancy than men at ages 65 and 85 throughout the period from 2000 to 2022.

Indicator 15: **Life Expectancy** (cont.)

Life expectancy at age 65, by race and Hispanic origin, 2019–2022

Years of Life
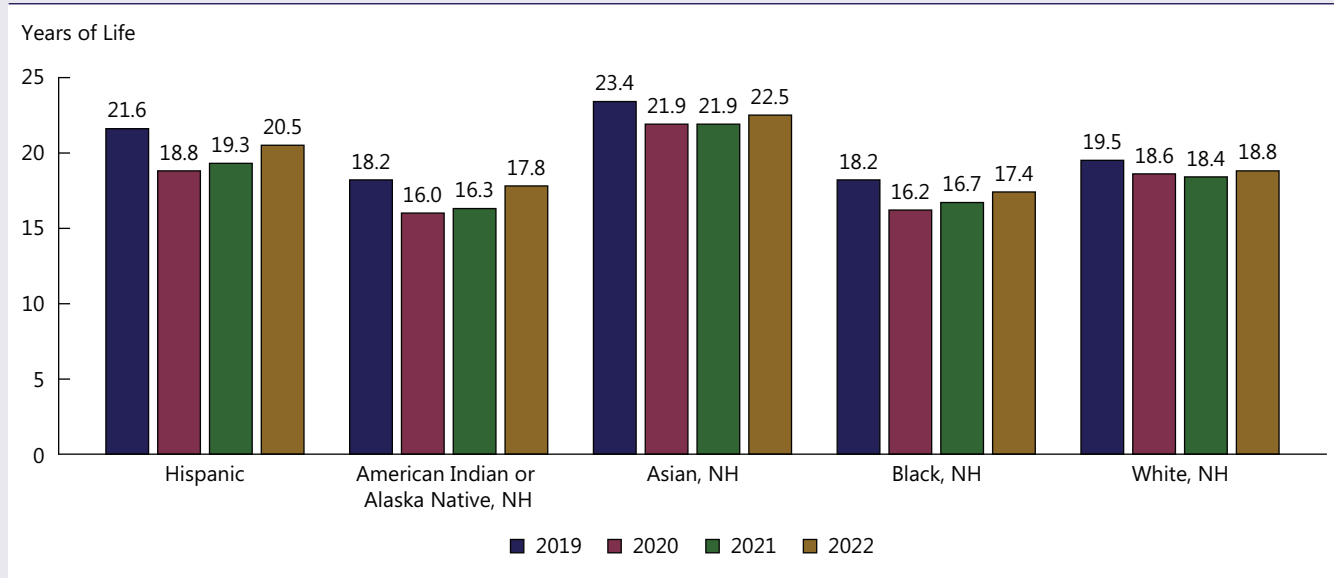
NH = Non-Hispanic.

NOTE: Life expectancy estimates are from annual life tables produced by the National Center for Health Statistics found at https://www. cdc.gov/nchs/products/life_tables.htm. Life expectancy by race and Hispanic origin are based on death rates that have been adjusted for Hispanic-origin and race misclassification on death certificates. Estimates for 2022 are based on provisional mortality data.[13] See data sources for the definition of race and Hispanic origin in the National Vital Statistics System.

Reference population: These data refer to the resident population.

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

- Life expectancy varies by race and Hispanic origin. In 2019, life expectancy at age 65 was highest among Asian, non-Hispanic people (23.4) followed by those who were Hispanic (21.6); White, non-Hispanic (19.5); American Indian or Alaska Native, non-Hispanic (18.2); and Black, non-Hispanic people (18.2).

- Life expectancy at age 65 declined from 2019 to 2020 for all groups. The largest decline was for Hispanic people (2.8 years), followed by those who were American Indian or Alaska Native, non-Hispanic (2.2 years); Black, non-Hispanic (2.0 years); Asian, non-Hispanic (1.5 years); and White, non-Hispanic (0.9 years).

- For all groups, life expectancy at age 65 in 2022 was higher than in 2020 and 2021 but lower than in 2019.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 16: **Mortality**

Overall, death rates for the population age 65 and over have declined in recent decades. However, for some causes of death, rates among older Americans have increased in recent years. COVID-19 has been a leading cause of death for older Americans since 2020. There are differences in death rates by sex and race and Hispanic origin for many causes of death.[14]

Death rates among people age 65 and over, by selected leading causes of death, 2000–2022

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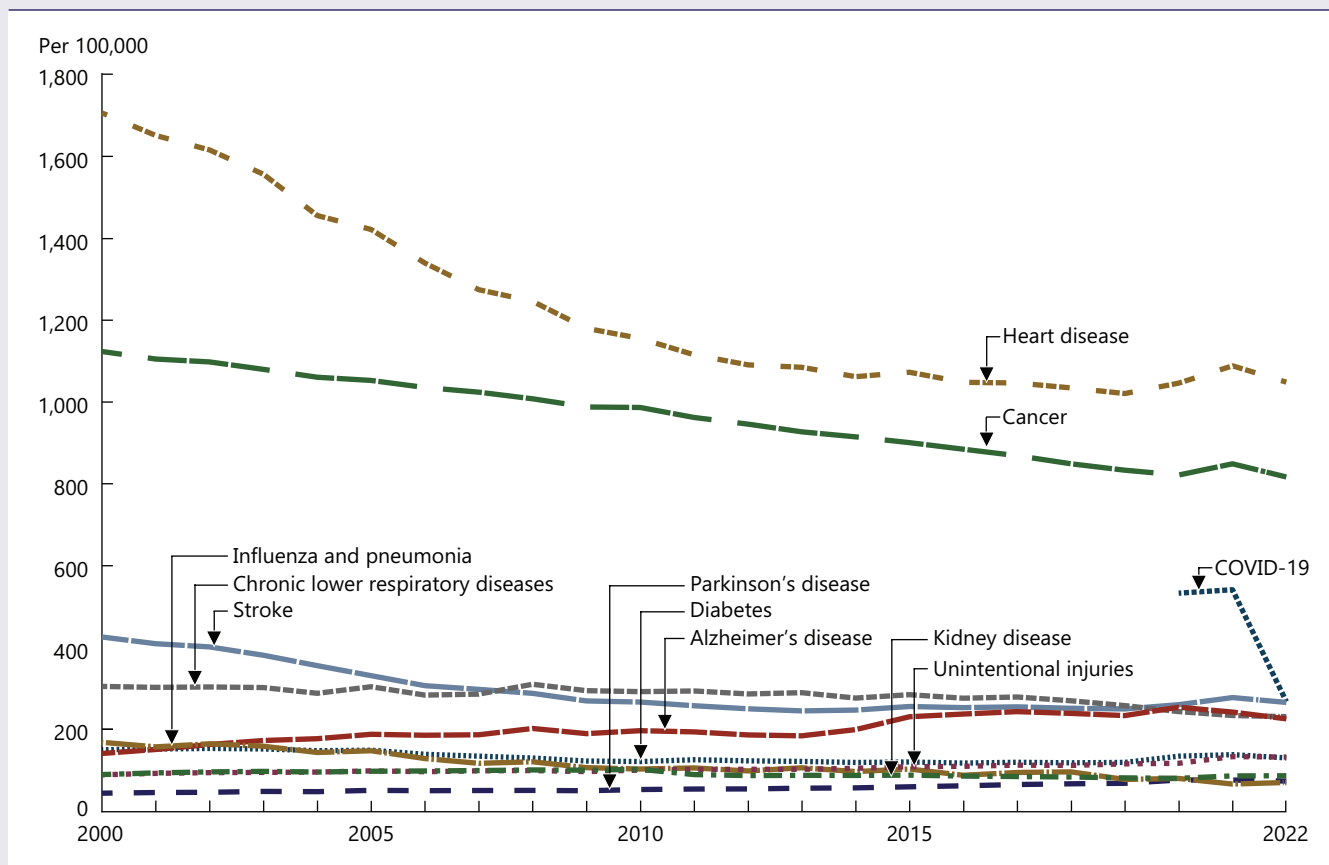SOURCE: National Center for Health Statistics, National Vital Statistics System.

- In 2022, the leading causes of death among people age 65 and over were heart disease (1,049 deaths per 100,000 U.S. standard population), followed by cancer (817), COVID-19 (269), stroke (266), chronic lower respiratory diseases (231), Alzheimer's disease (226), unintentional injuries (132), diabetes (130), kidney disease (87), Parkinson's disease (74), and influenza and pneumonia (70).

- Age-adjusted death rates for people age 65 and over were 14 percent lower in 2022 than 2000. Death rates were lower in 2022 than 2000 for heart disease, cancer, stroke, chronic lower respiratory diseases, diabetes, kidney disease, and influenza and pneumonia. Death rates for Alzheimer's disease, unintentional injuries, and Parkinson's disease were higher in 2022 than 2000.

- COVID-19 death rates increased from 2020 (534) to 2021 (542) and then declined by 50 percent in 2022 (to 269). COVID-19 was the third leading cause of death for adults age 65 and over between 2020 and 2022.

- Heart disease and cancer were the top two leading causes of death in 2022 for both men and women age 65 and over. Among women, they were followed by stroke, Alzheimer's disease, and COVID-19. Among men, they were followed by COVID-19, chronic lower respiratory diseases, and stroke.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 17: **Chronic Health Conditions**

The risk of many chronic diseases increases with age.[15] Chronic conditions usually require ongoing medical care and are leading causes of disability as well as major contributors to health care costs.[16] The majority of older adults have two or more chronic conditions.[17] Health risk behaviors such as tobacco use, poor nutrition, physical inactivity, and excessive alcohol use contribute to many chronic conditions.[16]

Percentage of people age 65 and over with selected chronic health conditions, by sex, 2022
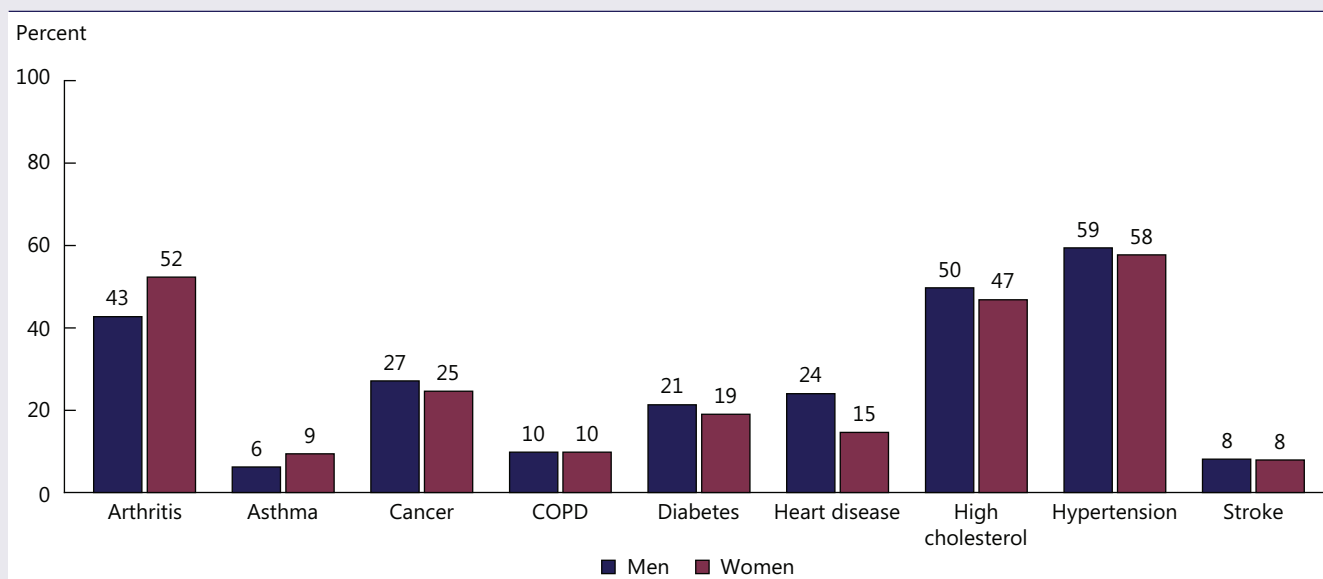
NOTE: Arthritis, cancer, chronic obstructive pulmonary disease (COPD), diabetes, and stroke are defined as responding yes to a question of whether a doctor or other health professional ever told the respondent that they had the condition. Heart disease is defined as responding yes to at least one of three questions of whether a doctor or other health professional ever told the respondent that they had coronary heart disease, angina, or a heart attack. Asthma is defined as responding yes to questions of whether a doctor or other health professional ever told the respondent that they had asthma and that they still have asthma. High cholesterol is defined as responding yes to questions of whether a doctor or other health professional ever told the respondents that they had high cholesterol and that they had the condition during the past 12 months or if the respondents reported taking prescribed medication for the condition. Hypertension is defined as responding yes to questions of whether a doctor or other health professional ever told the respondent that they had hypertension or high blood pressure on two or more visits and were also told they had hypertension during the past 12 months or if they were taking prescribed medication for the condition. Some definitions have 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 2022, the prevalence of certain chronic health conditions among people age 65 and over differed by sex. Women reported higher levels than men of arthritis (52 percent versus 43 percent) and current asthma (9 percent versus 6 percent). Men reported higher levels than women of cancer (27 percent versus 25 percent), diabetes (21 percent versus 19 percent), heart disease (24 percent versus 15 percent), and high cholesterol (50 percent versus 47 percent).

- The prevalence of some conditions was similar for men and women age 65 and over: chronic obstructive pulmonary disease (COPD) (10 percent for both), hypertension (59 percent and 58 percent, respectively), and stroke (8 percent for both).

- There were differences by race and ethnicity in the prevalence of certain chronic health conditions among people age 65 and over. For example, in 2022, Black, non-Hispanic adults reported higher levels of hypertension (74 percent) than White, non-Hispanic adults (56 percent); Asian, non-Hispanic adults (56 percent); and Hispanic adults (61 percent). White, non-Hispanic older adults reported lower levels of diabetes (17 percent) than Black, non-Hispanic (29 percent); Asian, non-Hispanic (31 percent); and Hispanic adults (31 percent).

- The prevalence of arthritis was similar among White, non-Hispanic adults (49 percent) and Black, non-Hispanic adults (53 percent), and the prevalence of arthritis for both of these groups was higher than the prevalence for Asian, non-Hispanic adults (38 percent) and Hispanic adults (42 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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Indicator 18: **Oral Health**

Oral health is an important component of an older person's general health and well-being. Oral health reflects overall health status and is related to the risk and treatment of various chronic conditions.[18] Regular dental care is not covered under Medicare.

Percentage of people age 65 and over who had dental insurance, had a dental visit in the past year, and had no natural teeth, by age group, 2021
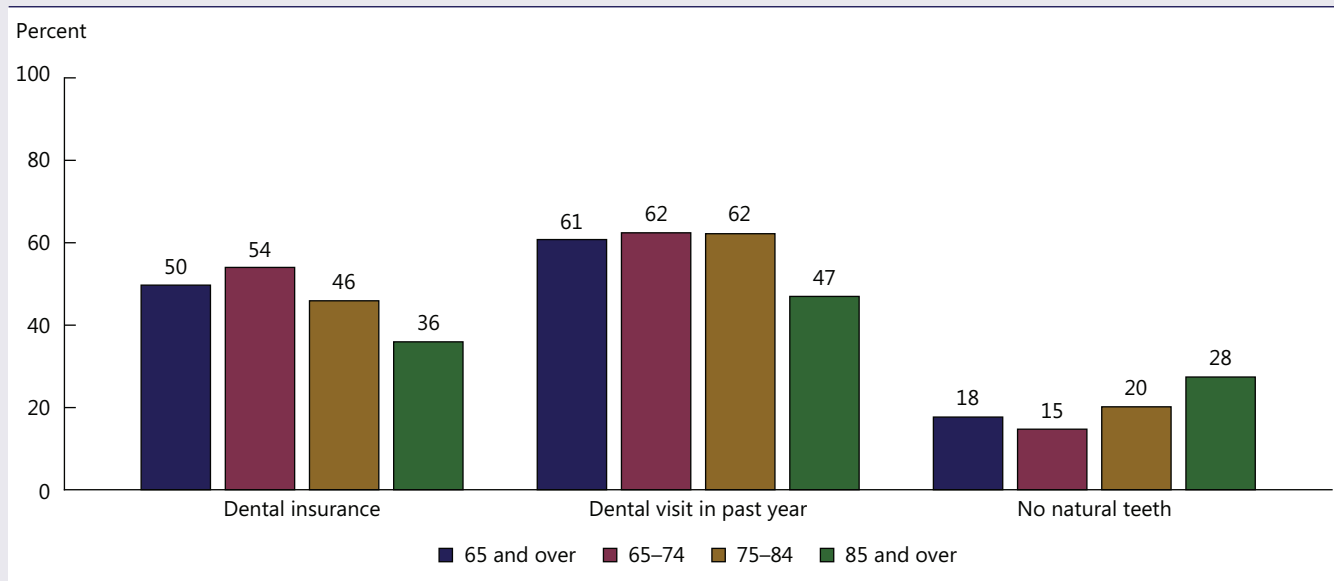
NOTE: Dental insurance is estimated from questions on whether the respondent's private health insurance plan covers dental care and whether the respondent has a standalone insurance plan covering dental care. Dental visits in the past year were estimated from survey-reported costs and utilization data. 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?" Versions of this indicator from 2020 and before used data from the National Health Interview Survey.

Reference population: These data refer to community-dwelling Medicare beneficiaries who were ever enrolled during the year.

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

- Fifty percent of people age 65 and over reported having an insurance plan that included dental coverage in 2021. The proportion of beneficiaries with dental insurance declined with age, from 54 percent among people ages 65–74 to 36 percent among people age 85 and over.

- In 2021, 61 percent of people age 65 and over had a dental visit in the past year. This percentage was higher among people ages 65–74 than among people age 85 and over (62 percent versus 47 percent).

- The prevalence of edentulism (i.e., having no natural teeth) was about twice as high among people age 85 and over (27 percent) than among people ages 65–74 (15 percent) in 2021.

- In 2021, similar percentages of men and women age 65 and over 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 Black and Hispanic people (15 percent compared with 30 percent and 25 percent, respectively), and a greater proportion of Non-Hispanic White beneficiaries reported dental visits compared to non-Hispanic Black and Hispanic people.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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

Asking people to rate their health as excellent, very good, good, fair, or poor provides an indicator of health status easily measured in surveys. It represents physical, emotional, and social aspects of health and well-being. Self-rated health has been shown to predict mortality and health care expenditures, although the results may vary by age and race and ethnicity.[19,20,21,22]

Percentage of people age 65 and over with respondent-assessed good to excellent health status, by race and Hispanic origin and age group, 2022
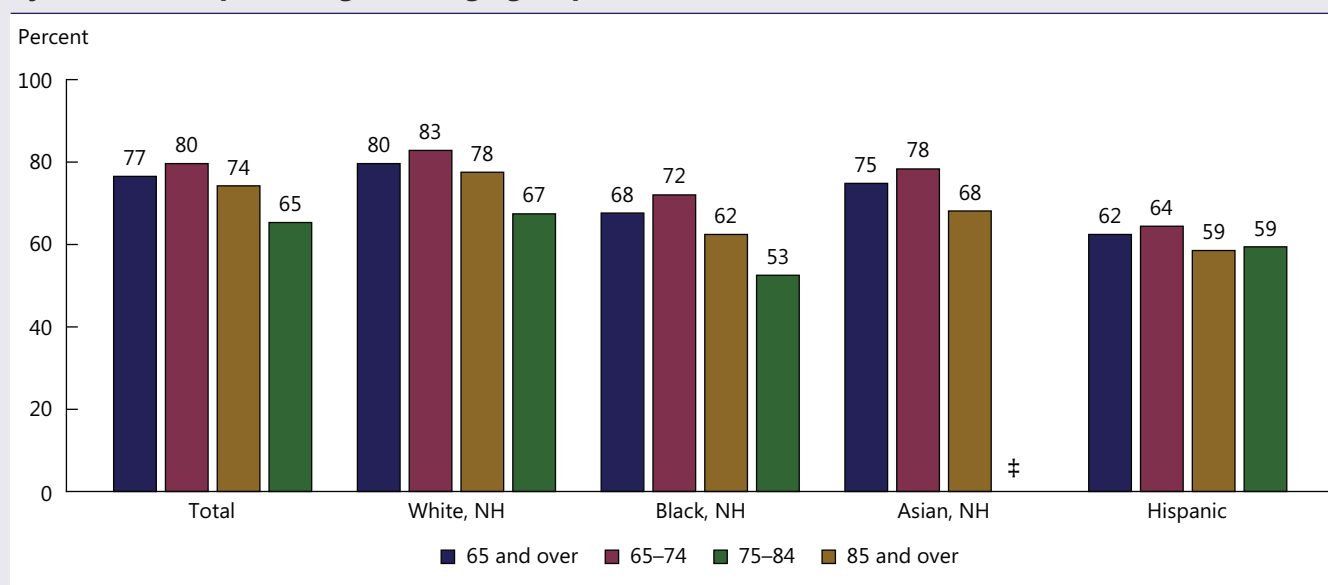
NH = Non-Hispanic.

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

NOTE: Total includes all races and ethnicities, including those 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 2022, 77 percent of people age 65 and over rated their health as good, very good, or excellent.

- The proportion of people reporting good to excellent health decreased with increasing age. Eighty percent of those ages 65–74 reported good or better health, compared with 74 percent of those ages 75–84 and 65 percent of those age 85 and over.

- In 2022, among people age 65 and over, 80 percent of those who were White, non-Hispanic reported good to excellent health, which was similar to the percentage for those who were Asian, non-Hispanic (75 percent) but

higher than the percentage for those who were Black, non-Hispanic (68 percent) and Hispanic (62 percent).

- The percentages of men and women age 65 and over who reported good to excellent health were generally similar. However, among those ages 65–74, a higher percentage of women then men reported good to excellent health (81 percent versus 78 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 20: **Dementia**

Dementias, including Alzheimer's disease and other related disorders that cause memory impairment and cognitive decline, affect the health and well-being of the U.S. population (see Indicator 16: Mortality). 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, 2015, and 2022
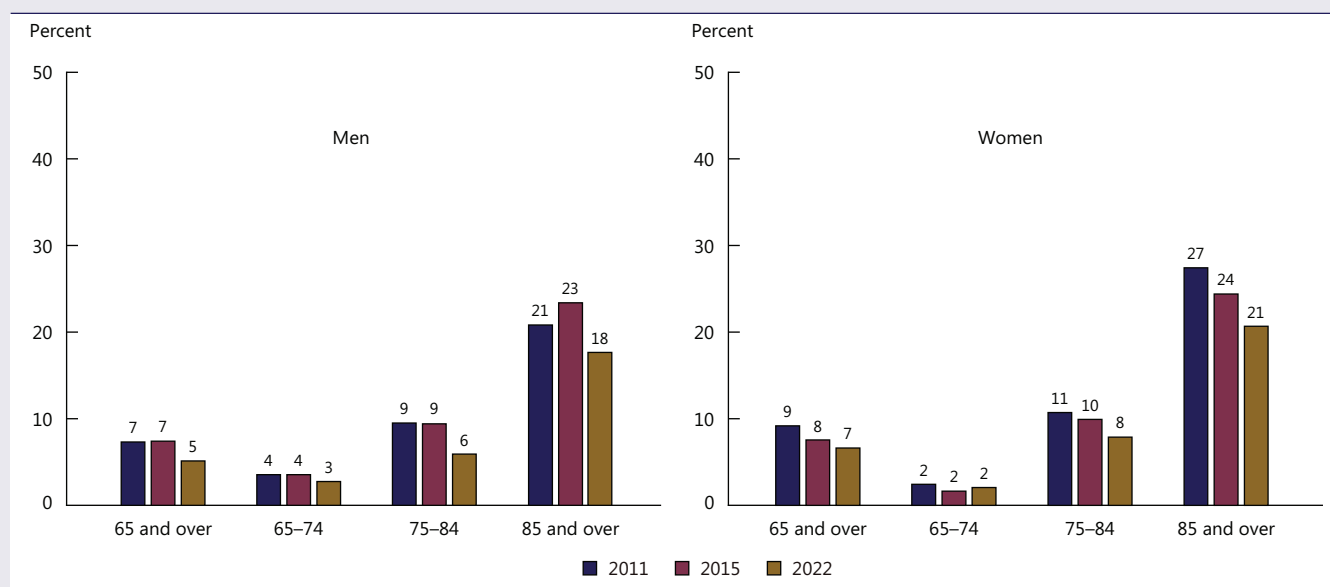
NOTE: The estimate of dementia includes Alzheimer's disease and other related dementias such as frontotemporal, Lewy body, mixed, and vascular dementia. Dementia status in the National Health and Aging Trends Study (NHATS) was determined using three types of information: (1) a report (by the respondent 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.[23] 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: National Institute on Aging, National Health and Aging Trends Study.

- Between 2011 and 2022, the number of adults age 65 and over with dementia not living in nursing homes held steady at about 3 million. During this time period, the prevalence of dementia for all adults age 65 and over declined from 8.4 percent to 5.9 percent.

- In 2022, 5.1 percent of men (1.2 million) and 6.6 percent of women (1.9 million) age 65 and over not living in nursing homes had dementia. Despite similar overall percentages with dementia in 2022 among women and men, the size of the population in the oldest age group was larger for women than men. As a result, far more women than men had dementia at older ages. Among those ages 85 and older, 20.7 percent of women (730,000) and 17.6 percent of men (360,000) had dementia.

- The prevalence of dementia among people age 65 and over remained largely unchanged for men between 2011 and 2015 but declined between 2015 and 2022; for women, the prevalence declined from 9.2 percent in 2011 to 7.6 percent in 2015 and to 6.6 percent in 2022. Declines in prevalence between 2015 and 2022 occurred for men and women in the two older age groups (75–84 and 85 and over).

- The prevalence of dementia decreased with educational level. In 2011, 2015, and 2022, among people age 65 and over, 16 percent with less than a high school education had dementia compared with 5 percent of people who had a bachelor's degree or higher. These differences by education level were similar for both men and women and across age groups.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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Indicator 21: **Depressive Symptoms**

Depressive symptoms are an important indicator of general well-being and mental health among older adults. People who report many depressive symptoms often experience higher rates of physical illness, greater functional disability, higher health care resource utilization,[24] and dementia.[25]

Percentage of people age 55 and over with clinically relevant depressive symptoms, by sex and age group, selected years, 1998–2020

NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D), adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "four or more symptoms" cut-off can be found in the following documentation: 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 to be more precise.

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 2020, 15 percent of women age 65 and over reported clinically relevant depressive symptoms, compared with 10 percent of men. There was no significant change between the sexes in this difference from 1998 to 2020. A slight downward trend is apparent for women in this age group, from 19 percent in 1998 to 15 percent in 2020.

- The percentage of people ages 55–64 reporting clinically relevant symptoms remained relatively stable from 1998 to 2020. Over this period, the percentage of men who reported clinically relevant depressive symptoms ranged between 11 and 14 percent, and the percentage of women who did so ranged between 16 and 18 percent.

Indicator 21: **Depressive Symptoms** (cont.)

Percentage of people age 55 and over with clinically relevant depressive symptoms, by age group and sex, 2020

Percent

NOTE: The definition of "clinically relevant depressive symptoms" is four or more symptoms out of a list of eight depressive symptoms from an abbreviated version of the Center of Epidemiological Studies Depression Scale (CES-D), adapted by the Health and Retirement Study (HRS). The CES-D scale is a measure of depressive symptoms and is not to be used as a diagnosis of clinical depression. A detailed explanation concerning the "four or more symptoms" cut-off can be found in the following documentation: 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 to be more precise.
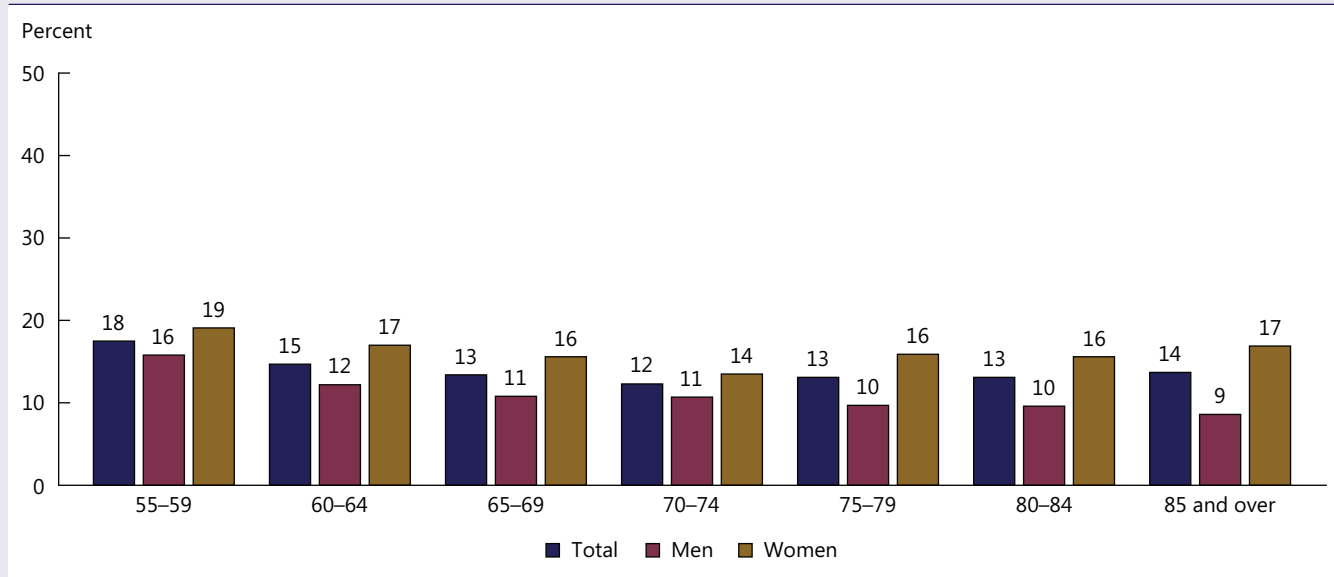
Reference population: These data refer to the civilian noninstitutionalized population.

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

- The prevalence of depressive symptoms varies by age. In 2020, the percentage of people who reported clinically relevant depressive symptoms was highest among those ages 55–59 (18 percent) and lowest among those ages 70–74 (12 percent).

- In 2020, a U-shaped pattern is apparent in the prevalence of clinically relevant depressive symptoms for women, with the highest prevalence for those ages 55–59 (19 percent) and those ages 60–64 and 85 and over (both 17 percent) and lowest for women ages 70–74 (14 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 22: **Functional Limitations**

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

Percentage of people age 65 and over with a disability, by sex and functional domain, 2022

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—that is, understanding or being understood by others (communication); remembering or concentrating (cognition); and self-care, such as washing all over or dressing (self-care). Any disability is defined as having difficulty with at least one of these activities.
Reference population: These data refer to the civilian noninstitutionalized population.
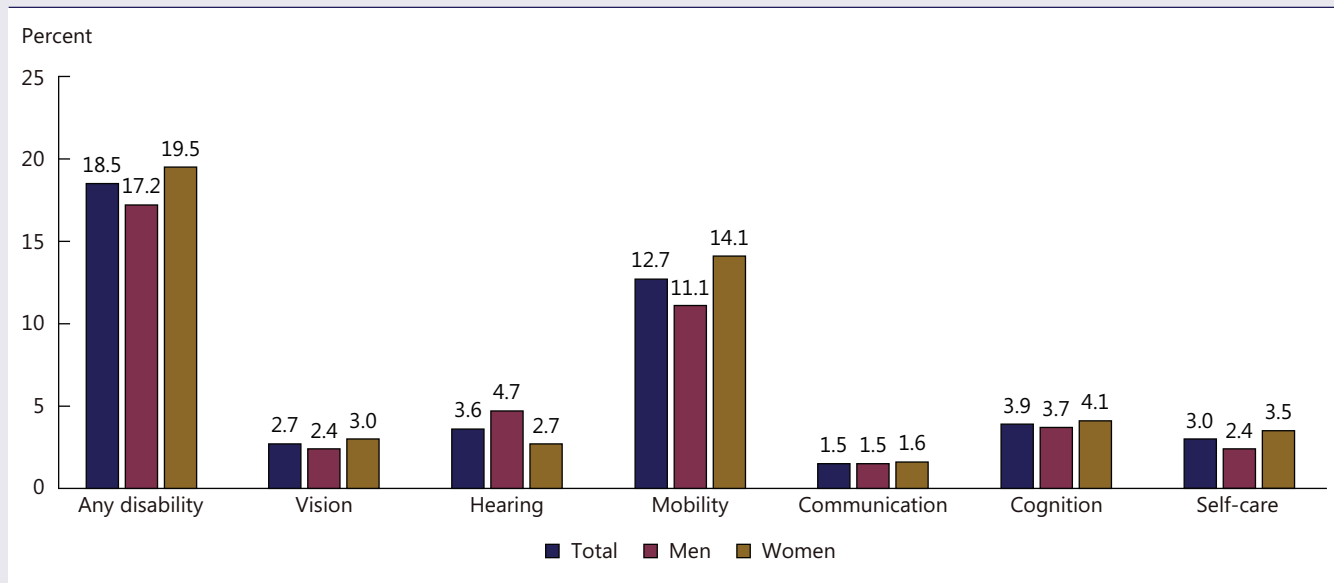SOURCE: National Center for Health Statistics, National Health Interview Survey.

- In 2022, 18.5 percent of the population age 65 and over reported having a disability, defined as having a lot of difficulty or being unable to do one of the following six functional activities: vision, hearing, mobility, communication, cognition, and self-care.

- In 2022, women were more likely than men to report any disability (19.5 percent versus 17.2 percent). They were also more likely than men to report disabilities related to mobility (walking or climbing stairs) (14.1 percent versus 11.1 percent) and self-care (3.5 percent versus 2.4 percent). In contrast, men were more likely to report hearing disabilities (4.7 percent versus 2.7 percent).

- Disability increased with age. In 2022, 39.4 percent of people age 85 and over reported having any disability, compared with 13.2 percent of people ages 65–74 and 22.0 percent of people ages 75–84. People age 85 and over were also more likely than people ages 65–74 to report disabilities in each of the functional domains.

- In 2022, Hispanic people age 65 and over were more likely to report having any disability (24.9 percent) than White, non-Hispanic (17.7 percent); Black, non-Hispanic (19.2 percent); and Asian, non-Hispanic (15.0 percent) people.

Indicator 22: **Functional Limitations** (cont.)

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 one's ability to live independently. Tracking these changes over time is helpful for planning for the care needs of the older population.

Percentage of Medicare beneficiaries age 65 and over who have limitations in performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs), or who are in a long-term care facility, selected years 1992–2021
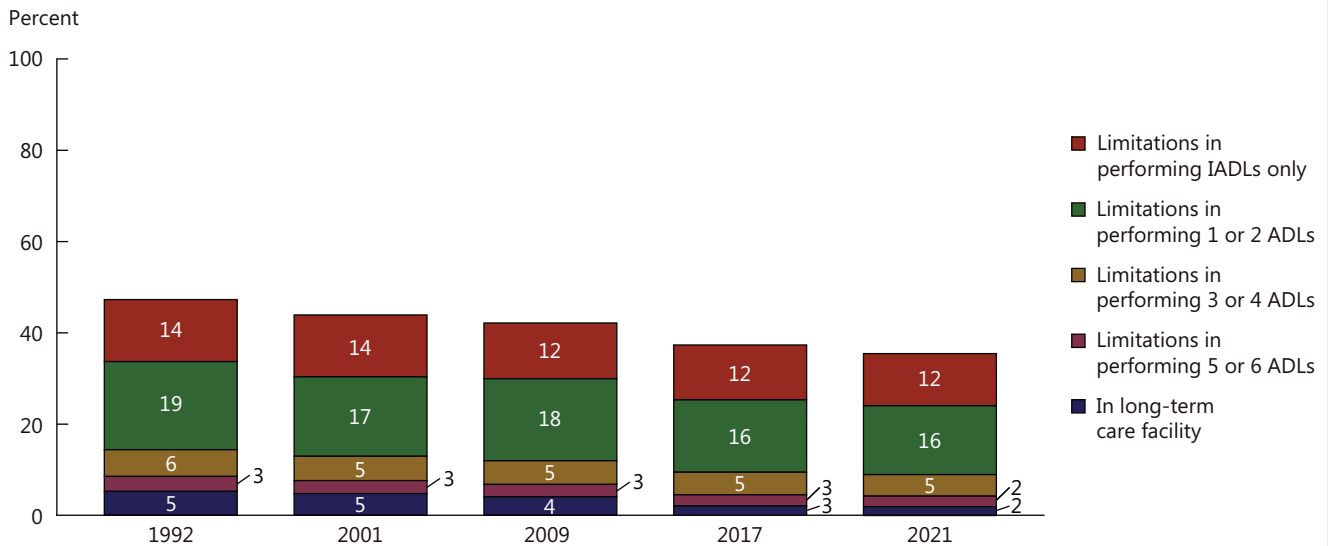
NOTE: A residence is considered a long-term care facility if it is certified by Medicare or Medicaid; has three or more beds, is licensed as a nursing home or other long-term care facility, and provides at least one personal care service; or provides 24-hour, 7-day-a-week supervision by a caregiver. Limitations in performing activities of daily living (ADL) refers 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) refers 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. 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 (2015–2021).

- In 2021, 37 percent of Medicare beneficiaries age 65 and over reported limitations in performing activities of daily living (ADLs) or instrumental activities of daily living (IADLs) or were living in a long-term care facility. Twelve percent had limitations in performing one or more IADLs but no limitations in performing ADLs. Twenty-three percent had limitations in performing at least one ADL, and 3 percent were in a facility.

- The proportion of Medicare beneficiaries age 65 and over with limitations in performing ADLs or IADLs or who were living in a long-term care facility was lower in 2021 than in 1992 (37 percent versus 47 percent).

- Among Medicare beneficiaries age 65 and over in 2021, women were more likely than men to report limitations in performing ADLs or IADLs or to live in a long-term care facility (42 percent versus 31 percent).

- The likelihood of Medicare beneficiaries reporting limitations in performing ADLs or IADLs or living in a long-term care facility varied by age in 2021: 65 percent for those age 85 and over, 40 percent for those ages 75–83, and 30 percent for those ages 65–74.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Health Risks
and Behaviors

Indicator 23: **Vaccinations**

Vaccinations against certain diseases are recommended for older Americans, who may be at higher risk for illness because immune systems tend to weaken with age.[26] Influenza (flu) vaccinations are given annually, and pneumonia and shingles vaccinations are usually given once or twice in a lifetime. Vaccinations against COVID-19 have been recommended since their development and approval during the COVID-19 pandemic.[27]

Percentage of people age 65 and over who reported receiving a vaccination for influenza, pneumonia, shingles, and COVID-19, by race and Hispanic origin, 2022
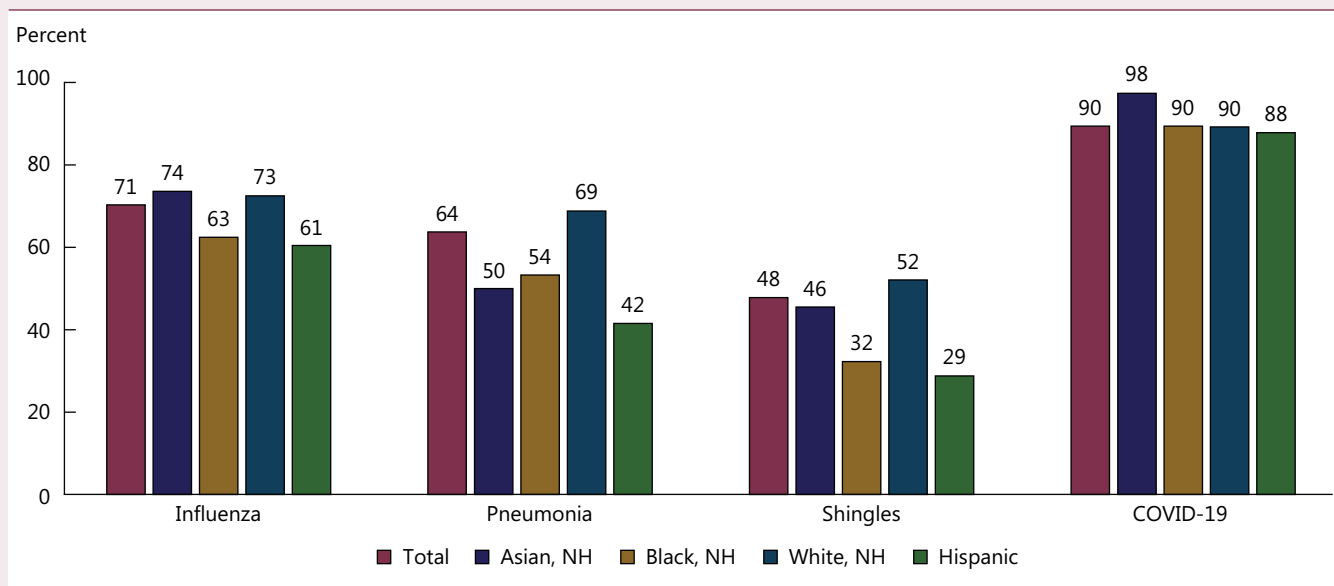
NH = Non-Hispanic.

NOTE: For influenza, the percentage vaccinated consists of people who reported receiving a flu vaccination during the past 12 months. For pneumonia, the percentage refers to people who reported ever receiving a pneumonia vaccination; some people receive more than one pneumonia vaccination in their lifetime. For shingles, the percentage refers to people who reported ever receiving a shingles vaccination; some people receive more than one shingles vaccination in their lifetime. For COVID-19, the percentage refers to people who reported receiving at least one dose of a COVID-19 vaccination. See data sources for the definition of race and Hispanic origin in the National Health Interview Survey. Total includes all races and ethnicities, including those not shown separately.

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

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

- In 2022, 71 percent of people age 65 and over reported receiving a flu vaccination in the past 12 months. Those who were Asian, non-Hispanic and White, non-Hispanic were more likely to have reported receiving a flu vaccination (74 percent and 73 percent, respectively) compared with those who were Black, non-Hispanic and Hispanic (63 percent and 61 percent, respectively).

- In 2022, 64 percent of people age 65 and over had ever reported receiving a pneumonia vaccination. Those who were White, non-Hispanic (69 percent) were more likely to have ever reported receiving ever receiving a pneumonia vaccination than those who were Asian, non-Hispanic (50 percent); Black, non-Hispanic (54 percent); and Hispanic (42 percent).

- In 2022, 48 percent of people age 65 and over reported ever receiving a shingles vaccine. Those who were Asian, non-Hispanic and White, non-Hispanic older adults were more likely to have ever reported receiving a shingles vaccine (46 percent and 52 percent, respectively) than those who

were Black non-Hispanic and Hispanic (32 percent and 29 percent, respectively).

- In 2022, 90 percent of adults age 65 and over reported having had at least one dose of a COVID-19 vaccination. The percentage was highest among Asian, non-Hispanic older adults (98 percent) followed by those who were Black, non-Hispanic (90 percent); White, non-Hispanic (90 percent); and Hispanic (88 percent).

- In 2022, the percentage of people age 85 and over who reported receiving flu and pneumonia vaccinations (76 percent and 69 percent, respectively) was higher than the percentage of people ages 65–74 (68 percent and 60 percent, respectively).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on aging stats.gov/reports-and-tables.html.

Indicator 24: **Cancer Screenings**

Health care services and screenings can help prevent disease or detect it at an early, treatable stage. The U.S. Preventive Services Task Force recommends regular colorectal cancer screenings for older adults through age 75 and breast cancer screenings for women through age 74.[28,29]

Percentage of people ages 50–75 who had colorectal cancer (CRC) screening and percentage of women ages 50–74 who had breast cancer screening, by sex and age group, 2021

Percent
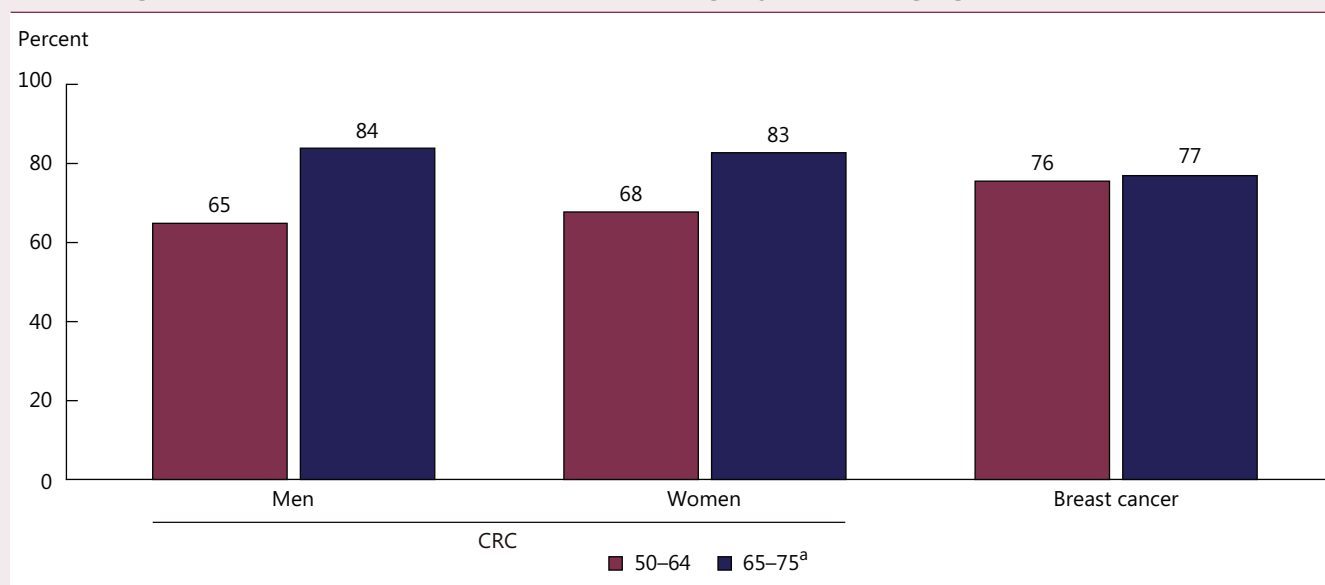
[a] For breast cancer screening, the age range is 65–74

NOTE: Colorectal cancer screening (CRC) is defined as reporting a home blood stool test or FIT in the past year, sigmoidoscopy during the past 5 years, colonoscopy during the past 10 years, computed tomography colonography or virtual colonoscopy during the past 5 years, or Cologuard or FIT-DNA test during the past 3 years. Breast cancer screening is defined as reporting having had a mammogram in the last 2 years. U.S. Preventive Services Task Force recommendations were updated in May 2021 for colorectal cancer screening and in April 2024 for breast cancer screening. Colorectal cancer screening is reported for men and women ages 50–75. Mammography is reported for women ages 50–74.

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

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

- In 2021, the percentage of people receiving colorectal cancer screening was higher among those ages 65–75 than among those ages 50–64 (84 percent versus 65 percent for men and 83 percent versus 68 percent for women).

- In 2021, there were no significant differences by sex among people ages 65–75 who received colorectal cancer screening. Among people ages 50–64, women were more likely than men to have received colorectal cancer screening (68 percent versus 65 percent).

- The percentage of women in 2021 who received breast cancer screening with a mammogram in the past 2 years was similar for those ages 50–64 (76 percent) and ages 65–74 (77 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 25: **Diet Quality**

Following a healthy dietary pattern is especially important for adults (those age 60 and over in this indicator), because of the changing dietary needs, increased risk of chronic diseases, changes in bone and muscle mass, and heightened risk of malnutrition that occurs with age. The USDA Dietary Patterns provide a framework to help older adults follow a healthy dietary pattern and meet the Dietary Guidelines for Americans recommendations. The Patterns provide a variety of food and beverage choices that allow individuals to customize their choices within each food group based on lifestyle, traditions, culture, and/or other individual needs. To improve the quality of their diet, older adults can increase their consumption of fruits, vegetables, whole grains, and dairy and ensure their protein intake meets recommendations. Consuming enough protein is important to prevent the loss of lean muscle mass that occurs naturally with age. Reducing intakes of added sugars, saturated fat, and sodium also will help older adults achieve recommendations and manage and avoid chronic conditions.[30]

- For both males and females in both age groups (60–69 and 70 and over), the average intakes of total vegetables, total fruit, and total dairy fall below the range of recommended intakes.

- For both males and females in both age groups (60–69 and 70 and over), the average intake of whole grains falls below the range of recommended intake, while the average intake of refined grains exceeds the range of recommended intake.

- For both males and females ages 60–69, the average intake of total protein foods exceeds or falls within the range of recommended intake. However, for females age 70 and over, the average intake of total protein foods falls below the range of recommended intake.

Figure for Indicator 25 appears on the following page. References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 25: **Diet Quality** (cont.)

Average daily food group intake compared to recommended intake ranges, by sex and age, 2017–March 2020

Selected characteristics

Total Vegetables (cup)[a]
Total Fruits (cup)[b]
Whole Grains (oz)[c]
Refined Grains (oz)[d]
Total Dairy (cup)[e]
Total Protein Foods (oz)[f]

(60–69 / 70 and over; Males / Females for each)

X-axis: Cup or ounce equivalent (0 to 8)

Legend:
● Male average daily food group intake
— Male recommended intake range
● Female average daily food group intake
— Female recommended intake range

[a] Total Vegetables include dark green, red and orange, starchy, and other vegetables as well as beans, peas, and lentils. Total vegetables do not include beans, peas, and lentils, which have average daily intakes of 0.07–0.12 cup equivalents depending on age range and sex.

[b] Total Fruits include intact fruit from all sources as well as 100 percent fruit juice.

[c] Includes whole-grain products and whole grains used as ingredients: for example, amaranth, barley (not pearled), brown rice, buckwheat, bulgur, millet, oats, popcorn, quinoa, dark rye, triticale, whole-grain cornmeal, whole-wheat bread, whole-wheat chapati, whole-grain cereals and crackers, and wild rice.

[d] Includes refined-grain products and refined grains used as ingredients: for example, white breads, refined-grain cereals and crackers, corn grits, cream of rice, cream of wheat, barley (pearled), masa, pasta, and white rice. Refined-grain choices should be enriched.

[e] Total Dairy includes fluid milks, cheeses, yogurts, and calcium fortified soy milk and yogurts.

[f] Total Protein includes subgroup quantities of meat, poultry, eggs, seafood, nuts, seeds, and soybean products.

NOTE: Estimated energy requirements (e.g., calorie ranges) are calculated based on median population height and calculated body weight for a normal body mass index (BMI) of 21.5 kg/m². For adults, the reference male is 5 feet 10 inches tall and weighs 154 pounds. The reference female is 5 feet 4 inches tall and weighs 126 pounds. Calorie needs vary based on many factors. The DRI Calculator for Healthcare Professionals, available at nal.usda.gov/fnic/dri-calculator, can be used to estimate calorie needs based on age, sex, height, weight, and physical activity level.

SOURCE: Average Intakes: What We Eat in America (WWEIA), NHANES 2017 to March 2020 pre-pandemic, individuals 60 years and older, day 1 dietary intake data, weighted. Available at www.ars.usda.gov/nea/bhnrc/fsrg. Recommended Intake Ranges: Dietary Guidelines for Americans, 2020–2025; Healthy U.S.-Style Dietary Patterns (Appendix 3). Available at DietaryGuidelines.gov.[31]

Indicator 26: **Physical Activity**

Physical activity is important for people of all ages. It improves overall health and reduces the risk of many chronic conditions. Physical activity may also reduce the risk of depression and dementia. For older adults, physical activity can lower the risk of falls and fall-related injuries.[32] Older adults are encouraged to do multicomponent physical activity that includes balance training as well as aerobic and muscle-strengthening activities. To be able to implement effective interventions, it is important to understand the barriers to being physically active faced by older adults.[33]

Percentage distribution of adults age 65 and over who met the 2018 *Physical Activity Guidelines for Americans* **for both aerobic physical activity and muscle-strengthening, by age group, 2022**
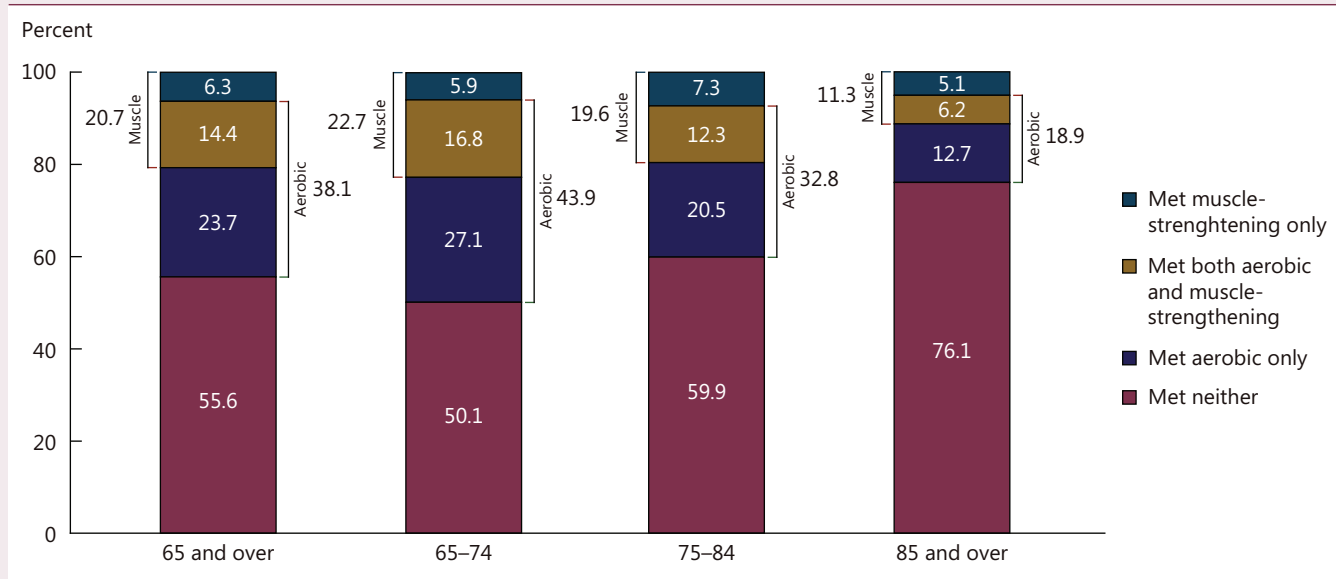
Muscle = Met muscle-strengthening guidelines; Aerobic = Met aerobic guidelines.

NOTE: Adults met 2018 federal physical activity guidelines if they met the guidelines for both aerobic physical activity and muscle-strengthening outlined in U.S. Department of Health and Human Services 2018 *Physical Activity Guidelines for Americans*, 2nd edition (available at https://health.gov/paguidelines). Aerobic guidelines recommend that adults should do at least 150 to 300 minutes a week of moderate-intensity or 75 to 150 minutes a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic physical activity. Muscle-strengthening activity guidelines recommend that adults do muscle-strengthening activities of moderate or greater intensity that involve all major muscle groups on 2 or more days a week. When older adults cannot do 150 minutes of moderate-intensity aerobic physical 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 met the aerobic 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 2022, 14.4 percent of people age 65 and over reported participating in aerobic physical activity and muscle-strengthening that met the 2018 Physical Activity Guidelines for Americans. This percentage decreased with age, ranging from 16.8 percent among people ages 65–74 to 6.2 percent among people age 85 and over.

- In 2022, 20.7 percent of people age 65 and over met the muscle-strengthening guidelines and 38.1 percent met the aerobic guidelines.

- In 2022, among those age 65 and over, men were more likely than women to meet both aerobic and muscle-strengthening guidelines (17.5 percent versus 11.9 percent). However, they had similar levels of meeting only muscle-strengthening guidelines (6.1 percent and 6.3 percent, respectively).

- White, non-Hispanic adults age 65 and over were more likely to meet the physical activity guidelines (15.7 percent) than those who were Black, non-Hispanic (10.9 percent) or Hispanic adults (9.8 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 27: **Obesity**

Obesity in all adults, including older adults, may increase risk for health problems such as type 2 diabetes, heart disease, stroke, and Alzheimer's disease. Risk factors for obesity include genetics, sleep, medications, and lifestyle habits such as diet and physical activity, among other factors. [34]

Percentage of the population age 65 and over with obesity, by sex and age group, selected years, 1988–1994 to August 2021–August 2023
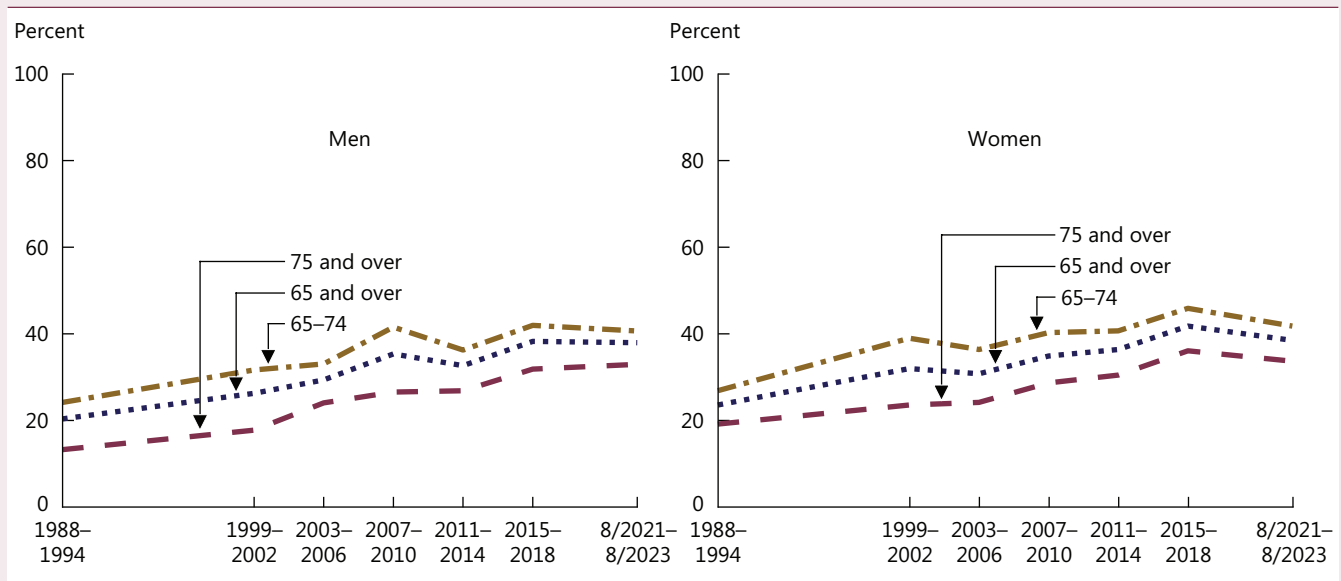
NOTE: Data are based on measured height and weight. Height was measured without shoes. Obesity is defined by a body mass index (BMI) of 30 kilograms/meter^2 or greater. Beginning in 1999, the National Health and Nutrition Examination Survey has been in the field continuously with data released every 2 years. Two survey cycles are often combined to create increased sample size, especially for subgroup estimates. After suspension of NHANES field operations in March 2020 due to the COVID-19 pandemic, data collection began for a new 2-year cycle in August 2021. The August 2021-August 2023 cycle had a new sample design and some data collection changes to reduce contact between interviewers and survey participants during the COVID-19 pandemic. No changes were made to the anthropometry component.

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

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

- During August 2021–August 2023, about 38 percent of people age 65 and over had obesity, 38 percent of men and 39 percent of women.

- The percentage of people age 65 and over with obesity was similar in 2015–2018 and August 2021–August 2023.

- During August 2021–August 2023, approximately 42 percent of women ages 65–74 and 34 percent of women age 75 and over had obesity.

- During August 2021–August 2023, approximately 41 percent of men ages 65–74 and 33 percent of men age 75 and over had obesity.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 28: **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 lung disease.[35] Smoking cessation is beneficial at any age.[36]

Percentage of people age 65 and over, by cigarette smoking status and sex, 2022
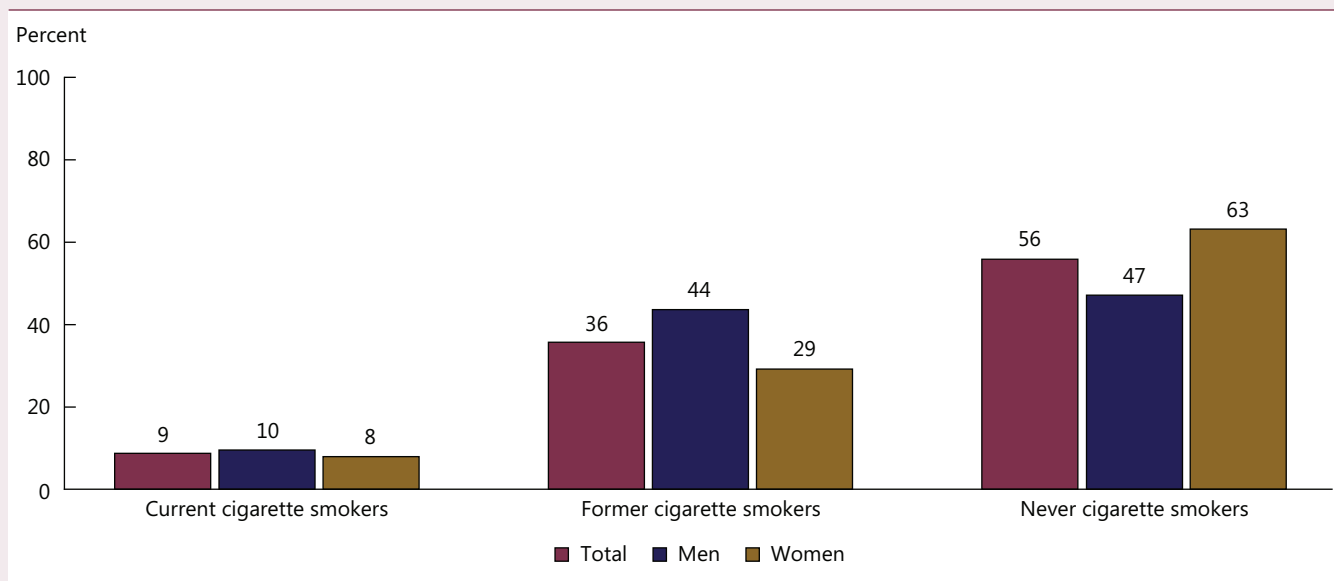
NOTE: Current cigarette smokers are persons who have smoked at least 100 cigarettes in their lifetime and currently smoke cigarettes every day or some days. Former cigarette smokers are persons who have smoked at least 100 cigarettes in their lifetime but do not currently smoke cigarettes. Never cigarette smokers are persons who have not smoked 100 cigarettes in their lifetime. The sum of current, former, and never cigarette smokers may not equal 100 percent because of rounding.

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

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

- In 2022, 9 percent of people age 65 and over were current cigarette smokers, 10 percent of men and 8 percent of women.

- Among people age 65 and over in 2022, men were more likely than women to be former smokers (44 percent versus 29 percent) and less likely to be never smokers (47 percent versus 63 percent).

- In 2022, Black, non-Hispanic people age 65 and over were more likely to be current smokers (14 percent) than those who were White, non-Hispanic and Hispanic people age 65 and over (8 percent).

- In 2022, the percentage of people age 65 and over who were current smokers was higher for those who lived below the poverty threshold (16 percent) than for those with incomes 200 percent or more above the poverty threshold (7 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

42
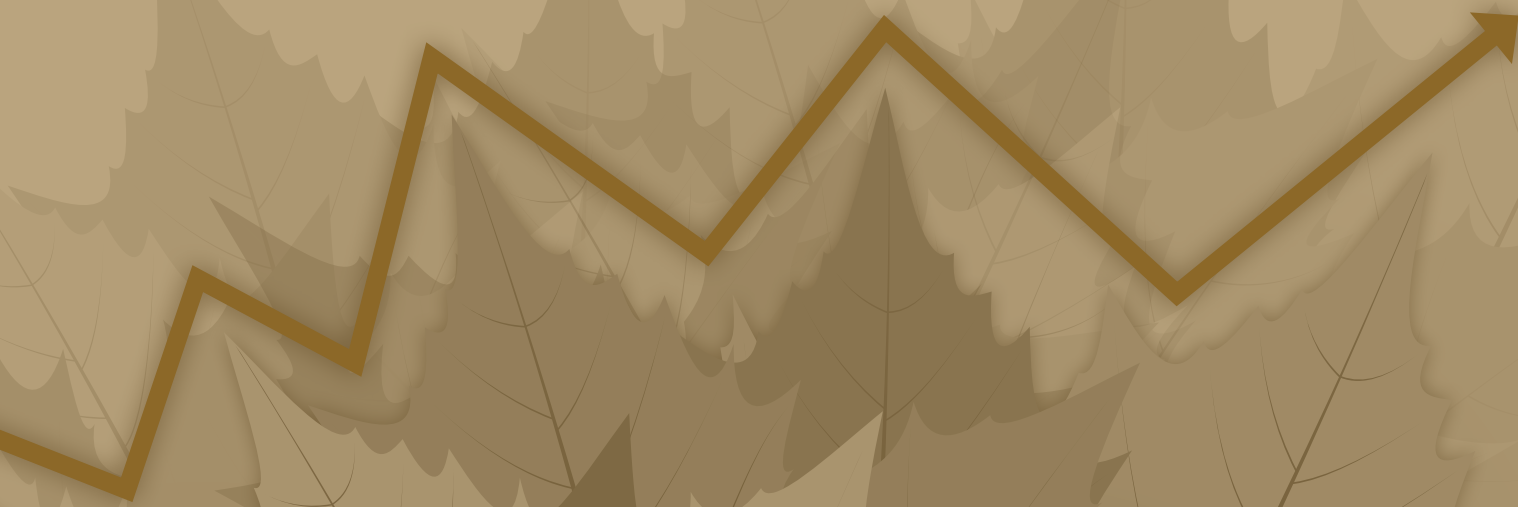
Health Care

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

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

Medicare-covered hospital and skilled nursing facility stays per 1,000 Medicare beneficiaries age 65 and over in fee-for-service, 1992–2021

Stays per 1,000 Medicare beneficiaries
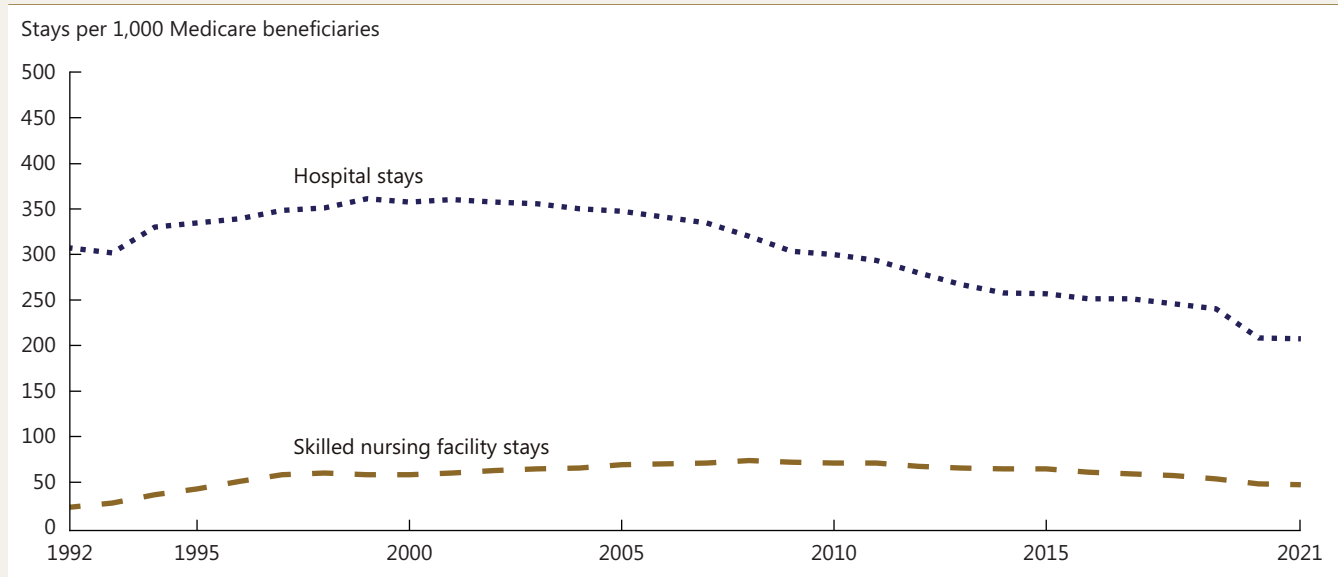
NOTE: Data are for Medicare beneficiaries in fee-for-service only. Beginning in 1994, managed care beneficiaries were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care beneficiaries were included in the denominators; 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 2021, Medicare beneficiaries had 197 hospital stays and 55 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 197 per 1,000 Medicare beneficiaries in 2021.

- 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 2011. Much of the increase occurred from 1992 to 1997. The number of skilled nursing facility stays has dropped slightly since 2011, decreasing to 55 per 1,000 Medicare beneficiaries in 2021.

Indicator 29: **Use of Health Care Services** (cont.)

Medicare-covered physician and home health care visits per 1,000 Medicare beneficiaries age 65 and over in fee-for-service, 1992–2021

Visits per 1,000 Medicare beneficiaries
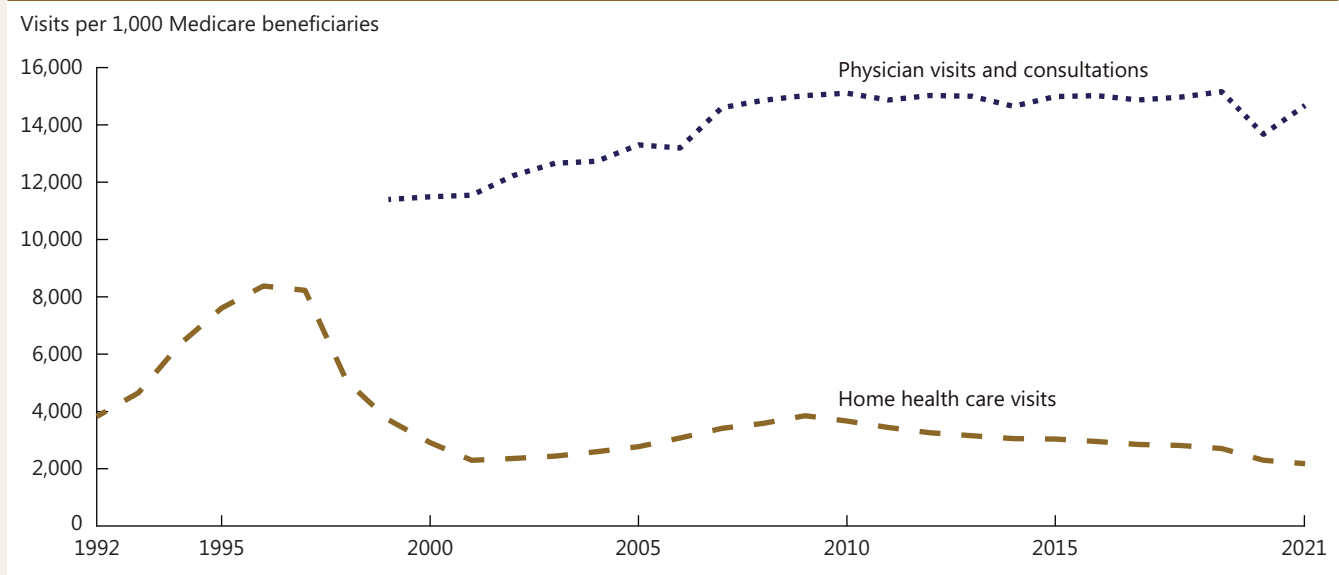
NOTE: Data are for Medicare beneficiaries in fee-for-service only. Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. The database used to generate rates of physician visits and consultations in previous *Older Americans* reports is no longer available. This chart uses two different databases based on the availability of data to estimate rates of physician visits and consultations. The first database provides data that begins with 1999 data through 2006 and the second database provides data beginning with 2007. As a result, some data for 2007–2009 have been revised and differ from previous editions of *Older Americans*. Beginning in 1994, managed care beneficiaries were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care beneficiaries were included in the denominators; they made up 7 percent or less of the Medicare population. See glossary for definition of fee-for-service.

Reference population: These data refer to Medicare beneficiaries.

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

- The number of physician visits and consultations was 14,679 per 1,000 Medicare beneficiaries in 2021—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 2,175 per 1,000 Medicare beneficiaries in 2021.

- Use of home health care increased with age. In 2021, home health care agencies made 1,045 visits per 1,000 Medicare beneficiaries ages 65–74 compared with 6,271 visits per 1,000 Medicare beneficiaries for those age 85 and over.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 30: **Health Care Expenditures**

Health care costs pose a major concern for older Americans. Among Medicare beneficiaries age 65 and over, these costs vary by 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 2021 dollars, for Medicare beneficiaries age 65 and over by age group, 1992–2021

NOTE: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation adjusted to 2021 dollars using the Consumer Price Index (CPI). Some data have been revised from previously published figures as a result of a CPI adjustment.

Reference population: These data refer to Medicare beneficiaries.

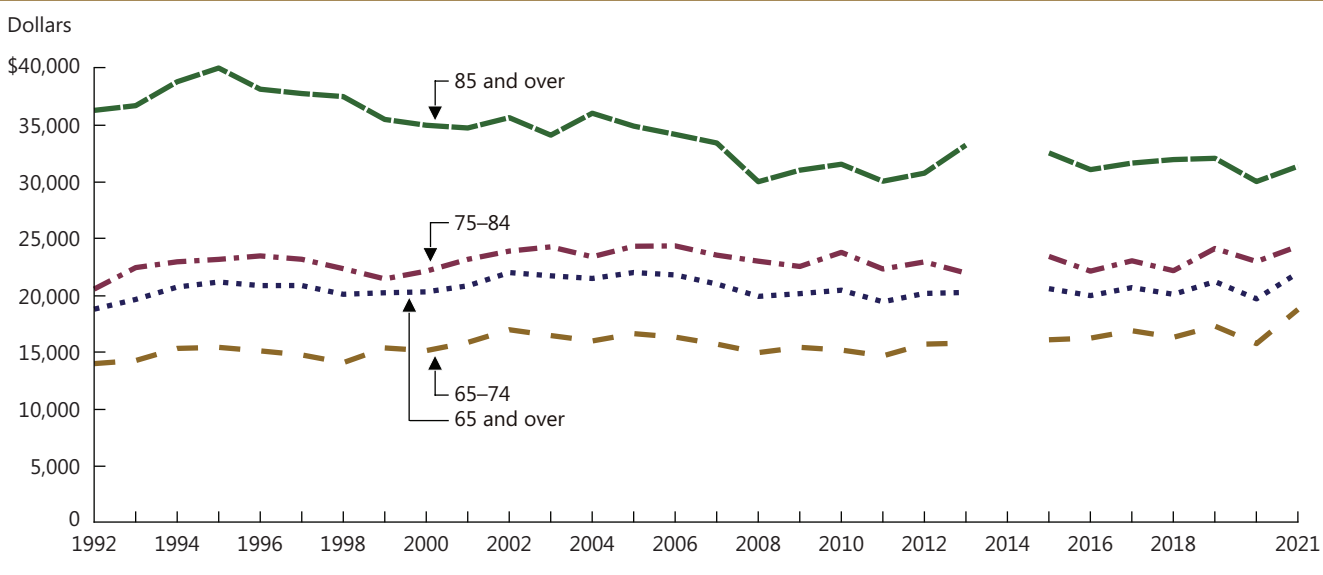SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use (1992–2013) and Cost Supplement (2015–2021).

- Average annual health care costs among Medicare beneficiaries age 65 and over were $21,930 in 2021.

- After adjusting for inflation, average annual health care costs among Medicare beneficiaries age 65 and over increased between 1992 and 2021—from $18,732 to $21,930.

- Average annual costs were substantially higher for Medicare beneficiaries age 85 and over compared with those in the younger age groups in 2021.

- Average annual health care costs for Medicare beneficiaries varied by demographic characteristics. In 2021, lower-income individuals incurred higher health care costs than higher-income individuals: those with incomes less than $10,000 and $10,000 to $19,999 averaged $29,403 and $31,560 in health care costs, respectively, while those with incomes of $30,000 or more averaged $19,268.

Indicator 30: **Health Care Expenditures** (cont.)

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, 2017, and 2021

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.
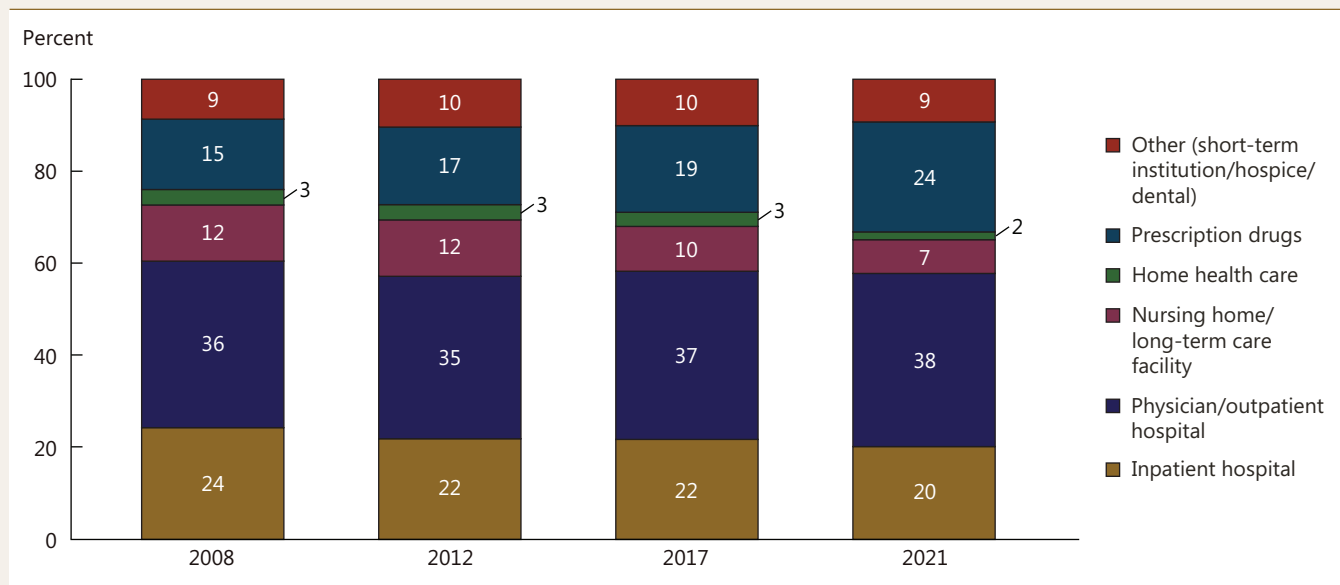SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use (2008, 2012) and Cost Supplement (2017, 2021).

- Outpatient hospital and physician services were the largest components of health care costs in 2021, accounting for 38 percent of total health care costs.

- In 2021, nursing homes and long-term care facilities accounted for 7 percent of total health care costs, and prescription drugs accounted for 24 percent.

- Inpatient hospital care accounted for 20 percent of total health care costs in 2021. "Other" costs (short-term institutions, hospice, and dental care) accounted for 9 percent of total costs.

- The percentage distribution of health care services changed between 2008 and 2021. Nursing home and long-term care facility costs dropped from 12 percent of total health care costs in 2008 to 7 percent in 2021. Conversely, prescription medication increased from 15 percent of total health care costs in 2008 to 24 percent in 2021.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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Indicator 31: **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 annual prescription drug costs, in 2021 dollars, among noninstitutionalized Medicare beneficiaries age 65 and over, by sources of payment, 1992–2021
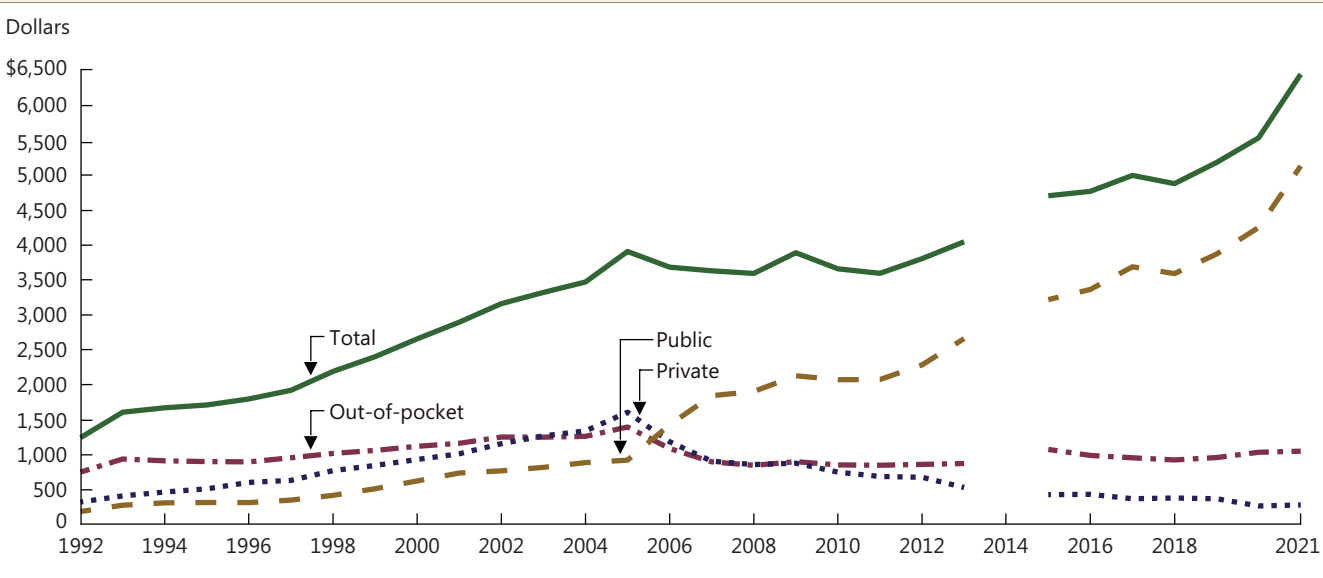
NOTE: Dollars have been inflation adjusted to 2021 dollars using the Consumer Price Index (CPI). Some data have been revised from previously published figures as a result of a CPI adjustment. Reported costs have been adjusted to account for underreporting of prescription drug use. The adjustment factor changed in 2006 with the initiation of the Medicare Part D prescription drug program. Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other State and Federal programs.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Cost and Use (1992–2013) and Cost Supplement (2015–2021).

- Average annual prescription drug costs for noninstitutionalized Medicare beneficiaries age 65 and over were $6,432 in 2021.

- After adjusting for inflation, average annual prescription drug costs for noninstitutionalized Medicare beneficiaries age 65 and over increased from $1,235 in 1992 to $3,896 in 2005. By 2021, average annual prescription drug costs were $6,432 per year.

- Relative to total costs of prescription drugs, the proportion of 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. Noninstitutionalized Medicare beneficiaries age 65 and over paid 60 percent of prescription drug costs out of pocket in 1992 compared with 16 percent in 2021. Private insurance covered 4 percent of prescription drug costs for noninstitutionalized Medicare beneficiaries age 65 and over in 2021, and public programs covered about 80 percent of those costs.

Indicator 31: **Prescription Drugs** (cont.)

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 2021
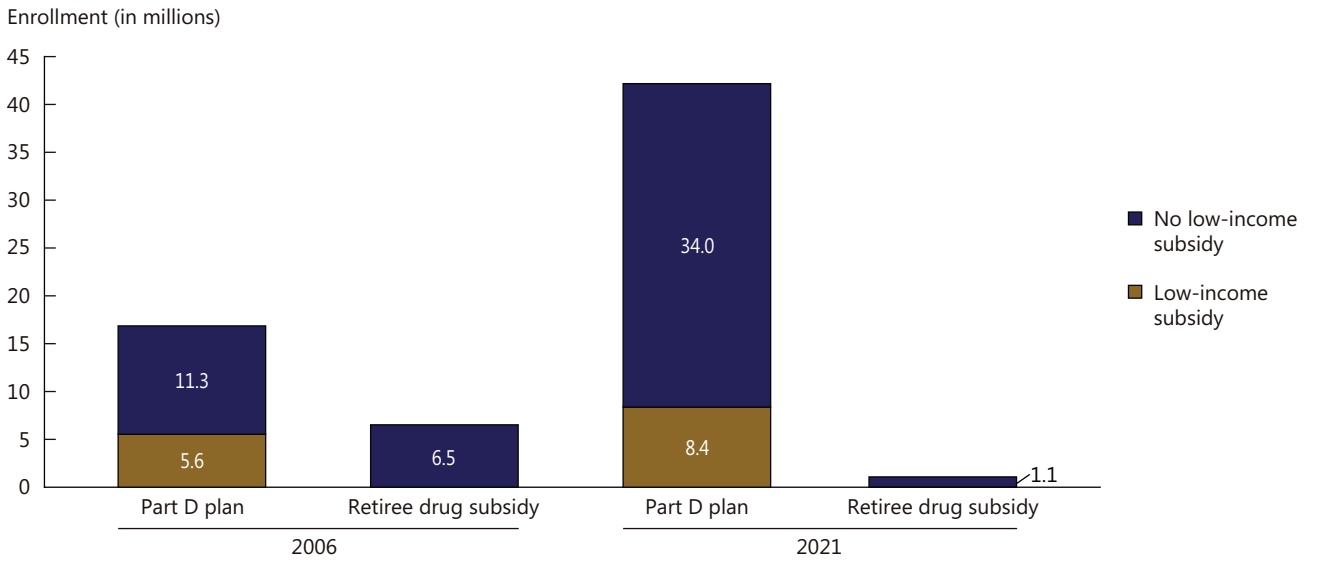
Reference population: These data refer to Medicare beneficiaries.
SOURCE: Centers for Medicare & Medicaid Services, Medicare claims and enrollment data.

- Approximately 1.1 million beneficiaries age 65 and over were covered by the retiree drug subsidy in 2021.

- In 2021, 8.4 million Medicare Part D beneficiaries received low-income subsidies. Many of these beneficiaries had drug coverage through the Medicaid program prior to enrollment in Part D.

- The number of Medicare beneficiaries age 65 and over enrolled in Part D prescription drug plans increased from 16.9 million (46 percent) in 2006 to 42.4 million (76 percent) in 2021.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 32: **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 to pay for services not covered by Medicare. Prior to 2006, many beneficiaries received prescription drug coverage through supplemental insurance. Since January 2006, beneficiaries have had the option of receiving prescription drug coverage under Medicare through standalone 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, 1991–2021
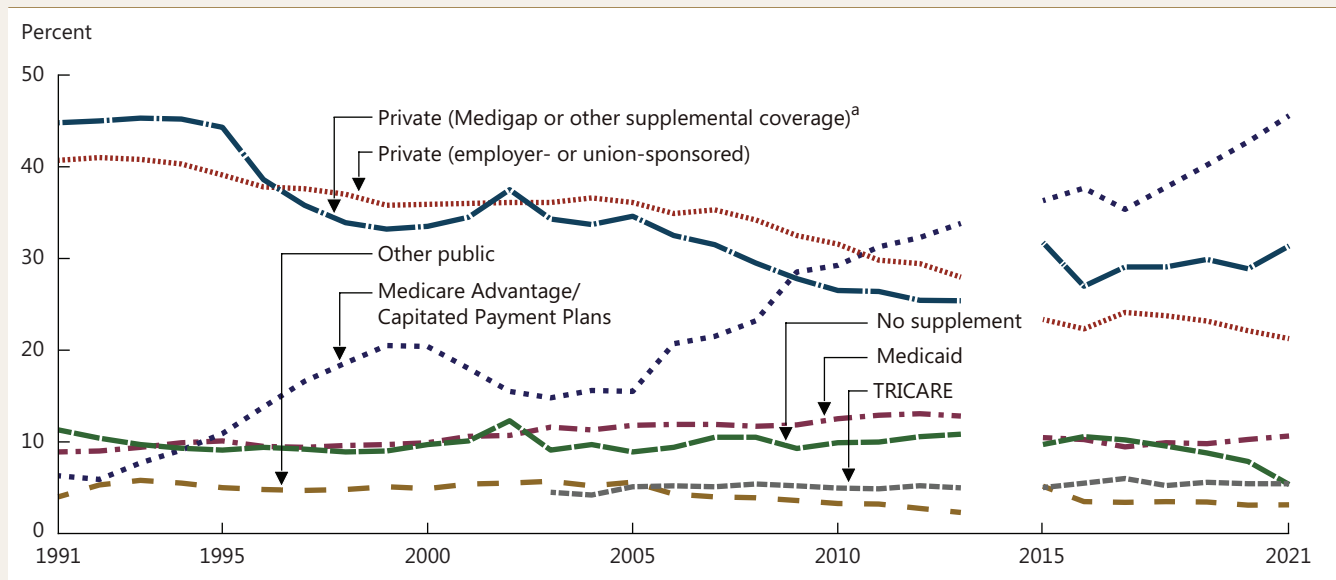
[a] Includes people with private supplement of unknown sponsorship.

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 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. Previous versions of *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.

Reference population: These data refer to noninstitutionalized Medicare beneficiaries.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1991–2013) and Survey File (2015–2021).

- In 2021, 53 percent of Medicare beneficiaries age 65 and over had a private insurance supplement, either provided by a former employer or union or purchased as a supplemental policy.

- In 2021, 46 percent of Medicare beneficiaries age 65 and over were enrolled in Medicare Advantage/Capitated Payment Plans.

- Five percent of Medicare beneficiaries age 65 and over had no health insurance supplement in 2021.

- 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 46 percent in 2021.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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

Large out-of-pocket expenditures for use of health care services have been shown to encumber access to care, affect health status and quality of life, and leave insufficient resources for other necessities.[37,38] 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 2021
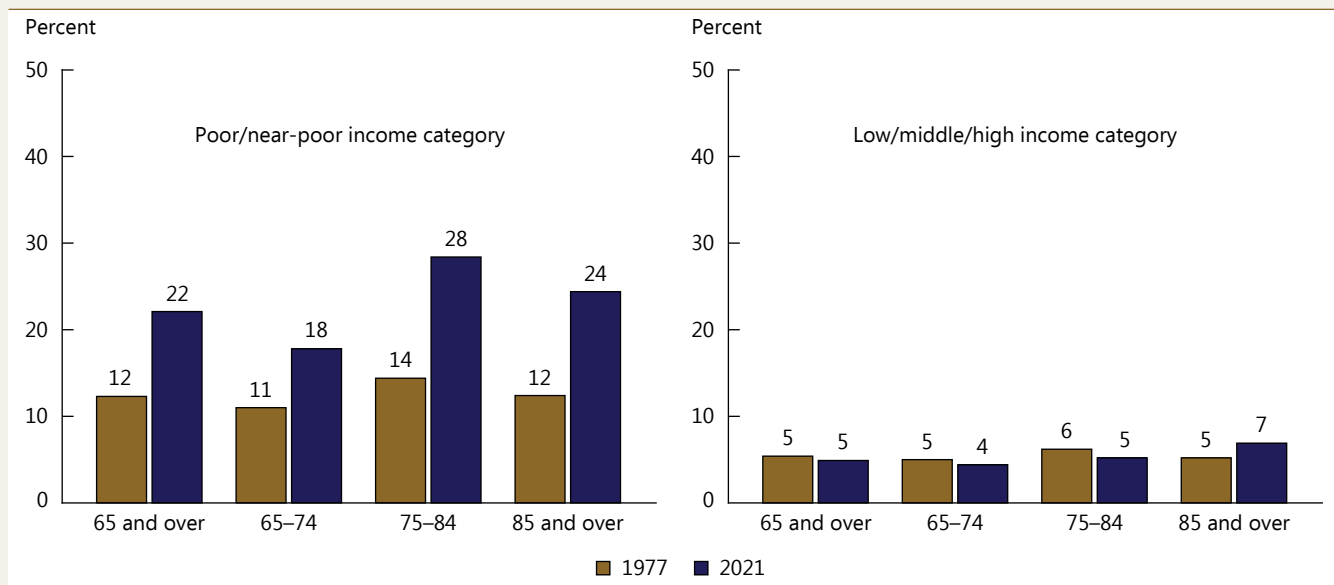
NOTE: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care. People are classified into the "poor/near 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 2021, the average per-person percentage of household income attributable to out-of-pocket spending for health care services for poor/near-poor people age 65 and over was 22 percent. The average percentage for persons age 65 and over in the low/middle/high income category was lower, at 5 percent in 2021.

- In 1977, the average per-person percentage of household income attributable to out-of-pocket spending for health care services for poor/near-poor people 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 people ages 65–74 in 2021 was 18 percent, an increase from 11 percent in 1977. For low/middle/high income people of the same age group, the difference was not significant at 4 percent in 2021 versus 5 percent in 1977.

- For people 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 people in 1977 was 12 percent, increasing to 24 percent in 2021.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on <u>agingstats.gov/reports-and-tables.html</u>.

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

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

Average cost per beneficiary and percentage distribution of sources of payment for health care services for Medicare beneficiaries age 65 and over, by type of service, 2021
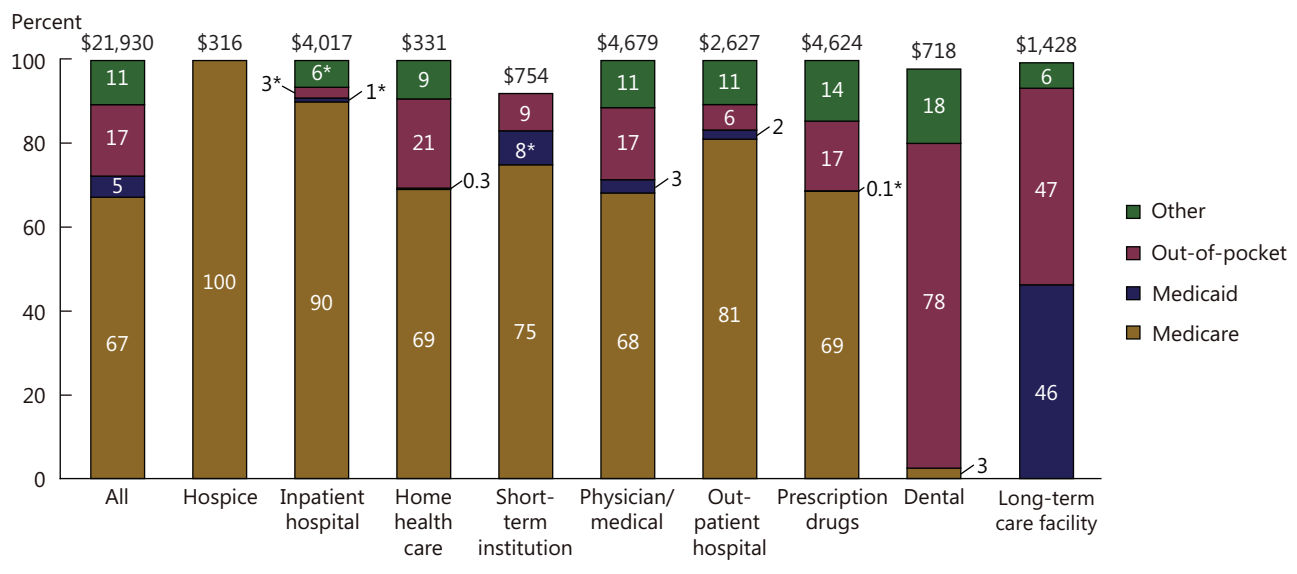
* Estimates are considered unreliable as they have a relative standard error of 20 to 30 percent.

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

Reference population: These data refer to Medicare beneficiaries age 65 and over.

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

- Total health care costs for Medicare beneficiaries averaged $21,930 in 2021. The largest components of this cost were physician/medical services ($4,679), prescription drugs ($4,624), inpatient hospital services ($4,017), outpatient hospital services ($2,627), and long-term care facilities ($1,428).

- Medicare paid for approximately 67 percent of all health care costs of Medicare beneficiaries age 65 and over in 2021. 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 in 2021, and other payers (primarily private insurers) covered another 11 percent. Medicare beneficiaries paid 17 percent of their health care costs out of pocket (not including insurance premiums).

- In 2021, about 46 percent of long-term care facility costs for Medicare beneficiaries age 65 and over were covered by Medicaid; another 47 percent of these costs were paid out of pocket. About 69 percent of prescription drug costs for Medicare beneficiaries were covered by Medicare, 15 percent were covered by third-party payers other than Medicare and Medicaid (consisting mostly of private insurers), and 17 percent were paid out of pocket. About 78 percent of dental care was paid out of pocket.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 35: **Veterans' Health Care**

The number of Veterans age 65 and over who are enrolled in the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), had been steadily increasing since eligibility for health benefits was reformed in 1999. Enrollment started declining in 2020 at the beginning of the COVID-19 pandemic and is expected to continue declining through the projection years as the overall Veteran population declines. However, older Veterans continue to turn to VHA for their health care needs, despite their eligibility for other sources of health care. VHA fills important gaps in older Veterans' health care needs not currently covered or fully covered by Medicare, such as long-term services and supports (nursing home care for eligible Veterans and community-based care for all enrolled Veterans) and specialized services for the disabled, including acute mental health services. In addition, VHA provides access to these important services in rural and highly rural communities.

Number of Veterans age 65 and over who are enrolled in the Veterans Health Administration, by age group, selected years 2007–2022 and projected years 2027–2042
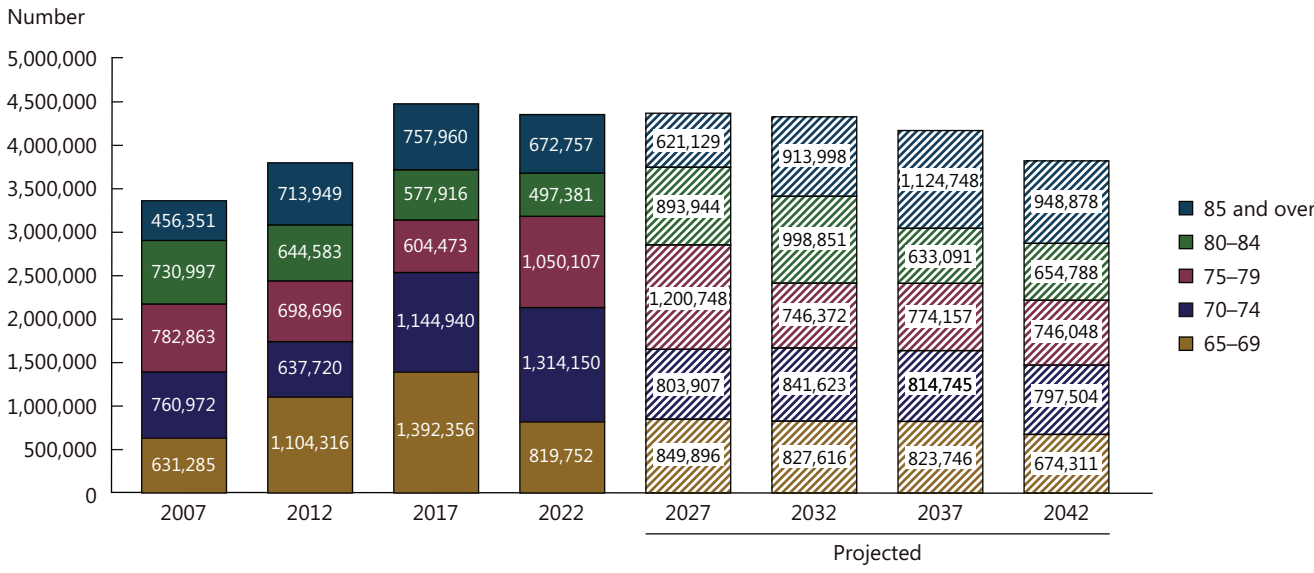
NOTE: Department of Veterans Affairs (VA) enrollees are Veterans who have signed up to receive health care from the Veterans Health Administration (VHA). Counts for 2027, 2032, 2037, and 2042 are projections from the 2023 VA Enrollee Health Care Projection Model.
Reference population: These data refer to the count of unique VHA enrollees per fiscal year.
SOURCE: Department of Veterans Affairs, Chief Strategy Office, 2023 VA Enrollee Health Care Projection Model.

- In 2022, approximately 4.4 million of the 9 million Veterans enrolled with VHA were age 65 and over (48 percent).

- The percentages of older Veterans among the enrollee population are expected to increase as the Vietnam-era enrollee cohort gets older. In 2022, approximately 25 percent of enrollees were age 75 and over; by 2042, approximately 27 percent of enrollees are projected to be age 75 and over.

- In 2022, the largest number of enrollees in the older Veteran cohort (age 65 and over) were in the age group 70–74 (1.31 million). By 2042, those in the age group 85 and over will comprise the largest number of enrollees in the older Veteran cohort (949,000).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 36: **Residential Services**

Most older Americans live independently in traditional communities. Others live in licensed long-term care facilities, and still others live in communities with access to various services through their place of residence. Such services may include meal preparation, laundry and cleaning services, and help with medications. Availability of such services through their 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, 2021

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 if it provides 24-hour, 7-day-a-week supervision by a paid nonfamily caregiver. 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, Survey File.

- In 2021, about 2 percent of Medicare beneficiaries age 65 and over resided in community housing with at least one service available. About 2 percent resided in long-term care facilities, and 96 percent resided in traditional community settings.

- The percentage of Medicare beneficiaries residing in community housing with services and in long-term care facilities was higher for those age 85 and over than for those ages 65–74.

- Among Medicare beneficiaries age 85 and over, 8 percent resided in community housing with services, and 8 percent resided in long-term care facilities. Among those ages 65–74, about 99 percent resided in traditional community settings.

Indicator 36: **Residential Services** (cont.)

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, 2021

Percent

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 if it provides 24-hour, 7-day-a-week supervision by a paid nonfamily caregiver. Long-term care facility residents with no limitations may include individuals with limitations in performing certain IADLs, such as doing light or heavy housework or meal preparation. These questions were not asked of facility residents.

Reference population: These data refer to Medicare beneficiaries.

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

- In 2021, among Medicare beneficiaries age 65 and over, 37 percent reported at least one limitation with an activity of daily living (ADL) or an instrumental activity of daily living (IADL), regardless of setting.

- In 2021, Medicare beneficiaries age 75 and over living in community housing with services had more limitations in performing ADLs and IADLs than traditional community residents but not as many limitations as those living in long-term care facilities. About 45 percent of those living in community housing with services had at least one ADL limitation, compared with 23 percent of traditional

community residents and 78 percent of long-term care facility residents.

- Approximately 65 percent of Medicare beneficiaries age 65 and over living in traditional communities had no ADL or IADL limitations, compared with 39 percent of those living in community housing with services and 7 percent of those living in long-term care facilities.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 37: **Personal Assistance and Equipment**

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

Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who have limitations in performing instrumental activities of daily living (IADLs) and who receive personal assistance, selected years 1992–2021
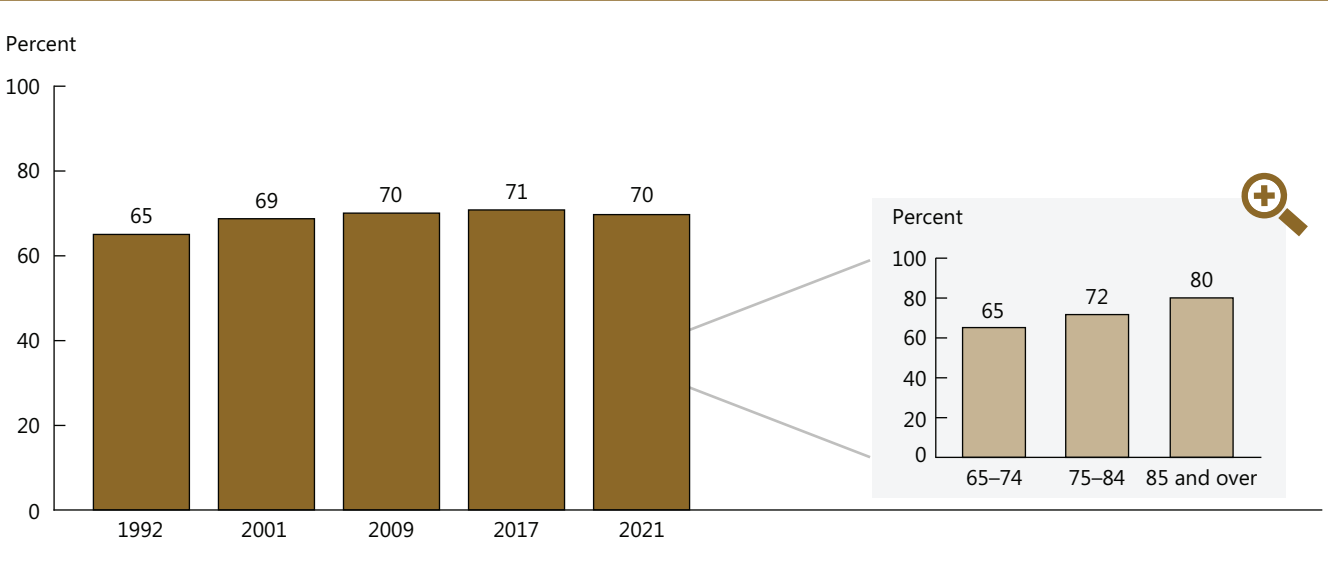
NOTE: Limitations in performing instrumental activities of daily living (IADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: using the telephone, light housework, heavy housework, meal preparation, shopping, or managing money.

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 (2015–2021).

- In each data year from 2001 to 2021, slightly more than two-thirds of noninstitutionalized Medicare beneficiaries age 65 and over who had difficulty with one or more instrumental activities of daily living (IADLs) received personal assistance.

- In 2021, noninstitutionalized Medicare beneficiaries age 85 and over were more likely to receive assistance with IADLs than were those ages 65–74 and ages 75–84.

- Among noninstitutionalized Medicare beneficiaries age 85 and over, men were less likely than women to receive personal assistance with their IADL in 2021.

Indicator 37: **Personal Assistance and Equipment** (cont.)

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 1992–2021

NOTE: Limitations in performing activities of daily living (ADLs) refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. 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.
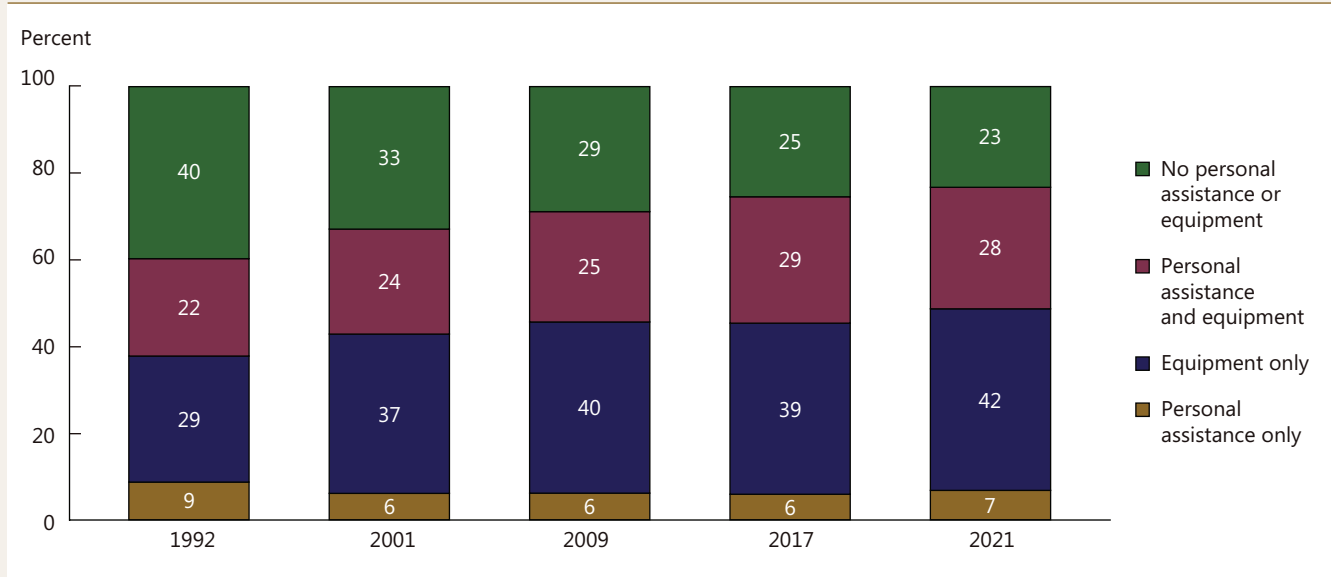
Reference population: These data refer to noninstitutionalized Medicare beneficiaries who have limitations in performing one or more ADLs and are continuously enrolled during the year.

SOURCE: Centers for Medicare & Medicaid Services, Medicare Current Beneficiary Survey, Access to Care (1992–2013) and Survey File (2015–2021).

- In 2021, about three-quarters of noninstitutionalized Medicare beneficiaries who had difficulty with one or more activities of daily living (ADLs) received personal assistance or used special equipment: 7 percent received personal assistance only, 42 percent used equipment only, and 28 percent used both personal assistance and equipment.

- Between 1992 and 2021, the proportion of noninstitutionalized Medicare beneficiaries 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 23 percent. During the same period, the percentage of those using equipment only increased from 29 percent to 42 percent, while the percentage of those using personal assistance only decreased from 9 percent to 7 percent.

- In 2021, among noninstitutionalized Medicare beneficiaries age 65 and over, men were more likely than women to have received no assistance with their limitations (29 percent versus 20 percent). Women were more likely than men to have received personal assistance and used equipment (31 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 2021, 9 percent of noninstitutionalized Medicare beneficiaries age 85 and over with limitations in performing ADLs did not receive assistance or use equipment, compared with 30 percent of those ages 65–74. In addition, those age 85 and over were more likely than those in the younger age groups to receive both personal assistance and use equipment.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

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

Long-term care is a range of services and supports to meet health or personal care needs of older adults and other people who are limited in their abilities for self-care because of chronic illness, injury, disability, or other health-related conditions. Post-acute care provides rehabilitative or palliative services to patients just after or instead of a stay in an acute care setting. Care can be provided in the home or in a variety of other settings. Services include those that are related to health-care and those that are not; they include assistance with activities of daily living (ADLs), assistance with instrumental activities of daily living (IADLs), and health maintenance tasks.[39,40]

Number of users of post-acute and long-term care services, by setting and age group, 2020 and 2022
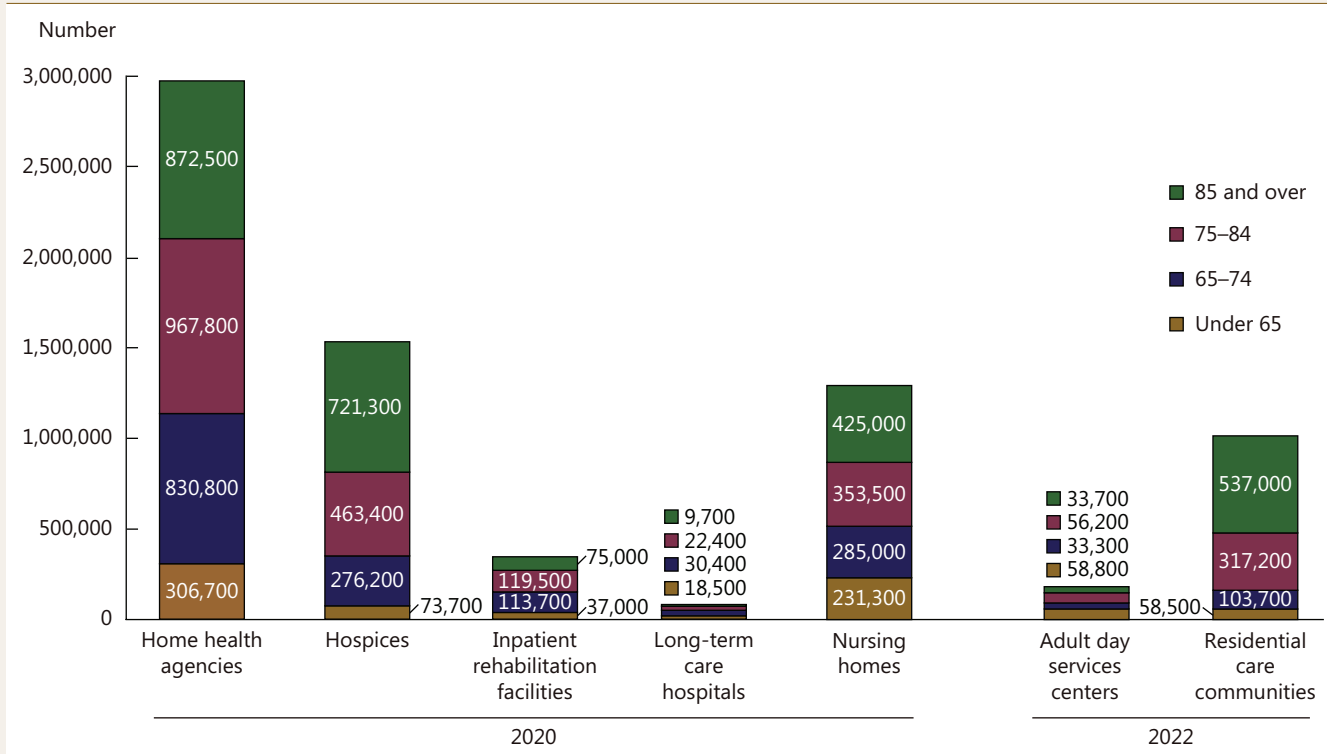
NOTE: The postacute and long-term care services described here are provided by paid, regulated providers. They comprise both services that are related to health care and those that are not. People can receive more than one type of service. Data on inpatient rehabilitation facilities and long-term care hospitals that exclusively provide postacute care have been added to the settings shown in *Older Americans 2020*. For adult day services centers, the estimated number of users is based on the total number of enrolled participants in 2022; for residential care communities in 2022 and nursing homes in 2020, the number of users is based on the current number of residents on any given day. For home health agencies, hospices, inpatient rehabilitation facilities, and long-term care hospitals, the number of users is based on the total number who received care at any time in 2020. 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/npals/webtables/overview.htm for more information.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Postacute and Long-Term Care Study.

- Almost 3 million people received care from a home health agency in 2020. People ages 75–84 made up the largest share by age group.

- In 2020, 1.5 million people received hospice care. Close to 50 percent of hospice patients were age 85 and over.

- Two settings offering only post-acute care served slightly less than half a million people in 2020; people 65 and over made up 89 percent of users of inpatient rehabilitation facilities and 77 percent of users of long-term care hospitals.

- In 2020, nearly 1.3 million people were residents of nursing homes, including about 1.1 million people age 65 and over. People age 85 and over made up the largest share by age group among residents.

- In 2022, about 182,000 participants received care in adult day services centers. Participants age 65 and over made up about two-thirds of all people using these services.

- In 2022, just over one million people lived in residential care communities such as assisted living facilities. Ninety-four percent of residents were age 65 and over, and more than half of residents were age 85 and over.

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Indicator 38: **Long-Term Care Providers** (cont.)

Percentage of users of post-acute and long-term care services needing assistance with activities of daily living (ADLs), by setting and activity, 2020
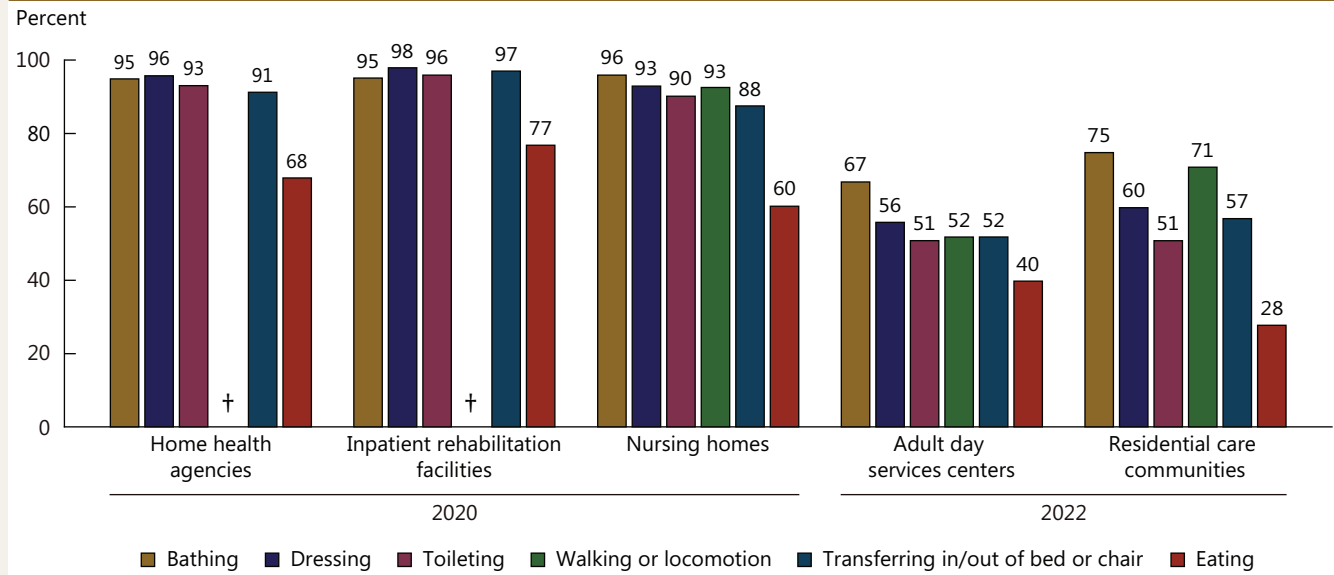
† Data not available.

NOTE: The post-acute and long-term care services described here are provided by paid, regulated providers. People can receive more than one type of service. Users of post-acute and long-term care services include persons of all ages. In 2020, 90 percent of home health patients, 89 percent of inpatient rehabilitation facility patients, and 82 percent of residents of nursing homes were age 65 and over. In 2022, 68 percent of participants of adult day services centers and 94 percent of residents of residential care communities were age 65 and over. Data were not available for hospice patients and patients in long-term care hospitals. Users 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/npals/2020-NPALS-Variable-Crosswalk-508.pdf for definitions.

Reference population: These data refer to the resident population.

SOURCE: National Center for Health Statistics, National Post-acute and Long-term Care Study.

- The majority of home health care patients in 2020 needed assistance with ADLs. Nearly all needed assistance with bathing (95 percent), dressing (96 percent), and toileting (93 percent); 91 percent needed assistance transferring from a bed or chair and 68 percent needed assistance with eating.

- Most people in inpatient rehabilitation facilities needed assistance with ADLs. Ninety-five percent or more needed assistance with bathing, dressing, toileting, and transferring, and 77 percent needed assistance with eating.

- In 2020, most residents of nursing homes needed assistance with activities of daily living (ADLs). Nearly all (97 percent) needed assistance with bathing, and almost as many needed assistance with dressing, toileting, and walking (93 percent, 90 percent, and 93 percent, respectively).

- In 2022, 51 percent of participants in adult day services centers needed assistance with toileting and 40 percent needed assistance with eating.

- In 2022, 75 percent of residents of residential care communities needed assistance with bathing. About 71 percent needed assistance with walking, and 60 percent needed assistance with dressing. Fifty-one percent needed assistance with toileting, but only 28 percent needed assistance with eating.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Environment

Indicator 39: **Use of Time**

How individuals spend their time reflects their financial, health, and personal situations; employment status; needs; and desires. Time-use data show that as Americans get older, they spend more of their time in leisure activities. As people age, they are less likely to be employed. In 2022, a majority (64 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.[41] 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, 2022
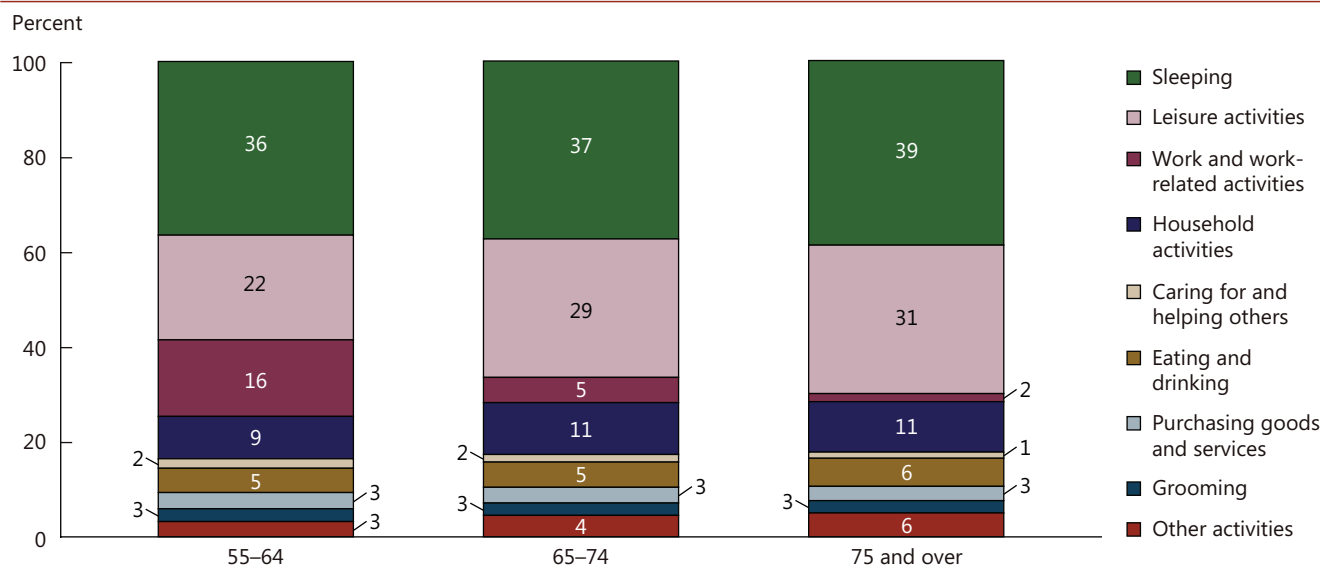
NOTE: "Other activities" includes activities such as educational activities; organizational, civic, and religious activities; and telephone calls. Chart includes people who did not work at all.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, American Time Use Survey.

- On an average day, people ages 55–64 spent 16 percent of their time (3 hours and 52 minutes) working or doing work-related activities compared with 5 percent (about 1 hour and 16 minutes) for people ages 65–74 and 2 percent (about 25 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 31 percent of their time in leisure activities compared with 22 percent for those ages 55–64.

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Indicator 39: **Use of Time** (cont.)

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, 2022
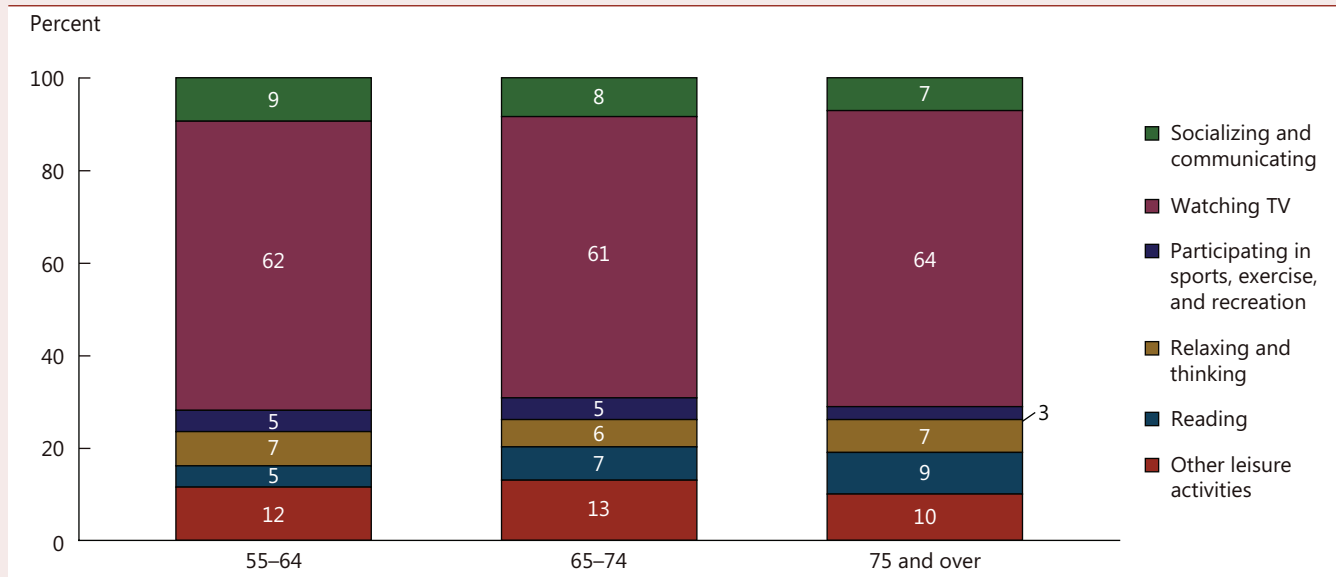
NOTE: "Other leisure activities" includes activities such as playing games, using the computer for leisure, doing arts and crafts as a hobby, experiencing arts and entertainment (other than sports), and engaging in related travel.
Reference population: These data refer to the civilian noninstitutionalized population.
SOURCE: Bureau of Labor Statistics, American Time Use Survey.

- In 2022, on an average day, people 55 and over spent more than half of their leisure time watching TV.

- Americans age 75 and over spent a higher percentage of their leisure time reading than did Americans ages 55–64 (9 percent versus 5 percent). Americans age 75 and over spent 40 minutes per day reading compared with 14 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 9 percent of leisure time was spent socializing and communicating compared with 7 percent for those age 75 and over.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

# Indicator 40: **Air Quality**

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

Counties with instances of "poor air quality" for any standard, 2022
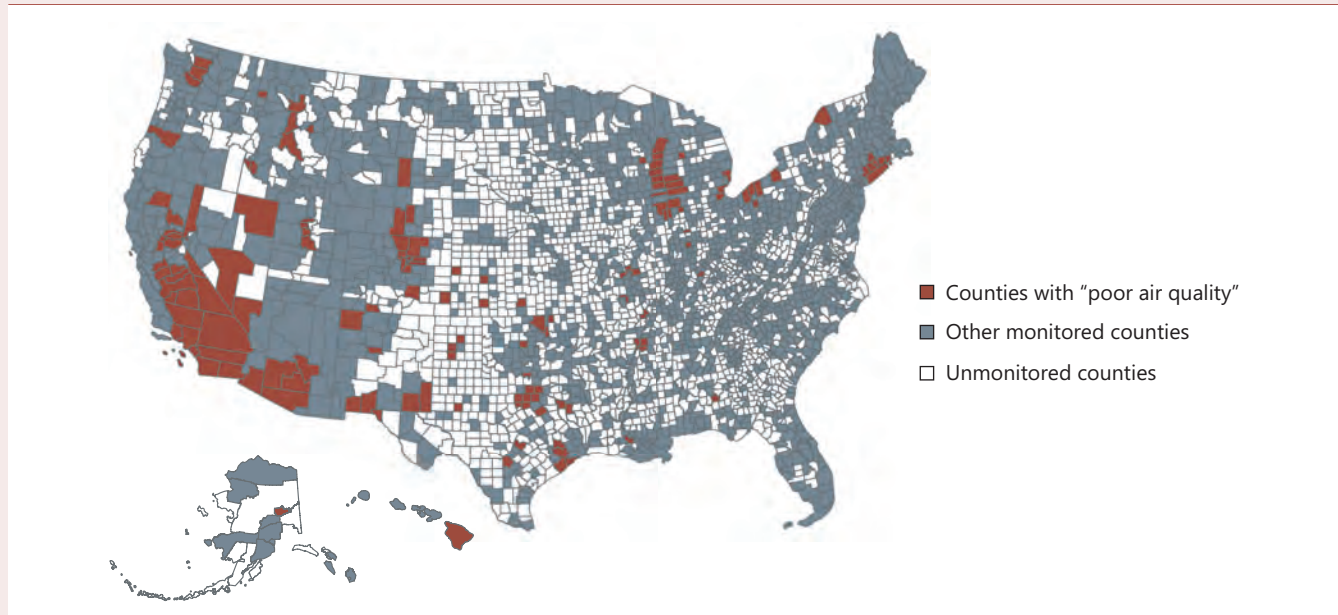
Legend:
- ■ Counties with "poor air quality"
- ■ Other monitored counties
- □ Unmonitored counties

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 2022, 85 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 11 percent, or roughly 9.5 million people, of those living in counties where monitored air quality was unhealthy at times were age 65 and over. The vast majority of areas that experienced unhealthy air did so because of one or both of two pollutants—ozone and $PM_{2.5}$.

Indicator 40: **Air Quality** (cont.)

Ozone and particulate matter (PM), especially the smaller, fine particle pollution called $PM_{2.5}$, have the greatest potential to affect the health of older adults. Fine particle pollution has been linked to premature death, cardiac arrhythmias and heart attacks, asthma attacks, and the development of chronic bronchitis. Ozone, even at low levels, can exacerbate respiratory diseases such as chronic obstructive pulmonary disease or asthma.[42, 43, 44, 45, 46]

Percentage of people age 65 and over living in counties with instances of "poor air quality," by selected pollutant measures, 2000–2022
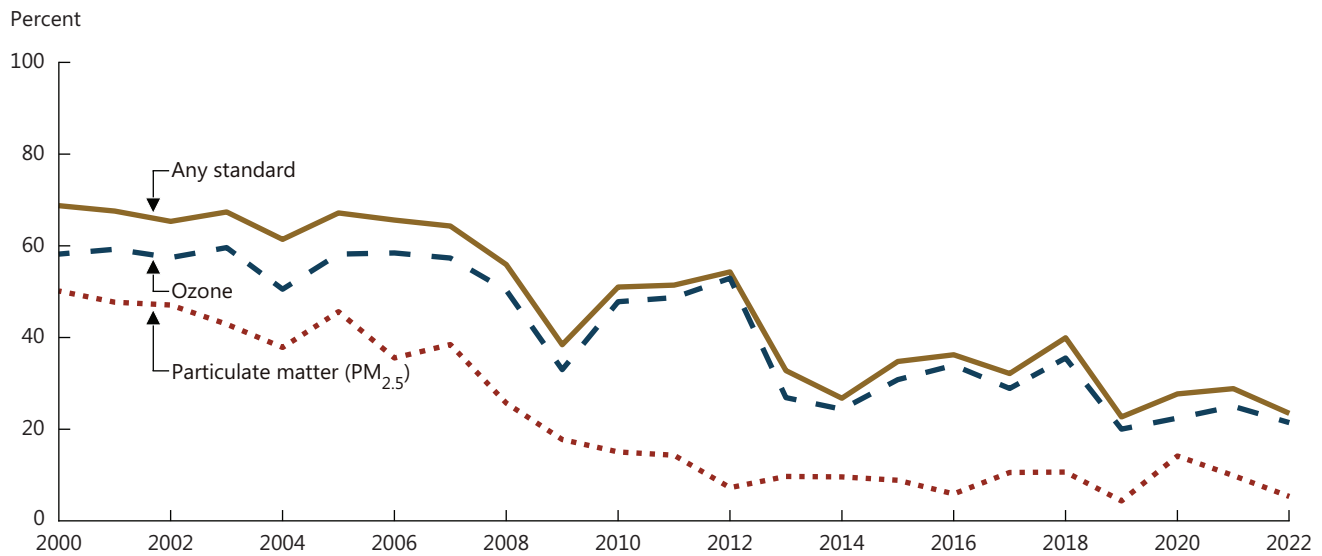
NOTE: The term "poor air quality" is defined as air quality concentrations above the level of the National Ambient Air Quality Standards (NAAQS). The term "any standard" refers to any NAAQS for ozone, particulate matter, nitrogen dioxide, sulfur dioxide, carbon monoxide, or lead. Data for previous years have been computed using the standards in effect as of December 2023 to enable comparisons over time. This results in percentages that are not comparable with 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 2022, 23 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 23 percent in 2022. Twenty-one percent of people age 65 and over lived in counties with poor air quality for ozone in 2022, compared with 58 percent in 2000.

- A comparison of 2000 and 2022 showed a reduction in $PM_{2.5}$ pollution. In 2000, 50 percent of people age 65 and over lived in a county where $PM_{2.5}$ concentrations were at times above the EPA standard, compared with 5 percent in 2022.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Indicator 41: **Transportation**

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

Percentage of noninstitutionalized Medicare beneficiaries age 65 and over who made a change in transportation mode due to a health or physical problem, by type of change and age group, 2021
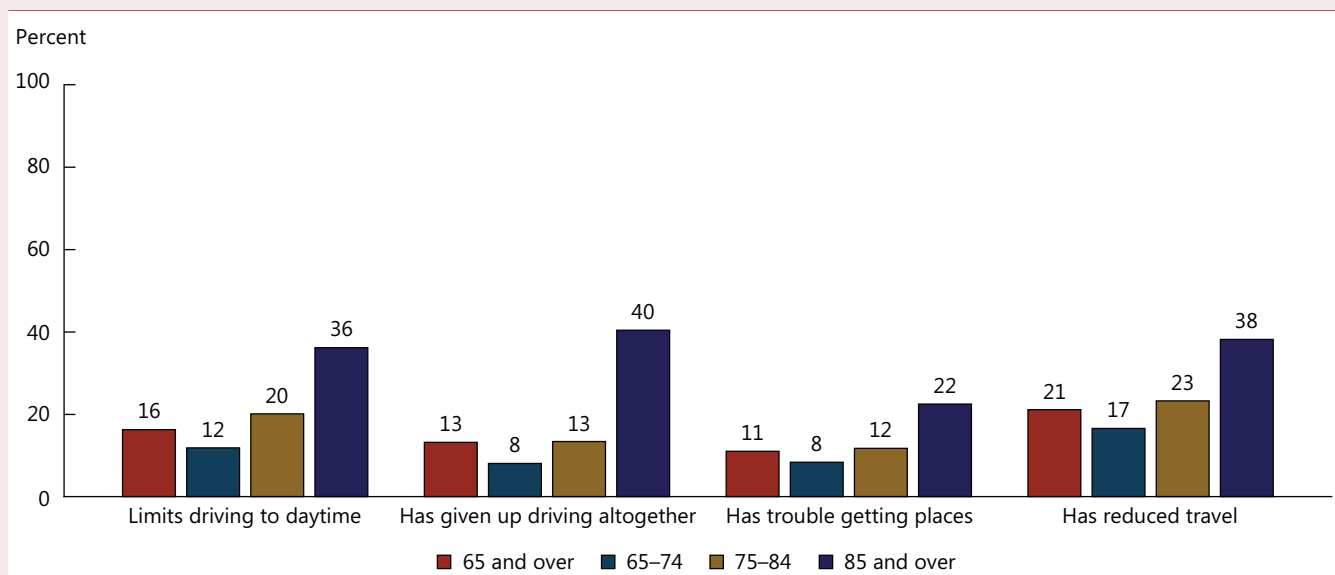
Percent

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 2021, 16 percent of noninstitutionalized Medicare beneficiaries 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 (36 percent) than for those ages 65–74 (12 percent).

- Furthermore, 13 percent of noninstitutionalized Medicare beneficiaries age 65 and over had given up driving altogether, about 11 percent had trouble getting places, and 21 percent had reduced their travel because of a health or physical problem.

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.

Special Feature

Telehealth

Telehealth, also known as telemedicine, allows patients to receive health care from a provider without an in-person visit. Telehealth visits can be conducted by telephone or, more commonly, online by video chat through a computer, tablet, or smartphone. Telehealth has many benefits, such as increasing healthcare access for people with health, mobility, or transportation challenges, as well as limiting exposure to disease. Telehealth is a particularly important means of providing health care to people with behavioral health conditions because of a shortage of licensed behavioral health providers. However, it is not appropriate for every patient or condition.[47] Older adults may have barriers to accessing telehealth due to certain health conditions or to inexperience or discomfort with the necessary technology.[47] At the beginning of the COVID-19 pandemic, changes to Medicare expanded telehealth access, and some of these changes continued past the end of the public health emergency that concluded on May 11, 2023.[48] Levels of telehealth are lower than the peak in 2020 but have remained higher than before the pandemic.[49]

This special feature uses three data sources to describe the use of telehealth among older adults: visit-based data from fee-for-service Medicare claims; person-level data from the National Health Interview Survey; and visit-based data from the Medical Expenditure Panel Survey.

Percent of Medicare Part B total visits that were telehealth by age group among fee-for-service Medicare beneficiaries, 2019–2022
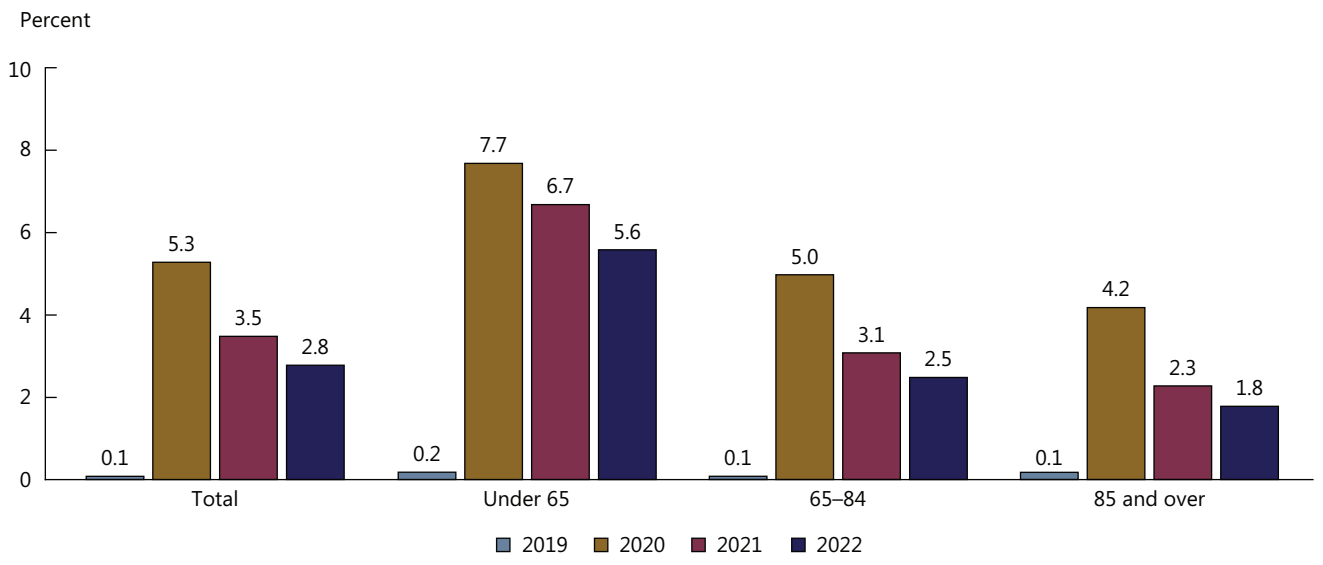
Reference population: Persons eligible for Medicare because of disability or age and enrolled in the program.
SOURCE: Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, Medicare fee-for-service claims, 2019–2022.

- In 2022, 2.8 percent of all Medicare Part B fee-for-service visits were telehealth, which reflects a decrease from the percentage in 2020 (5.3 percent).

- A similar pattern of decline in telehealth visits was observed across Medicare Part B beneficiaries of different ages, although the decrease at younger ages was smallest. Those under age 65 (who are eligible for Medicare because of disability) accounted for roughly one-quarter of all telehealth visits from 2020 to 2022.

- Among those ages 65–84, the percentage of all Medicare Part B fee-for-service visits that were telehealth decreased from 5.0 percent in 2020 to 2.5 percent in 2022. The corresponding percentages for those age 85 and over were 4.2 percent and 1.8 percent.

Telehealth (cont.)

Map of Medicare fee-for-service Part B telehealth visits, percent of total visits, 2022

Percentage by state
- ■ 4 or greater
- ■ 3.00 to 3.99
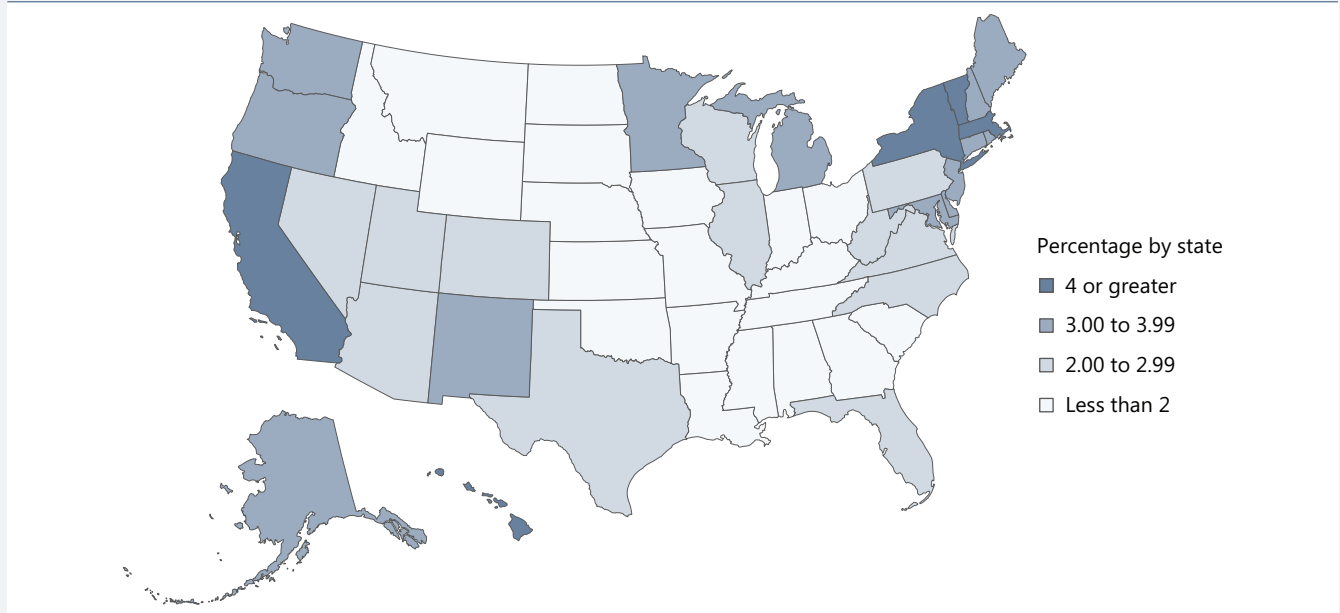- ■ 2.00 to 2.99
- □ Less than 2

Reference population: Persons eligible for Medicare because of disability or age and enrolled in the program.
SOURCE: Office of the Assistant Secretary for Planning and Evaluation, Office of Health Policy, Medicare fee-for-service Claims 2019–2022.

- The percentage of Medicare Part B fee-for-service visits that were telehealth in 2022 varied by region and state.

- The northeastern, upper mid-west, west coast, and southwestern regions of the United States had the largest percentage of Medicare Part B fee-for-service visits at the state-level that were telehealth in 2022. Massachusetts (5.6 percent), California (5.1 percent), and Vermont (5.1 percent) were the states with the largest percentages.

- The Great Plains region, southern, and southeastern U.S. were the geographic areas with the smallest percentage of Medicare Part B fee-for-service visits visits at the state-level that were telehealth in 2022. Mississippi (1.1 percent), Alabama (1.2 percent), and Louisiana (1.3 percent) were the states with the smallest percentages.

Telehealth (cont.)

The National Health Interview Survey provides information on the characteristics of noninstitutionalized people age 65 and over who used telehealth in the past 12 months.

Percentage of adults age 65 and over who had a telehealth visit during the past 12 months by age group, sex, race, and Hispanic origin, and disability status, 2022

Selected characteristic

Age group
- 65 and over: 31
- 65–74: 32
- 75–84: 30
- 85 and over: 26

Sex
- Men: 32
- Women: 30

Race/ethnicity
- Asian, NH: 33
- Black, NH: 28
- White, NH: 30
- Hispanic: 34

Disability
- Without disabilities: 29
- With disabilities: 38

Percent
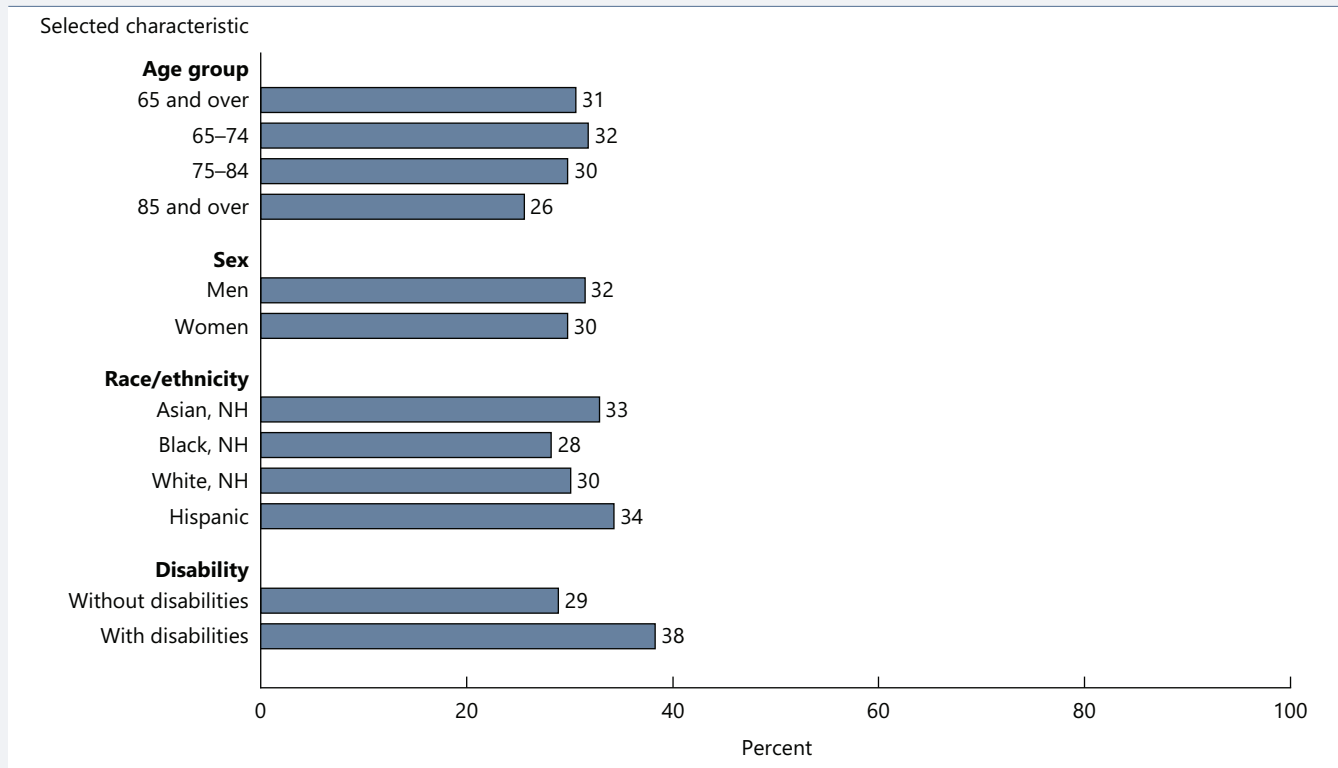
NH = Non-Hispanic.

NOTE: A telehealth visit is defined as an appointment with a doctor, nurse, or other health professional by video or phone. Total includes all races and ethnicities, including those not shown separately. See data source for the definition of race and Hispanic origin in the National Interview Survey. The definition of disability is found in Indicator 22.

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

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

- In 2022, 31 percent of adults age 65 and over had a telehealth visit in the past 12 months. The percentage with a telehealth visit declined with age, from 32 percent for those ages 65–74 to 26 percent for those age 85 and over.

- Similar percentages of men and women age 65 and over had a telehealth visit in the past 12 months in 2022 (32 percent and 30 percent, respectively).

- Black, non-Hispanic adults age 65 and over were less likely to have had a telehealth visit in the past 12 months (28 percent) than were Hispanic older adults (34 percent).

- The percentage of adults age 65 and over who had a telehealth visit in the past 12 months was higher for those with disabilities (38 percent) than those without disabilities (29 percent).

Telehealth (cont.)

Percentage of adults age 65 and over who had a telehealth visit during the past 12 months by urbanization level, region, education, and family income, 2022

Selected characteristic

Urbanization
- Large central metro: 37
- Large fringe metro: 32
- Medium and small metro: 29
- Nonmetropolitan: 21

Region
- West: 40
- South: 27
- Midwest: 25
- Northeast: 32

Education
- Less than high school: 22
- High school graduate or GED: 25
- Some college: 33
- College graduate: 37

Family income as % of FPL
- FPL >400%: 33
- FPL 200%–<400%: 30
- FPL 100%–<200%: 28
- FPL <100%: 26

Percent (x-axis: 0, 20, 40, 60, 80, 100)

NOTE: A telehealth visit is defined as an appointment with a doctor, nurse, or other health professional by video or phone. See data sources for definition of urbanization and federal poverty level (FPL) in the National Health Interview Survey.
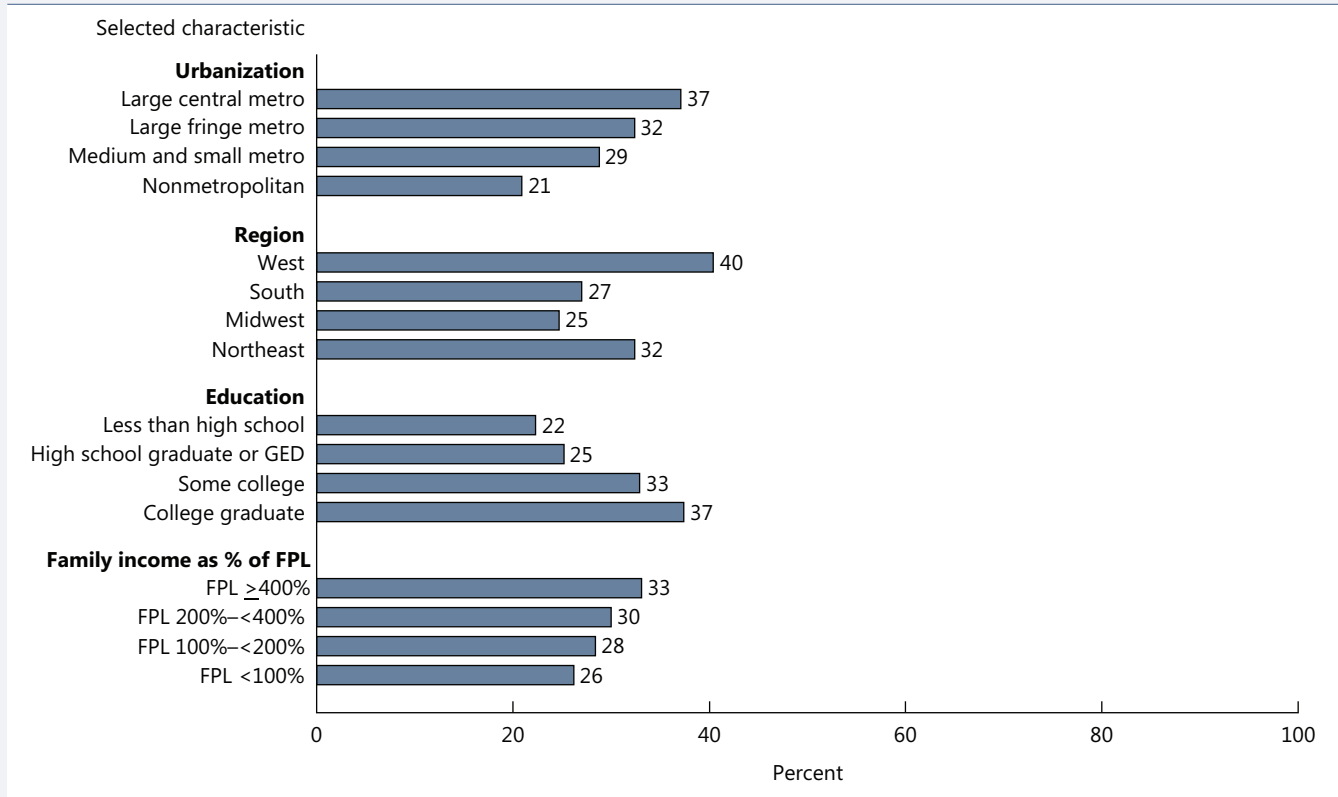
Reference population: These data refer to the civilian noninstitutionalized population.

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

- The percentage of adults age 65 and over in 2022 who had a telehealth visit in the past 12 months increased with urbanization level. Thirty-seven percent of those living in large central metropolitan areas had a telehealth visit, compared with 21 percent of those in nonmetropolitan (rural) areas.

- In 2022, adults age 65 and over living in the West were more likely than those in other regions to have had a telehealth visit in the past 12 months: 40 percent in the West compared with 27 percent in the South, 25 percent in the Midwest, and 32 percent in the Northeast.

- The percentage of adults age 65 and over who had a telehealth visit in the past 12 months rose with increasing education level. Thirty-seven percent of adults age 65 and over who were college graduates had a telehealth visit, compared with 25 percent of those who graduated from high school only or had a GED.

- The percentage of adults age 65 and over who had a telehealth visit in the past 12 months rose with increasing family income. Those with family income less than 400 percent of the federal poverty level (FPL) were less likely than those at or above 400 percent FPL (33 percent) to have had a telehealth visit.

Telehealth (cont.)

The Medical Expenditure Panel Survey provides information on the characteristics of the noninstitutionalized population of the United States. The following figures show data for adults age 18 and over who had at least one telehealth visit in 2022.

Average annual number of telehealth visits for those with a telehealth visit, by age group, 2022
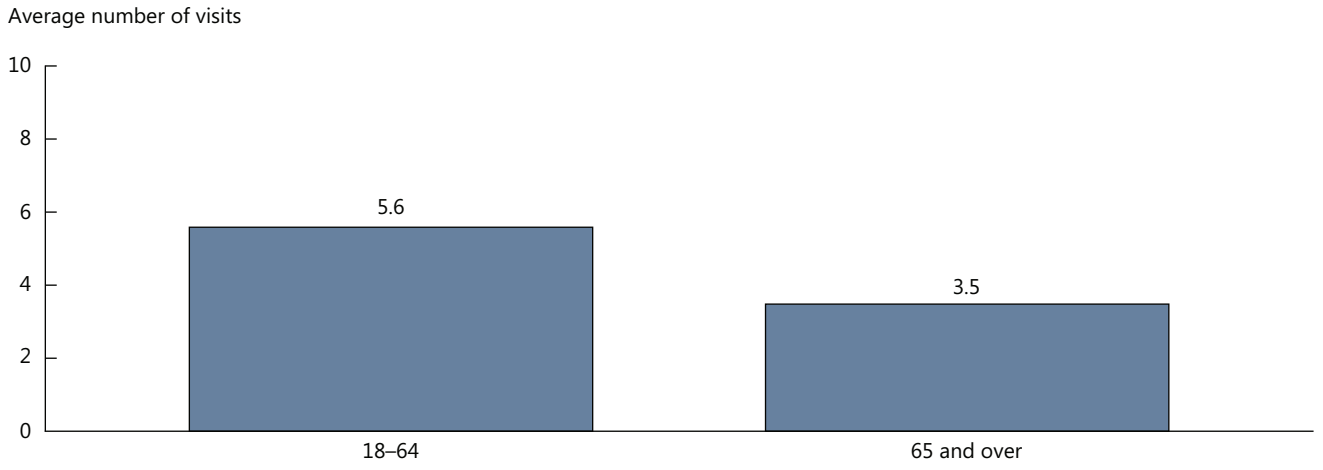
Average number of visits

Reference population: These data refer to the civilian noninstitutionalized population who had at least one telehealth visit.
SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

- Among adults age 18 and over who had at least one telehealth visit in 2022, the average number of visits was 3.5 for those age 65 and over and 5.6 for those ages 18–64.

Average expenditure per telehealth event by mode and age group for those with telehealth expenditures, 2022
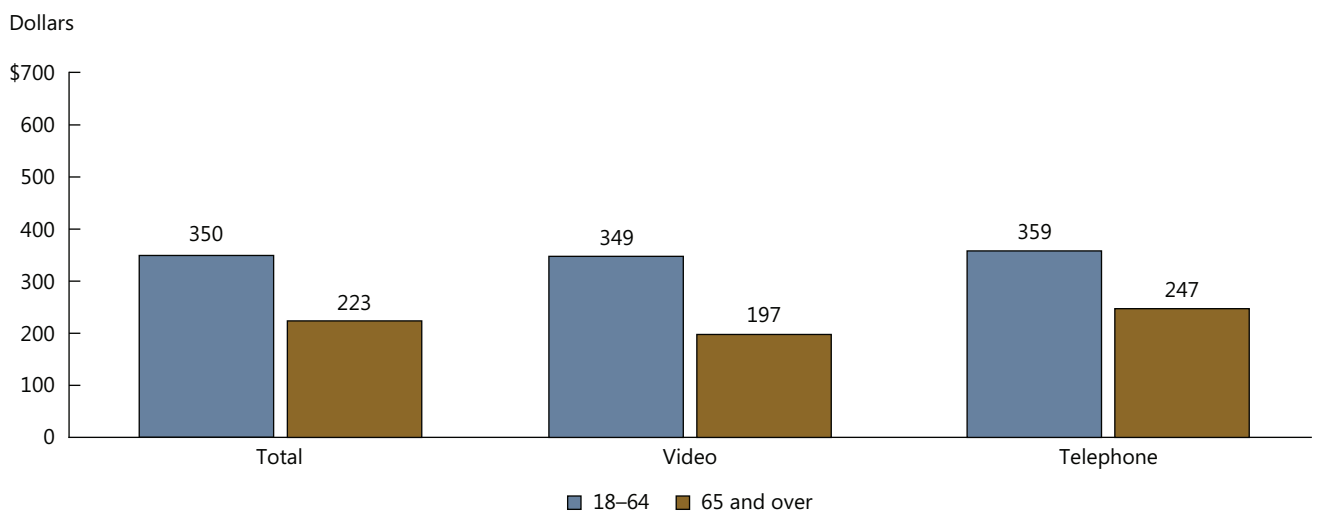
Dollars

Reference population: These data refer to the civilian noninstitutionalized population who had at least one telehealth visit.
SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

- Among adults age 18 and over who had a telehealth expenditure, the average expenditure per telehealth visit was $223 for those age 65 and over and $350 for those ages 18–64.

- The average expenditure for a video visit was $197 and the average expenditure for a telephone visit was $247 for people age 65 and over in 2022.

Telehealth (cont.)

Weighted percentage of telehealth visits with a doctor, by specialty and age group, 2022

Specialty

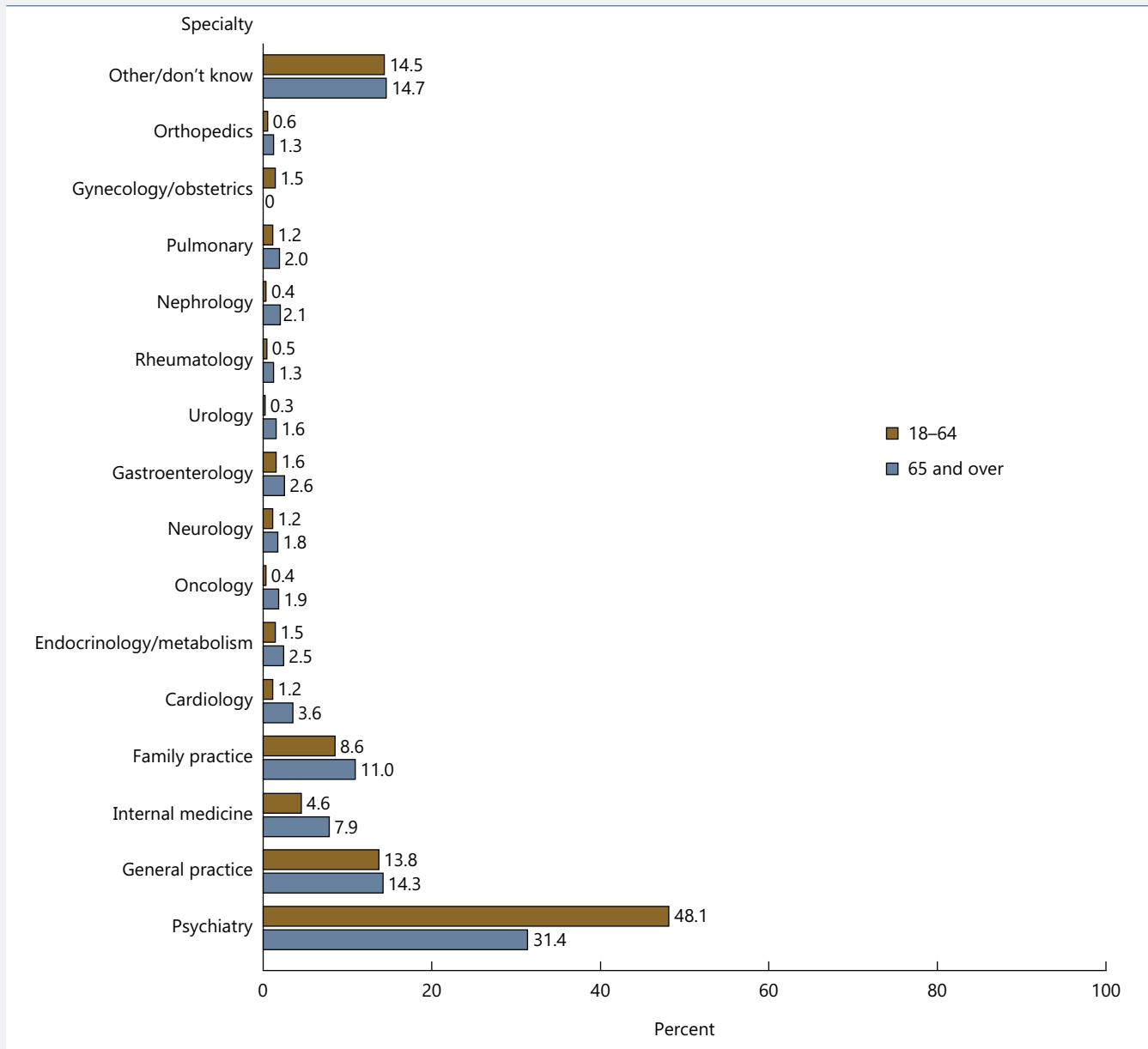| Specialty	18–64	65 and over
Other/don't know	14.5	14.7
Orthopedics	0.6	1.3
Gynecology/obstetrics	1.5	0
Pulmonary	1.2	2.0
Nephrology	0.4	2.1
Rheumatology	0.5	1.3
Urology	0.3	1.6
Gastroenterology	1.6	2.6
Neurology	1.2	1.8
Oncology	0.4	1.9
Endocrinology/metabolism	1.5	2.5
Cardiology	1.2	3.6
Family practice	8.6	11.0
Internal medicine	4.6	7.9
General practice	13.8	14.3
Psychiatry	48.1	31.4

Percent

Reference population: These data refer to the civilian noninstitutionalized population who had at least one telehealth visit..
SOURCE: Agency for Healthcare Research and Quality, Medical Expenditure Panel Survey.

- In 2022, for those age 65 and over, telehealth visits in the following specialties made up the highest percentages of all telehealth visits with a doctor: psychiatry (31.4 percent), general practice (14.3 percent), family practice (11.0 percent), internal medicine (7.9 percent), cardiology (3.6 percent), gastroenterology (2.6 percent) endocrinology/metabolism (2.5 percent), nephrology (2.1 percent), and pulmonary (2.0 percent).

- In 2022, for those ages 18–64 , telehealth visits in the following specialties made up the highest percentages of all telehealth visits with a doctor: psychiatry (48.1 percent), general practice (13.8 percent), family practice (8.6 percent), and internal medicine (4.6 percent).

Telehealth (cont.)

Weighted percentage of telehealth visits with a nondoctor, by specialty and age group, 2022

Specialty

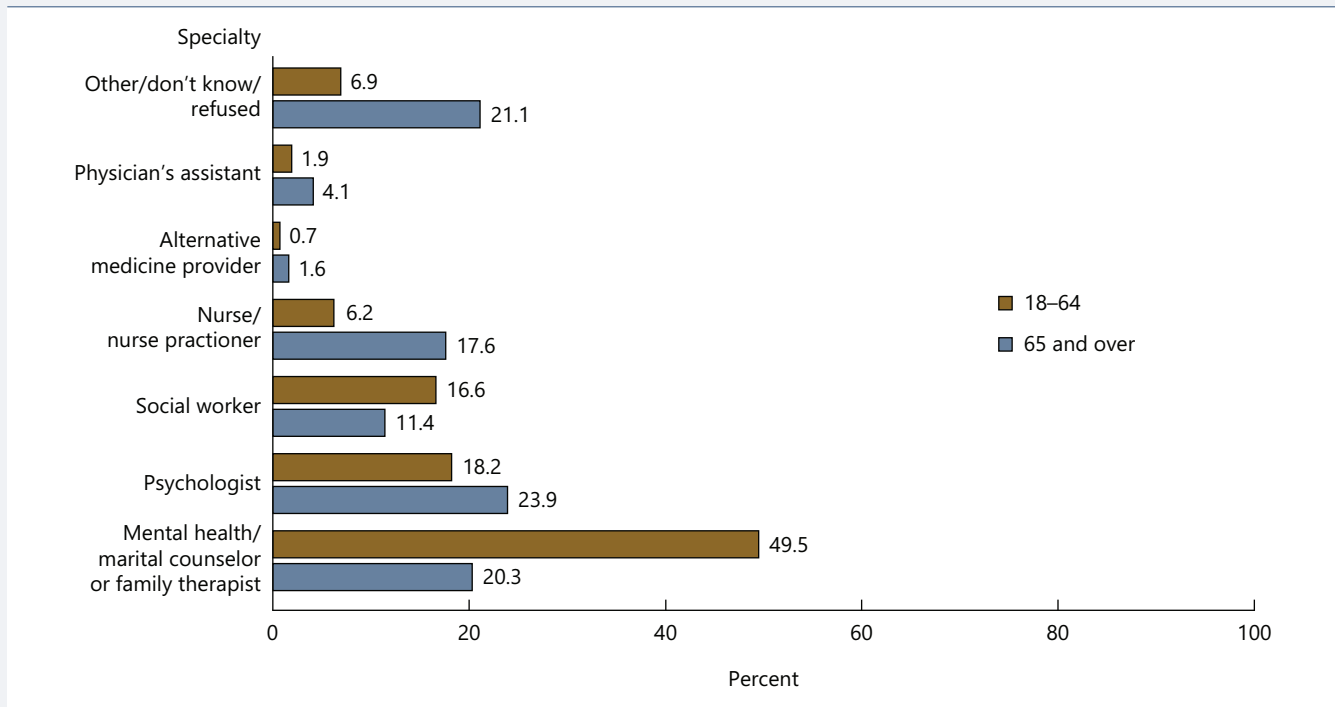| Specialty	18–64	65 and over
Other/don't know/refused	6.9	21.1
Physician's assistant	1.9	4.1
Alternative medicine provider	0.7	1.6
Nurse/nurse practioner	6.2	17.6
Social worker	16.6	11.4
Psychologist	18.2	23.9
Mental health/marital counselor or family therapist	49.5	20.3

Percent

Reference population: These data refer to the civilian noninstitutionalized population who had at least one telehealth visit.

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

- In 2022, for those age 65 and over, telehealth visits in the following specialties made up the highest percentages of all telehealth visits with a nondoctor: psychologist (23.9 percent), mental health/marital counselor/family therapist (20.3 percent), nurse/nurse practitioner (17.6 percent), and social worker (11.4 percent).

- In 2022, for those ages 18–64, telehealth visits in the following specialties made up the highest percentages of all telehealth visits with a nondoctor: mental health/marital counselor/family therapist (49.5 percent), psychologist (18.2 percent), and social worker (16.6 percent).

References begin on page 74. Bullets contain references to data that can be found in detailed tables on agingstats.gov/reports-and-tables.html.
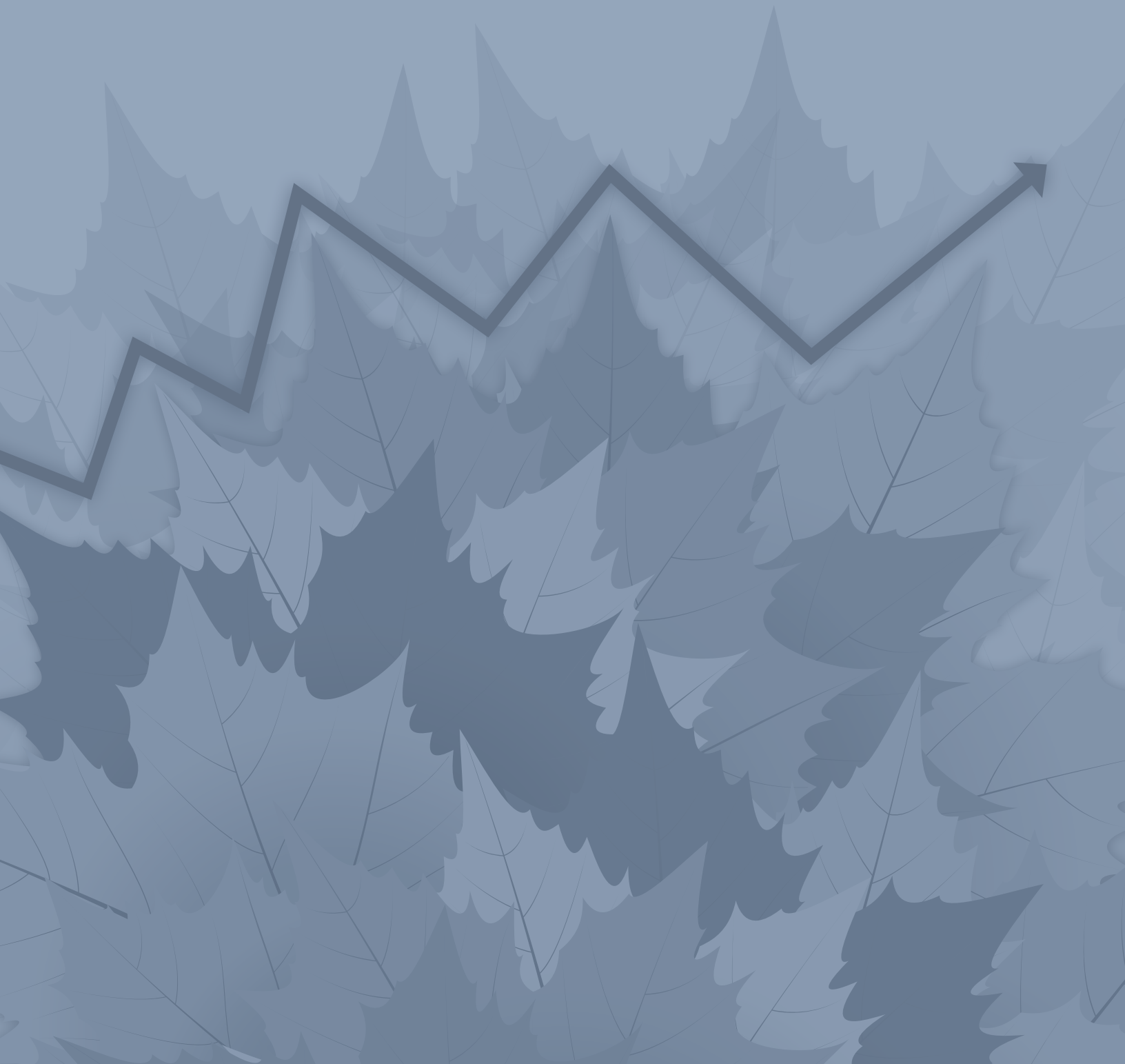
References

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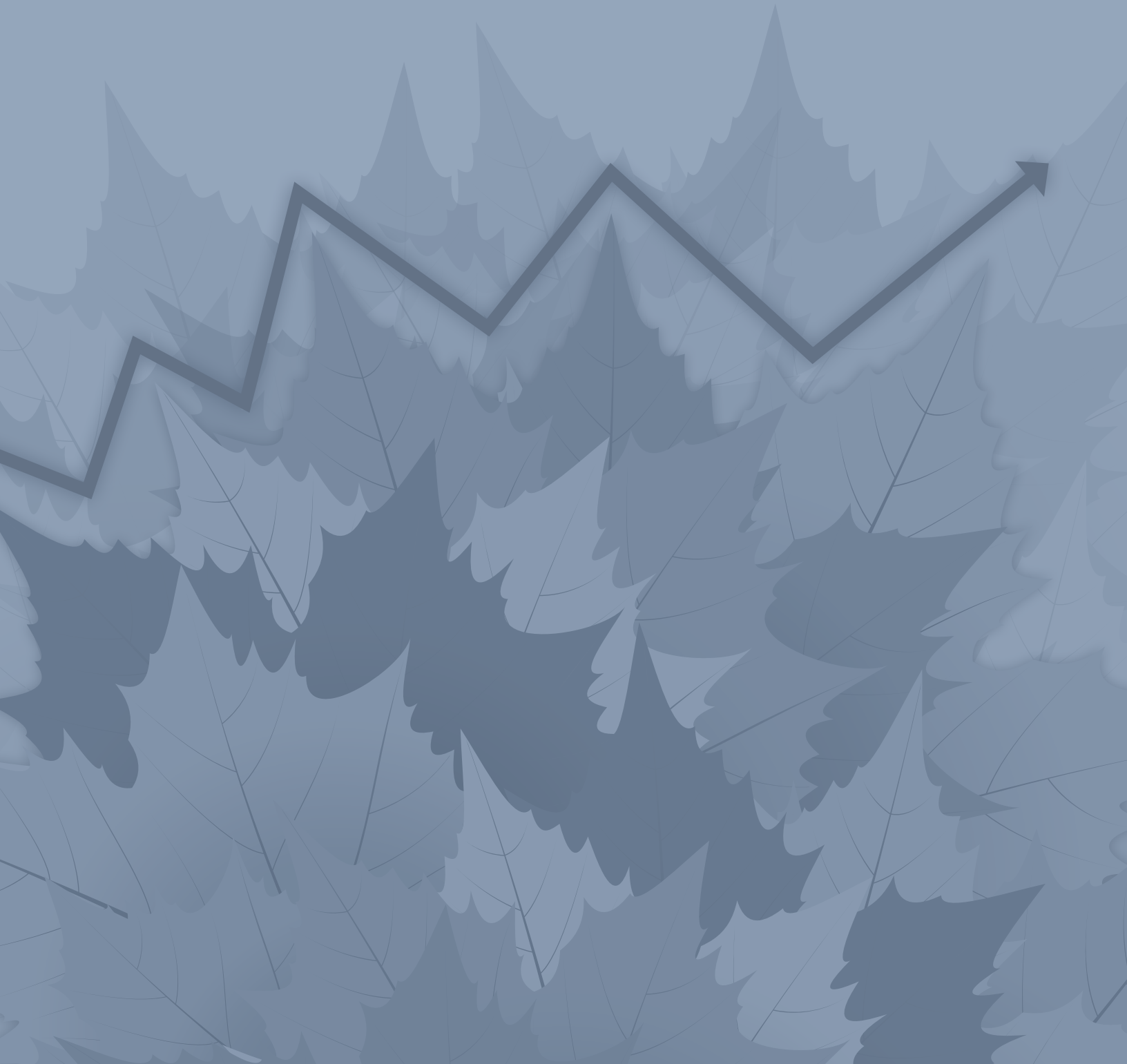
Data Sources

Data Sources

Air Quality System

The Air Quality System (AQS) contains ambient air pollution data collected by the U.S. Environmental Protection Agency (EPA) and state, local, and tribal air pollution control agencies. Data on criteria pollutants consist of air quality measurements collected by sensitive equipment at thousands of monitoring stations located across all 50 states plus the District of Columbia,

Puerto Rico, and the U.S. Virgin Islands. Each monitor measures the concentration of a particular pollutant in the air. Monitoring data indicate the average pollutant concentration during a specified time interval (usually 1 hour or 24 hours). AQS also contains meteorological data, descriptive information about each monitoring station (including its geographic location and its operator), and data quality assurance or quality control information. The system is administered by 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 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 higher 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/.

Race and Hispanic origin: ACS respondents are given the option of selecting one or more race categories to indicate their racial identities. People who respond 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 choose more than one of the race categories are referred to as the Two or More Races population. The six single-race categories and the Two or More Races category sum to the total population.

The ACS includes a separate question on Hispanic origin. People of Spanish/Hispanic/Latino origin can 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:
U.S. Census Bureau Customer Service Center
Phone: 800-923-8282
Website: https://www.census.gov/programs-surveys/acs/
Additional website: https://ask.census.gov

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 for numerous purposes, including reporting to Congress on the extent of need for affordable and assisted rental housing. 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 longitudinal data from the same panel of housing units for each survey. The AHS integrated national sample used for this report is surveyed biennially in odd-numbered years and includes a representative national sample, representative oversamples of the 15 largest metropolitan areas, and an oversample of HUD-assisted housing units. Two additional sets of 10 metropolitan samples are surveyed on an alternating basis in odd-numbered years on a 4-year cycle. The AHS collects detailed data about the types, characteristics, and conditions of housing in the United States; 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

Data Sources

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
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
Phone: 202-691-6900
Website: https://www.bls.gov/cex/

Current Population Survey

The Current Population Survey (CPS) is a nationally representative sample survey of about 60,000 households conducted monthly for the Bureau of Labor Statistics 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.

Data Sources

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 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
Phone: 202-691-6378
Website: http://www.bls.gov/cps
Additional website: https://www.census.gov/cps/

Current Population Survey Food Security Supplement

Since 1995, the U.S. Department of Agriculture (USDA) has collected information annually on food access and adequacy, food spending, and sources of food assistance for the U.S. population. The information is collected in an annual survey, the Food Security Supplement (FSS) conducted by the U.S. Department of Commerce, Bureau of the Census (U.S. Census Bureau), as a supplement to the nationally representative Current Population Survey (CPS). USDA, Economic Research Service (ERS) sponsors the annual Food Security Supplement and compiles and analyzes the responses.

The CPS-FSS asks one adult respondent per household about experiences and behaviors that indicate food insecurity at some time during the calendar year, such as being unable to afford balanced meals, cutting the size of meals, or being hungry because of too little money for food. The food security status of the household is assigned based on the number of food-insecure conditions reported.

Annual monitoring of food security contributes to the effective operation of Federal food and nutrition assistance programs, as well as private food assistance programs and other government initiatives aimed at reducing food insecurity. Reports in the series are available on the USDA, ERS website.

For more information, contact:
USDA ERS
Website: https://www.ers.usda.gov/topics/food-nutrition-assistance/food-security-in-the-u-s/

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 2020 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 head of household; 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 2020 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 starting with the 2000 Census, 2020 Census data are not directly comparable with data from the 1990 or earlier censuses.

As in earlier censuses, the 2020 Census included a separate question on Hispanic origin. In the 2020 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.

Data Sources

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 was 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 23,000 respondents from 2006–2018 supports genetic and genomic studies. Venous blood samples collected in 2016, 2018, and 2022 wavesare providing 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.

Intercensal Population Estimates: 2000 to 2010

Intercensal population estimates are produced for the years between two decennial censuses when both the beginning and ending populations are known. They are produced by adjusting the existing time series of postcensal estimates for the entire decade to smooth the transition from one decennial census count to the next. They differ from the annually released postcensal estimates in that they rely on mathematical formulae that redistribute the difference between the April 1 postcensal estimate and April 1 census count for the end of the decade across the postcensal estimates for that decade. For dates when both postcensal and intercensal estimates are available, intercensal estimates are preferred.

The 2000–2010 intercensal estimates reconcile the postcensal estimates with the 2010 Census counts and provide a consistent time series of population estimates that reflect the 2010 Census results. The 2000–2010 intercensal estimates were produced for the nation, states, and counties by demographic characteristics (age, sex, and race and Hispanic origin).

For a more detailed discussion of the methods used to create the intercensal estimates, see https://www2.census.gov/programs-surveys/popest/technical-documentation/methodology/intercensal/2000-2010-intercensal-estimates-methodology.pdf.

Data Sources

International Data Base

The U.S. Census Bureau produces the International Data Base (IDB), which includes regularly updated population estimates and projections for over 200 countries and areas. The series of estimates and projections provide a consistent set of demographic indicators, including population size and growth, mortality, fertility, and net migration. The IDB is accessible via the Internet at 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

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), demographics, health insurance, employment, income, priority conditions, disability days, health status, access to care, patient satisfaction 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 because 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.[50] Health care expenditures presented in this report refer to what is actually paid for health care services. More specifically, expenditures are defined as the sum of direct payments for care received, including out-of-pocket payments for care received. This definition of expenditures differs somewhat from what was used in the 1987 NMES, which used charges (rather than payments) as the fundamental expenditure construct. To improve comparability of estimates between the 1987 NMES and the 1996 and 2001 MEPS, the 1987 data presented in this report were adjusted using the method described by Zuvekas and Cohen (2002).[51] Adjustments to the 1977 data were considered unnecessary because virtually all the discounting for health care services occurred after 1977 (essentially equating charges with payments in 1977).

Due to the COVID-19 virus pandemic in 2020, MEPS added variables to collect the impact of the pandemic on health care use. The COVID section (CV) gathered information on whether a person was delayed in getting medical care, dental treatment, and prescription medicine due to the coronavirus pandemic from March 2020 to the interview date. Additional questions were added to ask about COVID-19 vaccinations and to measure Long COVID.

Several other quality-related enhancements were made to the MEPS beginning in 2000, including the fielding of an annual adult self-administered questionnaire (SAQ). This questionnaire collects a variety of health status and health

care quality measures of adults ages 18 and older. It contains three measures of health status: the Veteran's RAND 12-item (VR-12) health survey, the Kessler Index (K6) of non-specific psychological distress, and the Patient Health Questionnaire (PHQ-2). (In 2017, this replaced the Short-Form 12 Version 2 (SF-12v2®). The Veterans RAND 12 Version (VR-12) comprises 12 items used to measure health-related quality of life, to estimate disease burden and to evaluate disease-specific impact on general and selected populations. Kessler Index (K6) provides an index to measure non-specific, rather than disorder-specific, psychological distress, and PHQ-2 questions, which assess the frequency of the person's depressed mood and decreased interest in usual activities.

Starting in 2018, a Preventive Care Self-Administered Questionnaire (PSAQ) was added to MEPS. Currently, the SAQ and PSAQ are administered every other year. There are separate versions of the PSAQ for males and females to account for certain preventive care questions. In 2020, the PSAQ was further modified to include supplemental items on alcohol and drug use, as well as items on mental health counseling and treatment. These supplemental items were the same for males and females.

The Diabetes Care Survey (DCS), another self-administered questionnaire, was first fielded in 2000. The questionnaire collects information on diabetes care from those who are identified with having diabetes.

In 2018, a Veterans Self-Administered Survey (VSAQ) was first administered. The VSAQ asks questions about highly prevalent medical conditions among Veterans, such as PTSD and COPD; medical services (prosthesis, rehabilitation services, individual and group mental health care, caregiver support) used by Veterans; and assistive mobility devices.

In 2021, The Social and Health Experiences Self-Administered Questionnaire was first administered. This supplement asked questions about measures of general life satisfaction, housing quality, neighborhood characteristics, measures of financial strain, stress, food security, physical activity, transportation issues, measures of social connectedness, measures of loneliness, experiences of discrimination, experiences of physical and social violence, and adverse childhood experiences (ACEs).

The Cancer Self-Administered Questionnaire (CSAQ) was fielded in 2011, 2016 and 2017. The CSAQ asked adult respondents questions about the burden of cancer, medical care for cancer, long lasting effects of the disease, financial impact, and employment outcomes for cancer survivors and their families.

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

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
Phone: 1-888-973-7322
Website: https://www.resdac.org

Chronic Conditions Data Warehouse
Email: 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

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.

Data Sources

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 within the 50 states and the District of Columbia at the time of the interview. The NHIS universe includes residents of households and noninstitutional group quarters (e.g., homeless shelters, rooming houses, and group homes). Persons residing temporarily in student dormitories or temporary housing are sampled within the households that they reside in permanently. Persons excluded from the universe are those with no fixed household address (e.g., homeless and/or transient persons not residing in shelters), active-duty military personnel and civilians living on military bases, persons in long-term care institutions (e.g., nursing homes for the elderly, hospitals for the chronically ill or physically or intellectually disabled, and wards for abused or neglected children), persons in correctional facilities (e.g., prisons or jails, juvenile detention centers, and halfway houses), and U.S. nationals living in foreign countries. While active-duty Armed Forces personnel cannot be sampled for inclusion in the survey, any civilians residing with Armed Forces personnel in non-military housing are eligible to be sampled.

The content and structure of the NHIS were updated in 2019 to better meet the needs of data users. Aims of the questionnaire redesign were to improve the measurement of covered health topics, reduce respondent burden by shortening the length of the questionnaire, harmonize overlapping content with other federal health surveys, establish a long-term structure of ongoing and periodic topics, and incorporate advances in survey methodology and measurement.

One "sample adult" aged 18 years or older and one "sample child" aged 17 years or younger (if any children live in the household) are randomly selected from each household following a brief initial interview that identifies everyone who usually lives or stays in the household. Information about the sample adult is collected from the sample adult herself or himself unless she or he is physically or mentally unable to do so, in which case a knowledgeable proxy can answer for the sample adult. Information about the sample child is collected from a parent or adult who is knowledgeable about and responsible for the health care of the sample child. This respondent may or may not also be the sample adult.

The NHIS is conducted using computer-assisted personal interviewing. Face-to-face interviews are conducted in respondents' homes, but follow-ups to complete interviews may be conducted over the telephone. A telephone interview may also be conducted when the respondent requests a telephone interview or when road conditions or travel distances would make it difficult to schedule a personal visit before the required completion date. In 2022, 55.7% of the Sample Adult interviews and 56.1% of the Sample Child interviews were conducted at least partially by telephone.

Race and Hispanic origin: In accordance with the 1997 Office of Management and Budget's Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity for the collection of ethnicity and race in federal data systems, separate questions are asked about Hispanic origin and race. Persons of Hispanic origin may be of any race or combination of races. Hispanic origin includes persons of Mexican/Mexican American/Chicano, Central American, South American, Puerto Rican, Cuban, Dominican, or other Hispanic origin. Race is based on the Sample Adult's description of his or her own racial and ethnic identity, and an adult knowledgeable and responsible for the child's health provides this information for the Sample Child. More than one race can be reported for a Sample Adult and Sample Child. Public-use race and Hispanic origin variables are imputed when unknown using hot deck imputation methods where donor information was provided from either within the household or the local geographic area. Less than 1% of NHIS cases have imputed values for race or Hispanic origin. Race was not imputed for Hispanic persons who did not identify with any of the OMB race categories and thus race was coded as 'not ascertained' for these persons. Imputation was implemented to determine whether the person was of any Hispanic or Latino origin but not to determine the country or geography of origin. See the 2022 National Health Interview (NHIS) Survey Description for more information: Survey Description, National Health Interview Survey, 2022 (cdc.gov).

For more information, contact:
Division of Health Interview Statistics
Email: 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: Contact CDC-INFO
Phone: 1-800-232-4636
Website: https://www.cdc.gov/nchs/nhanes/index.htm

National Post-acute and Long-term Care Study

The National Study of Long-Term Care Providers (NSLTCP) is now called the National Post-acute and Long-term Care Study (NPALS). The new name reflects the addition of more post-acute sectors (i.e., inpatient rehabilitation facilities and long-term care hospitals), while keeping the same sectors that have been in the study since it launched in 2012 (adult day services centers, assisted living and similar residential care communities, home health agencies, hospices, and nursing homes).

The main goals of NPALS are to:

- Estimate the supply and use of paid, regulated post-acute and long-term care services providers.

- Estimate key policy-relevant characteristics and practices.

- Produce national and state-level estimates, where feasible.

- Compare estimates among sectors.

- Monitor trends over time.

NPALS expands NSLTCP, which replaced the National Center for Health Statistics' previous National Nursing Home Survey, National Home and Hospice Care Survey, and National Survey of Residential Care Facilities.

NPALS:

- Provides information on seven major sectors of paid, regulated post-acute and long-term care services providers and services users.

- Uses existing administrative data on nursing homes, home health agencies, hospices, inpatient rehabilitation facilities, and long-term care hospitals.

- Collects primary data on adult day services centers and residential care communities via national and state representative surveys because national administrative data are not available on these providers.

- Allows comparisons among sectors at a similar point in time and over time.

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
Phone: 301-458-4747
Website: https://www.cdc.gov/nchs/npals/index.html

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.

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. National-level mortality data help track the characteristics of those who have died, monitor and make decisions about public health challenges, determine life expectancy, and compare death 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. Life expectancy estimates reported in *Older Americans 2024* are for single-race groups.

For more information, contact:
Division of Vital Statistics
Email: Contact CDC-INFO
Phone: 1-800-232-4636
Website: https://www.cdc.gov/nchs/nvss/index.htm

Population Projections

The 2023 National Population Projections provide projections of the resident population and demographic components of change (births, deaths, and international migration) through 2100. Population projections are available by age, sex, and nativity detail for all projected years, with race and Hispanic origin limited to 2060 and earlier. Where both estimates and projections are available for the same time period, the Census Bureau recommends the use of the population estimates. Below is a general description of the methods used to produce the 2023 National Population Projections.

The 2023 National Population Projections start with the Vintage July 1, 2022, population estimates and are developed using a cohort-component method. Many of the characteristics of the U.S. resident population, as measured by the population estimates, are preserved as demographic patterns that work their way through the projection period. The components of population change (births, deaths, and international migration) are projected for each birth cohort (persons born in a given year). For each passing year, the Census Bureau advances the population 1 year of age. The

Census Bureau updates the new age categories using survival rates and levels of international migration projected for the passing year. A new birth cohort is added to form the population under 1 year of age by applying projected age-specific fertility rates to the female population age 14 to 54, and by updating the new cohort for the effects of mortality and international migration.

The assumptions for the components of change are based on time series analysis. Because of limited information about racial characteristics in the fertility and mortality historical series, the assumptions were developed for mutually exclusive and exhaustive groups. Six groups were used for the fertility assumptions: native-born Asian/Pacific Islander, native-born White, 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 United States Census Bureau produces and publishes population estimates for the nation, states, metropolitan and micropolitan statistical areas, counties, state/county equivalents, and Puerto Rico. 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.

The population estimate at any given time point starts with a population base (the date of the last decennial census or the previous point in the time series), adds births, subtracts deaths, and adds net migration (both international and domestic). 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 the spring of 1995.[52]

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.[54]

Since 2011, the Census Bureau has published poverty estimates using the new measure based on these suggestions. 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.

For more information, contact:
Dr. Liana Fox
U.S. Census Bureau
Email: liana.e.fox@census.gov
Phone: 301-763-2676
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. 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 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. 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 Non-White or Hispanic. Data are not shown by Hispanic origin.

For more information, contact:
Chris Tamborini
Social Security Administration

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Email: 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 (EHCPM) to project enrollment, utilization, and associated expenditures of the enrolled Veteran population for approximately 150 categories of health care services 20 years into the future. First, VA uses the EHCPM to determine how many Veterans will be enrolled each year and their age, priority, and geographic location. Next, VA uses the EHCPM 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 EHCPM accounts for the unique demographic characteristics of the enrolled Veteran population, including Post-9/11 Era Combat Veteran, female, new enrollees, 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)

- New policies, regulations, and legislation, including the Honoring our PACT Act of 2022 (PACT Act) and MISSION Act

- A continually evolving VA health care system (e.g., quality, efficiency, and hiring initiatives)

- Changes in health care practice and technology, such as new diagnostics, drugs, and treatments

- Service location (VA direct or community care)

- Impacts of pandemics or other global disruptions affecting health care delivery.

For more information, contact:
Sarah Bender
Veterans Health Administration, Chief Strategy Office
Email: sarah.bender1@va.gov
Website: https://www.va.gov/VHAStrategy/

Veteran Population Estimates and Projections

The VA National Center for Veterans Analysis and Statistics produces the Veteran Population Projection Model (VetPop), which provides Veteran population estimates and projections by key demographic characteristics such as age and gender as well as geographic areas. The latest model, VetPop2020, was updated using administrative data from VA and Department of Defense and data from the Census Bureau. VetPop2020 was released in fall 2022.

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: VACONCVAS@va.gov
Website: https://www.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): Body mass index (BMI), expressed as weight in kilograms divided by height in meters squared (kg/m^2), is used commonly to classify overweight (BMI 25.0–29.9), obesity (BMI at or above 30.0), and severe obesity (BMI at or above 40.0).

Cause of death: For the purpose of national mortality statistics, every death is attributed to one underlying condition. The underlying cause is selected from the conditions entered by the medical certifier in the cause-of-death section of the death certificate. When more than one cause or condition is entered by the medical certifier, the underlying cause is determined by the sequence of conditions on the certificate, provisions of the International Classification of Diseases (ICD), and associated selection rules and modifications. Effective with deaths occurring in 1999, the United States began using the 10th Revision of the ICD (ICD-10).[53]

Civilian noninstitutionalized population: *See Population.*

Civilian population: *See Population.*

Colorectal cancer screening (CRC): Defined as reporting a home blood stool test or FIT in the past year, sigmoidoscopy during the past 5 years, colonoscopy during the past 10 years, computed tomography colonography or virtual colonoscopy during the past 5 years, or Cologuard or FIT-DNA test during the past 3 years.

Crowded housing: Households that have more than one person per room.

Death rate: The death rate is the number of deaths divided by the population, multiplied by 100,000. The rate may be restricted to deaths in specific age, race, sex, or geographic groups or from specific causes of death. Age-adjusted death rates are useful when comparing different populations because they remove the potential bias that can occur when the populations being compared have different age structures.

The National Center for Health Statistics uses the direct method of standardization.

Defined benefit plan: A plan that promises a specified monthly benefit at retirement. The plan may state this promised benefit as an exact dollar amount, such as $100 per month at retirement. Or, more often, it may calculate a benefit through a plan formula that considers such factors as salary and service (e.g., 1 percent of average salary for the last 5 years of employment for every year of service with an employer).

Defined contribution plan: A plan that does not promise a specific benefit amount at retirement. Instead, employers and/or employees contribute money to each employee's individual account in the plan. In many cases, employees are responsible for choosing how these contributions are invested and deciding how much to contribute from their paychecks through pretax deductions. Employers may add to employees' accounts, in some cases, by matching a certain percentage of the employee's contributions. The value of an employee's account depends on how much is contributed and how well the investments perform.

Dental services: In the Medicare Current Beneficiary Survey (Indicators 30 and 34), the Medical Expenditure Panel Survey (MEPS), and the data from the MEPS predecessor surveys used in this report (Indicator 33), this category covers expenses for any type of dental care provider, including general dentists, dental hygienists, dental technicians, dental surgeons, orthodontists, endodontists, and periodontists. In Indicator 30, dental services are included as part of the "Other" category; in Indicator 34, dental services are included as a separate category.

Disability rating: Ratings reflect the severity of the disability and how much the impairment impacts the ability to work.

Emergency room services: In the Medical Expenditure Panel Survey (MEPS) and the data from the MEPS predecessor surveys used in this report (Indicator 33), this category includes expenses for visits to medical providers seen in emergency rooms (except visits resulting in a hospital admission). These expenses include payments for services covered under the basic facility charge and those for separately billed physician services. In the Medicare Current Beneficiary Survey (Indicators 30 and 34), emergency room services are included as a hospital outpatient service unless they are incurred immediately prior to a hospital stay, in which case they are included as a hospital inpatient service.

Fee-for-service: The method of reimbursing health care providers on the basis of a fee for each health service provided to the insured person.

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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. Initial benefits at age 62 increase approximately 75 percent for a delay from ERA to age 70. The FRA was age 65 for those born before 1938, increased at 2 months per year for each birth year from 1938 until 1943, remained at age 66 for those born from 1943 through 1954, increased at 2 months per year for each birth year from 1955 until 1959, and is age 67 for those born in 1960 and later. 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. Information about group quarters in the 2020 Census can be found here: https://www.census.gov/newsroom/blogs/random-samplings/2021/03/2020-census-group-quarters.html.

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 30 and 34), health care expenditures include all expenditures for inpatient hospital, medical, nursing home, outpatient (including emergency room visits), dental, prescription drugs, home health care, and hospice services, including both out-of-pocket expenditures and expenditures covered by

insurance. Personal spending for health insurance premiums is excluded. In the Medical Expenditure Panel Survey (MEPS) and the data from the MEPS predecessor surveys used in this report (Indicator 33), health care expenditures refer to payments for health care services provided during the year. (Data from the 1987 survey have been adjusted to permit comparability across years; see Zuvekas and Cohen [2002].[51]) 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).

Healthy 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.

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

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29, 30, and 34), home health care refers to skilled nursing care, physical therapy, speech language pathology services, occupational therapy, and home health aide services provided to homebound patients. In the Medical Expenditure Panel Survey (Indicator 33), home health care services are classified into the "Other Health Care" category and are considered any paid formal care provided by home health agencies and independent home health providers. Services can include visits by professionals, including nurses, doctors, social workers, and therapists, as well as home health aides, homemaker services, companion services, and home-based hospice care. Home care provided free of charge (informal care by family members) is not included.

Hospice care/services: Hospice care is a program of palliative and supportive care services providing physical, psychological, social, and spiritual care for dying persons, their families, and other loved ones by a hospice program or agency. Hospice services are available in home and inpatient settings. In the Medicare Current Beneficiary Survey (Indicators 30 and 34), hospice care includes only those services provided as part of a Medicare benefit. In Indicator 30, hospice services are part of the "Other" category. In Indicator 34, hospice services are a separate category. In the Medical Expenditure Panel Survey (MEPS; Indicator 33), hospice care provided in the home (regardless of the source of payment) is included in the "Other Health Care" category, while hospice care provided in an institutional setting (e.g., nursing home) is excluded from the MEPS universe.

Hospital care: In the Medical Expenditure Panel Survey (Indicator 33), 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 30 and 34), hospital inpatient services include room and board and all hospital diagnostic and laboratory expenses associated with the basic facility charge, as well as emergency room expenses incurred immediately prior to inpatient stays. Expenses for hospital stays with the same admission and discharge dates are included if the Medicare bill classified the stay as an "inpatient" stay. Payments for separate billed physician inpatient services are excluded. In the Medical Expenditure Panel Survey (Indicator 33), these services include room and board and all hospital diagnostic and laboratory expenses associated with the basic facility charge, payments for separately billed physician inpatient services, and emergency room expenses incurred immediately prior to inpatient stays. Expenses for reported hospital stays with the same admission and discharge dates are also included.

Hospital outpatient services: These services in the Medicare Current Beneficiary Survey (Indicators 30 and 34) include visits to both physicians and other medical providers seen in hospital outpatient departments or emergency rooms (provided the emergency room visit does not result in an inpatient hospital admission), as well as diagnostic laboratory and radiology services. Payments for these services include those covered under the basic facility charge. Expenses for in-patient hospital stays with the same admission and discharge dates and classified on the Medicare bill as "outpatient" are also included. Separately billed physician services are excluded.

Hospital stays: In the Medicare claims data (Indicator 29), 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 Affairs payments; Supplemental Security Income and cash welfare payments from public assistance;

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

Inpatient hospital: *See Hospital inpatient services.*

Institutionalized population: *See Population.*

Institutions: For the 2020 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 22 and 36), 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 30 and 34), a long-term care facility excludes "short-term institutions" (e.g., subacute care) stays. *See also Short-term institution (Indicators 30 and 34), and Skilled nursing facility (Indicator 29).*

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 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 2020 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 and 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 https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/demographic-and-housing-characteristics-file-and-demographic-profile/2020census-demographic-and-housing-characteristics-file-and-demographic-profile-techdoc.pdf.

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

Office-based medical provider services: In the Medical Expenditure Panel Survey (Indicator 33), this category includes expenses for visits to physicians and other health practitioners seen in office-based settings or clinics. "Other health practitioner" includes audiologists, optometrists, chiropractors, podiatrists, mental health professionals, therapists, nurses, and physician's assistants, as well as providers of diagnostic laboratory and radiology services. Services provided in a hospital-based setting, including outpatient department services, are excluded.

Other health care: In the Medicare Current Beneficiary Survey (Indicator 34), this category includes short-term institution, hospice, and dental services. In the Medical Expenditure Panel Survey (Indicator 33), other health care includes home health services (formal care provided by home health agencies and independent home health providers) and other medical equipment and services.

The latter includes expenses for eyeglasses, contact lenses, ambulance services, orthopedic items, hearing devices, prostheses, bathroom aids, medical equipment, disposable supplies, alterations/modifications, and other miscellaneous items or services that were obtained, purchased, or rented during the year.

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 34), this category includes visits to a medical doctor, osteopathic doctor, and health practitioner as well as diagnostic laboratory and radiology services. Health practitioners include audiologists, optometrists, chiropractors, podiatrists, mental health professionals, therapists, nurses, paramedics, and physician's assistants. Services provided in a hospital-based setting, including outpatient department services, are included.

Physician/outpatient hospital: In the Medicare Current Beneficiary Survey (Indicator 30), this term refers to "physician/medical services" combined with "hospital outpatient services."

Physician visits and consultations: In Medicare claims data (Indicator 29), physician visits and consultations include visits and consultations with primary care physicians, specialists, and chiropractors in their offices, hospitals (inpatient and outpatient), emergency rooms, patient homes, and nursing homes.

Population: Data on populations in the United States are often collected and published according to several different definitions. Various statistical systems then use the appropriate population for calculating rates.

Resident population: The resident population of the United States includes people 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, the 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.*

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Institutionalized population: For the 2020 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 https://www2.census.gov/programs-surveys/decennial/2020/technical-documentation/complete-tech-docs/demographic-and-housing-characteristics-file-and-demographic-profile/2020census-demographic-and-housing-characteristics-file-and-demographic-profile-techdoc.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., $14,040 for one person age 65 and over in 2022). 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 8, 28, 33, and 34 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 199.9 percent of the poverty threshold (i.e., between $14,040 and $28,079 for one person age 65 and over in 2022). Middle income is income between 200 percent and 399.9 percent of the poverty threshold (i.e., between $28,080 and $56,159 for one person age 65 and over in 2022). High income is income 400 percent or more of the poverty threshold.

Indicator 28: Cigarette Smoking: Below poverty is defined as having income less than 100 percent of the poverty threshold. Above poverty is grouped into two categories: (1) income between 100 percent and 199 percent of the poverty threshold and (2) income equal to or greater than 200 percent of the poverty threshold.

Indicator 32: Sources of Health Insurance: Below poverty is defined as having income less than 100 percent of the poverty threshold. Above poverty is grouped into two categories: (1) income between 100 percent and 199 percent of the poverty threshold and (2) income equal to or greater than 200 percent of the poverty threshold.

Indicator 33: Out-of-Pocket Health Care Expenditures: Two income categories were used to examine out-of-pocket health care expenditures using the Medical Expenditure Panel Survey (MEPS) and MEPS predecessor survey data. The categories were expressed in terms of poverty status (i.e., the ratio of the family's income to the Federal poverty thresholds for the corresponding year), which controls for the size of the family and the age of the head of the family. The income categories were (1) poor and near poor and (2) other income. The poor and near-poor income category includes people in families with income less than 100 percent of the poverty line, including those whose losses exceeded their earnings, resulting in negative income (i.e., the poor), as well as people in families with income from 100 percent to less than 125 percent of the poverty line (i.e., the near poor). The other income category includes people in families with income greater than or equal to 125 percent of the poverty line. *See also Income, household.*

Prescription drugs/medicines: In the Medicare Current Beneficiary Survey (Indicators 30, 31, 34) and in the Medical Expenditure Panel Survey (Indicator 33), prescription drugs are all prescription medications (including refills), except those provided by the doctor or practitioner as samples and those provided in an inpatient setting.

Prevalence: 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 and ethnicity: *See specific data source descriptions. The labels for specific race and ethnic groups used in this report vary according to the standards adopted by each reporting agency.*

Rate: A measure of some event, disease, or condition in relation to a unit of population, along with some specification of time.

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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?"

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 30 and 34) 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 29), Nursing facility (Indicator 36), and Long-term care facility (Indicators 22, 30, 34, and 37).*

Skilled nursing facility: As defined by Medicare (Indicator 29), 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 30 and 34), "skilled nursing facilities" are classified as a type of "short-term institution." *See also Short-term institution (Indicators 30 and 34) and Long-term care facility (Indicators 22, 30, 34, and 36).*

Skilled nursing facility stays: In the Medicare claims data (Indicator 29), 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 29).*

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: A person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable.

Veterans' health care: Health care services provided by the Veterans Health Administration (Indicator 35) include preventive care, ambulatory diagnostic and treatment services, inpatient diagnostic and treatment services, 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).

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The Historical Experience of Three Cohorts of Older Americans: A Timeline of Selected Events 1935–2022

1955 Cohort	1945 Cohort	1935 Cohort	Year	Historical Events	Legislative Events
		Born	1935		**1935**—Social Security Act passed
					1937—U.S. Housing Act passed, establishing Public Housing
		5 years old	1940		
			1941	**1941**—Pearl Harbor; United States enters WWII	
	Born		1944	**1944**—D-Day landings in Normandy	
			1945	**1945**—Yalta Conference; Cold War begins; Atomic bombings of Hiroshima and Nagasaki; **1946**—Baby boom begins	
	5 years old	15 years old	1950	**1950**—United States enters Korean War	
			1953	**1953**—Korean Armistice Agreement signed	
			1955	**1955**—Nationwide polio vaccination program begins	
					1956—Women ages 62–64 eligible for reduced Social Security benefits; **1957**—Social Security Disability Insurance implemented
Born					**1959**—Section 202 of the Housing Act established, providing assistance to older adults with low income
5 years old	15 years old	25 years old	1960		**1961**—Men ages 62–64 eligible for reduced Social Security benefits; **1962**—Self-Employed Individual Retirement Act (Keogh Act) passed
			1962	**1962**—Cuban Missile Crisis	
			1963	**1963**—March on Washington; Assassination of President John F. Kennedy; **1964**—baby boom ends; New York World's Fair	**1964**—Civil Rights Act passed
			1965		**1965**—Medicare and Medicaid established; Older Americans Act passed
			1968	**1968**—Assassination of Martin Luther King, Jr.	**1967**—Age Discrimination in Employment Act passed
15 years old	25 years old	35 years old	1970	**1969**—First man on the moon; Stonewall uprising **1970**—Kent State shootings	
			1973	**1973**—*Roe v. Wade*	**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
			1975		
					1978—401(k)s established
25 years old	35 years old	45 years old	1980	**1980**—First AIDS case is reported to the Centers for Disease Control and Prevention	
					1983—Social Security eligibility age increased for full benefits; **1984**—Widows entitled to pension benefits if spouse was vested
			1985		**1986**—Mandatory retirement eliminated for most workers
			1987	**1987**—Development of HyperText Markup Language (HTML), giving rise to the World Wide Web	**1987**—Reverse mortgage market created by the HUD Home Equity Conversion Program
35 years old	45 years old	55 years old	1990	**1989**—Berlin Wall falls **1990**—United States enters Persian Gulf War	**1990**—Americans with Disabilities Act passed
			1992	**1992**—Maastricht Treaty creates European Union	
			1995		
			1997	**1997**—WiFi first released for consumers **1998**—Launch of International Space Station	**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
45 years old	55 years old	65 years old	2000		**2000**—Social Security earnings test eliminated for full retirement age
			2001	**2001**—September 11: Terrorists attack United States; War on Terror declared and invasion of Afghanistan	
			2003	**2003**—United States enters Iraq War	**2003**—Medicare Modernization Act passed, creating the Medicare prescription drug benefit
			2005		**2005**—Deficit Reduction Act passed realigning Medicaid incentives to provide noninstitutionalized long-term care **2006**—Pension Protection Act passed
			2007	**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	
55 years old	65 years old	75 years old	2010	**2010**—Offshore explosion on the Deepwater Horizon drilling rig causes the largest oil spill in U.S. history **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	**2010**—Patient Protection and Affordable Care Act passed
			2015	**2013**—*United States v. Windsor* ruling Defense of Marriage Act unconstitutional **2015**—*Obergefell v. Hodges* ruling legalizes same-sex marriage across all 50 states	**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 (SECURE) Act passed; **2020**—Supporting Older Americans Act passed; **2021**—American Rescue Plan passed; **2022**—SECURE 2.0 passed
65 years old	75 years old	85 years old	2020	**2020**—First reported case of COVID-19 in United States	