A Report to the Nation on **Trends in Health Security**
Trends in Health Security

A Report to the Nation on

Thorough coverage of the dimensions of health security for this report would not have been possible without the contributions of many individuals and their organizations. In particular, AARP extends its gratitude to the following people who provided special analysis of data and/or shared proprietary information: Gerald Anderson and Robert Herbert, Partnership for Solutions, Johns Hopkins University School of Public Health; April Brackett and Molly Brody, Kaiser Family Foundation; Neal Cutler and Nancy Whitelaw, National Council on Aging; Dave Gibson and John Poisal, Centers for Medicare and Medicaid Services; Amy Bernstein, Yelena Gorina, Esther Hing, Robert Kuczmarski and David Woodwell, National Center for Health Statistics; Mary Dufour, National Institute on Alcohol Abuse and Alcoholism; and Jurgen Unutzer, University of California at Los Angeles Neuropsychiatric Institute.

We also greatly appreciate the insightful comments of those who reviewed this report, including Marc Berk, Project HOPE; Harriet Komisar, Georgetown University Institute for Health Care Research and Policy; James Lubitz and Ellen Kramarow, National Center for Health Statistics; and Marilyn Moon, The Urban Institute.

Leadership and coordination for development of the report were provided by Susan Raetzman of the Health Team in the AARP Public Policy Institute (PPI). Other authors of the report are PPI staff Craig Caplan, Joyce Dubow, Mary Jo Gibson, David Gross, Drew Smith, Gerry Smolka, and Judy Xu. Additional PPI staff who provided analyses used in the report are Jill Bernstein, Normandy Brangan, Carlos Figueiredo, and Steven Gregory. Elizabeth Clemmer, Paul Cotton, and John Gist of AARP reviewed earlier drafts of the report. We also acknowledge our colleagues throughout AARP who contributed in other ways to the development of this report, particularly Bob Prisuta, Boe Workman, and Sara Zapolsky. Finally, this report was prepared under the general guidance of John Killpack, John Rother, and Theresa Varner at AARP.

For additional information about this report, please contact the AARP Public Policy Institute, Health Team at 601 E Street, N.W., Washington, D.C. 20049 or call (202) 434-3890.

# TABLE OF CONTENTS

## Setting the Scene

**Introduction**
- Scope and Methodology of Report
- Drivers of Change in the Health Care Environment

## The Big Picture

**Overview of Findings**
- Overview of Trends Affecting People Age 50 and Older
- Overview of Trends Affecting People Age 50-64
- Overview of Trends Affecting People Age 65 and Older
- Overview of Trends Affecting People Age 85 and Older

## The Health of People Age 50 and Older

- The Impact of Demographics
- Health and Well-Being
- Chronic Illness and Disability

## The Importance of Health and Long-Term Care Coverage

- Coverage for People Age 50-64
- Coverage for People Age 65 and Older
- The Role of Managed Care
- Long-Term Care Coverage
Service Use Across the Continuum of Care 60
- How Older Americans Use the Health Care System 61
- Service Use by People with Chronic Conditions, Disability, and Functional Limitations 65
- How Older Americans Use Long-Term Care Services 66
- Care at the End of Life 68
- Barriers to Care for Older Americans 70

The Cost of Health and Long-Term Care 74
- Health Care Expenditures 76
- Out-of-Pocket Spending on Health Care 78
- Long-Term Care Expenditures 85
- Out-of-Pocket Spending on Long-Term Care 87

Health Care Quality 90
- Quality of Medical Care: The Consumer Perspective 92
- Quality of Long-Term Care 97

Conclusion 100
- Key Themes and Findings 100
- Implications for Policy 106

Endnotes 110
Credits 119
While the health care of older Americans is a popular topic of discussion, full exposure of the dimensions of the issue is rare. This year, AARP's Beyond 50 series sheds a strong light on the health and health care of America's midlife and older populations. “Beyond 50: A Report to the Nation on Trends in Health Security” is a comprehensive depiction of the state of health security of Americans age 50 and older. It's a portrait of health and well-being, health coverage, access to care, affordability of care, quality of care, and informed decision-making/navigation.

Where the data allow, trends over 10 to 20 years are exposed. Although the report discusses the significance of long-term care needs and long-term care services in the context of the overall picture of care for older Americans, a full discussion of non-medical, supportive services is reserved for a future edition of Beyond 50.

For this report, AARP conducted or commissioned original research and data analysis and also compiled a vast array of previously published research findings. The primary sources of data presented in the report are a series of national surveys conducted by the Agency for Healthcare Research and Quality (AHRQ) on the financing and use of medical care in the U.S., the Medicare Current Beneficiary Survey (MCBS), the Current Population Survey (CPS), a variety of nationwide sample surveys conducted by the National Center for Health Statistics (NCHS), and surveys of consumer attitudes conducted by polling companies and private organizations interested in health care issues.

To provide the context to the major findings presented in this report and to help determine the factors that may account for the changes found, we have identified five phenomena as major drivers of change:

- increased reliance on prescription drugs and other innovative technologies;
- chronic disease and chronic care;
- greater longevity and functional limitations;
- patients as consumers; and
- fluctuating cost growth.

These drivers of change have had an impact on the various components of health security addressed in this report. Although the impact on the health care system and on the lives of individuals has often been positive, as this report documents, there have been negative consequences as well, particularly for vulnerable subgroups. For example, the systems of care and support have become increasingly complex and fragmented, making the consumer role both more critical and more difficult. In addition, it is likely that the recent economic downturn will exacerbate the challenges the nation already faces to assure health security for all.

**Highlights of Findings**

Over the past two decades, strides in economic security and certain aspects of health care have improved many dimensions of life for middle age and older populations. People generally are using available services more, are receiving more sophisticated care, and are living longer. Far fewer older Americans smoke, more are getting vaccinations and screening tests, and, with the exception of the oldest age group, they are more likely than in the past to consider themselves to be in good health. Heart disease, stroke, and limitations in instrumental activities of daily living have declined. An older person is less likely to find himself in the hospital than in the past, and prescription drugs are often now routinely used as front-line treatment.
Alternatives to nursing home care are increasing, and there are signs that society is more aware of end-of-life issues. People can choose from a wider range of health coverage options, and consumers generally make efforts to be better informed about health issues. On several fronts, older Americans can be optimistic about the future.

However, challenges remain, because health security is out of reach for many people age 50 and older. The number of people without coverage for needed services has increased, average health care costs per person have grown, the expanded role of prescription drugs places a particular out-of-pocket burden on people without adequate drug coverage, and there are serious deficiencies in health care quality. This picture may get worse in the current environment. The situation is especially troubling for certain subgroups for which access to care has been compromised. In particular, poor health, disability, low income, and minority race and ethnicity status remain major threats to health security for all older Americans. In addition, despite their younger age and relative health advantages, 50 to 64 year olds face a variety of health care-related challenges.

General themes and specific findings discussed in the report include:

1. People age 50 and older are living longer and generally report being healthier than their predecessors. In addition, rates of disability among older adults have been declining. At the same time, the aging of the population means that there are more people age 50 and older with chronic conditions that limit their ability to function on a daily basis, often over an extended time period.
   - At age 50, Americans can expect to live another 30 years, almost nine years longer than expected in 1900.
   - Except for people age 85 and older, a larger proportion of each age group in 1999 assessed their health as “excellent” or “very good” compared to those that did so in 1982.
   - Broad measures of disability show declining rates among older people over the last few decades, especially among those with higher educations and for less severe levels of disability.
   - The majority of the population 50 years of age and older is living with at least one chronic condition. Although a much smaller proportion of people in this same age group experiences disability or functional limitations, the likelihood of disability or functional limitation increases dramatically with age. The share of individuals living contemporaneously with chronic illness, disability, and limitations in daily functioning rises steeply from 5 percent of 50 to 64 year olds to 44 percent of people age 85 and older. People age 85 and older represent the most rapidly growing segment of older Americans.
   - Only 30 percent of 50 to 64 year olds and 4 percent of people age 85 and older have no chronic condition, disability, or functional limitation.

2. Fewer people age 50 and older smoke, and more are using preventive services and are trying to exercise. At the same time, however, a much larger portion of this age group is obese than in previous years, and only some of these individuals are eating a healthy diet as recommended.
Although the prevalence of smoking has decreased approximately 30 percent over the last two decades, the epidemic of obesity—which nearly doubled for people age 50 and older between 1982 and 1999—could cancel out many of the gains achieved in other areas of prevention and treatment of diseases associated with aging.

Possibly as a result of rising obesity rates, diabetes has been increasing among older men and women, particularly 50 to 64 year olds.

More people age 50 to 64 are uninsured today than in the past. Individuals who are accustomed to feeling secure about their health coverage are increasingly at risk of not having needed protection. Medicare beneficiaries are frequently without adequate coverage, especially for prescription drugs. Vulnerable subgroups of people age 50 and older continue to experience problems in accessing health care services.

Although a disproportionate share of those in the lowest income quartile continue to be uninsured, larger shares of 50 to 64 year olds in the middle and upper income quartiles were uninsured in 1999 compared to 10 years previously. Fewer employers today offer health coverage to early retirees, and individual private insurance covers a smaller share of people age 50-64 in 1999 than it did in 1989. Public health insurance programs only protect about 25 percent of 50 to 64 year olds who are poor.

It is noteworthy that much of the evidence presented in this report came from a time period in the late 1990s when the economy was quite robust. The health coverage problem has grown worse. In a 2001 AARP survey, nine out of 10 people 50 to 64 years of age said they would be concerned about finding affordable coverage if they were suddenly without health insurance, and one in five insured 50 to 64 year olds said they are not confident that they will continue to have affordable coverage until they are eligible for Medicare.

Although Medicare is critically important to people age 65 and older, Medicare has major gaps in coverage—including the lack of a prescription drug benefit and inadequate coverage in other areas. This reality forces beneficiaries to buy additional insurance privately. Compounding the problem is the fact that the coverage needed to supplement Medicare is becoming increasingly unaffordable or unavailable. As a result, supplemental coverage of Medicare beneficiaries through the individual market has declined substantially. Even Medicare+Choice benefits that have been reasonably priced in the past are becoming more expensive and less generous.

Minorities of all ages, uninsured 50 to 64 year olds, and people of all ages needing such services as mental health care and long-term care continue to have difficulty accessing care.

For people age 50 and older, total health care costs are up substantially from 20 years ago, even after adjusting for general inflation. Health care costs pose a particular burden for those in need of prescription drugs or long-term care services and those with low incomes who do not have Medicaid. High out-of-pocket costs are increasingly a problem for older people who see themselves as unhealthy.
Between 1977 and 1996, average total health care spending per person age 50 and older (including home health care but not nursing home care or other long-term care services) increased 310 percent to $3,881—nearly twice as fast as general inflation. Prescription drugs accounted for a larger share of these costs in 1996 (15 percent) than in 1977 (6 percent), and they also became a more significant source of out-of-pocket costs.

Health care costs especially threaten the health and financial security of less healthy and lower-income people. For example, the share of 50 to 64 year olds in fair or poor health who spent more than 10 percent of their income on health care products and services increased from 21 percent in 1977 to 27 percent in 1996. More than four in 10 older adults in the lowest income quartile spent more than 10 percent of their income on health care in 1996.

Chronic conditions are responsible for a large—and increasing—share of dollars spent on health care in the U.S. Chronic illness, disability, and functional limitations increase with age, contributing to higher health care and long-term care costs. For the “oldest old” and people with disabilities, nursing home care and home care replace acute care as the major drivers of costs. A larger proportion of the older population spends a lot of money on health care. In 1996, the top 2 percent of elderly persons accounted for only 22 percent of total health spending for this age group compared to 33 percent in 1977.

Out-of-pocket spending on long-term care, as well as spending on prescription drugs, represents the greatest health-related financial risk for older Americans, particularly for people of advanced age who have or who may develop cognitive, mental, or physical disorders. Americans seem to understand their vulnerability to burdensome long-term care expenses: in 2000, most older adults said they were not confident that they could afford either nursing home care or home care.

Caregiving provided by family and friends remains the cornerstone of long-term care in the U.S. In 2001, about one in five Americans age 50 and older said they or a spouse were providing help with everyday activities to a disabled relative or friend. Caregivers age 50 and older make enormous unpaid contributions to caring for people with disabilities: an average of more than 20 hours of care per week, with more than half of the caregivers providing care for at least five years in duration.

Fifty to 64 year olds tend to view health and long-term care systems differently from people age 65 and older. Moreover, the perceptions and preferences of people age 50 and older do not match reality in several key areas.

Fifty to 64 year olds tend to be more skeptical and have higher expectations and more “proactive” views about the health care system than people age 65 and older. For example, people age 50 to 64 are much more likely than those age 65+ to want to participate actively in health care treatment decisions with their doctors. They are less likely to believe their doctors will tell them about medical mistakes. They are more likely to use complementary and alternative medicine. Finally, they are more
likely to use the Internet to obtain medical information.

- Areas in which reality does not match people’s perceptions or preferences with regard to health and long-term care include quality of care, pain control at the end of life, settings in which long-term care is provided, private long-term care insurance, and Medicare coverage. For example, consumers’ general satisfaction with the quality of health care they receive stands in stark contrast to the views of technical experts who warn of deficiencies. Low health literacy might contribute.

**Policy Implications**

Given these findings, the challenge for policy and practice is to ensure access to and delivery of high quality care at affordable costs so that individuals might reap the benefits of good health and society might reap the benefits of healthier populations.

1. Health security encompasses not only a person’s clinical condition but also underlying socioeconomic conditions that require attention. Older Americans in all age groups whose health security is most compromised include people in poor health, with low income, or of minority race or ethnicity. The health concerns of these special populations take on even greater significance given the increasing racial and ethnic diversity in midlife and elderly populations.

2. The health and long-term care “systems” must better address the needs of people who experience chronic illness, disability, or functional limitations. Increasingly, the needs of this population require a range of services that include physician, inpatient, outpatient, and long-term care. Thus, the goal should be a longer span of healthy life—improved quality of life and a greater ability to be active and function independently—not just a longer life.

3. Given that the public health system is the source of many tools important to improving and maintaining the health and functioning of Americans, health care resources should be used to strengthen the public health system, so that it can better support system goals. Specifically, a stronger and more visible public health system is needed in order to develop and promote population-based interventions aimed at modifying risky behaviors.

4. The general lack of long-term care coverage and the increasing inadequacy and instability of health care coverage for portions of the population age 50 and older must be addressed. Coverage is tenuous for some individuals in every age group 50 years of age and older, and all types of services are affected: basic medical, prescription drugs, other costs not covered by Medicare, and long-term care. Financially strong social insurance programs—such as Medicare or Social Security Disability Insurance—will need to become core elements of the solution. In particular, a new program of social insurance for long-term care is needed to complement the existing, mostly Medicaid-based sources of coverage, which are limited, fragmented, and do not protect people from impoverishment if they need extensive long-term care.

5. U.S. health care spending is high and varies across geographic regions, often without good reason. Societal values with regard to the availability and use of services and technologies, particularly the use of
“supply-sensitive” services, explain some of this spending pattern. Past improvements in health and well-being—and historical increases in health care spending—were, in part, the result of technological advances in preventing or treating health conditions; advances yet to come will, similarly, contribute to additional health gains. For many reasons, it is likely that future health improvements will require even greater resources, at least initially. It is desirable and possible to make better use of current and future resources.

6. Improving the quality of health care and long-term care is critical so that consumers receive greater value for their health care dollars spent. We must also invest greater resources in systems that will facilitate public reporting of information on health care performance which, in turn, could generate public demand for a more accountable system. Developing good measures of quality of life for people needing long-term care is another ongoing challenge.

7. Perhaps the single most significant barrier affecting our ability to improve health care quality and advance public accountability in health and long-term care is the lack of a health information infrastructure. Because substantial expenditures are required to develop this type of infrastructure, public/private sector collaboration is crucial. This kind of collaboration is also important in developing decision supports for consumers navigating their health and long-term care choices. Steps should be targeted toward improving the population’s health literacy.

Conclusion

This report presents a rich, varied picture of the current state of health security for Americans age 50 and older. Although we can applaud the successes of the past two decades, we also need to look at the serious problems that remain in ensuring access to and delivery of high quality care at affordable costs. These problems must be addressed if individuals are to reap the benefits of good health and society is to reap the benefits of healthier populations. Fortunately, public policy can make a difference. The challenges will be to find the right balance between individual and collective financial risk, between medical and supportive care, between private and public sector roles, between individual autonomy and public safety, and between public health and personal health services. At the root of these challenges is the need to generate and use information to better understand the nature of problems, to identify effective solutions, and to take action based on this knowledge. Finally, the problems documented in this report must be addressed along multiple fronts.
In 2001, AARP issued its first special report to the nation on the status of America’s midlife and older populations. The report focused primarily on overall well-being and economic security including three economic pillars of retirement security: Social Security, pensions and savings, and earnings. Health coverage was identified as the fourth pillar.

“Beyond 50: A Report to the Nation on Trends in Health Security” now captures a more comprehensive picture of the state of health care for older Americans.
Scope and Methodology of Report

The purpose of this report is to document the state of health care as it affects individuals age 50 and older. This report describes, and is organized by, a definition of the health care system and its adequacy that includes the familiar dimensions of coverage, access, cost, and quality. However, this report adopts an even broader view of health system adequacy that includes health and well-being and the need for informed decision-making/navigation. When applied to individual lives, these expanded dimensions of health system adequacy translate into a concept of health security that refers to:

- health and well-being—minimizing disease and maximizing physical and cognitive functioning for as long as possible. Factors affecting health and well-being include individual behavior or lifestyle, genetics, socioeconomic characteristics such as income and education, use of preventive and medical services, and the environment.
- coverage and cost—having health and long-term care insurance, through either public or private sources, that ensures needed services are affordable and that protects people from experiencing financial hardship as a result of using services;
- quality and access—receiving high quality, appropriate services when needed; and
- informed decision-making/navigation—using accurate information to become more knowledgeable so that decisions made and actions taken improve one’s health and long-term care circumstances.

In particular, informed decision-making/navigation is an increasingly important yet often-missing dimension in consumer thinking about health security. Informed decision-making has implications for each of the other dimensions. Equally important, the concept of enhancing understanding and acting on this knowledge is relevant to other players in—and functions of—the health care system, especially providers and government.

This report describes the health and health care of America’s midlife and older populations by examining the evidence related to these key dimensions of health security. In every case, the most current data available are used and, where possible, trends over time are noted. (The exact time frame will depend on the data source, but it often spans two decades for the overall population and covers the 1990s for the Medicare population). Every effort is made to present information for 50 to 64 year olds, 65 to 74 year olds, 75 to 84 year olds, and people age 85 and older. Depending on the issue, the data may be insufficient to support analysis for each of these groups. Whenever possible
and relevant, findings are presented for subgroups based on characteristics such as race or ethnicity, health status, income, gender, and insurance status or the type carried.

For this report, AARP conducted or commissioned original research and data analysis as well as compiled a vast array of previously published research findings. The primary sources of data presented in this report are:

- A series of national surveys conducted by the Agency for Healthcare Research and Quality (AHRQ) on the financing and use of medical care in the U.S. These surveys are the 1996 Medical Expenditure Panel Survey (MEPS), the 1987 National Medical Expenditure Survey (NMES), and the 1977 National Medical Care Expenditure Survey (NMCES). Unless otherwise indicated in the report, information presented for 1977, 1987, and 1996 comes from Project HOPE's analysis of these data sources for AARP.

- The Medicare Current Beneficiary Survey (MCBS), a continuous survey conducted since the early 1990s and sponsored by the Centers for Medicare and Medicaid Services (CMS). Unless otherwise indicated in the report, information presented about Medicare beneficiaries for 1992 and 1998 comes from WESTAT’s analysis of this data source for AARP.


- A variety of nationwide sample surveys of people (e.g., National Health Interview Survey); providers, including physicians (e.g., National Medical Ambulatory Care Survey), hospitals, emergency rooms, outpatient surgery facilities, home health agencies, and nursing homes; and vital statistics conducted by the National Center for Health Statistics (NCHS) as well as the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (BRFSS).

- Surveys of consumer attitudes conducted by polling companies and private organizations interested in health care issues, including AARP itself.

For analysis conducted or commissioned by AARP, results were not reported if the number of observations in cells was considered too small for estimates to be reliable. However, when comparing population responses, the results presented are not limited to those where differences among subgroups are statistically significant.

Consistent with the previous edition of Beyond 50, a convention of “quartiles” is used when analyzing income in some of the datasets mentioned above. This
means that all individuals age 50 and older are arrayed by family income and divided into four quartiles, each representing 25 percent of the population. The lowest income quartile refers to the 25 percent of individuals with the lowest incomes, the middle income group refers to individuals in the middle 50 percent of the distribution, and the upper income quartile refers to the 25 percent of individuals with the highest incomes.

While addressing a broad range of health care issues, this report acknowledges the significance of long-term care needs and long-term care services in the overall picture of care for older Americans. It does so by providing some information on the long-term care aspects of health and well-being, coverage, access, cost, quality, and informed decision-making/navigation. Long-term care, however, goes beyond services frequently thought of as “health care” to include a full range of non-medical services intended to help people function independently. Because the supportive services aspect of long-term care is so critical to the well-being of older Americans, a future edition of Beyond 50 will more thoroughly address independent living and long-term care.

Drivers of Change in the Health Care Environment

During the past 20 years, the health care system has undergone a significant and lasting transformation that has had profound effects on individuals. To give context to the major findings presented in this report and to help determine the factors that may account for the changes found, we have identified five phenomena as major drivers of change. These cross-cutting and recurring themes have had an impact on all of the components of health security addressed in this report.

Increased Reliance on Prescription Drugs and Other Innovative Technologies. Critical strides in the treatment of disease and related health conditions as well as technological advancement, especially in the form of new or improved prescription drugs, have brought major changes in the delivery of health care. These innovations have permitted less reliance on inpatient hospital care in favor of more outpatient ambulatory care, even for surgical and other medical procedures that had previously required lengthy hospitalizations. Accompanying the innovations—if not actually precipitating them—was the rapid transition from fee-for-service, where payment methods encouraged health care utilization and unfettered choice, to managed care, where capitated payments and other incentives forced a greater focus on cost containment and more restricted service use. Nevertheless, despite the rapidity of change in some areas, in others, the status quo was much more the norm.
Chronic Disease and Chronic Care. The aging of the baby boom generation has focused attention on their impending retirement and the demands they have already begun to place on the health care system. Although it is certainly true that aging is accompanied by chronic illness, even relatively young populations (i.e., age 50-64) have a high prevalence of chronic conditions. However, the system continues to be largely oriented toward acute medical care. Chronic conditions require more multi-disciplinary interaction and coordination, more patient-centeredness, and often more patient direction. People also in need of social and other supportive services face the daunting challenge of navigating a fragmented, uncoordinated “non-system” of long-term care. As society, in general, and the health and medical communities, in particular, prepare for the impact of the baby boomers, the health care system is being expected to address not only the acute and episodic needs of individuals, but also those needs that are longer term and sustained.

Greater Longevity and Functional Limitations. The greater longevity that characterizes the nation’s aging population has been hailed as a public health triumph. Indeed, the enhanced quality of life, as seen in the more active and vigorous lifestyles (including many of those affected by chronic conditions), has been an inspiring and gratifying product of the scientific progress noted above. On the other hand, for many others, greater longevity is eventually accompanied by disability and limitations in functioning. But such limitations do not need to lead to loss of independence. Increasingly, people who are older not only expect to live longer, they also expect to live independently and to “stay in charge.” Furthermore, there is growing awareness that quality of life matters, including at the end of life.

Patients as Consumers. Theories of competition and market-driven economics envision the role of patients as active change agents. In these scenarios, patients will make choices that should lead to improvements. This thinking is based on the assumption that consumers will “vote with their feet” if only they have the information to make good—that is, informed—health care choices. Examples of approaches that view patients as consumers include use of direct-to-consumer advertising to promote prescription drugs as well as “report cards” used to rate the performance of providers, such as nursing homes, dialysis centers, hospitals, and HMOs.

As consumers have become more assertive about their preferences, they also have begun to influence the types of “products” available in the health and long-term care market place. They have had a part in creating more “open access” and less restrictive models of managed care as well as in starting to
expand coverage for complementary and alternative medicine in the acute care
arena and consumer-directed services and assisted living in the long-term care
sector. The question of whether the informed consumer strategy will achieve
the desired results is an important one. Clearly, more research could determine
how to present information to consumers in salient and useful ways. In
addition, while information is undoubtedly a necessary component of quality
improvement, it may not be sufficient to ensure that consumers are protected
from outright poor quality care.

Fluctuating Cost Growth. The most recent data presented in this report
are from the mid and late 1990s when growth in health care spending was
relatively low, and the economy was quite robust, which facilitated and even
hastened change. Now, medical inflation and the cost of health care have
begun rising faster again: compared to average annual growth of 5.4 percent
from 1994 to 1999, national health expenditures are projected to have grown
9.6 percent in 2001 and to continue growing at about 7 percent annually on
average from 2003 to 2011, reaching $2.8 trillion by 2011. Factors contributing
to the accelerated spending growth are the continuing introduction of higher-
priced medicines, the popularity of less restrictive forms of managed care where
fewer cost containment tools are at the plan’s disposal, provider consolidation,
weaker payer influence in selective contracting, and increased spending by
public health programs. Health care payers are feeling the effects, as are
consumers: employers are cutting back on coverage for retirees and increasingly
shifting the cost of remaining coverage to employees, policymakers are more
closely scrutinizing public program operations, and individuals are finding it
difficult to purchase comprehensive private coverage on their own. Slowing of
the economy, which negatively affects state and federal revenues as well as the
corporate bottom line, further intensified the system-wide health care-related
financial pressures.

Although many of these drivers of change have had a positive effect on the health
care system and individuals, as this report documents, there have been negative
consequences as well. For example, the systems of care and support have become
increasingly complex and fragmented, making the consumer role both more
critical and more difficult. Without major redirection of resources and focus,
this overall picture is not likely to improve. It remains to be seen how severe
the effects of the recent economic slowdown will be, but undoubtedly, they
will exacerbate the challenges we already face to assure health security for all.
II. THE BIG PICTURE
Overview of Trends Affecting People Age 50 and Older

Over the past two decades, greater financial security, healthier lifestyles, and advances in medical care have improved the health and qualify of life of many people age 50 and older. Certainly, in general, people are using available services more, are receiving more sophisticated care, and are living longer. Far fewer older Americans smoke, more are getting vaccinations and screening tests, and, except for the oldest age group, people are more likely to consider themselves to be in good health than in the past. Rates of heart disease, stroke, and limitations in instrumental activities of daily living have declined. An older person is less likely to find himself in the hospital than in the past, and prescription drugs are often now routinely used as front-line treatment. Alternatives to nursing home care are increasing, and there are signs that society is more aware of end-of-life issues. People can choose from a wider range of health coverage options, and consumers generally make efforts to be better informed about health issues. Thus, strides in economic security and certain aspects of health care have improved many dimensions of life for middle age and older populations. On several fronts, older Americans can be optimistic about the future.
However, many challenges to health security remain for people age 50 and older. Enjoying good health, having adequate health and long-term care coverage, being able to gain access to high quality care, not being financially devastated by health care costs, and being able to make informed health care decisions are circumstances out of reach for many. The number of people without coverage for needed services has increased, average health care costs per person have grown, the expanded role of prescription drugs places a particular out-of-pocket burden on people without adequate drug coverage, and there are serious deficiencies in health care quality. This picture may get worse in the current environment.

The situation is especially troubling for certain subgroups for whom access to care has been compromised. In particular, poor health, disability, low income, and minority race and ethnicity status remain major threats to health security for all older Americans. In addition, despite their younger age and relative health advantages, 50 to 64 year olds face a variety of health care-related challenges. These challenges include chronic conditions, disability and functional limitations, especially those related to obesity; relatively expensive premiums and the possibility that they will be denied coverage if they must seek it in the individual health insurance market; and inadequate knowledge on which to base planning for their future health security.

Health and Well-Being. The single most important fact about the population’s health is that people are living longer, and historical differences in longevity across gender and race are narrowing. As life expectancy has increased, so too has the likelihood of living alone. What has not changed is that women age 50 and older continue to have lower incomes than men, and non-white incomes lag far behind those of the white population. This suggests that women and minorities may be less able than white men to afford health and long-term care services.

Chronic conditions contribute to reduced quality of life and disability, which is consistently more prevalent among women than men. The majority of people age 50 and older today have at least one chronic condition and most have two or more conditions. In every age group 50 and older, people with incomes below 200 percent of the poverty level account for more than half of those with chronic conditions, disabilities, and functional limitations. Chronic conditions are also the cause of death for nearly three out of four Americans. For the past two decades, heart disease and cancer have been the leading causes of death for people 50 years of age and older.

Americans have learned much about how to safeguard their health, and many are doing what they can to live healthier, not just longer, lives. Smoking is on the decline, and use of preventive services and exercise has increased. Another
gauge of the population’s health, self-assessed health, has improved over time. Nevertheless, older Americans have not been able to improve two related behaviors that are fundamental to good health: diet and weight control. After nearly doubling from 1982 to 1999, obesity, a major risk factor for several chronic conditions, is most pronounced among people age 50 and older.

Coverage. The relatively steady role of employers in providing health coverage to 50 to 64 year olds obscures two critical facts. First, it is workers who account for the largest number of uninsured 50 to 64 year olds. Second, 50 to 64 year olds are more likely than adults under age 50 to be unconnected to the workplace, thereby facing higher risks of being uninsured. People in this age group who do not have employer-sponsored coverage are more likely to be uninsured (14 percent) than to have coverage from any other single source. One sign that this age group is vulnerable to the inability to get health insurance is that today the shares of 50 to 64 year olds in the middle and upper income quartiles who are uninsured have grown slightly compared to 10 years ago. A disproportionate share of those in the lowest income quartile continue to be uninsured.

People with Medicare are not immune from worries about health coverage. Among other concerns, they are worried about how well they are protected against expenses not covered by Medicare—such as prescription drugs—as well as the costs associated with covered Medicare services. Although most Medicare beneficiaries still have supplemental coverage to Medicare, this type of coverage is believed to be less prevalent today than in the recent past. Even with relatively low enrollment levels, Medicare+Choice plans have provided an important source of supplemental coverage across all demographic groups except residents of rural areas, although benefits—particularly prescription drugs—have become less generous in recent years.

People over age 50 are using more health care than in the past...seeing more specialists...going to emergency rooms more often...and making greater use of hospice services.

People age 50 and older are concerned about the affordability of health care expenses in general and their ability to receive the treatment they need in the future.
People over age 50 are using more health care than in the past, having care delivered in office and outpatient settings more often, seeing specialists more, being prescribed more drugs (especially people in fair or poor health), going to emergency rooms more often, and making greater use of hospice services. The bulk of their doctor visits continue to be related to chronic conditions, mostly for ongoing care rather than treatment of flare-ups, and nearly 70 percent of doctor visits for people age 50 and older resulted in a prescription in 1999. People age 65 and older are increasingly benefiting from medical interventions, such as heart surgery, joint replacement, and cataract surgery, which were previously limited to younger populations. Individuals in fair or poor health or with chronic conditions have more doctor visits at all ages, but people who also have disabilities and functional limitations require a far greater number of home health visits. In general, people with disabilities or functional limitations rely more heavily on social and other supportive services in addition to medical services.

Most people age 50 and older do not report major problems gaining access to the health care system in recent years. However, there are important exceptions: minorities of all ages, uninsured 50 to 64 year olds, and people needing services such as prescription medicines, mental health treatment, long-term care, and coordination of chronic care. In addition, across all age groups over 50, men use fewer services. Fifty to 64 year olds and people age 65 and older have common worries about health care access. Both groups are concerned about the affordability of health care expenses in general—and prescription drugs in particular—and their ability to receive the treatments they need in the future.
Long-Term Care. More than one-third of older Americans expect that they or a family member will need help performing everyday activities in the next three years. Although over two-thirds of our nation's long-term care expenditures are for care in nursing homes, three of four people age 50 and older would prefer to receive these services in their own homes as long as possible—preferably under their own direction rather than that of a home care agency. Assisted living is also preferred over nursing homes. In practice, most long-term care is provided by family members and other unpaid, informal caregivers. Caregivers age 50 and older make enormous unpaid contributions to caring for people with disabilities: an average of more than 20 hours of care per week, with more than half of the caregivers providing care for at least five years in duration. One in five experiences physical or mental health problems as a result.

Although unpaid, informal caregivers contribute greatly to overall care, individuals needing long-term care often face enormous out-of-pocket costs. Out-of-pocket spending by long-stay nursing home residents of all ages in 1996 averaged $12,000, or 33 percent of the total nursing home cost. (This average figure includes residents receiving Medicaid or Medicare as well as those paying privately.) Estimates of median basic expenses for assisted living, which are primarily paid out of pocket, range from roughly $22,000 to $26,000 per year. Home care expenses are especially steep for chronically ill people with disabilities or functional limitations.

Given the costs eventually faced by people needing long-term care, it is disturbing that four in 10 people age 50 and older say they do not know whether Medicare covers most long-term care in the nursing home or home, and another 15 percent mistakenly believe it does cover such care. Moreover, four in 10 older Americans think they have private long-term care insurance policies, but only 3.5 to 4 million—less than 10 percent of older adults—have such policies. These products reach a limited number of people because they remain unaffordable for many individuals or are not available due to medical underwriting.

Costs. Total per capita health care expenditures for people age 50 and older have increased dramatically from an average of $2,452 (adjusted for inflation to 1996 dollars) in 1977 to $3,881 in 1996. However, the highest health care spending is concentrated among a relatively small but growing proportion of users. Health care spending also reflects the types of care received. The share of older adults' total expenditures accounted for by inpatient hospital services fell from 67 percent in 1977 to 35 percent in 1996, while the proportions spent on ambulatory care and prescription drugs increased.
There has been no relief from the spending that individuals and families feel directly: premium contributions, cost-sharing, and uncovered services. Between 1977 and 1996, inflation adjusted out-of-pocket spending (not including premiums) increased slightly in dollar terms. Out-of-pocket spending on prescription drugs, however, increased 150 percent after adjusting for inflation. During this same time, a major shift occurred in the components of out-of-pocket spending. The ratio of out-of-pocket payments for prescription drugs compared to that for ambulatory care services increased for older Americans from 0.6 in 1977 to 1.7 in 1996. Although not counted as out-of-pocket spending by the data source used for this trend analysis, the cost of insurance premiums paid in part or in full by people age 50 to 64 with employer or individual coverage and by many people age 65 and older who supplement Medicare coverage must also be taken into account.

Out-of-pocket spending varies according to a person’s age, health status, income, and insurance coverage. More people in fair or poor health spend at least 10 percent of their income on health than do people in excellent to good health. Over time, even more people in fair or poor health have out-of-pocket costs of this magnitude, while fewer people in good or excellent health do. A very large proportion—43 percent—of the population age 50 and older in the lowest income quartile spent more than 10 percent of income for out-of-pocket health costs in 1996. Low-income people with full Medicaid coverage are largely protected from significant out-of-pocket costs, even more so than are beneficiaries with other types of public insurance, including Medicare.

Satisfaction. Despite their relatively neutral ratings of the quality of the U.S. health care system, consumers age 50 and older report that they are quite satisfied with the health care they receive. In addition, the share of Medicare beneficiaries reporting satisfaction has increased slightly between 1992 and 1998. People with low incomes or fair or poor health are somewhat less satisfied with many dimensions of care. It is important to note that the rosy picture painted by these findings contrasts greatly with the alarm raised by experts who have studied health care quality in the United States.
Overview of Trends Affecting People Age 50-64

Although the health and long-term care trends described above generally apply to 50 to 64 year olds as well, findings in several areas are especially dramatic for the youngest of older Americans. On a positive note, the increase in self-assessed “excellent” or “very good” health from 1982 to 1999 was substantial, second only to the magnitude of improvement for 65 to 74 year olds. Other interesting findings for the 50 to 64 year old age group are as follows:

- Looking across the 50+ age group, obesity prevalence in 1999 was highest among 50 to 64 year olds. Due in part to the rise in obesity, diabetes has been increasing, particularly among 50 to 64 year olds.

- Even in this younger age group, in 1996, nearly half of the population had a chronic condition but no disability or functional limitation, 15 percent had a chronic condition and disability, and 5 percent had a chronic condition, disability, and functional limitation. Chronic obstructive pulmonary disease rose between 1985 and 1995 from the fifth to the third most common chronic condition for women of this age.

- Almost one-fifth of adults receiving community-based long-term care are age 50-64. This age group is more likely than others to rely exclusively on informal unpaid care. In addition, among those who are unpaid caregivers, people age 50-64 are more likely than older caregivers to have jobs, so they are required to make significant economic sacrifices during peak earning years.

- Although 87 percent of 50 to 64 year olds had a usual source of care in 1996, Hispanic and non-Hispanic blacks were less likely than others to have a usual source of care, more likely to use clinics as their usual source, and less likely to have seen a health care professional in the last 12 months.

- While a relatively small proportion of 50 to 64 year olds were affected, nearly two-thirds of those who encountered difficulties, experienced delays, or did not receive needed care cited their inability to pay as the main deterrent. Uninsured 50 to 64 year olds were five times more likely than those with insurance to experience these access problems.
One in five adults age 50-64 reported their individual share of private insurance premiums, whether employer-sponsored or individually purchased, to be $2,000 or more per year.

Twenty-seven percent of people in fair or poor health and 17 percent of the uninsured spent more than 10 percent of income out-of-pocket on health care, while only 7 percent of healthier individuals spent 10 percent or more of their income on health care.

Only slightly more than half—a smaller proportion than among people age 65 and older—think the doctor spends enough time with them, and they are more skeptical about being able to choose a quality doctor in the future.

Midlife adults differ from other older Americans in how they obtain health coverage. More than two-thirds of 50 to 64 year olds in 1999 had coverage from an employer, which represents a small increase since 1989. In response to employers’ desire to curb escalating health expenditures, managed care has become so pervasive that 93 percent of workers in 2001 are in some form of managed care plan, although most of these plans are “open access” options. Although managed care plans dominate the market, 55 percent of enrollees say they have never been in a managed care plan, which simply indicates that consumers are confused about their health coverage.

Also during the last decade, Medicaid’s importance as a source of coverage to 50 to 64 year olds with fair or poor health increased. Medicaid, the nation’s major public financing program for providing health and long-term care coverage to low-income people, is financed jointly by federal and state governments and administered by states within federal guidelines. People in this age group who...
are disabled and have Medicare are likely to have Medicaid as a supplement, if they have any additional coverage at all. Nevertheless, only 27 percent of poor people age 50-64 received Medicaid, yet 20 percent of people with household incomes of $35,000 or more mistakenly think they could get it. At the same time, private individual insurance—with premiums for a healthy person in their 50s or early 60s typically priced two to four times higher than premiums for a 25-year-old—is playing a smaller role.

In addition to the proliferation of managed care, a major change in coverage for people age 50-64 is that being uninsured is the second most likely (14 percent) “insurance” category. Previously, private individual insurance rivaled being uninsured as the second most prevalent coverage category at 12 percent each. People with low income, ethnic and racial minorities, women, and those who are unemployed or not in the labor force are most likely to be uninsured; moreover, larger shares of 50 to 64 year olds in the middle and upper income quartiles are uninsured than 10 years ago.

So, it is not surprising that one in five people age 50-64 with health insurance are not confident that they will continue to have affordable health coverage until age 65 when they become entitled to Medicare. Especially vulnerable groups include early retirees and spouses of Medicare beneficiaries, particularly when the person has health problems. A troubling sign for these future Medicare beneficiaries is that, in 2000, four in 10 did not know that Medicare does not cover prescription drugs. In addition, uninsured 50 to 64 year olds are one of the groups least likely to know that Medicare does not cover most nursing home or home care.

Overview of Trends Affecting People Age 65 and Older

Due to data limitations, it was not possible to report consistently on people in the 65-74, 75-84, and the 85 and older age groups. Therefore, this section describes important findings regarding health care access, spending, and coverage for the combined age group of 65 and older or, in some cases, elderly Medicare beneficiaries. In addition to the information in the section on Trends Affecting People Age 50 and Older, the following specifically applies to people age 65 and older:

- The cost of prescription drugs can be a barrier to good health care. In 1999, 1.2 million Medicare beneficiaries did not fill a prescription written for them. More than half of these beneficiaries said it was due to financial reasons. People without coverage to supplement Medicare are nearly two times as likely not to have filled a prescription.
Among people age 65 and older living in the community, more than one in three report an unmet or undermet need for long-term care services. In addition, 20 percent of beneficiaries who began receiving home health care in January 2001 reported not receiving all of the home health care they need, particularly aide and rehabilitation services.

Non-Hispanic blacks and Hispanics are more likely than whites to report not having seen a health professional in the last 12 months and are most likely to use emergency rooms.

Unlike the case for people younger than age 65, as services and technologies have been made available to more older Americans, a larger proportion of elderly people spend a lot of money on health care today than in the past. The top 2 percent of elderly spenders accounted for only 22 percent of total spending in 1996 versus 33 percent in 1977.

About 26 percent of out-of-pocket health care spending by Medicare beneficiaries age 65 and older who are not living in institutions was accounted for by premiums paid for supplemental coverage from Medicare+Choice, employer-sponsored coverage, or private Medicare+Choice coverage. This reality indicates the magnitude of the gaps in Medicare coverage.

Out-of-pocket prescription drug spending has risen dramatically compared to ambulatory care, reflecting shifts in both use and coverage. For this age group, out-of-pocket payments in 1996 for prescription drugs were nearly three times that for ambulatory care services.

Average Medicare liabilities for elderly beneficiaries have increased from $1,260 (adjusted for inflation to 1999 dollars) in 1991 to $1,390 in 1999. The biggest liabilities and the components that have increased the most are Part B coinsurance and the Part B premium. Under current law, Medicare beneficiaries will bear an even higher share of program spending in the future than they do now.

By 2025, elderly Medicare beneficiaries are projected to spend about 30 percent of their income on health care. In 1996, beneficiaries in Medicare managed care plans were less likely to spend 10 percent or more of their income on health care than beneficiaries with private supplemental coverage or no such coverage.

Compared to people younger than age 65, elderly people are less likely to fear dying, being an emotional burden on family, depleting resources, and having their life artificially prolonged. They also are more likely (73 percent) than people younger than age 65 (60 percent) to trust their doctor to be forthcoming with information about a medical error.
Although nearly everyone age 65 and older has Medicare coverage, fully nine of 10 beneficiaries in 1998 had additional coverage to supplement Medicare. This number rose in the mid-1990s due to growth in Medicare+Choice enrollment: 17 percent of beneficiaries enrolled in Medicare managed care, 37 percent had employer-sponsored coverage, and 22 percent purchased individual Medigap coverage in 1998. Supplemental coverage among Medicare beneficiaries is now believed to be declining due to trends in employer-sponsored coverage, prices of Medigap policies, and managed care plan participation. Beneficiaries without a supplement to Medicare are more likely to have low incomes, be male (women are more likely to have Medicaid), be younger than age 65, or represent a racial or ethnic minority. Compared to the 90 percent of beneficiaries with supplemental insurance in 1998, roughly three-quarters of all Medicare beneficiaries had any drug coverage and only six of 10 had it through the entire year. Despite relatively low enrollment, Medicare+Choice has been a key source of supplemental coverage in the recent past because of its accessibility to all demographic groups except rural residents.

Lack of knowledge about their health coverage is a serious issue for older Americans. Among Medicare beneficiaries, minorities are least knowledgeable about coverage limitations of the program, and only one in 10 of all beneficiaries had adequate knowledge of the differences between original Medicare (fee-for-service) and Medicare managed care. People age 65 and older are also less confident than 50 to 64 year olds about their ability to make a good decision about long-term care insurance.

Overview of Trends Affecting People Age 85 and Older

To the extent that many of the health security indicators have an age-related pattern, the findings for people age 85 and older represent the extremes. For

PLAY

Compared to people younger than age 65, elderly people are less likely to fear dying, being an emotional burden on family, depleting resources, and having their life artificially prolonged. They also are more likely than people younger than age 65 to trust their doctor to be forthcoming with information about a medical error.
example, the oldest age group has, on average, far more limited financial resources to draw upon than their younger counterparts. Due to their higher rates of chronic conditions, disability, and functional limitations, their health needs can be extensive, ranging from technically sophisticated clinical and surgical care; to complex medical care; to extensive supportive assistance with physical, cognitive, and behavioral disorders. Therefore, while the general profile for the population age 65+ applies to this group as well, the following characteristics are unique to this age group:

- The pattern of higher additional years of life among whites than non-whites diminishes with age and eventually reverses for men such that additional life expectancy at age 85 is higher for black men than for white men.
- Compared with other age groups 50 and older, exercise, and gardening in particular, has increased the most for people age 75 and older. In addition, the prevalence of obesity was lowest for people age 85+ at 8.3 percent in 1999; nevertheless, obesity increased the most—it more than doubled—among this age group between 1982 and 1999.
- The “oldest old” face serious health risks. Unlike every other age group, the proportion of people age 85 and older who self-assessed their health as “excellent” or “very good” has declined slightly over time, which probably reflects the fact that people are surviving with conditions that previously would have resulted in earlier death. Forty-four percent of people age 85+ have chronic conditions combined with disability and functional limitations. White men age 85 and older have the highest rate of suicide compared with other subgroups of age, gender, and race.
- In addition to being less likely than other Medicare beneficiaries to know that Medicare does not cover all health care costs, the “oldest old” are less likely to be enrolled in a Medicare+Choice plan or have Medicaid as a supplement. Although Medicaid coverage among non-institutionalized poor elderly beneficiaries overall is higher (54 percent) than among poor 50 to 64 year olds, participation among people age 85 and older is especially low.
As age increases, ambulatory services and drugs decline as a share of total per capita health spending while home health care increases. The likelihood of this age group using home health services also increased over time from 25 percent in 1987 to 30 percent in 1996.

The share of older people in nursing homes declined between 1985 and 1999, and the steepest decline was among people age 75 and older. At the same time, the severity of disability has increased among nursing home residents, suggesting that people may be remaining longer in the community before entering nursing homes.

Because total per capita health care spending increases sharply with age, it is highest for people age 85+. This also is the age group for whom the difference between average total health spending ($7,453) and median total spending ($2,025) is most noticeable, demonstrating that not everyone in this age group incurs the very highest expenses.

By 2025, out-of-pocket health care spending among the oldest women with poor health, low incomes, and no supplemental coverage is projected to increase to $9,378 (in 2000 dollars), including $3,782 in Medicare-related liabilities.

Summary
To help readers profile each age group in terms of health security, this section provided an overview of the findings on the major age groups, which are presented in more depth in subsequent sections of this report. Many of the health security indicators have an age-related pattern with vulnerability generally increasing with age. At the same time, the fact that themes recur in each age group indicates that factors other than age have a large influence on health security.
The health of people age 50 & older
Over the last two decades, advances in medical care, healthier lifestyles, and greater financial security have improved the lives of many older Americans. Gains have been especially great for people in their 50s and early 60s and for those in the early years of retirement (age 65-74). For the “oldest old,” however, as well as for people with low incomes—especially women and ethnic or racial minorities—poor health remains a major threat to quality of life.
The Impact of Demographics

At the beginning of this new century, almost 77 million Americans are over the age of 50. More than half, 41.9 million Americans, are age 50-64. About 18.4 million Americans are between 65 and 74 years of age, 12.4 million are age 74-84, and more than 4.2 million people are age 85 or older. These individuals have clearly benefited from the capacity of medical technology to cure or manage the health problems associated with aging. But the health of the population 50 years of age and older is also shaped by complex interactions among economic status, education, lifestyle, and more subtle factors affecting access to and the use of health care, such as race and where people live.

Economic Well-Being. Economically, Americans age 50 and older have fared well over the past two decades. Median family income increased by more than 17 percent. One reason for this increase is greater workforce participation among older people and, in particular, among women, who currently constitute the majority (55 percent) of those older than age 50. Between 1979 and 1999, the percentage of Americans age 50-64 who were employed grew from 60 to 67 percent. Workforce participation among people age 65-74 also increased. In 1999, 2.1 million people referred to as “post-retirement” age (65-74 years) worked full time, and another 2.2 million worked part time. Altogether, more than 19 percent of people age 65-74 were employed in 1999, compared to less than 17 percent in 1979.

Over these same two decades, however, the family income of older retirees relative to the poverty level remained substantially lower than that of younger cohorts. The total median family income of people age 50-64 in 1999 was about $52,000. This level of income is significantly above the poverty level for a typical family of four ($17,029). Income is far lower for older groups, who are more likely to have retired, either by choice, due to loss of employment opportunities, or because of health limitations. In 1999, median family income was $29,900 for those age 65-74, $23,200 for people age 75-84, and only $17,500 for people over 85. For the oldest groups, median family income has remained several thousand dollars above the federal poverty level for couples in family units headed by someone age 65 or older ($10,075).

Within each age cohort, gender, race, education, and urban or suburban versus rural residence are all important—and often interdependent—factors affecting income and other aspects of economic and health security. Women's incomes are significantly lower than men's for every age group over 50. Within the oldest group, where close to 69 percent are women, this difference is profound: median family income for women age 85 and older amounts to
only 65 percent of median family income for men over 85. Nonwhite older Americans’ incomes lag far behind those of the white population. This disparity is especially notable among younger age groups, for whom differences in earnings before retirement affect resources during retirement. In 1999, whites age 50-64 had median family incomes $11,600 higher than nonwhite families (a difference of 27.6 percent), and the median family income for nonwhites age 65-74 was $8,300 (37 percent) less than that of whites.

The post-retirement population received less formal education than the newest older Americans, and this too has a bearing on retirement income. Only about 15 percent of Americans age 50 to 64 have less than a high school education, compared to 31 percent of Americans age 65 and older. Educational levels matter because they affect earnings: more than 45 percent of those over age 65 who did not graduate from high school have incomes in the lowest quartile among all people over age 50. There is, however, potentially good news here: as the U.S. population ages, more elderly people can be expected to enjoy the benefits of greater education, including higher earnings and better retirement incomes.

**Home and Family.** As people age, family support—either economic or in the form of social support, help with the activities of daily living, or personal health care—can become critically important for maintaining good health. Spouses help care for many older Americans. But the longer people live, the more likely they are to live alone than to share a household. This is especially

---

**PAUSE**

Among the older age groups, about one-third of the people providing help to older people who have some limitation in daily activities are adult children.

**FAST FORWARD**

During the “baby bust” that began in the 1960s, there was a marked increase in the number of women not having any children. This means that people now in their 50s or early 60s will be more likely than past generations to have no adult children to help them as they age.
true for women above the age of 75: half of all women age 75-84 and 58 percent of women age 85 or older lived alone in 1999. Also important is the fact that, compared to two decades ago, a somewhat smaller proportion of women age 65 to 84 and a much larger share of women age 85+ are living alone. Overall, the percentage of people age 50 and older who are living alone has increased slightly over time. As these individuals age, they are likely to add to the ranks of people who need help but cannot depend on a spouse to provide it (Figure 1).

Adult children also provide vital support to parents. Among the older age groups, about one-third of the people providing help to older people who have some limitation in daily activities are adult children. The likelihood of having adult children, however, varies across ages. Parents of the baby boomers are now moving into their 70s and 80s. But during the so-called “baby bust” that began in the 1960s, there was a marked increase in the number of women not having any children. This means that people now in their 50s or early 60s will be more likely than past generations to have no adult children to help them as they age.

Another demographic factor that affects the health and health care of older Americans is where people live. Older Americans, especially people 75 years of age or older, are more likely than others to reside in rural areas, where incomes are generally lower, and populations and services are more geographically dispersed. More than half of people 75 years of age or older living in nonmetropolitan areas have incomes in the lowest quartile of incomes of people age 50 and older. As the population ages and migration patterns within the U.S. shift, residential patterns will change. Current trends include the movement of working age adults to more urban areas, particularly in the West and the South. Population subgroups that represent a growing percentage of the total U.S. population, including African Americans and Hispanic populations, are also more likely than their counterparts to live in urban areas. Over time, subgroups of people age 50 and older are, therefore, more likely to live in urban areas than today’s older Americans. These individuals are expected to benefit from factors—such as less exposure to risks for unintentional injury, greater economic resources, access to health care services, and availability of social supports—that appear to be associated with better health in urban and suburban communities.
Health and Well-Being

Living Longer. The single most important fact about the health of the population age 50 and older is that people are living longer. At age 50, Americans can, on average, expect to live another 30 years, almost two years longer than expected 20 years ago and nearly nine years longer than expected in 1900. Americans age 65 have an additional life expectancy of almost 18 years, people who are now 75 can expect to live more than 11 more years, and people 85 years old today can expect to live to past 90.11

Across the total population, life expectancy is higher for women and for whites (versus nonwhites). The differences in life expectancy among men and women have narrowed over the last two decades (Figure 2). Among the older age groups, racial differences in additional years of life diminish; in fact, for the 85 and older group, the additional life expectancy of black men actually exceeds that of white men. Income is also a factor in life expectancy. Within age subgroups of white men, white women, black men, and black women age 65 and older, those with higher incomes have longer life expectancies, although the benefits of higher income are less pronounced among older Americans than among younger people (those younger than 45).12

While longer life expectancy contributes to the aging of the population in the U.S., factors with greater impact include the aging of the “baby boomers” and declining fertility. By the year 2025, there will be almost 25 million Americans age 75 or older, and, of these, more than 6 million will be older than 85 years of age.13 Among industrialized nations for which the aging of the population is a common phenomenon, the United States population is relatively “young.”14
Increased life expectancy is related, partly, to better public and environmental health and to medical care, including advances in the prevention, treatment, and management of serious illness. Cleaner air and water and workplace health and safety programs designed to reduce exposure to environmental hazards reduce the risk of cancer, lung disease, and heart disease. Health care interventions such as medications to control blood pressure, adult onset diabetes, and blood cholesterol can prevent or delay the onset of serious debilitating disease. Surgical procedures developed and significantly refined over the past several decades—such as coronary bypass grafts, major joint replacements, and procedures to remove cataracts—greatly enhance the quality of life of older Americans.

For their part, Americans have learned a lot about how to safeguard their health, and many have made an effort to do what they could to live healthier, not just longer, lives.

- **Smoking:** A lot fewer older Americans are smoking. Over the last two decades, smoking among women age 50 and older declined by 23 percent and the percentage of men reporting that they smoke declined by 36 percent. For this age group overall, smoking has been reduced by 29 percent. Still, in 1998, one in four 50 to 64 year olds reported that they smoked, compared to only one in 10 people age 65 and older. Men are more likely to smoke than women at nearly every age.\(^\text{15}\)

- **Preventive Care:** More American women are having mammograms and Pap smears than a decade ago, and more Americans are having their blood pressure checked and getting pneumonia shots.\(^\text{16}\) Other data show that the percentage of Medicare beneficiaries age 65 and older reporting that they received basic preventive services (including blood pressure checks, cholesterol
screening, prostate exams, flu shots, mammograms, and breast exams) has increased markedly from previous levels. In addition, disparities in the use of these services across subgroups—including racial and ethnic groups as well as those with different levels of education—have narrowed. These findings suggest greater awareness of the importance of prevention and early detection of illness across the population.17

- **Alcohol Consumption:** Except for an increase in light drinking among people age 75 and older, changes in drinking patterns among older Americans over the past decade have been small. The proportion of nondrinkers among people age 75 and older fell from 67 percent in 1988 to 49 percent in 1998 for men, and from 87 percent to 75 percent for women. At the same time, the proportion of light drinkers (i.e., three or fewer drinks per week) in this age group increased from 12 percent to 31 percent for men, and from 12 to 18 percent for women. Increases in drinking in this age group were among whites; among blacks age 75 and older, the percentage of nondrinkers increased from 82 to 93 percent over the same time period.18

- **Exercise:** More Americans age 50 and older report they are making some efforts to exercise. The increase in the rates of people reporting that they do any form of exercise, in general, and gardening for exercise, in particular, was greatest in the 75 years of age and older cohorts. In the most recent studies, 35 percent of people age 85 and older reported walking to get exercise, while 25 percent reported gardening.19

There is, however, some bad news. There is no evidence that older Americans are, as a group, making much progress in improving their diets or controlling their weight. In fact, public health experts characterize obesity—defined as excessively high amounts of body fat in relation to lean body mass—in the United States as epidemic. The problem is most profound among older Americans: the prevalence of obesity among people age 50 and older increased 85 percent from 1982 to 1999 (Figure 3). In 1999, more than one-quarter of Americans age 50-64 and 22 percent of people age 65-74 were obese.20 The proportion of 50 to 64 year olds who are obese almost doubled, increasing from 14.4 percent in 1982 to 26.7 percent in 1999. Obesity increases the risk of serious illness, including high blood pressure,
type 2 diabetes, coronary heart disease, congestive heart failure, stroke, gallstones, gout, osteoarthritis, sleep apnea, and some forms of cancer (e.g., breast, prostate, and colon).  

People older than age 50 who are overweight or obese are having little success trying to lose or maintain weight. Less than one-third are eating the recommended portions of fruits and vegetables, less than half are exercising or trying to increase their level of physical activity, and less than 20 percent are trying to lose weight by combining diet with increased physical activity.  

Another gauge of population health is health status as perceived by individuals themselves. Over time, greater numbers of older Americans say that their health status is either “excellent” or “very good.” Among people age 50–64, the percentage saying that they are in “excellent” or “very good” health increased from 46 percent in 1982 to more than 54 percent in 1999, and among those age 65–74, the percentage grew from 35 percent to 42 percent.  

The oldest age groups, however, report only modest gains in health status. About 33 percent of people age 75–84 said they were in “excellent” or “very good” health 20 years ago, compared to 35 percent in 1999. The percentage of people age 85 and older reporting “excellent” or “very good” health actually declined.  

Expectations about health may change with age. As people age, “health” begins to encompass an increasingly complex set of considerations, including risk of disease and disability as well as threats to quality of life and independence. So perhaps it is not surprising that the oldest age groups report lower levels of self-assessed health. However, reported health status also varies significantly within age groups. The proportion of African Americans who rate their health
as “excellent” or “very good” is markedly lower than for whites among all age cohorts; furthermore, among African Americans age 50 and older, the percentage reporting “excellent” or “very good” health increased slightly over the past decade (Figure 4).

Chronic Illness and Disability

Changes in population health status are clearly related to changes in the prevalence of illness and disability: there is evidence that disability rates among older Americans have been declining in recent years. However, these declines vary across types and levels of disability, and among different groups of older persons. Evidence of disability declines is strongest for the most highly educated—a broad marker of higher socioeconomic status. Declines have also been greater for people with limitations in “instrumental activities of daily living” (IADLs), who need assistance with everyday household chores such as shopping and cooking, compared to those with more severe limitations in “activities of daily living” (ADLs), who need assistance with personal care.

Considerable debate is occurring among researchers about what might be causing these declines. Among possible explanatory factors are improvements in medical care and technology; changes in socioeconomic status; changes in health behavior; changes in disease exposure; increased use of assistive aids (ranging from shower handrails to microwaves to street ramps); and changes in social and family support. There is also no consensus among researchers about whether these changes have been persistent over the last several decades, or whether they are likely to continue.

Common Chronic Conditions. Although many chronic conditions are leading causes of mortality among people age 50 and older, some of the most prevalent chronic conditions lead to reduced quality of life or disability rather than death. Typically, individuals must cope with such conditions, which can only rarely be cured, over many years. Although some chronic conditions—such as mild visual impairments—may be a problem only occasionally, others—such as severe arthritis—place ongoing health and financial burdens on individuals and their families. The great majority of Medicare beneficiaries age 65 and older experience two or more chronic illnesses at the same time, i.e., 62 percent of 65 to 74 year olds; 76 percent of people age 75-84; and 82 percent of those age 85 and older.

Arthritis is the most common chronic condition among all groups age 50 and older. Hypertension, which can lead to both heart disease—the fourth leading chronic condition—and stroke, is second. Hearing impairments and deafness...
are third; these and other sensory losses, such as visual impairments, can limit independence in performing activities of daily living, getting from place to place, and communicating with others. Chronic obstructive pulmonary disease (COPD), diabetes, and cataracts (or other visual impairments) round out the top seven chronic conditions. A less visible chronic illness affecting millions of older adults is depression, which often co-occurs with heart disease, stroke, diabetes, cancer, and dementia. Major depression, a significant predictor of suicide in older adults, is widely under recognized and under treated. Approximately 5 percent of people age 65 and older living in the community are diagnosed with major depression, and another 15 percent have significant depressive symptoms that are substantially disabling.

Although the likelihood of having at least one chronic condition increases with age, the prevalence of specific chronic conditions differs by gender as well as age (Figure 5). For example, arthritis is more prevalent among women; it is the most common chronic condition across all older female age groups, followed by hypertension. For men, the pattern is more varied: hypertension is the leading chronic condition among those age 50-64, arthritis among those age 65-74, and hearing impairment/deafness among those age 75 and older.

Important trends over the last several decades include the increasing prevalence among women ages 50-64 of COPD, which rose from the fifth to the third most prevalent chronic condition among women of these ages between 1985 and 1995. This trend may reflect prior smoking patterns among this age group. In addition, diabetes has been increasing among older men and women, particularly 50 to 64 year olds, due in part to the growing epidemic of obesity. Among racial and ethnic groups, blacks have the highest rate of diabetes.

Chronic Conditions and Disability. As with chronic conditions, functional limitations become more common with age. The vast majority of Americans age 50 and older are living with one or more chronic conditions, disability, or limitation in their ability to function (Figure 6).
For example, only 30 percent of 50 to 64 year olds and 4 percent of people age 85 and older have no chronic condition, disability, or functional limitation.

Many people with chronic conditions are able to lead active lives without significant health burdens. But “life expectancy” is not synonymous with “health expectancy,” e.g., the years one lives free of activity limitation. As people age, health and independence are threatened: it becomes increasingly rare as one grows older to have a chronic condition without accompanying disability or limitation in daily functioning. While 47 percent of 50 to 64 year olds are coping with chronic conditions only, this is true for only 17 percent of people age 85 and older. Moreover, the share of individuals who are living simultaneously with chronic illness, disability, and limitations in functioning rises steeply from 5 percent of 50 to 64 year olds to 44 percent of people 85 and older. Individuals in this very physically vulnerable subgroup are disproportionately low income. In 1996, more than half of those in every age group 50 and older with all three types of limitations had incomes below 200 percent of the poverty line ($7,525 was the poverty threshold for a single-person family over age 65).

The prevalence of disability is consistently higher in women than men. For example, among people age 70 and older, a larger share of women than men have difficulty with basic activities of daily living, such as dressing or eating. More than half of women in this age group, compared to 36 percent of men, report difficulty with mobility, such as walking across a room or climbing stairs. The gender differential is even larger—57 percent versus 28 percent—for difficulty with strength activities. Whether these differences are due to gender per se or to gender differences in diseases and conditions causing disability is the subject of ongoing research although, according to a recent study, there is evidence of both.
Leading Causes of Death. Nearly three out of four Americans die as a result of chronic illnesses. Despite improvement in prevention, management, and treatment of health problems, heart disease and cancer have remained the leading causes of death for people age 50 and older for the past two decades, although deaths from heart disease and stroke have declined dramatically for all older age groups. The order of ranking of these leading causes of death differs somewhat by age. For example, cancer is the leading cause of death for people age 50-74, while heart disease is for people age 75 and older (Figure 7). COPD—including bronchitis, emphysema, and asthma—is the third leading cause of death among people age 65-74, and the fifth leading cause among 50 to 64 year olds and people 75 and older. Other chronic conditions that are major causes of death for people age 50 and older are stroke and diabetes.

Beyond these key causes of death affecting all age groups are other causes that have greater significance to the oldest age groups. Although infectious diseases are no longer the most common causes of mortality, the relative importance of pneumonia and flu as causes of death increases with age. Among people age 75 and older, these infections rank as the fourth major cause of death. In addition, Alzheimer’s disease is now among the 10 leading causes of death for people age 75 and older, and its prevalence increases steeply for people 85 and older. Although the number of deaths from suicide remains relatively small, the rate of suicide deaths is much higher for older white men—and highest for white men age 85 and older—than for any other age group, including teenagers. Suicide ranks among the 10 leading causes of death for people 50-64, with the prevalence also being much higher for men (Figure 8).
Summary

Older people are living longer and, in some cases, living healthier too. The health improvements documented in this section have been attributed to improved socio-economic status, to the health system—including public health measures, the delivery of medical care, and better coverage for preventive services—and to individuals being more informed and taking better care of themselves. At the same time, there are plenty of indications that the behavioral and system changes to date have not been enough. For example, men age 85 and older are at the highest risk of suicide, and obesity is considered “epidemic” by some experts. Chronic conditions continue to be common among people age 50 and older. Yet it’s the presence of disability and/or functional limitations that has the greatest implications for health and well-being and, as will be seen in subsequent chapters, for coverage, service use, and spending.
IV. IN THE SPOTLIGHT

the

import

of health &
Having health coverage is associated with better access to care and better clinical outcomes. Age and employment status are major factors in whether and where older Americans get health coverage. Prior to age 65, the vast majority of adults age 50 and older have coverage through their employer or their spouse's employer. People age 50-64 who do not have coverage through an employer are more likely to have no coverage than to either buy coverage as an individual in the private market or be covered through a public program. At age 65, the role of public health coverage changes: Medicare becomes the near-universal source of health coverage—only 1 percent do not have Medicare—and the role of employer-sponsored coverage diminishes. Although Medicare provides a reliable source of basic coverage, beneficiaries are not free from financial worries: slightly more people age 65 and older say they are concerned about health expenses, such as Medicare cost-sharing and uncovered services, and coverage compared to adults age 50-64.36

Patterns of long-term care coverage are more closely related to income, since Medicaid eligibility and private insurance purchase is largely a function of financial resource levels.
Coverage for People Age 50-64

**Sources of Coverage.** In 1999, 70 percent of adults age 50 to 64 relied on private health coverage that they obtained through an employer (Figure 9). This represents a small increase since a decade ago and likely reflects both the strong economic conditions at the end of the 1990s and the generally higher labor force participation by this age group. The second largest “coverage category” for 50 to 64 year olds in 1999 was the uninsured (14 percent or 5.6 million) and represents the most striking change compared to 1989, when individual private insurance tied with being uninsured as the second most prevalent coverage category (12 percent each). By 1999, only 7 percent of the age group purchased private insurance on their own, and 8 percent were covered through public programs such as Medicaid (5 percent), Medicare, and military health. The rising cost of private health insurance in the 1990s may have led those without employer-sponsored coverage or eligibility for public coverage to simply go without.

Within the 50-64 year age group, the role of different sources of coverage varies. Most notably, between the ages of 50-54 and the ages of 60-64, there is a sizeable decrease in the share of people with coverage through an employer (from 75 percent to 63 percent in 1999) and an increase in people with individually purchased private coverage (from 6 percent to 10 percent) or public coverage (from 6 percent to 12 percent). In addition, a slightly larger share of people age 60 to 64 are uninsured (15 percent) than are 50 to 54 year olds (13 percent).

A person’s health status also has a dramatic impact on the source of health coverage. In 1996, 50 to 64 year olds who rated their health as “fair” or “poor” were less likely than their peers in “good” to “excellent” health to have private health insurance coverage (53 versus 85 percent) and more likely to rely on public programs (29 versus 5 percent) or be uninsured (18 versus 10 percent). Medicaid, in particular, has grown in importance over the past decade,
covering twice as many people age 50-64 in fair or poor health in 1996 (20 percent) as it did in 1987 (10 percent).

Sources of Coverage Vulnerability. Adults age 50 and older feel vulnerable when it comes to health care. Three-quarters of the 50 to 64 year old age group consider the cost of health care and medical expenses to be a major challenge facing people older than age 55, ranking second only to concern about financial security after retirement. Lack of adequate health coverage ties for third along with concern about taking care of elderly parents. This vulnerability extends well beyond people who are currently uninsured and is borne from an awareness that changing life circumstances—leaving the labor force or the death of a spouse—can mean losing access to health coverage upon which one has relied. Not surprisingly, an overwhelming majority of uninsured 50 to 64 year olds say they are very or somewhat concerned about finding health insurance they can afford. However, an additional one in six insured people in the same age group are not confident that they will continue to have affordable health coverage until they become eligible for Medicare.

In 1999, 1.7 million more 50 to 64 year olds were uninsured than in 1989. People age 50-64 with certain demographic characteristics are at greatest risk of being without health coverage:

- 30 percent of people in the lowest income quartile were uninsured in 1999. This group is twice as likely to be uninsured as 50 to 64 year olds in the middle income quartiles and five times as likely as people in the highest income quartile. It is important, however, to note that the risk of being uninsured grew over time for 50 to 64 year olds in the middle and highest income quartiles (Figure 10).
- One in three Hispanics, nearly one in five non-Hispanic blacks, and one in four other non-Hispanic minorities were uninsured, compared to one in 10 whites.
- Women (15 percent) were somewhat more likely to be uninsured than men (13 percent).
- People who are widowed, divorced, separated, or never married were at least one and a half times as likely to be uninsured than their married counterparts. Likewise, households composed of a single adult with dependents were twice as likely as married couples or single adults without dependents to be uninsured.

More adults in their 50s and early 60s have faced or will face the problem of being uninsured.
than indicated by the number of uninsured at any given point in time. While 15 percent of people age 50-64 reported that they were uninsured in 1999, 21 percent reported having been without health insurance for a period of time since they reached age 50. Americans age 50-64 were more likely to have been previously uninsured if their incomes were below 250 percent of the poverty level (48 percent) or if they were an ethnic or racial minority (33 percent). Two-thirds of 50 to 64 year olds who were uninsured in 1999 were without health coverage for a year or longer, and roughly half were without coverage for more than three years.

For those who live with others as part of an economic unit, having someone in the household without insurance can result in the need to contribute personal resources to help pay for that individual's health care. Among the 4.9 million uninsured individuals age 50-64 living in a household with others in 1999, 37 percent were in households where no one had insurance, a drop of more than 10 percentage points since 1989. This may reflect the strong economy of the 1990s or expansions in public program coverage, particularly for uninsured children. Among the 29.7 million insured individuals age 50-64 living in a household with others, 15 percent were in households where at least one person was uninsured and may have been receiving direct or indirect assistance with health expenses from the older adult.

Because health coverage for 50 to 64 year olds depends highly on labor force participation of the individual or a spouse (Figure 11), the absence of a direct connection to the workplace increases the risk of being uninsured. Among the very small share of 50 to 64 year olds who were unemployed in 1999, three in five had employer coverage—mostly in their own name but some as dependents—but the majority of the remaining 40 percent were uninsured. In addition, about one-third (31 percent) of adults age 50-64 were not in the labor force in 1999 because they were taking care of the home, retired, or unable to work, e.g., for health reasons. Employer-sponsored coverage provided for only about half (49 percent) of these individuals; 23 percent had this coverage as a dependent. Of the remaining 50 to 64 year olds not in the labor force, 23 percent had coverage through a public program, 18 percent were uninsured, and 10 percent purchased private individual coverage.

“Early” retirees, who make up nearly half of 50 to 64 year olds not in the labor force, risk changes in their health coverage when they sever employment. Nearly eight in 10 adults age 50-64 who were employed in 1999 had coverage through an employer: 66 percent held it in their own name and 15 percent were covered as a dependent under a family member. By comparison, only 60 percent of early

![Figure 11: Source of Insurance Coverage for People Age 50-64, by Employment Status, 1999](source: AARP Public Policy Institute analysis of Current Population Survey, 2000, March Supplement.)
retirees had health coverage through an employer, including 35 percent as a dependent, and the proportion that purchased coverage on their own or were uninsured was slightly higher than among working 50 to 64 year olds. These differences in access to health coverage affect retirement decisions. Just more than one-third of early retirees said that their own coverage and that of their family was either somewhat of a factor or a major factor in their decision, and nearly two-thirds of people who are still working but considered changing jobs, cutting back work, or retiring before age 65, said the same. About 14 percent of early retirees are Medicare eligible, suggesting that disability played a role in their retirement.

A decline in the availability of employer-sponsored coverage for early retirees means that, in the future, more people who retire early will need to find alternative coverage until they are eligible for Medicare. Between 1993 and 2000, the share of employers with 500 or more employees who offered health benefits to early retirees dropped from 46 percent to 31 percent. Less than 8 percent of small employers offer coverage to retirees of any age.

Married couples of different ages eventually face the situation where one person is eligible for Medicare and the other is not yet eligible. Between 1989 and 1999, the number of people age 50-64 whose spouses were on Medicare rose from 680,000 to 1.1 million, or 8 percent of 50 to 64 year olds who are married. If these 50 to 64 year olds and other family members were covered dependents on the health plan of the spouse now enrolled in Medicare, their coverage is likely to be affected, particularly if Medicare becomes the spouse's primary source of coverage. Coverage options for people in this situation include buying into the same employer

Married couples of different ages eventually face the situation where one person is eligible for Medicare and the other is not yet eligible.
group (under the Consolidated Omnibus Budget Reconciliation Act (COBRA) protections); enrolling in coverage from their own employer, if they work and coverage is available; buying private insurance on their own; and qualifying for Medicaid or another public program. If none of these options is available, the people not on Medicare typically go without health insurance for a time.

Among people age 50 to 64 with a spouse on Medicare, the majority relied on employer-sponsored coverage in both 1989 and 1999 (53 percent and 57 percent, respectively), which was markedly lower than their counterparts whose spouses were not on Medicare (80 percent in 1999). The fact that this employer-sponsored coverage is predominantly in the non-Medicare enrollee’s name suggests that these individuals are working or have continued coverage through COBRA. However, other private insurance plays a larger role—accounting for the coverage of 13 percent of 50 to 64 year olds with Medicare spouses, compared to 6 percent among people whose spouses are not on Medicare— as does Medicaid and being uninsured.

Health coverage in the private insurance market can be difficult to find and expensive for 50 to 64 year olds. Examples of people in this situation include younger spouses of Medicare beneficiaries, early retirees, part-time workers without employer-sponsored health benefits, and people whose poor health prevents them from continuing to participate in the workforce. Nine in 10 adults in this age group said that they would be somewhat or very concerned about being able to find affordable coverage if they were suddenly without health insurance. Although employers are not allowed to discriminate among employees or their dependents in offering health coverage, people seeking private insurance outside of a group do not always have the same legal protections. Insurers generally screen people applying for coverage to determine whether they are acceptable risks. Because health risk increases with age, people in their 50s and early 60s who are offered policies are usually charged higher premiums. For example, compared to a 25-year-old, healthy people in their 50s generally face premiums two times higher, and healthy people in their 60s face premiums three to four times higher (Figure 12).

When an individual applicant or family member on a family policy has an existing health problem, most states allow insurers in the nongroup market to turn down the application;
to restrict (or exclude) health care related to the particular health problem for a specified time period (or permanently); or to charge higher premiums based on health status. People who are switching from group to individual policies are guaranteed access to certain types of coverage under the Health Insurance Portability and Accessibility Act (HIPAA), but the premium may still be unaffordable. One recent study found that, regardless of age, individuals with a health condition face average premiums that are 38 percent higher than those quoted to similar people without health problems. The average premium in the individual market for people of all ages with health problems was $3,966 per year in 2000 compared to $2,988 for someone in good health. The average premium for someone with a health problem rose to $4,056 and $9,936 for applicants age 56 and 62, respectively.

People age 50-64 without access to private sources of coverage may have the option of coverage through public programs. However, eligibility requirements limit how many will qualify. For example, for people younger than age 65, Medicare coverage is only available to people qualified as disabled and receiving Social Security Disability Insurance.

Similarly, eligibility for Medicaid coverage is limited mostly to low-income people who fall into certain categories—such as children, pregnant women, disabled, and elderly—and who meet financial and other requirements. Medicaid is the nation's major public financing program for providing health and long-term care coverage to low-income people. Financed jointly by federal and state governments, Medicaid is administered by states according to federal guidelines, which results in large state variations in coverage.

A glaring omission in Medicaid eligibility is the exclusion of coverage for low-income adults without children. Therefore, people age 50-64, who account for 8 percent of the total Medicaid population, primarily qualify for Medicaid by being totally and permanently disabled and either having low enough financial resources to meet eligibility criteria or using a state's medically needy program to deduct medical expenses from income in order to meet the financial criteria. As a result, only about one in four poor 50 to 64 year olds (27 percent) have Medicaid coverage. Because people are unfamiliar with eligibility rules, they may have the false impression that public programs can help them. In 2001, roughly 20 percent of 50 to 64 year olds with household incomes greater...
While nearly 80 percent of Medicare beneficiaries living in the community are aware that Medicare does not cover all health care costs, this awareness is much lower among the very youngest (70 percent) and the very oldest beneficiaries (69 percent) as well as among Hispanics (69 percent) and non-Hispanic blacks (57 percent). Knowledge about traditional Medicare's lack of coverage for most prescription drugs has improved over a relatively short period of time, but it is still lower among 50 to 64 year olds (59 percent) in 2000 than people age 65 and older who are already enrolled in the program (69 percent).  

Coverage to Supplement Medicare. Roughly 90 percent of beneficiaries in 1998 supplement Medicare with coverage from other sources, including a current or former employer (37 percent), private individual “Medigap” insurance only (22 percent), and Medicaid (14 percent). In addition, Medicare managed care plans, referred to as Medicare+Choice plans, have historically functioned as a supplement by offering additional benefits to enrollees (17 percent). The share of beneficiaries with supplemental coverage rose somewhat from 88.3 percent in 1992 to 90.6 percent in 1998, a trend that primarily reflects the large growth in Medicare managed care enrollment during the mid-1990s that outweighed decreases in private sources of supplemental coverage (Figure 13). However, since 1998, there are signs of a potential overall reduction in the share of Medicare beneficiaries who have supplemental coverage, which can be attributed to (1) continued decline in employer-sponsored insurance coverage; (2) rising prices for Medigap policies; and (3) withdrawals of Medicare+Choice plans from the program starting in 1999.
Certain Medicare beneficiaries are more likely to have only had coverage through traditional Medicare in 1998 (Figure 14):

- **Income**—Sixteen percent of beneficiaries in the lowest income quartile had traditional Medicare only, compared to about 9 percent and 3 percent of those in the middle and highest income quartiles, respectively.
- **Gender**—Men are somewhat more likely (12 percent) than women (7 percent) to have traditional Medicare only, primarily because a larger share of women have Medicaid.
- **Disability**—While there is little age difference among beneficiaries age 65 and older in terms of the likelihood of having traditional Medicare only, beneficiaries age 50-64 who qualify for coverage due to disability are far more likely (nearly 25 percent) than those who qualify as aged (less than 10 percent) to have traditional Medicare only. Disabled beneficiaries are more likely to supplement Medicare with Medicaid but less likely to supplement it with private coverage.
- **Ethnicity**—Non-Hispanic black beneficiaries were more than twice, and Hispanics about 1.5 times, as likely as their non-Hispanic white counterparts, to rely only on traditional Medicare.

Insurance plans that supplement Medicare do not necessarily protect against all of the holes.

**FIGURE 14** Share of Medicare Beneficiaries Who Have Coverage Only Through Traditional Medicare, by Selected Demographic Characteristics, 1998

Source: WESTAT analysis of Medicare Current Beneficiary Survey for AARP Public Policy Institute.
in coverage— for example, long-term care or prescription drugs— thus leaving beneficiaries with sizeable expenses for health products or services in addition to the cost of supplemental coverage itself. Consider prescription drug coverage: while 90 percent of Medicare beneficiaries had supplemental coverage in 1998, only roughly three-quarters of beneficiaries had any coverage for prescription drugs and that figure is believed to have fallen to about two-thirds of beneficiaries by 2001 due to the actions of some employers and Medicare HMOs. Even those who have drug coverage through a supplemental source may only have it for part of the year. Although the share of Medicare beneficiaries without any prescription drug coverage for the entire year fell from 31 percent in 1995 to 24 percent in 1998, an additional 18 percent of beneficiaries had only part year coverage in 1998 (Figure 15). Beneficiaries with high incomes are more likely, and those with no chronic illnesses are less likely, to have drug coverage than their counterparts.

Sources of Supplemental Coverage.
Although its cost and generosity vary widely across employers, coverage from a current or former employer is the most common source of supplemental health coverage and is most frequently associated with prescription drug coverage: 45 percent of Medicare beneficiaries with prescription drug coverage in 1998 had an employer-sponsored supplemental plan. The share of employers offering supplemental health coverage to Medicare-eligible beneficiaries has fallen dramatically since 1993—explaining why the share of beneficiaries with employer-sponsored coverage has dropped from 39 percent in 1992 to 36 percent in 1998—and is expected to continue to decline. The reality is that access to employer-sponsored coverage is far from uniform among Medicare beneficiaries. Beneficiaries who have higher incomes and are age 65-74, male, or non-Hispanic white are more likely to have employer-sponsored coverage. Larger firms are also more likely than smaller ones to offer such coverage to retirees age 65 and older. Based on a recent survey finding that 60 percent of people age 65 and older believe that employers who provide pension benefits are also required to provide health insurance to their retirees, many beneficiaries will be unprepared to meet their health coverage needs in retirement.

While individually purchased “Medigap” coverage is the second largest source of supplemental coverage for Medicare beneficiaries, the
proportion of beneficiaries who purchased these policies fell from 30 percent in 1992 to 22 percent in 1998, largely due to the growth of Medicare+Choice enrollment during the same period. In many cases—for beneficiaries who are not low-income, do not live in an area with Medicare managed care plans, and are not offered employer coverage—Medigap is the only potential source of supplemental coverage. However, it may not be easy for beneficiaries to obtain or afford a policy. Medicare beneficiaries younger than age 65 and those who do not seek Medigap coverage within six months of enrolling in Medicare can be denied coverage. Some insurers have decided not to issue new policies; many of those that still do are not actively marketing their product, particularly if it includes prescription drug coverage. Premiums can be substantial—again, especially if drug coverage is included—and are rising (Figure 16). As a result, only 8 percent of Medicare beneficiaries with Medigap coverage had drug benefits in 1999. Even people who have drug coverage through their Medigap policies may face substantial out-of-pocket costs: on average, Medigap plans paid just 42 percent of policyholders’ prescription drug costs, while employer-sponsored coverage paid 71 percent of prescription drug costs for Medicare beneficiaries.

Men, lower-income beneficiaries, nonwhite beneficiaries, and those younger than age 65 are less likely to have individually purchased Medigap coverage than their counterparts. Disabled beneficiaries are disadvantaged because federal law that requires Medigap insurers to guarantee access without underwriting during the first six months of Medicare coverage does not apply to beneficiaries younger than age 65.

Medicare HMOs. Medicare HMOs—which have a long history of offering lower cost-sharing and covered benefits, such as prescription drugs, not included in the traditional Medicare package—are a key source of supplemental coverage. In 1992, about 6 percent of beneficiaries were enrolled in these plans, compared to 17 percent in 1998. However, following several years of declining participation by plans in the Medicare+Choice program, it is estimated that about 14 percent of Medicare beneficiaries received coverage through Medicare+Choice plans in 2001. Medicare HMOs also reduced the generosity of their coverage over this time period, either by eliminating or limiting benefits, increasing cost-sharing, or charging higher premiums. In particular, the proportion of Medicare+Choice enrollees with prescription drug benefits fell from 68 percent in 1992 to 52 percent in 1999.
drug coverage fell from 84 percent in 1999 to 70 percent in 2001.\(^5\) About 10 percent of Medicare+Choice enrollees with prescription drug benefits in 1999 had a relatively low cap of $500 or less and nearly 26 percent had a cap exceeding $2,000 or had no cap, compared to 2001 when more than 26 percent had the lower caps and 16 percent had the higher caps or none at all (Figure 17).

In 1998, Medicare HMOs were a key source of supplemental coverage for almost all demographic groups, except those who lived in rural areas. Men were as likely to be enrolled as women, and whites were as likely as blacks, Hispanics, and other ethnic groups. Beneficiaries less likely to be enrolled in Medicare HMOs had lower incomes, were age 85 or older, or were younger than age 65 and disabled. Since 1999, however, more beneficiaries have limited or no access to Medicare+Choice plans.\(^6\) As of 2001, approximately 6.7 percent of enrollees in Medicare HMOs were disabled beneficiaries, a slight increase from 4.5 percent in 1994.\(^6\)

For older Americans who meet categorical and financial eligibility requirements, Medicaid provides fairly comprehensive coverage— including prescription drugs, long-term care and, when applicable, payment of Medicare premiums and cost-sharing—that serves as a supplement to Medicare's coverage. Medicaid is available to low-income Medicare beneficiaries, disabled people who receive Supplemental Security Income benefits and, depending on the state, other low-income older adults who meet categorical requirements (e.g., parents with dependent children). However, being poor does not ensure help from Medicaid: in 1998, Medicaid provided coverage to only 54 percent of Medicare beneficiaries who had incomes at or below the federal poverty level. Among noninstitutionalized Medicare beneficiaries who are poor, disabled people younger than age 65 are most likely to have Medicaid coverage.
while those age 85 and older are least likely to be enrolled (Figure 18).

Medicaid plays an important role in supplementing Medicare coverage for disabled beneficiaries and for minorities who are disproportionately low income. Among Medicare beneficiaries, more than 35 percent of non-Hispanic blacks, Hispanics, and other nonwhites, more than one-quarter of disabled beneficiaries age 50-64, and 16 percent of women relied on Medicaid in 1998; by comparison, only 9 percent of non-Hispanic white beneficiaries, 10 percent of people age 65 and older, and 12 percent of men have Medicaid. There is evidence that Medicaid may be playing a larger role for whites and some racial or ethnic groups, while diminishing as a source of coverage for others.62

The Role of Managed Care

Employer-Sponsored Plans. The beginning of the new millennium marks the virtual completion of the transition in the nation’s private insurance market from indemnity insurance coverage to managed care. The dramatic growth in managed care enrollment that occurred in the early 1990s (Figure 19) was fueled by employers’ desire to curb their escalating expenditures for health benefits. In 2001, only 7 percent of workers with employer-sponsored coverage had conventional (indemnity) insurance, compared to almost three-quarters in 1988. The remainder are currently enrolled in health maintenance organizations (HMOs) (23 percent), preferred provider organizations (PPOs) (48 percent), and point-of-service plans (POS) (22 percent).63, 64 As enrollment increased, there has also been a gradual shift toward looser, less restrictive forms of managed care in response to consumer demand and the
“managed care backlash.” Today, PPO and POS options and other “open access” plans have supplanted HMOs as the dominant type of managed care plan for workers.

The Medicare Program. The picture is starkly different in the Medicare program. Although enrollment in managed care plans increased rapidly during the 1990s and is considerably higher today at 5 million than it was in 1988 with only 1.8 million beneficiaries,64 enrollment in managed care plans has declined each year since 1999. This occurred despite Congress’ intention to make Medicare “look more like the private sector” by introducing a greater variety of plan types through the Medicare+Choice program and despite relatively high enrollee satisfaction. In contrast to the private sector, Medicare managed care enrollment is predominantly in HMOs and few other options are offered.

Consumer Understanding of Managed Care. Although it has been available in certain geographic locations since the mid-20th century, managed care as a delivery system came of age in the 1990s. For many individuals, then, the concept of managed care is relatively new. Less than one-quarter of 50 to 64 year olds (20.8 percent) and people age 65 and older (23.3 percent) reported in 2001 that they were “very” or “extremely” familiar with managed care plans.66 This self-assessed level of knowledge can be compared to other research that finds considerable confusion among consumers about managed care. In fact, many older adults do not understand the type of coverage they have: in 2001, 55 percent of managed care enrollees between the ages of 50-64 said they have never been in a managed care plan. People in PPOs generally are more confused about the type of coverage they have than HMO enrollees.67 In addition, only one in 10 Medicare beneficiaries in 1997 had adequate knowledge of the differences between the traditional program and HMOs; beneficiaries with less knowledge were more likely to have lower income and less education.68

Most long-term care expenditures are for care in institutions such as nursing homes. Yet three out of four Americans age 50 and older in 2001 expressed a strong preference for receiving services in their own homes for as long as possible if they or a family member had a disability and needed help with everyday activities.
Long-Term Care Coverage

Current coverage for long-term care services is generally inadequate and fragmented. Medicaid, the primary source, funds nursing home care and a limited amount of home and community-based care, but people do not qualify unless they are poor to begin with or they have exhausted most of their assets and income to pay for their care. Medicare funds a limited share of long-term care—mostly home health care and short-term nursing home benefits—as does private long-term care insurance. Other funding comes directly out-of-pocket from individuals and families.

Preferences for Long-Term Care. Most long-term care expenditures are for care in institutions such as nursing homes. Yet three out of four Americans age 50 and older in 2001 expressed a strong preference for receiving services in their own homes for as long as possible if they or a family member had a disability and needed help with everyday activities. When asked to rate their first choice for receiving care if they or a family member had a disability, this group split between preferring to have families and friends provide all of the care (37 percent) and having such care provided by an agency (38 percent) (Figure 20). A substantial minority (15 percent) would prefer care in an assisted living or other residential setting, and only 4 percent considered nursing homes to be their first choice. Care preferences change somewhat if 24-hour care were to be needed. In this case, assisted living settings (23 percent) and nursing homes (12 percent) were a first choice more often and family and friends was preferred less often (25 percent); these data may reflect concerns people have about becoming a burden when they need more intensive care or their recognition of the inability to receive the needed level of care at home. These findings, which have implications for the type of long-term care benefits that are valued, underscore both the continuing preference for home care, and the recent growth of assisted living residences as an alternative to nursing homes.

Regarding the amount of autonomy desired—such as hiring and firing home care workers and directing the care themselves—in managing home care services, the overwhelming majority (77 percent) of people age 50 and older said they would prefer to direct their own services rather than receive services managed by an agency. This proportion is virtually identical to that reported in 1997.

Figure 20: First Choice in Long-Term Care Provider, 2001

- Need for LTC:
  - Family and Friends: 37%
  - Unsure: 6%
  - Assisted Living/Other Residential: 15%
  - Nursing Home: 4%
  - Agency: 38%

- Need for 24-Hour Care:
  - Family and Friends: 25%
  - Unsure: 7%
  - Assisted Living/Other Residential: 23%
  - Nursing Home: 12%
  - Agency: 33%

Source: AARP Health Survey of Persons Age 50+, September 2001. *Defined as needing help with everyday activities, such as bathing, dressing, and cooking.
Medicare and Long-Term Care.

Americans age 50 and older are confused about the extent of Medicare coverage for long-term care in a nursing home or the home. More than four out of 10 older adults in 2001 said they did not know whether Medicare covers most long-term care in a nursing home. People who were most likely to indicate a lack of knowledge were uninsured 50 to 64 year olds, people age 65 and older with no insurance to supplement Medicare, low-income individuals, and those without a high school education. Not surprisingly, people age 50-64—who are not yet eligible for Medicare—were more likely (21 percent versus 13 percent for people age 65 and older) to mistakenly believe that Medicare does cover most long-term care in a nursing home. Those most likely to answer correctly that Medicare does not cover most long-term care in a nursing home were age 65 and older and had insurance supplementary to Medicare, or were non-Hispanic white.

Similarly, 42 percent of people age 50 and older do not know whether Medicare covers most long-term care in a person’s home. As with nursing home care, higher proportions of those with lower incomes and less education said they did not know the answer. Fifteen percent of older adults answered incorrectly that Medicare covers most of such care. People most likely to answer correctly that Medicare does not cover most long-term care in the home expected that they or someone in their family could need such care in the next three years (47 percent), had incomes higher than $50,000, were college-educated, or were non-Hispanic white.

Private Long-Term Care Insurance.

Private long-term care insurance policies have become more comprehensive in recent years, with many insurers now covering not only nursing home care but home health care, adult day services, assisted living, personal care, and hospice care. Despite such improvements, these products reach a limited number of people because they remain unaffordable for many individuals or are not available due to medical underwriting. In 2000, annual premiums averaged $1,677 but varied widely by the age of purchase and by the type of protection provided. While premiums for long-term care insurance are considerably lower if purchased at a younger age, buyers younger than age 65 still represent only one-third of all purchasers (Figure 21); the average age at the time of purchase has declined somewhat from age 69 in 1994 to age 67 in 2000. In addition, a disproportionate share of purchasers—more than 40 percent—have incomes of $50,000 or more. (In 2000, median family income was $29,900 for people age 65-74.)
There appears to be a mismatch between people's perceptions of what long-term care coverage they already have or may need and the reality. According to a recent survey by the National Council on Aging, 43 percent of people age 50-64 and 41 percent of people age 65 and older said they had purchased long-term care insurance. Yet in 2000, only 3.5 to 4 million older Americans (well below 10 percent) had private long-term care insurance. Regardless of such discrepancies, a large majority (78 percent) of 50 to 64 year olds are very or somewhat confident that they know enough to make a good decision about buying long-term care insurance, a higher proportion than those who are confident (67 percent) about their ability to select a mutual fund. People age 65 and older are less confident than the younger group about either option (67 percent and 55 percent, respectively).

Summary

Even with the important distinction between age groups created by the availability of Medicare at age 65 for most people, older Americans—regardless of age—are vulnerable to being without adequate coverage for their health and long-term care needs: not all workers have health coverage, people age 50-64 without a connection to the workforce are at higher risk of being uninsured, Medicare’s coverage has major gaps, and Medicare managed care is increasingly less available as an option for supplementing Medicare. In addition, older people who seek coverage through the private insurance market—whether it be 50 to 64 year olds, Medicare beneficiaries, or people anticipating long-term care needs—are usually subject to underwriting. Older Americans’ lack of knowledge about these realities is a problem because people will be less motivated to influence public policy or to plan ahead if they think these needs are adequately met. As demonstrated in the subsequent section, not having coverage matters when it comes to accessing services to meet these needs.
SERVICE USE ACROSS THE CONTINUUM OF CARE
How Older Americans Use the Health Care System

**Doctors.** People age 50 and older are seeing doctors more than their age group did in the past, and the care they get is more often delivered in office and outpatient settings than was the case two decades ago. Although the average number of office visits to doctors increased only slightly among people age 50-64, the rate of office visits for people age 65 and older increased by 22 percent from 1985 to 1999.73
Between 1977 and 1996, the average number of visits to doctors or clinics per person age 65 and older increased from 7.4 to 8.1. The biggest increase in physician visits occurred among people age 75 to 84 (Figure 22).

The reasons for going to the doctor encompass all sorts of care—acute health problems; managing chronic illness; visits related to surgery; and "non-illness" visits such as for preventive services and checkups. Although rates for each of these types of visits have increased over time, pre- or post-surgery visits and non-illness care increased the most between 1979 and 1999. Health needs related to chronic illness continue to send a lot of people to the doctor: in 1999, routine care of chronic problems or acute flare-ups of chronic problems account for about half of office visits for people age 65-74 (48.6 percent) as well as people age 75 and older (51.4 percent). The health care that people are getting is more likely to be provided by medical specialists (Figure 23).

Visits to internists, cardiologists, orthopedists, urologists, ophthalmologists, psychiatrists, and neurologists for people age 65 and older have increased rapidly over time.

Among older Americans, variations in the use of health care follow a fairly clear pattern across age groups. People age 50-64 in fair or poor health see medical providers in office settings more frequently than those in excellent, very good, or good health. The average number of visits for people age 50-64 in fair or poor health was close to 10 per year in 1996, compared to about five for those in better health. Among people 65 and older in fair or poor health, visits numbered just a shade over 10 per year, compared to seven for people of the same age in good to excellent health. Across all age groups, men are less likely than women to use any ambulatory services (i.e., those provided in settings such as doctors’ offices, clinics, outpatient departments,
or emergency rooms), and whites are more likely than blacks, Hispanics, or other ethnic groups to use these services (Figure 24).

**Going to the Emergency Room.** Over the past two decades, the use of emergency departments has increased for the nation as a whole, but the increase in use has been most pronounced in the population age 65 and older. And, among people 65 years of age and older, there is an especially serious racial disparity related to the use of emergency departments. African Americans age 65 and older were 50 percent more likely to use emergency departments than whites in 1999. Even when taking age, sex, and history of chronic conditions into account, African Americans were 38 percent more likely than whites to make multiple visits to emergency departments. Increases in emergency department use may indicate that more people do not have access to a regular source of care, that they are waiting until their medical situations become unstable before seeking care (and then need urgent medical attention), or that people are experiencing greater acute illness or injuries than would otherwise be anticipated.

**Hospitals.** For older Americans, the likelihood of being in the hospital at least once per year has declined over the past 20 years (Figure 25)—particularly for people younger than age 75—and, among those who were hospitalized, the length of stay is, on average, far shorter than two decades ago. The average length of a hospital stay for people age 50-64 fell from 13.0 days in 1977 to 7.6 days in 1996; for people age 65 and older, the length of stay fell from 16.4 to 9.1 days during this same time period.

**FIGURE 25** People Using a Hospital, by Age, 1977 and 1996

![Graph showing hospital usage by age group in 1977 and 1996](image)

The decline in length of stay does not, however, reflect any decline in the complexity of the care older Americans receive while in the hospital. On the contrary: more people, especially people age 65 and older, are benefiting from major medical interventions, including open heart surgeries, total hip replacements, knee replacements, and lens implants following cataract surgery. The average age of patients undergoing coronary artery bypass grafts (more than 383,000 people in 1997) was 66; for those having pacemakers inserted, removed, replaced, or revised (209,000 people), the average age was 74; and 72 was the average age for hip replacements (293,000 people). Among the “oldest old,” who also are benefiting from medical care that was not possible a decade or two ago, the greatest utilization increase is not in acute, inpatient services but in home health and nursing home services generally associated with episodes of illness that included some hospital care.

Just as people in poorer health use more doctor services than people in better health, so too do older people in fair or poor health use more hospital services than younger people with health problems. For example, among people age 50-64 reporting that they are in “fair” or “poor” health, about 20 percent were hospitalized in 1996, compared to only 5 percent of 50 to 64 year olds reporting “excellent,” “very good,” or “good” health. Among people age 65 and older in fair or poor health, 25 percent were actually hospitalized, while 11 percent of those reporting “excellent,” “very good,” or “good” health had at least one hospital stay.

**Medicines.** Advances in biomedical research and pharmaceutical development have given prescription drugs a greater role in improving the health of older Americans. By 1999, nearly 70 percent of physician visits for people age 50 and older resulted in the patient receiving a prescription, and the average number of prescriptions per doctor’s visit did not vary substantially by age. Compared to 20 years earlier, all age groups of people 50 and older were more likely to use prescription drugs in 1996, and they filled more prescriptions per person. While the likelihood of using any prescription medicines has increased the most for healthier people (Figure 26), the number of prescription drugs used has risen most rapidly among older adults in fair or poor health. Between 1977 and 1996, the median number of prescriptions for people age 65 and older who considered themselves to be in poor or fair health rose from 14 to 26 per year. By contrast, the median number for healthier individuals in the same age group increased from 8 to 13 prescriptions per year. Although the utilization levels are lower for people age 50-64, the pattern is similar.

**Complementary and Alternative Medicine.** Compared to both younger and older adults, people age 50 to 64 are most likely (44 percent) to use complementary and alternative medicine (CAM). Older and younger consumers alike
use alternative medicine for a number of reasons, such as to treat an existing illness, to prevent future illness, or to maintain their vitality. Common types of alternative medicine include chiropractor services, acupuncture, homeopathy, herbal remedies, massage therapy, and naturopathy. While 35 percent of people age 65 and older use CAM, one-quarter of people age 65 and older use herbal medicine, making it the most popular form of alternative medicine among that age group. Although many people use alternative medicine, the majority of adults do not tell their doctor about these medications or therapies.

Service Use by People with Chronic Conditions, Disability, and Functional Limitations

People use more health care as they age. However, when trying to understand how health care is used, even age-related averages can be misleading because service use within a group varies tremendously based on individual needs. In fact, among people age 50 and older, as with all age groups, a large proportion of health care goes to a relatively small number of people: those with multiple chronic health problems who are also coping with physical or cognitive disabilities that limit their ability to function independently. These individuals typically rely more heavily on services that may not be solely medical in nature, such as home health care, which combines skilled nursing care with personal care. Figure 27 compares physician and home health visits by people age 50 and older and who have one or more chronic conditions only with those whose chronic conditions are accompanied by disability and functional limitation. People in the second group have more physician visits (and, as indicated in the figure note, more hospital visits) than people in the first group. However, the most striking contrast relates to the use of home health visits.
How Older Americans Use Long-Term Care Services

A majority of Americans (54 percent) still erroneously believe that most long-term care is provided in nursing homes. The reality is that most long-term care is provided in community settings and involves a wide range of services, such as personal care and adult day services, needed to help people function independently for as long as possible (Figure 28). Such services may be provided by formal service providers or informal, unpaid caregivers, such as family and friends. Long-term care also encompasses social and environmental needs, such as supportive housing, which are not part of the "medical model." For example, assisted living facilities typically provide personal care and supportive services, basic health care, and meals in a congregate residential setting. From 1991 to 1999, the number of senior housing properties offering assisted living services increased by 49 percent, compared to a 22 percent increase in those offering skilled nursing services.

Although most adults (53 percent) receiving long-term care assistance in the community are age 65 and older, a substantial share are younger than 65 years of age, with people 50-64 representing almost one-fifth (19 percent) of the total (Figure 29). Looking to the future, one-third of people age 50 and older who were recently surveyed thought it was very or somewhat likely that they or a member of their family would need help performing everyday activities in the next three years. Not surprisingly, considerably more people age 65 and older (39 percent) said they expected to need such help than people age 50-64 (27 percent).

Informal Long-Term Care Services. The vast majority of long-term care users age 65 and older (57 percent) relies exclusively on their families

---

**Figure 28** Adults Receiving Long-Term Care, by Age and Type of Residence, 1994

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Nursing Home Residents</th>
<th>Community Residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-64</td>
<td>4%</td>
<td>96%</td>
</tr>
<tr>
<td>65+</td>
<td>29%</td>
<td>71%</td>
</tr>
</tbody>
</table>


**Figure 29** Adults Receiving Long-Term Care Assistance in the Community, by Age, 1994

<table>
<thead>
<tr>
<th>Age Group</th>
<th>Number of Users</th>
</tr>
</thead>
<tbody>
<tr>
<td>18-49</td>
<td>2.0 million</td>
</tr>
<tr>
<td>50-64</td>
<td>1.4 million</td>
</tr>
<tr>
<td>65+</td>
<td>3.9 million</td>
</tr>
</tbody>
</table>

and other informal, unpaid sources of care. Another 36 percent rely on both family care and formal care, such as home care provided through an agency. Reliance on informal care only is even higher (84 percent) for people age 50-64 who receive long-term care (Figure 30). Such caregiving is the foundation of long-term care and support in the United States. In 2001, nearly one in five (19 percent) people age 50 and older—more than 14 million Americans—said they or their spouse were providing help with everyday activities, such as bathing, dressing, and cooking, to a relative or friend with a disability. These unpaid caregivers were more likely to have a high school education or less, and have a living parent age 85 or older; they were less likely to be white, non-Hispanic.

Regardless of age, people involved in supporting sick or disabled family members and friends at home for as long as possible share certain experiences, according to a 1997 survey of caregivers. For example, more than half of caregivers age 50 and older reported having provided care to their primary care recipient for at least five years, while about one in five had provided care for more than 10 years. Almost one in five experienced physical or mental health problems as a result of caregiving; an even larger share experienced physical strain or emotional stress. Just under one in five had sought help from a counselor or other professional, and more than four in five used prayer as a way of coping with their caregiving responsibilities.

Nevertheless, the survey also found that caregivers age 50-64 often have different caregiving roles and vulnerabilities than caregivers 65 years of age and older. The latter were more likely to be widowed, to have lower incomes, or to have not graduated from high school than caregivers age 50-64. Although the average number of hours of care provided per week was high for both groups, older caregivers spent substantially more time caregiving (31 versus 20 hours). Finally, younger caregivers were five times more likely than those age 65 and older to have full- or part-time jobs (60 percent versus 12 percent). People age 50 and older who had been in the workforce while caregiving often made significant economic sacrifices during their peak earning years, including taking a leave of absence, changing to part-time work or a less demanding job, or giving up work altogether.

Home Health Care. One of the most important services used by people with disabilities or functional limitations living in the community is home health care. Between 1987 and 1996, the likelihood of using home health care services increased substantially among people age 75 and older—who are the most likely to have disabilities or functional limitations—from 12 to 14 percent of people age 75-84 and from 25 to 30 percent of people age 85 and older. The shares of people age 50-74 with any home health use remained stable over the same time period. The overall trend toward greater use of home health care services recently reversed when the rate of home

---

**Figure 30** People Age 50+ in the Community Receiving Long-Term Care, by Age and Type of Care, 1994

health service use by people age 65 and older fell by almost 15 percent from 1996 to 1998 (Figure 31). This pattern is likely the result of provisions in the 1997 Balanced Budget Act, which reduced Medicare spending on home health after several years of substantial growth in this benefit area.

Nursing Home Care. Only a very small share—4.7 percent in 1999—of individuals age 65 and older are residents in nursing homes at any given time, and this share has declined from 5.3 percent in 1985; the decrease is greatest for people age 75 and older, who are those most likely to be in nursing homes (Figure 32). Well below 1 percent of people age 50-64 reside in nursing homes. Circulatory conditions, cognitive impairment, which affects a little more than half of nursing home residents, and mental disorders, including depression and anxiety disorders, continue to be the most common diagnoses at admission.

The profile of nursing home residents is becoming more racially diverse and more severely disabled. While older white women still predominate, the share of black residents increased from 6 percent in 1985 to 10 percent in 1997, when blacks age 65-74 were almost twice as likely as whites in the same age category to be in a nursing home. The fact that black nursing home residents are, on average, significantly younger than white residents may be related to their shorter life expectancy and earlier onset of disability. Asians and Hispanics continue to represent less than 1 percent of the nursing home population.

Although residents’ average age only increased from 81 to 83 between 1985 and 1997, over the same time period, the average number of basic activities of daily living (ADLs) for which residents needed help rose from 3.8 (out of 6) to 4.4. The proportion of incontinent residents also rose substantially from 55 percent to 65 percent of all residents. This increase in severe disability among the nursing home population suggests that older Americans may be living in the community longer before entering nursing homes.

Care at the End of Life

Every year, more than 2 million people die in America, approximately seventy percent of whom die after a decision is made to forego life-sustaining treatment. Surveys reveal that beliefs about dying and expectations regarding
certain aspects of the care that loved ones receive as the end of life approaches differ considerably by age group. The older people are, the less likely they are to be afraid of dying. A Modern Maturity survey found that major fears associated with dying, including depleting family resources and having one’s life prolonged by artificial means, declined as respondents’ age increased (Figure 33). In a separate survey, only 43 percent of people age 65 and older were worried about the emotional burden on their family when they had to make an end-of-life care decision for the respondent, compared to 55 percent of people age 50-64 (and 70 percent of people younger than age 50). There was little disparity by age, however, regarding whether the family could be trusted to make the right decision concerning end-of-life care should the respondents become incapable of making a decision. More than 80 percent of people age 65 and older said they would completely trust their families, while nearly as high a proportion of people age 50-64 agreed.

Research has shown that a high percentage of patients die in a significant amount of pain, possibly indicating that people’s expectations—especially those of older Americans—about doctors’ abilities to control pain may not be met. Three-quarters of people age 65 and older and 70 percent of 50 to 64 year olds believe that doctors will be able to control their pain when they are terminally ill, compared to only 58 percent of people younger than age 50. The increasing use of hospice services, which focuses on making patients comfortable by controlling symptoms rather than curing their illness, may provide a hopeful sign for improvements in palliative care for dying patients. The total number of hospice patients increased from about one-quarter million in 1992 to approximately 700,000 in 1999. Nearly 80 percent of hospice patients are age 65 and older. It is widely conceded that hospice services remain underutilized. Among the reasons cited are lack of knowledge about the benefit by both providers and consumers and confusion.
Barriers to Care for Older Americans

Most people age 50 and older have not reported major problems gaining access to the health care system in recent years. In 1996, less than 6 percent of people age 50-64 reported that they did not receive care, or that they experienced any difficulty or delay in getting care. Among people age 65 and older, virtually all of whom are enrolled in Medicare, the percentage reporting these types of access problems was even lower (less than 2 percent).

Despite this generally good assessment of access to care today for older adults overall, disturbing variations in conventional measures of access across the older population demonstrate that the health care system does not work the same way for all older Americans, particularly the uninsured and minorities. Overall, 38 percent of uninsured 50 to 64 year olds and 13 percent of the elderly without coverage to supplement traditional Medicare reported in 1996 that they had not seen a health care professional in the past 12 months.

In addition, older Americans with certain conditions often do not receive needed care. For example, only 35 percent of 50 to 64 year olds with depression receive either antidepressant medication or four or more counseling sessions, and 22 percent receive outpatient specialty mental health services (Figure 34). Access to these services is even worse for people age 65 and older with depression: a mere 19 percent receive medication or counseling and 8 percent receive outpatient specialty services.

Among the population more generally, people age 65 and older were less likely (5.2 percent) than people age 45-64 (7.3 percent) to use ambulatory mental health or substance abuse services in 1996. On the other hand, older Americans were more likely than other age groups to use psychotropic drugs (9.1, 8.3, and less than 5 percent for elderly, people age 45-64, and people younger than age 45, respectively). However, there was virtually no change in psychotropic drug use for the elderly between 1987 and 1996, compared to a 63 percent increase for all ages.

Furthermore, many consumers are apprehensive about their future access to care in general. Only 35 percent of people age 50-64 and 39 percent of people age 65 and older in 2001 were "very confident" or "extremely confident" that, in the next 10 years, they will be able to get the treatments they need.

Usual Source of Care. Having a usual place or provider of care is one measure of access to care, because a "medical home" helps ensure continuity which, in turn, facilitates coordination of care. Among the 50-64 age group, close to 87 percent had a usual source of care in 1996,
and the percentage is higher among older groups. Some in these age groups, however, are less likely to report having a usual source of care. In particular, only 74 percent of Hispanic people age 50-64, who are at higher risk of being uninsured, report having a usual source of care, compared to nearly 90 percent for other ethnic subgroups. Also, non-Hispanic white people age 50-64 are more likely to see a physician in an office setting than non-Hispanic black or Hispanic 50 to 64 year olds, who are more likely than non-Hispanic whites to use clinics as their usual source of care. Some of these differences also may be associated with the likelihood of seeing any health care professional. In the 50 to 64 year old age group, 27 percent of Hispanics and 25 percent of non-Hispanic blacks report not seeing a health care professional in the past 12 months, compared to 20 percent of non-Hispanic whites. A smaller share of ethnic and racial minorities age 65 and older—19 and 13 percent of blacks and Hispanics, respectively—than whites (10 percent) report not seeing a health professional in the last 12 months.

Another indicator of health care access—and underlying problems in our health care system—is the greater extent to which elderly black Medicare beneficiaries use emergency rooms compared to whites. Some potential explanations are that this population has lower rates of coverage that supplements Medicare and facilitates access to needed prescription drugs, or that it has higher rates of poverty and, therefore, Medicaid coverage which, in some communities, may not be universally accepted by office-based physicians. Higher emergency room use might also be explained by a higher likelihood, based on disproportionate use in the past, of not being approved for Medicare home health services after an acute illness due to payment policy changes in the late 1990s.

The older people are, the less likely they are to be afraid of dying. A Modern Maturity survey found that other major fears associated with dying, including depleting family resources and having one's life prolonged by artificial means, declined as respondents' age increased.
Both adequate insurance coverage and financial resources to pay out-of-pocket costs associated with services play important roles in ensuring access to care. Only 71 percent of uninsured 50 to 64 year olds had a usual source of care in 1996, compared to 89 percent of those with insurance. Similarly, elderly people with traditional Medicare coverage only are less likely to have a usual source of care (88 percent) than those with some form of supplemental coverage (93 percent).

In addition to that cited above, other evidence shows that, in 1996, one in five uninsured people age 50-64 experienced difficulties or delays or actually did not receive needed health care, compared to only 3.5 percent of those with insurance. For most people age 50-64 who experienced problems getting care, inability to pay was cited as the main deterrent to obtaining care (63 percent). Similarly, in 2001, less than 3 percent of all people age 65 and older failed to obtain needed medical care in the past year due to financial barriers. Although 3 percent is a small proportion of the population, it represents at least 1 million people.

Concerns about financial barriers to care may become more prominent in the future as the cost of health coverage continues to climb. Already, 23 percent of people age 50-64 and 15 percent of people age 65 and older in 2000 report a “serious” problem with having enough money to pay doctor or hospital bills. Financial barriers also contribute to people using fewer needed medicines than they would if money were not an issue. In 1999, 1.2 million Medicare beneficiaries did not fill a prescription written for them, and more than half of those cited financial reasons. Beneficiaries without any coverage to supplement traditional Medicare were nearly twice as likely not to have filled a prescription that was written.

Not having health coverage has a similar effect upon access to drugs for people age 50-64: 79 percent of those with insurance used a prescription drug in 1996, compared to only 58 percent of those without coverage. There is also evidence that the expanded role of prescription drugs in medical care over the past few decades did not convey equally to older Americans without insurance. For example, the share of 50 to 64 year olds without insurance who used drugs increased only 2 percentage points from 1977 to 1996, compared to 11 percentage points for those with insurance.

Reduced access to prescription drugs can have serious health implications. For example, Medicare beneficiaries with high blood pressure who lacked drug coverage were less likely to fill prescriptions for anti-hypertensive medications, increasing their risk of heart attack, heart failure, stroke, and kidney failure.

Long-Term Care. Among people age 65 and older living in the community in 1994, more than one in three reported an unmet or “undermet” need for long-term care services, which are not generally covered by Medicare. Assistance was most often needed for the less intense instrumental activities of daily living (IADLs), particularly meal preparation, outdoor mobility, and money management, rather than activities of daily living (ADLs). In other national surveys in 1994-1995, 21 percent of 50 to 64 year olds and 18 percent of people age 65 and older with long-term care needs living in the community reported needing help, or more help, with ADLs or IADLs. Furthermore, more than one out of three people age 50 and
older with chronic illness (37 percent) said it would be important to have one person who could coordinate both their medical and non-medical care, if such a service were available. Widespread misconceptions about what long-term care services are paid for by Medicare and private insurance create further barriers to arranging for needed care.

Summary

The way in which people use health services generally confirms the view that health care can improve and lengthen the lives of Americans age 50 and older. At the same time, less inpatient hospital use (a result of changes in both technology and reimbursement) has been accompanied by more doctor visits and greater use of prescription drugs overall. However, as demonstrated in this section, the lack of insurance can serve as a deterrent to accessing services or, in the case of emergency room care, it can become an incentive to using services inefficiently. In the case of long-term care, a general lack of financing options exacerbates the stress on family members and other informal caregivers, who continue to provide a large share of services in the home. The fact that frail individuals seem to be remaining longer in the community before entering nursing homes highlights the need for more supportive home and community-based services for both older persons and their caregivers. The subsequent chapter illustrates how changes in the use of these services affect spending, particularly out-of-pocket costs.
VI. A FINANCIAL PORTRAIT

THE
Cost of Health & Long-Term Care

Health and long-term care costs have increased dramatically over the past generation. In 1970, spending in the United States for personal health care services totaled about $63 billion; by the beginning of the 21st century, personal health care expenses reached $1.3 trillion. Although the rate of growth in health care spending slowed in the last decade compared to the late 1980s and early 1990s, health care costs continue to absorb an increasing share of both national income and the economic resources of individuals and families. Furthermore, in the last few years, the costs of health care coverage as well as specific items, such as prescription drugs—for which
national spending increased by double digits in 2000 for the sixth consecutive year—have begun growing more rapidly. In addition, a large and increasing share of dollars spent on health care in the U.S. is attributed to chronic conditions. In 2000, 75 percent of total health care spending was for people of all ages with chronic conditions, a figure that is projected to rise to 80 percent in 2020. Because people 50 years of age and older use more health care services than younger cohorts, health care costs are a major—and growing—concern for older Americans.

Health Care Expenditures

Health care spending across age groups is a function of the price of goods and services, the amount of health care that people use, and the types of health care they use. Health care spending is, moreover, not uniform within age or demographic categories. Understanding how health care spending affects people age 50 and older therefore requires some extra attention. Unless indicated otherwise, when used in this section, the term “health care” spending refers to expenditures for inpatient hospital services, physician and nonphysician services in ambulatory settings, home health services, dental services, other medical equipment and services, and prescribed medicines by the noninstitutionalized population. Not included are payments for health expenses incurred by another person, whether a relative or not.

Total Per Capita Spending. One measure commonly used to illustrate the importance of health care spending is per capita expenditures, i.e., what expenditures would be if averaged across the population. The average cost per person provides a useful way to think about how expensive insurance might be if the premiums reflected the health care costs spread equally among the group. Average health care expenditures per person age 50 and older in the
U.S. increased dramatically—310 percent or nearly twice as fast as general inflation of 159 percent—in the last 20 years. Even after adjusting for inflation, average spending rose from $2,452 in 1977 (in 1996 dollars) to $3,881 in 1996. Average per capita costs increase sharply with age (Figure 35), ranging from $2,930 for people age 50-64 to $7,453 for people age 85 and older in 1996.

Averaging across a group, however, does not provide a complete understanding of health care costs of individuals in the group. The median expenditure—the amount that divides the top half of people from the bottom half in terms of spending—has some advantages for describing how health care costs affect individuals. Because health care spending is concentrated among the subgroup of people who have health problems, median per capita costs are much lower than average costs (Figure 36). For example, median per capita costs for people age 50-64 in 1996 were $911, meaning that less than half of 50 to 64 year olds had total health care costs of more than $1,000 even though the average per capita expenditure for this age group was almost $3,000. The median expenditure for women age 50-64 ($1,137) is higher than for men ($700) of the same age. Median expenditures for all people age 65 and older were $1,704, compared to average per capita expenditures of $4,922. For the “oldest old,” the median expenditure of $2,025, compared to the much higher average ($7,453), reflects the fact that a relatively small proportion of people age 85 and older incur very high expenses.

Changes in how health care spending is distributed among older age groups illustrate important differences in how health care is being used by our aging population. In the total younger-than-65 population, the concentration of spending in a small proportion of the population has been very stable over the past 20 years. However, the same is not true for people age 65 and older, for whom spending is less highly concentrated among a small proportion of the population. In 1977, the top 2 percent of people age 65 and older accounted for close to 33 percent of expenditures; by 1996, the top 2 percent accounted for 22 percent of total health care expenditures for this age group.

Furthermore, while about half of the population age 65 and older continues to account for most (more than 90 percent) of the dollars spent for the health care of that age group, the spending is more spread out among these people than in the past (Figure 37). For example, in 1977, the top 5 percent of spenders accounted for 53 percent of total spending among people age 65 and older, compared to 1996 when the same proportion of spending was spread
out among the top 10 percent of spenders. Even more dramatically, 91 percent of total spending was concentrated in the top 30 percent of spenders age 65 and older in 1977, yet a similar proportion of spending (93 percent) was spread among half of the population in 1996. These patterns of spending and shifts over time apply equally to both the 65-74 and 75+ age groups.

The fact that the total dollars spent have been redistributed to people other than the top few percent of the population suggests that health costs have increased disproportionately for many in the remainder of the elderly population. Such an increase in the proportion of the elderly with relatively high health care expenses today as compared to 20 years ago is consistent with the greater availability and use of new technologies and services by greater numbers of older Americans.

Spending for Specific Services. The kinds of health care services people use have changed a great deal in the past 20 years. Hospitals today are used for complex, often invasive, surgical and medical interventions. Average charges by the hospital facility for major procedures performed primarily on older people—not counting separate bills for the services of surgeons and other physicians—can be staggering (Figure 38). But even with the emergence of these expensive, high-tech procedures, the proportion of older adults’ total health care expenditures accounted for by inpatient hospital services fell from 67 percent in 1977 to 35 percent in 1996. Over the same time period, expenditures on other types of health care services increased: the share spent on prescribed medicines more than doubled and the proportion on ambulatory care nearly doubled. Given the dramatic increases in dollars spent on prescription drugs in the last few years since 1996, it is likely that the proportion attributed to medicines is even higher today. Because the use of services varies by age, the distribution of total expenditures also varies significantly by age (Figure 39). For example, with older age, expenditures for ambulatory services decline as a share of the total, while the home health care share increases.

Out-of-Pocket Spending on Health Care

With the pressure of high health care expenditures, affordability, including confidence in the future ability to afford health care services and products without financial hardship, becomes a big concern for both individuals and
policy makers. For example, nearly one of every five people age 50 and older—18 percent—recently reported that they or a family member had serious difficulty paying for prescription drugs in the last 12 months. About 30 percent of Americans age 50 and older reported that they were very worried that their prescription drug costs would increase in the near future and an additional 30 percent reported being somewhat worried.

Out-of-Pocket Spending for Services. The burden of health expenses on individuals and families is felt most directly in the form of out-of-pocket payments for services and supplies, which includes co-payments, co-insurance, and deductibles for services or items (e.g., supplies, medications) covered by health insurance as well as the full cost of health care not covered by insurance. In 1996, out-of-pocket health care spending—not including spending on insurance premiums, which are usually paid in part or in full by the individuals receiving coverage—ranged from an average of $573 for people age 50-64 to $1,285 for people age 85 and older. Like total spending for health services, out-of-pocket spending is skewed: the median was $255 for people age 50-64 and $425 for people age 85 and older. Between 1977 and 1996, average out-of-pocket spending for older Americans increased in inflation-adjusted dollar terms, particularly among the oldest age groups (Figure 40).

![Figure 39](image_url)

**FIGURE 39** Total Health Care Expenditures For Noninstitutionalized Population, by Service and Age, 1996

Source: Project HOPE Analysis of Medical Expenditure Panel Survey 1996 for AARP Public Policy Institute. Note: Numbers do not add to 100% because “other medical equipment and services” spending is not shown.
Some types of services represent a greater financial burden to older Americans than other services. Prescription drugs have risen quickly as a major source of out-of-pocket costs, particularly for Medicare beneficiaries. After adjusting for inflation, the amount paid out of pocket for prescription drugs by people 50 years of age and older increased 150 percent between 1977 and 1996. During this same time period, inpatient hospital care and ambulatory care services were displaced by prescription drugs as the major component of out-of-pocket spending, reflecting changes in both use and coverage. The ratio of out-of-pocket payments for prescription drugs to that for ambulatory care services increased for older Americans from 0.6 in 1977 to 1.7 in 1996. The significance of prescription drugs compared to ambulatory care as a source of out-of-pocket payments increases with age, from 1.0 among 50 to 64 year olds in 1996 to 2.9 in people age 65 and older. More evidence of these shifts in use and coverage comes from looking at mental health and substance abuse treatment. In 1996, people age 65 and older who used psychotropic drugs paid 56 percent of these costs out of their own pocket—compared to users of all ages who paid 40 percent—but elderly users of outpatient mental health services paid only 10 percent of these cost out of pocket.122

Not surprisingly, out-of-pocket health care spending as a percentage of income varies according to one's health status and age, with older age groups spending more of their income on health care. In 1996, older Americans reporting excellent to good health spent an average of 4.4 percent of their income on health care, while people of the same age in poor or fair health spent 10 percent of their income on average. Furthermore, 29 percent of the population age 50 and older in poor or fair health spent more than 10 percent of their income on health services and related items. Within the 50-64 age group, the share of people reporting poor or fair health that also spent more than 10 percent of their income increased from about 21 percent to 27 percent over the last two decades, while healthier individuals spending more than 10 percent of their income decreased from nearly 11 percent to 7 percent (Figure 41). A similar health-related pattern occurred among people age 65 and older, although the changes over time were not as large as for the younger age group.
Out-of-pocket health care spending also varies tremendously among people with different sources of health coverage. Low-income people with full Medicaid are largely protected from significant out-of-pocket costs for goods and services—an average of $251 for 50 to 64 year olds in 1996—compared to 50 to 64 year olds relying on other types of public insurance, such as Medicare or veterans benefits ($808). The average out-of-pocket spending for uninsured 50 to 64 year olds was a relatively high $682, plus they were twice as likely (17 percent) to spend more than 10 percent of their income on health than a person with private insurance (9 percent). It is important to note that these estimates substantially underestimate the out-of-pocket burden for people with private insurance because the premiums they pay for the coverage itself are not included. In addition, people with insurance coverage face fewer financial barriers to using services when needed and, consequently, more often incur cost-sharing expenses.

Despite the existence of public programs offering medical assistance, health care expenditures paid out of pocket constitute a threat to the income security of many people with lower incomes. For example, in 1996, the average out-of-pocket spending on health as a percentage of income for people age 50-64 in the lowest quartile of family income was 15.5 percent, compared to less than 2 percent of income for the top quartile. About 43 percent of the age 50 and older population in the lowest income quartile spent more than 10 percent of their income for out-of-pocket health care costs in 1996.

Liability for Medicare Services. The beneficiary liability for Medicare services is the cost incurred—but not necessarily paid—by beneficiaries when using Medicare-covered services and includes the Part B (and, for some people,
Part A) premium, deductibles, and coinsurance. The average Medicare-related liability increased from $1,260 (adjusted for inflation to 1999 dollars) in 1991 to $1,390 in 1999 for those age 65 and older and increased from $1,380 to $1,525 for disabled beneficiaries younger than age 65. In 1999, the largest components of both elderly and disabled beneficiary’s average liability for Medicare services—in dollar terms—were the Part B premium and Part B coinsurance (Figure 42). Differences in service use patterns between elderly and disabled beneficiaries have implications for what constitutes the key components of Part A liabilities. Skilled nursing facility coinsurance accounted for a substantially larger share of Part A liabilities for the elderly than for the disabled, and hospital coinsurance accounted for a larger share for the disabled than for the elderly.

The largest dollar increase in Medicare liabilities since 1991 has been for Part B coinsurance and premium, which have grown as a proportion of beneficiary Medicare-related liabilities, while the Part B deductible has remained at the same dollar level. Liability for balance billing (payments to physicians who charge more than Medicare-allowed rates) decreased substantially after 1989 when balance billing restrictions were introduced as part of the overhaul of physician payment legislated by Congress. On the other hand, Part A liability has been relatively stable in both dollar and percentage terms. The Part A deductible constitutes the bulk of Part A liability, though its share has generally diminished over time with the decline in use of hospital services. There is some evidence that hospital-related cost-sharing may now be increasing as a percentage of Medicare-related liability, most likely as a result of changes in Medicare payment policies that led to a reduction in the use of post-hospital services.

Without changes in current law, beneficiaries will bear a higher share of Medicare spending in the future. Between 2000 and 2025, the beneficiary’s share of total per capita Medicare expenditures is projected to increase from 22.7 percent to 25.3 percent. In real terms (using 2000 dollars), a striking increase of more than 80 percent is expected for the annual Part B premium, which will reach $1,151; in 2000, the Part B premium totaled $546. It is predicted that the total Medicare liability will be especially high for low-income women older than age 85 in poor health who live in the community: $3,782 in 2025.
How much of the Medicare-related liability—or other health care expenses—a beneficiary actually pays out of pocket depends on which type of supplemental coverage, if any, he or she has to fill in Medicare’s gaps. For example, average out-of-pocket health care costs (including uncovered services but excluding insurance premiums) in 1996 for noninstitutionalized Medicare beneficiaries age 65 and older enrolled in managed care were $698. This compared to $971 for those with no coverage to supplement the traditional fee-for-service Medicare plan and $1,092 for people with individual Medigap policies. Similarly, only 14 percent of enrollees in a Medicare managed care plan spent more than 10 percent of their income out-of-pocket for health care, compared to 20 percent and 27 percent for elderly people with Medigap and traditional Medicare only enrollees, respectively, in 1996.

While the differences in out-of-pocket spending between beneficiaries with traditional Medicare only, Medicare managed care, and Medigap are likely to continue, there has been a discernable increase in out-of-pocket costs for Medicare managed care enrollees, particularly less healthy enrollees, in the last few years. Total annual out-of-pocket costs (including premiums) increased 43 percent between 1999 and 2001 for Medicare managed care enrollees in good health, compared to 62 percent increase for enrollees in poor health.
Out-of-Pocket Spending Including Private Insurance Premiums. Medicare pays only about half of beneficiaries’ total health care costs when long-term care is included in the total. Not surprisingly, most beneficiaries supplement Medicare with additional coverage, largely in the form of employer-sponsored private insurance or individually purchased Medigap insurance. Thus, insurance premiums can account for a substantial share of Medicare beneficiaries’ out-of-pocket health care costs.

In 2000, beneficiaries age 65 and older who did not live in institutions were estimated to have spent an average of $2,580 on health care, including premiums but excluding the costs of home health and long-term nursing facility care. Of this total amount spent out-of-pocket, premiums for Medicare Part B accounted for 18 percent, while premiums for Medicare+Choice, employer-sponsored coverage, and individual Medigap coverage accounted for a combined 26 percent. Beneficiaries with Medigap insurance and, to a lesser extent, employer-sponsored coverage, devoted the largest dollar amounts and highest shares of out-of-pocket costs to premiums (including Part B) compared to those with other types of supplemental insurance.

Insurance premiums also constitute a significant expense for people under age 65. To begin with, if their employers offered coverage, private sector employees under age 65 were far more likely to pay a share of their health insurance premiums in 1998 than two decades ago. In addition, in 1999, 20 percent of adults age 50 to 64 reported their individual share of private insurance premiums, whether employer-sponsored or individually purchased, to be $2,000 or more per year (Medicare enrollees younger than age 65 reported only private insurance premiums, not Medicare Part B premiums).

Together with insurance premiums, medical expenses can represent a major financial burden. By 2025, typical elderly Medicare beneficiaries are projected...
to spend about $5,248, or 30 percent of their income, on health care.110 Out-of-pocket spending among the oldest women with poor health and low incomes—and with no coverage to supplement Medicare—will increase from an estimated $5,969 to $9,378 (in constant 2000 dollars), even higher than elderly beneficiaries in poor health without additional insurance, for whom out-of-pocket spending is expected to reach $7,263 in 2025.

Another source of out-of-pocket costs, although not typically captured by data sources, is spending for alternative medical treatments. In 1997, Americans age 18 and older are estimated to have spent between $27 and $34.4 billion out of pocket on alternative medical treatments. This is similar in magnitude to the $29.3 billion paid out of pocket for all physician services in the same year. The largest share of out-of-pocket spending on alternative medicine was for professional services, such as visits to chiropractors or acupuncturists. A majority—58 percent—of people visiting alternative providers paid out of pocket for all costs associated with such treatments.131

Long-Term Care Expenditures

Sources of Payment. Most individuals who need long-term care rely primarily on the unpaid, informal help of family and friends, the value of which has been estimated to range from $45 billion to $196 billion per year.132 However, spending on formal long-term care services is also substantial: in 1999, our nation spent a total of roughly $134 billion on long-term care with 67 percent of that on nursing home care and 33 percent on home care.133 Other types of long-term care services, such as those provided at assisted living facilities and adult day centers, are not included in this total because of a lack of data.

The main sources of financing for long-term care are Medicaid, which requires exhausting one’s assets and “spending down” one’s income on medical or long-term care in order to qualify, and direct out-of-pocket payments by individuals (Figure 43). Medicaid is an especially important payment source for the “long-stay” individuals who reside in a nursing home for the entire year. These two sources, Medicaid and out-of-pocket payments, accounted for 44 percent and 25 percent,
respectively, of total nursing home and home care expenditures in 1999. Medicare, which accounts for about 14 percent of total long-term care spending, funds a limited amount of skilled nursing home care and some home health care. Payments from private insurance account for only 10 percent of national long-term care expenditures. Medicare and private insurance, including Medigap policies, are an important source of payment for “short-stay” individuals who typically reside in a nursing home for 3 months or less, and who often need intensive rehabilitative care after discharge from a hospital.

Chronically Ill, Disabled, and Functionally Limited. Spending is a function, in part, of the amount and type of care that people use. The relatively small share (22 percent) of people age 50 and older who have no chronic illnesses, disability, or functional limitations have relatively low health care expenses, regardless of age (Figure 44). Among the larger share (45 percent) of all people age 50 and older who have a chronic condition but no accompanying disability or functional limitation, total expenses averaged $3,028. These expenses rise steeply as the number of chronic conditions increases. For the 2.4 percent of noninstitutionalized older Americans who live with severe disability and/or functional limitations in addition to multiple chronic illnesses, average health expenses reached $16,895. (These figures include home health care but not nursing home care.) This general pattern holds for all older subgroups, e.g., 50-64, 65-74, 75-84, and 85 and older.

End of Life. The ongoing interest in the cost of care at the end of life is accompanied by widespread misperceptions about the nature of this care and its cost to the Medicare program. While spending for Medicare beneficiaries who die each year is about five times as high per person as for survivors, spending in the last year of life actually decreases with age. Several studies have found that older patients at the end of their lifespan are treated much less aggressively than younger patients. Moreover, new evidence underscores the effect of longevity on spending for acute versus long-term care services. Acute care expenditures, principally for hospital care and physicians’ services, increase at a slower rate as the age of death increases, while expenditures for
long-term care, such as nursing home and home care, increase at an accelerated rate\(^\text{139}\) (Figure 45).

### Out-of-Pocket Spending on Long-Term Care

Long term care services are often very expensive. For example, in 2002, nursing home care cost, on average, roughly $55,000 per year\(^\text{140}\) and a home health aide was $18 per hour\(^\text{141}\). In fact, out-of-pocket spending on long-term care services, along with that for prescription drugs, represents the greatest health-related financial risk for older Americans, particularly people who are most vulnerable due to advanced age or cognitive or physical disability. It is not surprising that older adults—especially 50 to 64 year olds—are not confident that they will be able to afford either nursing home care or home health care if they or a family member needed it\(^\text{142}\). In 2000, 70 percent of 50 to 64 year olds and 60 percent of people age 65 and older said they were not confident in their ability to pay for nursing home care; 60 percent of the younger age group, compared with 55 percent of people age 65 and older, lacked confidence in their ability to afford home health care. The absence of adequate insurance coverage for long-term care services also results in a burden that “dollars spent” cannot convey, including the stress on caregivers and substantial levels of unmet need.

**Nursing Home Services.** Average out-of-pocket nursing home costs vary greatly depending upon residents’ length of stay, source of coverage (e.g., Medicaid, Medicare, private insurance) and other factors. For example, “long-stay” nursing home residents who remained institutionalized throughout 1996 spent, on average, $12,000 per person out-of-

---

[Figure 45: Cumulative Health Care Expenditures per Person, by Service and Age at Death, 1996]

[Figure 46: Annual Out-of-Pocket Expenses of Nursing Home Residents, by Age, 1996]

---

A Financial Portrait 87
pocket, accounting for 33 percent of the total bill of $36,368. (This average amount includes spending by residents who receive Medicaid coverage as well as those who do not.) In contrast, “short stay” residents who were discharged during 1996, paid $1,200 out of pocket, representing 14 percent of the total $8,569 in expenses. Out-of-pocket expenses for nursing home care also rise steeply with age, largely because length of stay increases with age. At the extreme are people age 90 and older who, on average, paid 2.8 times more out of pocket ($10,048) than did people younger than age 65 ($3,536) (Figure 46). The share of nursing home expenses paid directly out of pocket was found to be highest—50 percent or more, on average—for people with the highest income (at least 400 percent of the poverty level) and those who were not eligible for Medicaid.143

Assisted Living. The cost of assisted living varies considerably, depending on factors such as facility location and the services provided. Estimates of the median basic rate, including daily congregate meals, range from $21,600 to $26,300 per year. Residents often pay more if they need more than basic assistance. While Medicaid coverage is increasing, assisted living expenses are primarily paid out of pocket by residents.144

Home Care. Out-of-pocket home care expenses for people living in the community increase dramatically with age. People age 85 and older paid an average out of pocket amount of $601 for home health care in 1996, while people age 50-64 paid less than $1. Note that, as demonstrated previously with health care spending, a discussion of averages for home health care spending fails to convey the extent to which some people pay a great deal more. People in the oldest age group are likely to experience higher total health-related out-of-pocket costs, of which home care costs are the single largest component, followed by prescription drugs. Furthermore, out-of-pocket home health care

---

**FIGURE 47** Average Out-of-Pocket Spending* for Home Health Care in Noninstitutionalized Population Age 50+, by Functional Status, 1996

<table>
<thead>
<tr>
<th>1+ ADL Limitation</th>
<th>No ADL Limitation</th>
<th>1+ IADL Limitation</th>
<th>No IADL Limitation</th>
</tr>
</thead>
<tbody>
<tr>
<td>$900</td>
<td>$800</td>
<td>$700</td>
<td>$600</td>
</tr>
<tr>
<td>$500</td>
<td>$400</td>
<td>$300</td>
<td>$200</td>
</tr>
<tr>
<td>$100</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Excludes insurance premiums paid.

Source: Project HOPE analysis of Medical Expenditure Panel Survey 1996 for AARP Public Policy Institute.
spending is very high for people with one or more functional limitations, regardless of age. People age 50 and older who needed assistance with one or more ADLs, such as bathing or dressing, spent $809 out of pocket on home care in 1996 while people needing help with one or more IADLs, such as managing their medications or their finances, spent an average of $573 (Figure 47).

Private Long-Term Care Insurance Premiums. Annual premiums for private long-term care insurance averaged $1,677 in 2000 but varied widely according to age at time of purchase and type of protection provided. For example, annual premiums in 1997 averaged $888 for policies purchased at age 50, $1,850 if purchased at age 65, and $5,880 if purchased at age 79. Despite the lower premiums, private long-term care insurance is rarely purchased by younger individuals.

Summary

This section demonstrates that the health gains experienced by older Americans and shared with society are not without substantial costs. Due to changes in how services are used, cost trends, and the nature of insurance coverage, Medicare beneficiaries have experienced a major increase in out-of-pocket spending for prescription drugs, relative to spending for ambulatory care services. The beneficiary liability for Part B premiums in the future is a particular concern in terms of out-of-pocket costs, as are the dramatically rising premiums for Medigap coverage. The fact that a sizeable share of people age 50 and older with low-income or fair or poor health pay more than 10 percent of their income toward out-of-pocket health costs suggests that public programs are not adequately protecting people in need. Furthermore, the shift in concentration of health spending among the elderly indicates that a larger share of this population makes relatively heavy use of services today than in the past. Similarly, individuals using long-term care services face significant costs. Not only do these facts raise important questions about how to maintain access to beneficial services, technologies, and drugs, but they also point to the necessity of getting value out of the dollars spent.
Research indicates that there are serious and pervasive problems with the quality of care throughout the U.S. health system in both the private and public sectors; traditional fee-for-service and managed care delivery systems; all care settings; and in the delivery of preventive, acute, and chronic care services. Experts classify these problems into three categories: (1) too little care, or underuse of proven interventions that are known to be effective; (2) too much care, or overuse of procedures, treatments, or medications where the risk of their use exceeds their potential benefit; and (3) wrong care or misuse, when the correct service is provided inappropriately and avoidable complications occur.
Very little systematic information exists about the state of health care quality in the nation, allowing researchers to make only crude estimates of the gaps between the care that patients should get versus the care they actually receive. The information that is available is derived from sources such as administrative data, medical records, and patients themselves. In combination, these sources create a more complete picture of the status of health care quality than does any individual source on its own. Nevertheless, information from patients provides a unique perspective on their health care experiences, including how responsive doctors have been, what the outcomes of treatment are, and how well they understand instructions about their care (Figure 48).149

Quality of Medical Care: The Consumer Perspective

Most consumers are relatively content with their health care and give high ratings to their doctors’ attentiveness and interest. However, older people tend to view various aspects of the health care system more favorably than younger individuals. In addition, people who have lower incomes or who report their health condition as poor or fair tend to be more critical and give lower ratings. Overall, consumer views contrast greatly with those of the technical experts who warn of system deficiencies and the urgent need to improve health care quality.

Satisfaction with Quality.

Slightly less than half of older adults rate the health care system in America today as “good,” “very good,” or “excellent.”150 However, when adults were asked more specifically about the quality of care they personally receive, they gave much higher ratings. Among Medicare beneficiaries in 1998, satisfaction is very high across all age groups (about 90 percent say they are “very satisfied” or “satisfied” with the quality of care they receive), although beneficiaries age 65 and older are slightly more satisfied than those who qualify for Medicare due to disability. Disabled beneficiaries rate their health plans lower across all dimensions of performance, even in comparison to elderly beneficiaries with exceptional health care needs.151

FIGURE 48 What is Quality?

While consumer and clinical experts value certain common elements, they have different perspectives on what constitutes health care quality. The Institute of Medicine defines health care quality as “... the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.” Adults who were recently asked to name the most important factors in determining the quality of care a patient receives identified the following:

- **Physician’s Qualifications**: 23%
- **The Ability to Choose the Doctor**: 7%
- **The Patient-Provider Relationship**: 7%
- **Coverage of Care and Procedures**: 6%
- **Availability of Appointments**: 5%

While this age-related pattern has held since 1992, satisfaction levels in 1998 were higher than in the earlier period. When looking at satisfaction with quality by source of supplemental coverage over the same time period, the vast majority of Medicare beneficiaries in every category—Medicare fee-for-service only, Medicare+Choice, or other source of supplemental insurance—are still either "satisfied" or "very satisfied." The finding that satisfaction among Medicare managed care enrollees was similar to other Medicare beneficiaries is of particular interest since this six-year period was marked by wide media coverage of the "managed care backlash" and concluded with the beginning of instability in the Medicare+Choice program.

Patients who change their usual source of care—and, in the process, possibly compromise continuity of care—often do so because of dissatisfaction with the quality of their care. In 1996, about one-quarter (26 percent) of 50 to 64 year olds and slightly more (28 percent) of people age 65 and older who changed providers did so because they were dissatisfied with the quality received. Among people age 50 and older, those in the top income quartile are more likely (34 percent) to change their usual source of care due to dissatisfaction than are middle or lower-income individuals (26 and 22 percent, respectively).

Technical Quality. Coordination is a core dimension of primary care quality identified by clinical experts, although achieving this goal is challenging in today’s environment, where most care is not provided in an integrated setting. This dimension is especially relevant to older patients. For example, Medicare beneficiaries age 65 and older who have more than one chronic illness report seeing an average of 10 different doctors during the year.
One way for doctors to coordinate care is to inquire about prescription medications and treatments provided to their patients by other doctors. For every age group 65 and older (i.e., 65-74, 74-84, and 85+), about one of four individuals reported in 1996 that their doctors usually did not make such inquires, while approximately one of five people age 50-64 indicated the same (Figure 49). Although doctors may obtain this information in other ways, it is disturbing that such a significant proportion of doctors are not asking their patients about other care received, and that they more often fail to do so with older patients. On the other hand, patients also have a role in facilitating coordination. The fact that the majority of adults using complementary and alternative therapies do not reveal this to their doctor hampers coordination and may pose health risks for patients. For example, interactions between certain herbal medicines and prescription drugs can be dangerous and even fatal.

From a patient’s perspective, the thoroughness of an examination is one way to judge a doctor’s competence. The vast majority of consumers—95 percent of people age 65 and older and 92 percent of people age 50-64—rated the thoroughness of the exams they receive from their doctors as “excellent,” “very good,” or “good” in 1998/1999. However, as income or self-reported health declined, the proportion of each age group that rated their exam “poor” or “fair” increased.

Another way that consumers judge technical competence is to assess safety and preventable medical injury. The Institute of Medicine’s report, To Err is Human, estimated that between 44,000 and 98,000...
people die annually due to medical mistakes, and many more suffer disabling injuries. A study of medical records in the early 1990s, whose basic findings were confirmed by a similar study conducted more recently, estimated that older patients are at greater risk of medical injury than their younger counterparts: 5.7 percent of patients age 65 and older and 4.4 percent of those age 45-64 suffered medical injury during their hospitalizations, compared with rates of 2.7 or lower for patients in younger age groups.

According to consumers themselves in 2000, slightly under 40 percent of adults age 50 and over—and a somewhat larger share (46 percent) of all adults—believed either they themselves, a relative, or a close friend had been involved in a situation where a medical mistake was made. Nevertheless, it appears that a majority of adults of all ages who were surveyed in 1998 trusted that their doctor would tell them if a mistake was made about their treatment. However, people age 65 and older were more likely to trust their doctor to be forthcoming with information about a mistake (73 percent) than were 50 to 64 year olds and people younger than age 50 (60 percent).

Choice. Consumers often view choice as a proxy for good quality. In 2000, 79 percent of Americans age 18 or older reported that they were “very confident” or “somewhat confident” that they had enough information to make the right choice in choosing a doctor. In addition, most adults over age 50 reported satisfaction with their choice of primary care physician (over 90 percent) in 1998/1999, as they did with choice of specialist physician. Looking toward the next decade, about two-thirds of consumers in 2001 are very confident of being able to choose a quality doctor in the future, with people age 50-64 slightly less confident (64 percent) than people over age 65 (70 percent).

Patient-Provider Relationship. Given the importance of a doctor’s “bedside manner” to many people, it is not surprising that the patient-provider relationship and interpersonal communications is mentioned by consumers as an important dimension of quality. One measure of this relationship is whether consumers feel that their doctors are concerned about their health. More than four of five Medicare beneficiaries in 1998 believed that their doctors were concerned. Except among the “oldest old,” this conviction increased slightly between 1992 and 1998 for all age

FAST FORWARD

Looking toward the next decade, about two-thirds of consumers in 2001 are very confident of being able to choose a quality doctor in the future, with people age 50-64 slightly less confident than people over age 65.
groups; even the proportion of those who were not satisfied that their doctors were concerned declined during this period. Medicare beneficiaries with functional limitations were about twice as likely to be “unsatisfied” with this aspect of the doctor-patient relationship in 1998 as their counterparts with no limitations (Figure 50). As was the case for each age group, the share of beneficiaries reporting dissatisfaction with their doctor’s concern for their health decreased from 1992 to 1998 for each category of functional limitation.

With regard to another measure of the doctor-patient relationship—time spent with the doctor—the majority of consumers over age 50 in 2001 feel confident that their doctor spends enough time with them. Nearly two-thirds (63 percent) of adults age 65 and older were “very confident” or “extremely confident” that their doctor spent enough time with them compared to slightly more than half (54 percent) of 50 to 64 year olds.163

In addition, most older adults in 1996, regardless of age, income or gender, believed that their usual provider generally listened to them and gave them the information they needed. However, compared to their counterparts, a larger share of people in poor or fair health say their usual source of care does not generally listen or provide needed information (Figure 51). Finally, the vast majority of older adults reported in 1998/1999 that the explanations they receive from their doctors are “very good” or “excellent.”164 Doctors' explanations are more likely to be rated highly by people age 50 and older with higher incomes and better health. Thus, 83 percent of people age 50 and older with income in the top quartile and 88 percent of those in excellent health rate the explanations “very good” or “excellent” compared to 71 percent of those with incomes in the lowest quartile and 69 percent of those in poor health.

The Patient's Role in Ensuring Quality. The era in which patients were passive recipients of care, without rights or responsibilities, is rapidly fading. It is increasingly accepted that patients can and should play a more active part in ensuring the quality of care they receive. However, adults of all ages are roughly split in two regarding perceptions of their current level of control over their health care: in 2000, 53 percent believed they had enough control over their care while 45 percent disagreed.165 People age 65 and older, although they did not differ substantially from their 50 to 64 year old counterparts, were somewhat less
likely to believe they had enough control (51 percent versus 55 percent, respectively).

One indicator of patients’ involvement in their health care is their level of participation in decision-making. In 2001, 58 percent of older Americans said they prefer to work with doctors and get recommendations before making treatment decisions, while 38 percent prefer to rely on their doctors because doctors have the necessary knowledge and training to make such decisions. Nearly two-thirds (64 percent) of people age 50-64 favored the more participatory decision-making approach, compared to only half (51 percent) of people age 65 and older.

Another potential sign of health care involvement is that people age 50 and older are substantially more likely to actively seek out health information than younger age groups. Younger people, however, are more likely than older people to use the Internet to obtain medical information. More than 40 percent of 21 to 34 year olds reported in 2000 that they used the Internet to obtain such information, while only 20 percent of people age 50-64 and 12 percent of people age 65 and older said the same.

Quality of Long-Term Care

Nursing Home Care. Nursing home residents, by virtue of their frailty and vulnerability, need special protection from potentially poor quality care. While quality of care in nursing homes remains a major concern, modest improvements have been made over the past decade in certain key areas, including maintaining residents’ dignity; preventing pressure (bed) sores; using physical restraints properly; and ensuring that
residents receive comprehensive assessments of their needs. These improvements are likely linked to implementation of the Nursing Home Reform Act of 1987, which established state requirements for certifying nursing homes that participate in the Medicare and Medicaid programs. Still, the continued presence of deficiencies identified by state surveyors during the annual certification process underscores the ongoing need to implement and enforce strong nursing home quality standards (Figure 52).

In addition to receiving information on nursing home quality from surveys, it is useful to get consumer perspectives—from residents or their families—on the quality of care and the quality of life in nursing homes. A national survey in 2001 found that while people who have substantial experience as a patient, with a friend, or with a family member in a nursing home have generally positive views about care provided, a sizeable share say the person received poor quality care. About 25 percent say the resident developed bed sores or skin ulcers, was overmedicated, had been placed in physical restraints, or had been abused by staff.169

Home Care. In 2000, most people age 50 and older who had received home health care services over the previous two years, or whose family member had received such services, reported being satisfied with the care (Figure 53). These general findings were echoed by a recent survey reporting high satisfaction levels among virtually all Medicare beneficiaries (93 percent) who began receiving home health care services in January 2001.170 Satisfaction did not differ among beneficiaries who lived in urban versus rural locations or had different diagnoses. While beneficiaries expressed satisfaction with the services they were receiving, a substantial share (20 percent) reported not receiving all of the home health care that they need, most frequently home health aide services and physical therapy.


Summary

An examination of consumers’ perceptions of different aspects of the quality of care they receive finds high levels of satisfaction overall among people age 50 and older, except for residents of nursing homes. However, even on those aspects of quality where most consumers are satisfied, differences are discernible: as people age, they tend to be more generous in their ratings of health care quality, reporting somewhat greater satisfaction; and people who are in poorer health tend to be somewhat less satisfied. In most cases, consumers’ views contrast with experts’ assessments of health care quality in the nation, which are generally considerably more critical. In addition, although it is clear that, throughout the system, consumers will be expected to bear more responsibility for making informed health care choices, only about half believe they now have sufficient control over their own care. Moreover, because at least one-third of older people favor a less participatory approach to medical decision-making, the shift in responsibility may not be welcome.
Key Themes and Findings

“Beyond 50” presents a rich and varied picture of the current state of health security for Americans age 50 and older. The conclusion focuses on some of the most essential themes, which reflect the health care considerations for America’s aging population. Because any effort to summarize large amounts of information risks failing to highlight findings of interest on specific topics, readers are encouraged to refer to the previous chapters for a more in depth perspective.
1. Today's population age 50 and older is living longer and is generally healthier than its predecessors. In addition, rates of disability among older adults have been declining. At the same time, the aging of the population means that there are more people age 50 and older with chronic conditions that limit their ability to function on a daily basis, often over an extended time period. Socioeconomic status is a risk factor for these and other problems, regardless of age.

- At age 50, Americans can expect to live another 30 years, almost nine years longer than the average years of life past age 50 expected for Americans in 1900. Although racial differences in longevity continue to exist, additional life expectancy at age 85 is higher for black men than white men.
- For every age group but one, the proportion of people who assessed their health as “excellent” or “very good” increased over time. The exception was people age 85+, for whom the proportion declined slightly over time, possibly reflecting the fact that more people are surviving with conditions that previously would have resulted in earlier deaths.
- Broad measures of disability show declining rates among older people over the last few decades, especially among those with higher educations and for less severe levels of disability.
- The majority of the population age 50+ is living with at least one chronic condition. Although a much smaller proportion of people experience disability or functional limitations, the likelihood of disability or functional limitation increases dramatically with age. The share of individuals living simultaneously with chronic illness, disability, and limitations in daily functioning rises steeply from 5 percent of 50 to 64 year olds to 44 percent of people 85 and older. People age 85 and older represent the most rapidly growing segment of older Americans.
- Only 30 percent of 50 to 64 year olds and 4 percent of people age 85 and older have no chronic condition, disability, or functional limitation.

2. People are taking certain steps in order to live healthier lives, such as quitting smoking, using preventive services, taking medicines, and trying to exercise, but many are not changing their diets or losing weight. Despite a decrease of approximately 30 percent over two decades in the prevalence of smoking, the epidemic of obesity could cancel out many of the gains achieved in other areas of prevention and treatment of diseases associated with aging.

- A lot fewer older Americans smoke, more report making efforts to exercise (with the greatest gains in the population age 75 and older), more women are having mammograms and Pap smears, and more are having their blood pressure checked and getting pneumonia shots.
- Although heart disease is still the leading cause of death, the death rates from heart disease and stroke have declined dramatically for all older age groups over the past two decades. The prevalence of hypertension also has dropped, especially among people age 50-64.
- Obesity nearly doubled for people age 50 and older between 1982 and 1999. Within this age group, obesity is highest for 50 to 64 year olds. Affluent and sedentary lifestyles, hectic schedules that leave little time for physical activity, and the lure of computers and televisions as entertainment are possible culprits.
- Undiagnosed and under treated conditions continue to threaten the health and quality of life for people of all ages. For example, white men age 85 and older have the highest rate of suicide—which is often a consequence of a mental health condition such as depression—comapred to other subgroups of age, gender, and race.
3. By virtue of the higher health care costs associated with age and their greater likelihood of not being in the workforce, 50 to 64 year olds are very vulnerable to being without health coverage. More are uninsured today than in the past, and individuals who are accustomed to feeling secure about their health coverage are increasingly at risk of not having needed protection. It is important to note that much of the evidence presented in this report was for a time period in the late 1990s when the economy was quite robust. The health coverage problem has grown worse in the last year as corporate America has responded to the recession and rising health care costs by reducing business expenses, including laying off workers.

- Even as a disproportionate share of those in the lowest income quartile continue to be uninsured, larger shares of 50 to 64 year olds in the middle and upper income quartiles are uninsured today compared to 10 years ago. Although workers account for the largest number of uninsured 50 to 64 year olds, those without a connection to the workplace—50 to 64 year olds who are unemployed or not in the labor force—have a higher risk of being uninsured than do their employed counterparts. Half of people age 50-64 who were uninsured in 1999 reported being without coverage for three years or more.

- Fewer employers today offer health coverage to early retirees. In 2001, two-thirds of 50 to 64 year olds who were still working but considered changing their work status (e.g., retiring, cutting back hours, changing jobs) said that concerns about health coverage affected their decision.

- The combined effects of insurance underwriting and rising premiums mean that individual private insurance is less accessible and covers fewer people than 10 years ago. Individuals with health problems face average premiums that are substantially higher than those quoted to similar people without health problems. According to one recent study, the premium cost for someone with a health problem was $4,056 and $9,936 for applicants age 56 and 62, respectively.

- Public programs only protect about 25 percent of 50 to 64 year olds who are poor. Many higher income people think—probably mistakenly—that Medicaid will be able to help them should they not have any other coverage.

- In 2001, nine of 10 people age 50-64 say they would be concerned about finding affordable coverage if they were suddenly without health insurance.

4. Although Medicare is critically important to people age 65 and older, the program has major gaps in coverage—including the lack of a prescription drug benefit and inadequate coverage in other areas—that force beneficiaries to buy additional insurance privately. However, this supplemental coverage is increasingly inadequate, unaffordable, or not available.

- Beneficiaries with only traditional Medicare—who lack supplemental coverage—are disproportionately low income, black, or Hispanic. In addition, nearly 25 percent of disabled beneficiaries between the ages of 50 and 64 have only traditional Medicare for their health care coverage.

- Only about three-quarters of Medicare beneficiaries had any coverage for prescription medicines in 1998, and that figure had likely fallen to about two-thirds by 2001. Fewer still have coverage through the entire year. Financial barriers contribute to lower use of needed medicines.

- Medicaid covers only 54 percent of all noninstitutionalized Medicare beneficiaries with incomes at or below the federal poverty level. Poor people age 85 or older are least likely to be enrolled in Medicaid.
• Medicare+Choice has played a critical role in both the earlier expansion and the recent contraction of supplemental coverage. Contrary to popular opinion about managed care generally, Medicare beneficiaries in Medicare HMOs are just about as satisfied with their care as those in the traditional Medicare program.

5. While access to health care services can make a difference in a person's health and, overall, people age 50 and older are using more services than in the past, the evidence is mixed as to whether they are getting value out of the health care dollars spent. Older Americans appear to benefit from the health care services they receive; however, health care resources continue to be used inefficiently.

• Most expensive, invasive, complex medical interventions are being used on a "young-old" population that can genuinely benefit: 66 years is the average age for heart bypass surgery, 72 years for hip replacement, and 74 years for pacemaker-related procedures. Hospital charges only for a heart bypass in 1997 averaged nearly $48,000 while the average charges for partial and total hip replacement were a little more than $22,000. Nevertheless, the share of older adults' total expenditures for inpatient hospital services fell from 67 percent in 1977 to 35 percent in 1996, while the proportions spent on ambulatory care and prescription drugs increased.

• Although most older Americans do not report major problems with access to care, exceptions include minorities of all ages, uninsured 50 to 64 year olds, and people needing certain services.

• Missed opportunities to improve health and functioning abound. Among those in the oldest age groups is the need for better care for chronic illnesses and for supportive services, such as personal care, which insurers typically do not define as "medically necessary." Also, 1.2 million Medicare beneficiaries did not fill a prescription written for them in 1999; more than half said they did not fill them for financial reasons.

6. For people age 50 and older, total health care costs are up substantially from 20 years ago, even after adjusting for general inflation. Health care costs pose a particular burden for those in need of prescription drugs or long-term care services and those with low incomes who do not have Medicaid. High out-of-pocket costs are increasingly a problem for older people who see themselves as unhealthy. Again, it is important to remember that in the last few years (which are not covered by data presented in this report), health spending has accelerated, likely exacerbating affordability problems.

• Between 1977 and 1996, average total health care spending per person age 50 and older (including home health care but not nursing home care or other long-term care services) increased 310 percent, compared to general inflation of 159 percent. Spending rose from $2,452 to $3,881, after adjusting for inflation. Factors contributing to spending growth during this period include technological advances, inflation of prices for items such as prescription drugs, and greater service use.

• Prescription drugs for the 50+ population accounted for a larger share of total health spending in 1996 (15 percent) than two decades ago (6 percent). During this same time, a major shift occurred in the components of out-of-pocket spending. The ratio of out-of-pocket costs for prescription drugs to costs for ambulatory care services increased for older Americans from 0.6 in 1977 to 1.7 in 1996. Many people, particularly Medicare beneficiaries, do not have coverage to ensure access to medicines and financial protection from burdensome costs.
Forty three percent of people age 50 and older in the lowest income quartile spent more than 10 percent of their income on health care goods and services in 1996. Over the past two decades, the share of people in poor or fair health who spent more than 10 percent of income on health care increased, while the share of healthier individuals who spent this amount decreased.

7. Major shortcomings in the degree to which the U.S. meets the health and long-term care needs of its population means that people age 50 and older—among whom, a larger share have high health care expenses than in the past—are concerned about their ability to pay for services as they age. Among older populations, a traditional insurance model is less effective than a social insurance model (like the Medicare and Social Security Disability Insurance programs) at providing affordable coverage.

Chronic conditions are responsible for a large and increasing share of dollars spent on health care in the U.S. In 2000, 75 percent of total health care spending was for people of all ages with chronic conditions, a figure that is projected to rise to 80 percent in 2020. As people age, more individuals experience chronic illness, disability, and functional limitations, which contributes to higher health and long-term care costs. This means that there is less “good risk” to spread among the “bad risk.”

In addition, over time, high health care spending has become less concentrated and now affects a larger proportion of the population. The top 2 percent of elderly spenders accounted for only 22 percent of total spending in 1996 versus 33 percent in 1977. For the “oldest old” and people with disabilities, nursing home care and supportive services, primarily home health care and related home and community-based services, have replaced inpatient procedures as the major drivers of health-related costs.

Although the financial status of older people has improved, both private health coverage and private long-term care coverage are costly, on average, which is a problem for many older people.

8. The U.S. has no overall approach to long-term care and relies too heavily on individuals bearing the financial and nonfinancial burdens. The mere fact that there is no long-term care “system” of coverage and financing that is comparable to that for health care contributes to the criticism that organized services are too heavily geared toward acute care.

Caregivers age 50 and older make enormous unpaid contributions to caring for people with disabilities: they provide an average of more than 20 hours of care per week, and more than half provide services for a duration of at least five years. In 2001, about one in five Americans age 50 and older said they or their spouse were providing help with everyday activities to a disabled relative or friend.

Out-of-pocket spending on long-term care, along with that for prescription drugs, represents the greatest health-related financial risk for older Americans, particularly those with advanced age, who have or may develop cognitive, mental, or physical disorders.

Private long-term care insurance is not affordable for many individuals. A large share of purchasers—more than 40 percent—have incomes of $50,000 or greater.

Individuals are most likely to need extensive long-term care services precisely when their resources are most limited. Americans seem to understand this vulnerability. Most older adults lack confidence in their ability to afford either nursing home care or home care.
9. One form of diversity within the 50+ population is that 50 to 64 year olds view the health and long-term care systems differently from older individuals. The younger group tends to be more skeptical, have higher expectations, and be more proactive consumers. Possible explanations include differences in educational attainment and family structure between the age groups, a tendency to become less assertive with age, a presumption that the Medicare program will provide protection, and greater exposure of younger people to multiple sources of information.

- Compared to consumers under age 65, older consumers tend to rate various factors in the health system more favorably. Still, people of all ages who have lower incomes or who report their health condition as “poor” or “fair” tend to be more critical and give lower ratings.
- People age 65 and older are substantially more likely than 50 to 64 year olds to believe their doctors would tell them about medical mistakes.
- In general, fears connected with the dying process decline with age.
- People age 50-64 are much more likely than those age 65+ to want to actively participate in health care treatment decisions with their doctors. Conversely, people age 65+ are more likely than 50 to 64 year olds to rely on their doctors to make these decisions.
- Compared to populations both over age 65 and under age 50, 50 to 64 year olds are the age group most likely to use complementary and alternative medicine.
- Fifty to 64 year olds are more likely than people age 65 and older to use the Internet to obtain medical information.

10. On several issues, perceptions and preferences of older Americans often do not match reality. To the extent that the public is unaware of shortcomings in the health and long-term care system— in part, a manifestation of low health literacy— it may be harder to make improvements.

- Consumers' perceptions of health care quality stand in stark contrast to the views of technical experts who warn of deficiencies. For example, although it is known that many people, including Medicare beneficiaries, do not receive appropriate care, the vast majority of consumers across all the age groups are very satisfied with the health care quality they receive.
- A high percentage of people age 50 and older believe the pain they experience at the end of life will be effectively treated, but data indicate that such expectations may not be met.
- There is a serious mismatch between older Americans' preferences for receiving long-term care— in their home— and our nation's spending on long-term care— in nursing homes. In addition, the vast majority of people age 50 and older (77 percent) would prefer the greater autonomy of directing their own home care rather than having an agency do so.
- People age 50 and older are very confused about private long-term care insurance. Four in 10 say they already have such insurance, yet only 3.5 to 4 million older Americans (well below 10 percent) have private long-term care insurance.
- Older Americans who will be among those at the greatest risk for needing services— people with low incomes and the least education— are the least knowledgeable about whether Medicare covers long-term care and other services.
Implications for Policy

Given these findings, the challenge for policy and practice is to ensure access to and delivery of high quality care at affordable costs so that individuals might reap the benefits of good health and society reap the benefits of healthier populations. This requires finding the right balance—for example, between individual and collective financial risk, between medical and supportive care, between private and public sector roles, between individual autonomy and public safety, and between public health and personal health services. Underlying much of this challenge is the need to generate and use information to better understand the nature of problems, to identify effective solutions, and to take action based on this knowledge. The following implications for public policy are relatively straightforward and indicate that the problems documented in this report must be addressed along multiple fronts.

First, health security encompasses not only a person’s clinical condition but also the underlying socioeconomic conditions that require attention. The health concerns of special populations take on even greater significance considering the increasing racial and ethnic diversity in the composition of the midlife and elderly population. Older Americans in all age groups whose health security is most compromised include people in poor health, with low income, or of minority race or ethnicity. The intertwining of health, economic status, race, income, geography, and education means that health security cannot be accomplished without also addressing underlying socioeconomic disparities. For example, the fact that Hispanics are the most rapidly growing ethnic minority among older Americans and that minorities are disadvantaged in many ways mean that cultural differences—such as language, at a minimum—must be taken into account when developing solutions. Information in this report also suggests the emergence of other categories of at-risk populations, such as older men. Not only has the life expectancy of men increased, but men increasingly live alone, interact with the health care system less often than women, and are at much greater risk of suicide.

Second, the health and long-term care “systems” must better address the needs of people who experience chronic illness, disability, or functional limitations. The goal should be a longer span of healthy life, not just a longer life. At a time when people of all ages are living with chronic conditions, disability, and/or functional limitations, the significance of health and well-being as an indicator of a person’s health security cannot be overstated. Increasingly, the needs of this population require a range of services that include physician, inpatient, outpatient, and long-term care. Reducing the fragmentation in the delivery and funding of these services would go a long way toward improving the quality of care and the health care experiences of this population. Finding better ways to manage the care of people with multiple and complex health problems should help to improve quality and contain costs as well as result in higher patient satisfaction. Developing the infrastructure of services and supports for the population in need of long-term care is also essential. Our nation’s willingness to address the needs of people who have chronic conditions is critical to the well-being—that is, the quality of life and ability to be active and function independently—of an aging population.

Third, health care resources should be used to strengthen the public health system, so that it can better support system goals. In particular, the impact of individual behavior and personal choices on health and disability must be acknowledged—but not overstated—and acted upon using public health approaches. There is a substantial imbalance between current spending to support these types of activities at the public health level and the resources allocated for personal health services. However, the public health system played a major role in improving health over the past century and continues to be the source of many tools important to improving and maintaining the health and functioning of Americans. These include already proven population-based, low-tech approaches, such as immunizations and screening, greater public safety, and the identification and control of
environmental risks. A greater capacity to share epidemiological information among communities and states is another critical public health function that would benefit from information infrastructure improvements discussed below.

In addition, a stronger and more visible public health system is needed to develop and promote population-based interventions aimed at modifying risky behaviors. While there is no denying the relationship between age and health, a sizeable share of even the "oldest old" are living without disability or functional limitations. Clearly, genetics plays an important role in how we age, but how well we take care of our bodies throughout our life span also matters because many chronic conditions are caused, in substantial part, by the environment and by individual behaviors. Such conditions are preventable or controllable through early detection and better medical management using both new technologies and established methods. A stronger and more visible public health system is needed to develop and promote population-based interventions aimed at influencing better behavior at both the individual and organizational levels, in much the same way that has been done and continues to be done with tobacco use. Reducing the prevalence of chronic conditions also has the future long-term benefit of lower spending to treat such diseases. After all, today's 50 to 64 year olds are tomorrow's Medicare beneficiaries.

Fourth, the general lack of long-term care coverage and the increasing inadequacy and instability of health care coverage for portions of the population age 50 and older must be addressed. Financially strong social insurance programs—such as Medicare or Social Security Disability Insurance—will need to be core elements of the solution. The tenuous coverage situation affects individuals in every age group 50 and older and involves coverage for all types of services: basic medical, prescription drugs, other costs not covered by Medicare, and long-term care. Even the Medicaid program, which has traditionally provided fairly comprehensive coverage and a safety net of financial protection to people who are eligible and able to enroll, is at risk of contraction by states under budget pressures.

This report shows that a large proportion of health and long-term care use and cost is a function of the treatment and management of chronic illness, disability, and functional limitations. Given the prevalence of these conditions in older people, it is a fact that health spending in older populations is less concentrated among a few individuals than it is among younger populations. The implication is that traditional insurance models, which rest on the assumption that only a small proportion of the insured will need services in a particular year, are simply not able to provide affordable coverage to older age groups. In addition, costs for a large proportion of the population at risk, including many people with incomes above the poverty level, will exceed their individual financial capacity, making traditional insurance coverage unaffordable. This reinforces the critical role of the Medicare program. However, due to recent and future expected growth in the number of Medicare enrollees, existing revenue streams that finance the Medicare program—including substantially higher Part B premiums for beneficiaries—will eventually be inadequate to guarantee the current level of protection.

Similarly, private long-term care insurance and individual savings will not be sufficient to provide adequate long-term care for most older Americans. Together, the data on long-term care in this report suggest that there is a major "missing piece" in our nation's approach to providing long-term care. That piece is a new program of social insurance to complement the care provided by family and other informal caregivers, coverage by the private long-term care industry, and the safety net provided by Medicaid.

Fifth, U.S. health care spending is high and varies across geographic regions, often without good reason. Societal values with regard to the availability and use of services and technologies, particularly the use of "supply-sensitive" services, help to explain some of this pattern. While reducing aggregate system costs
is unlikely for a variety of reasons, it is desirable and possible to make better use of resources. Past improvements in health and well-being— and historical increases in health care spending— were, in part, the result of technological advances in preventing or treating health conditions. A strong consumer demand to receive and provider desire to give patients the benefits of these capabilities contributes to higher health care spending. It is likely that future health improvements will require even greater resources, at least initially. For example, simply maintaining people in better health and functional status will be costly, especially when one considers the magnitude of current underuse of services and products with this potential. Furthermore, although it also often comes at a cost, technology will continue to provide opportunities for improving the delivery and outcomes of care. Nevertheless, it is both possible and necessary to direct current and future resources toward activities that generate dividends, e.g., providing primary care in order to reduce inefficient use of emergency room services, preventing medication misuse that contributes to avoidable hospital admissions, reducing medical errors in all care settings, and improving information systems that streamline administration and eliminate duplication.

Sixth, improvement in health and long-term care quality is a key component in ensuring that consumers receive greater value from health care dollars spent. Disparities among insured populations, such as Medicare beneficiaries, are a reminder that coverage alone cannot guarantee access to services and access to services does not necessarily mean delivery of high quality care. And yet the generally high satisfaction expressed by older Americans with regard to their health care overlooks the overwhelming clinical evidence about the state of health care quality in the U.S. Experts “guesstimate” that only half of people of all ages receive recommended preventive services; 30 percent do not receive recommended acute care services; 30 percent get acute care that is contraindicated; and 40 percent do not receive recommended services for chronic illness while care received for chronic conditions is contraindicated in 20 percent of the population. Therefore, greater effort is needed in all sectors of the health and long-term care systems to improve quality. In addition, investment is needed in systems that will facilitate public reporting of performance information which, in turn, could educate customers about health care quality problems and create public demand for a more accountable system.

Seventh, a national health information infrastructure should be developed. Perhaps the single most significant barrier in our ability to improve health care quality and advance public accountability in health and long-term care is the lack of a health information infrastructure. By failing to apply recent information technology advancements in a concerted and focused manner, we have been unable to address quality concerns. A national infrastructure would facilitate improvements in several areas identified by the Institute of Medicine, including consumer health, clinical care, administrative and financial transactions, public health, professional education, and research. In view of the large expenditures that are required to develop this infrastructure, no one sector can be expected to bear the burden alone. Collaboration between the public and private sectors and joint support will be crucial to achieve the desired objectives.

As with infrastructure development, collaboration between the public and private sectors is necessary to develop the needed decision supports that will help consumers navigate the health and long-term care systems and evaluate their choices. Consumers are learning to become better informed about the choices they have with respect to their coverage and treatment options, particularly as employers shift more of the responsibility for cost and risk of health decision-making to the users of service. However, the shift may be advancing faster than the development and dissemination of meaningful and useful information.

Given the complexity of the health care system and the growing emphasis on the importance of being able to make informed decisions, the health literacy of the population, particularly among
Medicare beneficiaries, is a major challenge. Targeted steps must be taken to assist people who have special needs, including those who are incapable of using written materials. However, even people who are literate find it frustrating to make decisions about health and long-term care. Considerable evidence shows that many people lack the knowledge they need to select the options most appropriate for them. Areas that are ripe for major educational efforts include basic information about the Medicare program, navigation of the health care system, safe medication use, end-of-life care (including the availability of pain management techniques and palliative care), and long-term care options and costs.
ENDNOTES


2. Not included in the 22 percent is the 4 percent of Medicare beneficiaries who had both employer-sponsored and individually purchased coverage in 1998; for our purposes, these individuals are counted only in employer-sponsored coverage.

3. AARP Public Policy Institute analysis of Census 2000 Summary File 1 (SF 1) 100-Percent Data. Number represents all people, including those living in institutions.


5. See ibid, for a detailed analysis of these factors.

6. Differences in family structure—that is, the fact that women of this age are twice as likely as men to live alone—may explain some of the gender differential in income.

7. For example, the Family Circle/Kaiser Family Foundation Survey of Health Care and Other Elder Care Issues conducted in mid-July 2000, which obtained information from a random sample of people age 18 years and older with a living parent age 65 or older, found that 24 percent routinely gave their mother and/or father money to help with expenses.

8. Including the basic activities of daily living (walking, dressing, bathing, eating, dressing, getting to or out of bed, and toileting), or instrumental activities (meals, shopping, using the telephone, taking medicine, or using money).


14. Anderson, G. and Hussey, P., Health and Population Aging: A Multinational Comparison. (New York, NY: The Commonwealth Fund, October 1999). The proportion of the population age 65 and older in the United States is markedly lower than in other large industrialized nations, including Japan, Germany, France, and the United Kingdom. By 2020, more than one-quarter (26 percent) of the Japanese population, and 22 percent of the German population are projected to be older than age 65, compared to less than 17 percent in the United States. Almost 8 percent of the Japanese population will be older than 80 by 2020, compared to less than 4 percent in the United States.


18. Analysis by the Alcohol Epidemiologic Data System of the National Institute on Alcohol Abuse and Alcoholism of data from the National Household Survey on Drug Abuse, 1988, 1990-1998, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. A nondrinker was defined as one who did not use alcohol in the past month; a light drinker is one who had three or fewer drinks per week in the past month.


20. National Center for Health Statistics, Trends in Aging Database. “Prevalence of Obesity and Overweight by Age, Sex, and Race, United States, 1982-2000.” Overweight refers to increased body weight in relation to height, when compared to some standard or desirable weights. Obesity may or may not be due to body fat. Obesity refers to an
excessively high amount of fat or adipose tissue in relation to lean body mass. The body mass index, a ratio of height to weight, is highly correlated with body fat. As reported here, obesity is defined as a body mass index (BMI) of 30 or more, and overweight is defined as a body mass index of 25 to 29.9.


26. A chronic condition is defined by the National Center for Health Statistics as any specific illness, injury, or impairment that ordinarily has a duration of longer than three months.


29. As distinct from the definition used by the National Center for Health Statistics, an individual was considered to have a chronic condition if it has lasted or is expected to last 12 months or longer and either (1) requires ongoing medical care or (2) places limitations on age-appropriate task performance, basic self care, independent living skills, or social interactions. Functional limitations were defined as the need for help or supervision with any ADL or IADL. Disability was defined by any one of the following characteristics: (1) the use of assistive technology, (2) difficulty walking, climbing stairs, grasping objects, reaching overhead, lifting, bending or topping, or standing for long periods of time, (3) any limitation in work, housework, or school, (4) social/recreational limitations, (5) cognitive limitations such as confusion or memory loss, or decision-making problems that lead to interference with daily activities or require supervision to ensure one's safety, (6) vision problems, and (7) deafness or difficulty in hearing.


31. Partnership for Solutions, Johns Hopkins University analysis of 1996 Medical Expenditure Panel Survey. Similarly, it is uncommon at any age to have a disability and/or functional limitation in the absence of a chronic condition. For example, less than 3 percent of those in any of the 50+ age groups fell into this category.


35. For more facts on depression and suicide among older adults, see http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm.
37. Ibid.
45. Not included in the 22 percent are 4 percent of Medicare beneficiaries who had both employer-sponsored and individually purchased coverage in 1998; for our purposes, these individuals are counted only in employer-sponsored coverage.
46. In analyzing the Medicare Current Beneficiary Survey, insurance categories were constructed to be mutually exclusive by prioritizing insurance. According to this hierarchy, beneficiaries whose only supplemental coverage was a public source other than Medicaid (e.g., Veterans Administration benefits, state-sponsored prescription drug program) were assigned to “traditional Medicare only.”
56. Chollet, D.J., Medigap Coverage for Prescription Drugs.
58. Poisal, J.A. et al., “Growing Differences Between Medicare Beneficiaries With and Without Drug Coverage.”
61. HCFA, Office of Prepaid Health Care Operations and Oversight, unpublished data.
64. Recognizing that there is considerable variation within, and increased blurring between, categories of managed care products, the terms health maintenance organization (HMO), Preferred Provider Organization (PPO), and Point-of-service plan (POS) can generally be described as follows: In a group or staff model HMO, physicians are paid either a fixed amount per enrollee (capitation) or a salary. The providers may practice together as a group, often in a medical center or clinic. In a looser form of HMO, physicians or groups of physicians contract with an individual practice association (IPA) that, in turn, contracts with an HMO. The physicians may be paid on either a capitation or a fee-for-service basis. HMO enrollees are usually required to use the plan's participating physicians. In a POS, HMO enrollees are permitted to obtain services of nonparticipating providers, typically with higher deductibles and/or coinsurance and, sometimes, with higher premiums. PPOs can be configured in a variety of ways although, regardless of the arrangement, the participating physicians are usually paid on a discounted fee-for-service basis. Enrollees may use providers outside of the network but will pay more out of pocket than if they use “participating providers.”
66. 2001 Health Confidence Survey.
67. 1999 Health Confidence Survey.
70. AARP Health Survey of Persons 50+, September 2001.


88. People age 65 or older receiving long-term care assistance were defined as receiving human assistance or stand-by help with one or more ADLs or IADLs. People between the ages of 18 and 64 receiving long-term care assistance who were receiving human help for ADLs or IADLs. 1994 National Health Interview Survey, Disability Supplement, National Center for Health Statistics.

100. 1998 General Social Survey.


102. 1998 General Social Survey.

103. Centers for Disease Control, National Center for Health Statistics, National Home and Hospice Care Survey, unpublished data.

104. Lynn, J., Testimony before the Senate Special Committee on Aging, July 17, 2000.

105. Tschantz, K., Klap, R., and Unutzer, J., “Health and the Treatment of Common Mental Disorders,” paper presented at UCLA Hartford/AFAR Geriatric Scholars Presentation, 2001. Health Care for Communities 1996/97 household survey of 9,585 adults. “Counseling” refers to visits with a mental health specialist during the course of a year or visits with a primary care provider that included some counseling for mental health problems. “Outpatient specialty mental health” care refers to visits to mental health providers such as psychiatrists, psychologists, social workers, psychiatric nurses, or counselors for emotional or mental health problems.


118. Because the 1977 NMCES and 1987 NMES collected expenditure data on charges while 1996 MEPS collected data on payments, NMES charges were adjusted to account for payers receiving discounts for provided care, a practice which was relatively infrequent in 1977 but considered common by 1987. The methodology used to make NMES charges more comparable to payment data in MEPS was developed by the Agency for Healthcare Research and Quality. (See Zuvekas, S. and Cohen, J., “A Guide to Comparing Health Care Expenditures in the 1996 MEPS to the 1987 NMES,” Inquiry (forthcoming)). Overall, these adjusted payments represent about 85 percent of charges.


121. The NewsHour with Jim Lehrer/Kaiser Family Foundation/Harvard School of Public Health, National Survey on Prescription Drugs.


123. Full Medicare coverage refers to the comprehensive set of benefits available under traditional Medicare coverage, as opposed to assistance with Medicare premiums and cost-sharing which is provided to certain low-income Medicare beneficiaries through the Medicaid program.

124. AARP Public Policy Institute calculations based on Centers for Medicare and Medicaid Services, Office of Strategic Planning, unpublished data, February 2002.


129. Schoen, C. et al., Counting on Medicare: Perspectives and Concerns of Americans Ages 50 to 70.

130. Maxwell, S. et al., Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries.


133. HCFA, Office of the Actuary, National Health Expenditures, 2001; and Burwell, B., MEDSTAT Group, Medicaid Long-Term Care Expenditures in FY 1999, April 2000. See also GAO, GAO-01-1167T, September 2001. In 1999, nursing home care expenditures totaled $90 billion and home care expenditures totaled $44 billion, including $10.4 billion for Medicaid home and community-based waivers.


138. Ibid.


140. Rough estimate of national average cost is based on data from the two most recently available market surveys; costs
vary widely by state. (1) GE Long-Term Care Insurance Nursing Home Survey, 2002, in which the cost for a private room, when available, is $54,900; and (2) MetLife Market Survey on Nursing Home and Home Care Costs, April 2002, in which the cost for a semi-private room is $52,195 and for a private room is $61,320.

141. MetLife Market Survey on Nursing Home and Home Care Costs, April 2002. Hourly private pay rate is for a home health aide; hourly rate for a licensed practical nurse (LPN) is $37.


144. Wright, B., Assisted Living in the United States. The base rate generally includes three congregate meals daily, 24-hour protection and oversight, laundry service, activities, and an emergency response system. Other services that might be offered, usually at additional cost, include transportation, assistance with medication, social services, and therapy services.

145. Health Insurance Association of America. Long-Term Care Insurance in 1997-1998, March 2000. Reference to findings of 1999 Long-term Care Survey. Based on a policy providing $100/day for nursing home care; at least $80/day for assisted living; and at least $50/day for home care; four years of coverage; 20 day elimination period, and 5 percent compounded coverage for inflation protection.


150. 2001 Health Confidence Survey.


158. 2000 Health Confidence Survey.

159. 1998 General Social Survey.


161. Center for Studying Health System Change, CTS Household Survey.

162. 2001 Health Confidence Survey.

163. Ibid.

164. Center for Studying Health System Change, CTS Household Survey.
165. Yankelovitch Monitor.

166. AARP Health Survey of Persons 50+, September 2001.

167. Yankelovitch Monitor.


169. The News Hour with Jim Lehrer/Kaiser Family Foundation/Harvard School of Public Health, National Nursing Home Survey, September 2001. A telephone survey of 1,309 adults age 18 and older. People with substantial nursing home experience were defined as those who, in the past three years, had been a resident in a nursing home or had known someone in a nursing home and visited them at least once a month over that time period.


172. Schuster, M. et al., “How Good is the Quality of Health Care in the United States?”


Credits

DESIGN: Fathom Creative, Inc.

PRINTING: Smith Lithograph Corporation

PHOTOGRAPHY:

COVER:
- CHARLES GULLUNG Photonica
- JOHNER Photonica
- KAREN BEARD Stone
- JEREMY RENDELL FPG
- JEREMY WALKER Stone
- KEN CHERNUS FPG

TOC:
- BOB KRIST Stone
- KEN REID FPG
- KAREN BEARD Stone
- RON CHAPPLE FPG
- GEORGE LEPP Imagebank
- STEVE COHEN Foodpix
- MARC ROMANELLI Imagebank
- COLOR DAY PRODUCTION Imagebank

PAGE 8:
- BOB KRIST Stone

PAGE 14:
- JOHNER Photonica
- JOSH MITCHELL Stone

PAGE 16:
- PETER ADAMS FPG

PAGE 17:
- SHANNON FAGAN Stone

PAGE 18:
- KAREEM BLACK Stone

PAGE 19:
- TONY LATHAM Stone

PAGE 20:
- PAUL HARRIS Stone

PAGE 22:
- ANGELA WYANT Stone

PAGE 23:
- ANDREW SHENNAN FPG

PAGE 24:
- KEN REID FPG

PAGE 25:
- SPENCER ROWELL FPG

PAGE 26:
- MARY STEINBACHER Photonica

PAGE 28:
- DENNIE CODY FPG

PAGE 29:
- JIM WEHTJE Artville

PAGE 30:
- THOMAS PETERSON Stone

PAGE 31:
- SUSAN VOGEL Stone

PAGE 33:
- KAREN BEARD Stone

PAGE 34:
- RON CHAPPLE FPG

PAGE 36:
- MILES LOWRY Photodisc

PAGE 39:
- KAREN BEARD Stone

PAGE 41:
- LORNE RESNICK Stone

PAGE 42:
- BENELEX PRESS FPG

PAGE 44:
- V.C.L. FPG

PAGE 47:
- RON CHAPPLE FPG

PAGE 49:
- DANIEL ALLAN FPG
- RON KRISSEL Stone

PAGE 51:
- JEREMY RENDELL FPG

PAGE 54:
- ELICOTT DAVIES Imagebank

PAGE 56:
- PEGGY FOX Stone

PAGE 59:
- JOHNER Photonica

PAGE 60:
- GEORGE LEPP Imagebank

PAGE 61:
- ZIGY KALUZNY Stone

PAGE 62:
- RON CHAPPLE FPG

PAGE 63:
- AL III PETTEWAY National Geographic

PAGE 65:
- BARRY MYERS

PAGE 66:
- RYAN MCVAY Photodisc

PAGE 67:
- MARC MORITSCHE National Geographic

PAGE 68:
- DAVID HARRIMAN Stone

PAGE 70:
- STEVE COHEN Foodpix

PAGE 71:
- ROBERT MIZONO Workbook Stock

PAGE 72:
- EYEWIRE COLLECTION Getty

PAGE 74:
- DARREN MODRICKER Corbis

PAGE 75:
- NICK KOUDIS Photodisc

PAGE 76:
- DAVID SACKS FPG

PAGE 78:
- KEN CHERNUS FPG

PAGE 79:
- KEN CHERNUS FPG

PAGE 80:
- COLOR DAY PRODUCTION Imagebank

PAGE 81:
- REZA ESTAKHRIAN Stone

PAGE 82:
- GARY BUSS FPG

PAGE 83:
- COLOR DAY PRODUCTION Imagebank

PAGE 84:
- YELLOW DOG PRODUCTIONS Imagebank

PAGE 85:
- CHARLES GULLUNG Photonica

PAGE 86:
- KARAN KAPOOR Stone

PAGE 87:
- JEREMY WALKER Stone