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Executive Summary

The State of 50+ America 2005, AARP's second annual "report card" on the quality of life of Americans age 50 and older, continues our examination of the many changes in the well-being of the 50+ population.

Aging in America is increasingly in the spotlight as policy makers, forecasters and the media focus attention on the experience of baby boomers and its implications for the economy, for health care, for living arrangements, for consumer patterns, and for government policy. Critical thinking about the changes taking place within the 50 and older population requires systematic and periodic assessment of these changes.

As in last year's debut version, this year's *The State of 50+ America* report card tries to answer basic questions about how well older Americans have fared over the past several years (up to a decade, where data permit) as well as over the most recent year. Have they made progress toward greater economic and health care security? Are pre-retirees better prepared for retirement than a decade ago? How healthy are they, and how well is the health system serving them in terms of insurance coverage, access, and cost? How well connected do "50+ Americans" feel to their families, neighbors, and communities? Do they enjoy a healthy level of social engagement

and participation? How do people age 50 and older assess their own quality of life and prospects for the future?

Looking back over the last decade, our economic indicators show some signs of real improvement in the well-being of the total 50+ population, although progress, where it existed, was often slow or uneven (see Table 1 at end of the Overview section). For example, median family incomes adjusted for inflation have grown by more than 10 percent over the past decade, but incomes were actually *lower* in 2003 than they were in 1999 for people age 50 and older—and for people age 50 to 64 they were lower in 2003 than in 1998, and lower than in 1997 for those 75 and older.

While the average or typical household may show substantial betterment, the improvement has sometimes not been enjoyed equally by all segments of the 50+ population. For example, median financial assets have grown by more than 70 percent over a decade, but the distribution of those assets has grown more unequal. Elsewhere, some broader

gains have occurred. The proportion of the 50+ population above twice the poverty line (a minimally adequate standard of living) has improved by nearly five percentage points in this period. More 50+ Americans are working today than 10 years ago, and more are in the labor force seeking work. Of course, the data do not tell us whether these increases are by choice or necessity. And the proportion of workers with pension coverage has increased by almost 10 percent, although this rate still falls short of covering a majority of working Americans age 50 and older, let alone all working Americans. One decidedly negative economic trend is the shrinking percentage of people age 62 and older who receive half or more of their income from sources other than Social Security. This increased dependence on Social Security is both revealing and disturbing in view of efforts to partially privatize Social Security.

The health care situation is also mixed. Self-reported health status has improved slightly for the 50+ population, although not for the oldest (75+). Less than half the 50+ population considers their health to be excellent or very good. A new mental health measure in this year's report, the percent without possible signs of depression, improved for all segments of the 50+ population. The percent who engage in physical activity has increased, although only one in four Americans age 50 and older were physically active in our most recent data. On the negative side, the proportion of 50 to 64 year-olds with health insurance coverage declined. Another new indicator—the percent who were not overweight and not obese—declined, which mirrors the unhealthy trend toward obesity in the overall population and suggests a looming health problem. The percent unable to afford needed medical care declined, and the percentage of Medicare beneficiaries,

including both disabled and age 65+, with drug coverage has increased since 1995, but appears to have topped out.

In the area of independent living/long-term care, the percent of people age 50 and older having no functional limitations increased modestly, consistent with declining disability rates found in other studies. However, over 40 percent of those 50 and older provide care to others and one-third of these face substantial caregiving burdens.

In the area of consumption and lifestyle trends, the percent of family budgets spent on items other than necessities (food, housing, health care, and utilities) increased slightly for all 50+ households. Not surprisingly, Americans age 50 and older are increasingly active online, as over half now use the Internet. Almost one-half of people age 65 to 74 and one-quarter of those age 75+ go online to communicate, keep up-to-date, and stay in touch.

The multi-year report card shows improvement on 13 of 17 indicators for the overall 50+ population.

In the most recent year, the report card overall showed more signs of improvement than signs of decline, but most changes were very small. Economic improvements were hampered by a painfully sluggish recovery from the 2001 recession, which left the economy with fewer jobs than four years ago, no net growth in personal incomes, stagnation in the equities market, and rising deficits and public debt. Median income for the 50+ population increased slightly, but remained below 1999 levels. The best economic news was fairly robust financial asset growth in 2003, although small improvements were also seen in pension coverage, employment, and labor force participation. Despite only 15 percent saying they are better off economically than a year before—a smaller percentage than last year's 19

percent— the percent who feel confident about their retirement future shot up by nine percentage points, and the extent of confidence increased with increasing age.

As with the longer historical picture, the one-year health indicators were mixed. Declines occurred in health status, health insurance coverage for 50 to 64 year-olds, and in the percent able to afford needed medical care, but very slight improvements occurred in the percent who were physically active, the percent who were not overweight and not obese, and the percent with no functional limitations. A relatively large four percentage point increase occurred in the percent without possible signs of depression. Overall, improvements occurred in 12 of 18 indicators that were measurable over the one-year period.

Although we have documented modest progress over the last decade, the future remains uncertain because of the greater responsibility people are required to take for their own retirement, the decline in traditional pensions, reductions in retiree health benefits, weakness in personal income and job growth, uncertainty in the stock market, and threats to the Social Security system posed by proposals to partially privatize the system. All these changes pose challenges to the 50+ population.

While this report card attempts to capture some of the more salient and important trends affecting Americans fifty and older, it does not attempt to explore in detail more complex issues such as distributional trends, demographic patterns, or more vulnerable populations such as women, minorities, persons with disabilities, and those with low incomes. For such in-depth analysis of the data, we refer the reader to the annual AARP *Beyond Fifty*¹ series of in-depth reports on selected topics.



Tables Inside [→](#)



Indicator Overview

Overview of 25 Indicators

Last year's inaugural edition of *The State of 50+ America* reported substantial progress over the preceding decade on most quality of life measures we examined, for which historical data were available, but declines in the preceding year on two-thirds of those measures overall and on most of the important economic and health indicators.

This year's report expands the total number of indicators to 25. We again find the condition of the total 50+ population improved on most indicators (13 of 17), which we can compare over the past decade (see Table 1 in this section for data on indicators for the 50+ population, and Table 2 for data on the 50 to 64, 65 to 74, and 75+ age groups). All but one economic indicator (dependence on sources of income other than Social Security) on which we have data going back a decade improved. Four health indicators improved (health status, Medicare beneficiaries' prescription drug coverage, percent physically active, and percent without possible signs of depression), and three declined (health insurance, being able to afford medical care when needed, and the percent who were not obese and not overweight). The other two indicators for which we have historical data going back more than one year—use of the Internet (six years) and absence of functional limitation (five years)—both improved.

The past year saw improvements in 12 and decline in six indicators—three each in the economic and health areas. This is a turnaround from last year's edition where we reported deterioration in all but two important economic and health indicators among the total 50+ population.

Revisions from the First Report Card

The debut edition of *The State of 50+ America* launched what we hope will become the standard quick reference work on the well-being of midlife and older Americans. In devising the set of 20 indicators that formed the heart of that report, we attempted to encompass broad areas of human experience, including economic, health, independent living/long-term care, and consumption and social/lifestyle needs. Last year's experience taught us some valuable lessons about the inherent difficulties in devising such an up-to-the-minute "report card" because of numerous shortcomings in the data, especially in their lack of currency and inconsistency of reporting. Although we haven't solved the data availability problems, we modified some of our indicators of well-being and identified some areas that we had ignored. We see this report card as a work in progress, and we expect to make improvements in it over time. As we did last year, we look at change over the past decade, or as close to a decade as possible, as well as change in the most recent year. In some cases, where we have asked our own survey questions, the most recent year is 2004. In other cases, due to delays in gaining access to the most authoritative public data sets, it is an earlier year.

Based on last year's experience, we modified or consolidated several of our indicators, added six new ones, and added a new breakout this year of the population age 75 and older. New measures have been added in each of four broad areas of well-being—economic (percent with no increase in personal debt), health (percent not overweight and not obese, percent without possible signs of depression), independent living/long-term care (percent with access to transportation when needed, perceived neighborhood safety), and consumption and social/lifestyle (self-assessed overall quality of life).

Table 1

Changes in Key Indicators of Well-Being of Population Age 50+

| Indicator | Economic | Health | Consumption/Social/Lifestyle | Independent Living/Long-Term Care |
|-----------|--|--------|------------------------------|-----------------------------------|
| 1 | Median family income | | | |
| 2 | Median financial assets | | | |
| 3 | Percent of the population above 200 percent of poverty | | | |
| 4 | Percent of the population age 62+ who receive more than half of their income from sources other than Social Security | | | |
| 5 | Pension coverage rate | | | |
| 6 | Employment rate | | | |
| 7 | Labor force participation rate | | | |
| 8 | Percent better off economically than a year earlier | | | |
| 9 | Percent confident in their retirement future | | | |
| 10 | Percent reporting no increase in personal debt | | | |
| 11 | Percent reporting health as "excellent" or "very good" | | | |
| 12 | Percent of noninstitutional Medicare beneficiaries (including disabled beneficiaries of all ages) with Rx coverage throughout the year | | | |
| 13 | Percent of population 50 to 64 with health insurance from any source for any length of time during the year | | | |
| 14 | Percent able to afford medical care when needed during the past 12 months | | | |
| 15 | Percent who engage in leisure time physical activity | | | |
| 16 | Percent who are not overweight and not obese | | | |
| 17 | Percent without possible signs of depression | | | |
| 18 | Percent of expenditures for "non-necessities" | | | |
| 19 | Percent who use the Internet | | | |
| 20 | Percent very satisfied with amount of contact with family, friends, and neighbors | | | |
| 21 | Percent who say their quality of life has improved during the past 12 months | | | |
| 22 | Percent with no functional limitations requiring assistance from another person | | | |
| 23 | Percent of caregivers with no substantial caregiving burdens | | | |
| 24 | Percent who rarely or never miss something away from their residence due to lack of transportation | | | |
| 25 | Percent who rate their community as excellent in terms of how safe they feel | | | |

Age 50+

| Indicator/Year | Most Recent Year | Previous Year | 1-Year Change | Historical Year* | 10-Year Change | |
|----------------|------------------|---------------|---------------|------------------|-----------------|----|
| 1 | 2003 | \$34,855 | \$34,496 | ↑ | \$31,053 | ↑ |
| 2 | 2003 | \$44,521 est. | \$40,102 est. | ↑ | \$26,096 (1992) | ↑ |
| 3 | 2003 | 71.6% | 71.7% | ↓ | 67.0% | ↑ |
| 4 | 2003 | 49.5%** | 49.9%** | ↓ | 50.8%** | ↓ |
| 5 | 2003 | 49.5% | 49.2% | ↑ | 45.1% | ↑ |
| 6 | 2003 | 44.7% | 44.2% | ↑ | 37.9% | ↑ |
| 7 | 2003 | 46.7% | 46.3% | ↑ | 39.8% | ↑ |
| 8 | 2004 | 15.0% | 19.0% | ↓ | NA | NA |
| 9 | 2004 | 76.0% | 67.0% | ↑ | NA | NA |
| 10 | 2004 | 83.0% | NA | NA | NA | NA |
| 11 | 2002 | 46.8% | 47.3% | ↓ | 45.6% | ↑ |
| 12 | 2001 | 57.4%† | 56.7%† | ↑ | 51.1%† | ↑ |
| 13 | 2003 | 86.5%†† | 86.9%†† | ↓ | 87.1% (1999)†† | ↓ |
| 14 | 2002 | 95.5% | 95.9% | ↓ | 95.9% (1997) | ↓ |
| 15 | 2002 | 25.6% | 25.4% | ↑ | 23.6% (1998) | ↑ |
| 16 | 2003 | 35.4% | 35.0% | ↑ | 39.7% (1998) | ↓ |
| 17 | 2002 | 84.6% | 80.6% | ↑ | 83.3% (1997) | ↑ |
| 18 | 2002 | 46.7% | 46.3% | ↑ | 45.9% (1990) | ↑ |
| 19 | 2004 | 53.0% | NA | NA | 19.3% (1998) | ↑ |
| 20 | 2004 | 71.0%§ | NA | NA | NA | NA |
| 21 | 2004 | 14.0% | NA | NA | NA | NA |
| 22 | 2002 | 92.2% | 92.1% | ↑ | 91.5% (1997) | ↑ |
| 23 | 2004 | 67.0%§§ | NA | NA | NA | NA |
| 24 | 2004 | 93.0% | NA | NA | NA | NA |
| 25 | 2004 | 88.0% | NA | NA | NA | NA |

NA Comparison data not available

* The 'Historical Year' is 10 years prior to the 'Most Recent Year'—or 'Indicator Year'—unless otherwise noted.

** Ages 62+ only.

† All ages including under 65.

†† Ages 50 to 64 only.

§ The value for 2003 was 76.0% but the survey question was changed for 2004.

§§ The value for 2003 was 78.0% but the survey question was changed for 2004.

Table 2

Changes in Key Indicators of Well-Being of Three Subgroups of Population Age 50+

| | | Ages 50 to 64 | | | | | Ages 65 to 74 | | |
|----------------|------|------------------|---------------|---------------|------------------|----------------|------------------|---------------|--|
| Indicator/Year | | Most Recent Year | Previous Year | 1-Year Change | Historical Year* | 10-Year Change | Most Recent Year | Previous Year | |
| 1 | 2003 | \$49,600 | \$49,436 | ↑ | \$45,307 | ↑ | \$28,808 | \$27,830 | |
| 2 | 2003 | \$50,224 est. | \$45,238 est. | ↑ | \$29,082 (1992) | ↑ | \$53,531 est. | \$47,978 est. | |
| 3 | 2003 | 79.3% | 79.4% | ↓ | 75.3% | ↑ | 67.5% | 67.3% | |
| 4 | 2003 | ** | ** | ** | ** | ** | 61.3%*** | 61.5%*** | |
| 5 | 2003 | 53.8% | 53.2% | ↑ | 50.0% | ↑ | 26.1% | 27.3% | |
| 6 | 2003 | 67.0% | 66.9% | ↑ | 61.8% | ↑ | 21.7% | 20.8% | |
| 7 | 2003 | 69.8% | 70.1% | ↓ | 65.0% | ↑ | 22.6% | 21.8% | |
| 8 | 2004 | 19.0% | 23.0% | ↓ | NA | NA | 12.0% | NA | |
| 9 | 2004 | 73.0% | 63.0% | ↑ | NA | NA | 78.0% | NA | |
| 10 | 2004 | 78.0% | NA | NA | NA | NA | 87.0% | NA | |
| 11 | 2002 | 53.9% | 54.5% | ↓ | 52.4% | ↑ | 41.9% | 42.6% | |
| 12 | 2001 | ‡ | ‡ | ‡ | ‡ | ‡ | 57.9% | 58.4% | |
| 13 | 2003 | 86.5% | 86.9% | ↓ | 87.1% (1999) | ↓ | †† | †† | |
| 14 | 2002 | 93.9% | 94.4% | ↓ | 94.3% (1997) | ↓ | 97.0% | 97.4% | |
| 15 | 2002 | 28.8% | 28.9% | ↓ | 26.9% (1998) | ↑ | 25.6% | 26.1% | |
| 16 | 2003 | 31.5% | 31.7% | ↓ | 35.6% (1998) | ↓ | 34.3% | 34.6% | |
| 17 | 2002 | 85.2% | 81.2% | ↑ | 83.6% (1997) | ↑ | 85.2% | 82.4% | |
| 18 | 2002 | 50.0% | 50.4% | ↓ | 50.2% (1990) | ↓ | 43.5% | 42.2% | |
| 19 | 2004 | 70.0% | NA | NA | 31.3% (1998) | ↑ | 45.0% | NA | |
| 20 | 2004 | 69.0%* | NA | NA | NA | NA | 77.0% | NA | |
| 21 | 2004 | 18.0% | NA | NA | NA | NA | 12.0% | NA | |
| 22 | 2002 | 96.0% | 96.2% | ↓ | 96.1% (1997) | ↓ | 93.5% | 92.6% | |
| 23 | 2004 | 70.0%♦♦ | NA | NA | NA | NA | 58.0% | NA | |
| 24 | 2004 | 95.0% | NA | NA | NA | NA | 92.0% | NA | |
| 25 | 2004 | 89.0% | NA | NA | NA | NA | 86.0% | NA | |

NA Comparison data not available

* The 'Historical Year' is 10 years prior to the 'Most Recent Year'—or 'Indicator Year'—unless otherwise noted.

** Ages 62+ only.

*** Ages 62 to 74 only.

†† Ages 50 to 64 only.

‡ Ages 65+ only.

♦ The value for 2003 was 75.0% but the survey question was changed for 2004.

♦♦ The value for 2003 was 77.0% but the survey question was changed for 2004.

| | | | Age 75+ | | | | | | |
|---------------|------------------|----------------|------------------|---------------|---------------|------------------|----------------|----------------|----|
| 1-Year Change | Historical Year* | 10-Year Change | Most Recent Year | Previous Year | 1-Year Change | Historical Year* | 10-Year Change | Year/Indicator | |
| ↑ | \$26,380 | ↑ | \$19,127 | \$19,367 | ↓ | \$17,817 | ↑ | 2003 | 1 |
| ↑ | \$28,889 (1992) | ↑ | \$38,161 est. | \$34,202 est. | ↑ | \$20,436 (1992) | ↑ | 2003 | 2 |
| ↑ | 63.9% | ↑ | 53.8% | 54.6% | ↓ | 49.4% | ↑ | 2003 | 3 |
| ↓ | 62.2%*** | ↓ | 40.0% | 41.1% | ↓ | 38.7% | ↑ | 2003 | 4 |
| ↓ | 24.4% | ↑ | 19.3% | 18.0% | ↑ | 12.2% | ↑ | 2003 | 5 |
| ↑ | 15.8% | ↑ | 5.9% | 5.4% | ↑ | 5.6% | ↑ | 2003 | 6 |
| ↑ | 16.6% | ↑ | 6.2% | 5.6% | ↑ | 5.9% | ↑ | 2003 | 7 |
| NA | NA | NA | 6.0% | NA | NA | NA | NA | 2004 | 8 |
| NA | NA | NA | 83.0% | NA | NA | NA | NA | 2004 | 9 |
| NA | NA | NA | 91.0% | NA | NA | NA | NA | 2004 | 10 |
| ↓ | 40.8% | ↑ | 32.1% | 32.9% | ↓ | 34.6% | ↓ | 2002 | 11 |
| ↓ | NA | NA | 55.2% | 54.8% | ↑ | NA | NA | 2001 | 12 |
| †† | †† | †† | †† | †† | †† | †† | †† | 2003 | 13 |
| ↓ | 97.4% (1997) | ↓ | 98.1% | 98.3% | ↓ | 98.2% (1997) | ↓ | 2002 | 14 |
| ↓ | 24.1% (1998) | ↑ | 16.3% | 15.1% | ↑ | 14.2% (1998) | ↑ | 2002 | 15 |
| ↓ | 39.1% (1998) | ↓ | 47.0% | 45.8% | ↑ | 52.3% (1998) | ↓ | 2003 | 16 |
| ↑ | 84.8% (1997) | ↑ | 82.1% | 77.1% | ↑ | 80.4% (1997) | ↑ | 2002 | 17 |
| ↑ | 41.3% (1990) | ↑ | 36.1% | 36.4% | ↓ | 34.3% (1990) | ↑ | 2002 | 18 |
| NA | 12.3% (1998) | ↑ | 23.0% | NA | NA | 4.3% (1998) | ↑ | 2004 | 19 |
| NA | NA | NA | 70.0% | NA | NA | NA | NA | 2004 | 20 |
| NA | NA | NA | 8.0% | NA | NA | NA | NA | 2004 | 21 |
| ↑ | 92.6% (1997) | ↑ | 79.9% | 80.0% | ↓ | 77.8% (1997) | ↑ | 2002 | 22 |
| NA | NA | NA | 67.0% | NA | NA | NA | NA | 2004 | 23 |
| NA | NA | NA | 88.0% | NA | NA | NA | NA | 2004 | 24 |
| NA | NA | NA | 87.0% | NA | NA | NA | NA | 2004 | 25 |

In addition, we modified a few indicators from our first report in ways that we think improve clarity or relevance, even if it meant sacrificing some comparability with last year's report. We have modified the employment rate (Indicator 6),² the percentage of the population having Internet access at home (Indicator 19),³ satisfaction with the amount of contact with family and with friends and neighbors (Indicator 20),⁴ and the percent with no substantial caregiving burdens (Indicator 23).⁵ We also have moved Indicator 15 (the percentage who are physically active) from the consumption and social/lifestyle section to the health section.

As we did last year, we have attempted to structure all the indicators in such a way that higher numbers denote improved well-being, so that it is easier to summarize improvement across a complex array of indicators. But, as a result of this attempt to phrase all indicators so that increases are favorable and decreases are unfavorable, some indicator labels are inelegant, such as "percent of caregivers who have *no* substantial caregiving burdens," the "percent of expenditures for *non-necessities*," "the percent who rarely or *never* miss something away from their residence due to lack of transportation," and "the percent *without* possible signs of depression." We have tried to maintain the integrity of meaning of the indicators despite these linguistic twists. We apologize to language purists for sacrificing phrasing to the demand for simplicity.

As a result of the changes and added indicators, this year's report has 10 economic indicators, seven health indicators, four independent living/long-term care indicators, and four consumption and social/lifestyle indicators. No attempt is made to integrate them into a single overall index. The indicators are derived from either well-established government surveys or from AARP's own survey of the population 50 and older, the 2004 Aging Indicators Study.⁶ The 2004 AARP Aging Indicators Study

accounts for nine of the indicators in this year's report, the Annual March Demographic Supplement to the Census Bureau's *Current Population Survey* is the source for seven indicators, the National Center for Health Statistics' *National Health Interview Survey* accounts for five, and the Bureau of Labor Statistics' *Consumer Expenditure Survey*, the Federal Reserve's *Survey of Consumer Finances*, the Centers for Medicare and Medicaid Services' *Medicare Current Beneficiary Survey*, and the Centers for Disease Control and Prevention's *Behavioral Risk Factor Surveillance System* each provides one.

Another important change from last year is the inclusion of a separate analysis of the 75 and older population for each indicator. We recognized the diversity within the population age 50 and older last year by examining the 50 to 64 and 65+ subgroups separately, but this year we have further broken out the 65 to 74 and 75+ age groups because of significant economic and health differences between the "recently retired" and "older retirees." As one commentator pointed out last year, "aggregating the population over 65 may be more useful to retailers than policymakers. People age 65 to 74 are more prosperous than their elders." The 2004 Aging Indicators Study, conducted in conjunction with this report, oversampled the population age 75 and older. This year, for the sake of variety and brevity, we will often refer to the 50 to 64 year-olds as the "youngest" age group, the 65 to 74 year-olds as the "middle" age group, and the 75+ year-olds as the "oldest" age group.

10-Year Change

50+ Overall

In the past decade, Americans age 50 and older showed modest signs of improvement economically and in their personal health, although not in terms of health affordability. They realized increases in real (adjusted for inflation) median family income (+10.9 percent), although all of that growth occurred between 1993 and 1999, and no net growth in incomes has occurred since then. Real median financial assets grew more robustly (+70 percent) from 1992 to 2003, thanks to the stock market boom in the late 1990s that was largely offset by the stock market crash of 2000 to 2002. This growth in assets has been accompanied by increased wealth inequality.

The income status of the most vulnerable Americans improved, as the percent above 200 percent of poverty increased (+4.6 percentage points). There are also trends suggesting that people do intend to work longer as they contemplate a longer retirement, demonstrated by an increasing employment rate (+6.8 percentage points) and a higher labor force participation rate (+4.9 percentage points), primarily among the two younger (50 to 64 and 65 to 74) age groups. If these work trends indicate choice rather than need, they are favorable, but the data do not allow us to determine which predominates. The increased overall pension coverage rate (+4.4 percentage points) is a welcome though modest sign of improved retirement security. Despite gains in pension coverage in all three of our age subgroups, the rate still falls short of covering even a majority of the 50+ worker population.

One decidedly negative economic trend, and one that should not be dismissed despite the other positive economic news, is the shrinking percentage of people age 62+ who receive more than half their income from non-Social Security sources (-1.3 percentage points). This trend suggests that people are not saving enough to reduce reliance on Social Security in

retirement, which was only intended to be the base for retirement income.

Health status, both physical and mental, has improved, as evidenced by increases in the percent with excellent or very good self-reported health status (+1.2 percentage points), the proportion without possible signs of depression (+1.3 percentage points) and the proportion that is physically active (+2.0 percentage points). Still, only about one quarter of the 50+ population is physically active, and the proportion that is *not* overweight and not obese declined over the most recent 5-year period (-4.3 percentage points).

Even if people feel and appear healthier, the health care system is not serving them well in terms of coverage and affordability. The percentage of Medicare beneficiaries, including both disabled and age 65+, with drug coverage has increased (+6.3 percentage points) since 1995, but appears to have topped out. Health insurance coverage declined for those age 50 to 64 (-0.6 percentage points), as did the percent able to afford needed medical care (-0.4 percentage points) (see the final section of the report on the health care challenges we face).

Two other measures also showed improvement over several years' time—the proportion of the 50+ population using the Internet increased dramatically (+33.7 percent) since 1998 and the proportion of the total 50+ population with no functional limitations also increased slightly (+0.7 percentage points) over a five-year period.

Three Age Subgroups

In a later section we will highlight separately and in greater detail the results for each indicator for the 50 to 64, 65 to 74, and 75+ age groups separately. To preview that section briefly here, the “youngest” (50 to 64) group’s fortunes improved on all economic measures on which we had data over the past 10 years—more income, more financial assets, more in the work force and employed, and more with pension coverage (see Table 2). They also felt healthier physically and mentally, and were more active, but fewer were not overweight and not obese. Their health coverage declined and became unaffordable for more. There were also very slight declines in discretionary (“non-necessities”) spending and in the percent without functional limitations. Overall, the “youngest” age group had improved on 10 indicators and declined on five.

The “middle” (65 to 74) age group improved on six of the seven economic measures on which we have data covering the past decade (income, financial assets, percent above 200% of poverty, pension coverage, employment rate, and labor force participation rate), while relying more on Social Security for retirement income (see Table 2). They improved on six of the other eight indicators, including health status, being physically active, mental health, increased discretionary spending, use of the Internet, and absence of functional limitations. However, there were setbacks in terms of affordability of medical care and obesity and overweight. Overall, the “middle” age group improved on 12 and declined on three indicators.

Change for the “oldest” (75+) group was similar to that of the “middle” age group, with improvements on 12 and declines on three indicators. The only declines were in three health indicators—self-reported health status declined, as did the percent able to afford health care when needed and the percent who were not overweight and not obese.

One-Year Change

50+ Overall

Over the most recent year, the total 50+ population improved on 12 indicators and declined on six for which we have comparative data. This differs substantially from last year’s report card which showed 10 indicators declining and five improving.

Over a one-year period, the story for the 50+ population is one of slightly improved economic circumstances, with gains on six of nine economic indicators. Increases occurred in median family income (+1.0 percent), the first real increase since 1999, but still well below 1999 levels in 2003 dollars. Median financial assets increased (+11 percent), as did the pension coverage rate (+0.3 percentage points), the employment rate (+0.5 percentage points), the labor force participation rate (+0.4 percentage points), and the percent confident in their retirement future, which increased a substantial 9.0 percentage points. More than eight in 10 said their debt amounts had not increased in the past year. In the one-year comparison, small setbacks occurred in the percent above 200 percent of poverty (-0.1 percentage points), and the percent of people age 62+ who receive half or more of their income from sources other than Social Security (-0.4 percentage points). A large decline occurred in the percent who say they are better off economically than last year (-4.0 percentage points). This last appears puzzling in light of the large increase in the percent who expressed confidence in their retirement future, which occurred in the age subgroups too (see Indicators 8 and 9). Despite different trends since last year, these two variables are positively correlated within this year’s sample.

The near-term health picture was mixed, with small improvements in regular physical activity (+0.2 percentage points and the proportion not overweight and not obese (+0.4 percentage points), and a larger proportion without possible signs of depression (+4.0 percentage points), but small declines in the proportion with

excellent or very good self-reported health status (-0.5 percentage points), health insurance coverage for those age 50 to 64 (-0.4 percentage points), and the percent able to afford needed medical care (-0.4 percentage points). The percent of Medicare beneficiaries (including some under age 50 who are eligible due to disability) with drug coverage increased slightly (+0.7 percentage points).

One indicator relating to independent living and long-term care can be compared with last year—the total 50+ population with no functional limitations. This indicator improved only slightly (+0.1 percentage points) in the past year. Measurement of a second indicator pertaining to long-term care—the percent of caregivers who do not have substantial caregiving burdens—was changed slightly from last year. The indicator declined from 78 percent in last year’s report to 67 percent this year. However, the substantial change is likely due to differences between this year’s and last year’s questions.

Three Age Subgroups

In the most recent year, the “youngest” group experienced more losses than gains, and the two older subgroups showed roughly equal gains and losses. The “youngest” group made progress on five economic indicators (income, financial assets, pension coverage, employment rate, and confidence in retirement future), but setbacks in three others (the percent above two times the poverty line, the labor force participation rate, and the percent better off economically than last year). They fared even worse in terms of health, declining on all but one health indicator (mental health status). They also declined slightly in spending on non-necessary items and on the percent without functional limitations.

The “middle” age group improved on all but two economic indicators (the percent with more than half their income from non-Social Security sources, and pension

coverage), but declined on all health measures but one (mental health), and improved on the remaining two indicators (percent spent on discretionary items and percent without functional limitations).

The “oldest” age group improved on four of the seven economic indicators (financial assets, pension coverage, employment rate, and labor force participation rate), but declined on three others (income, percent above twice poverty, and the percent with more than half their income from Social Security). They fared better than the “middle” age group on health indicators, improving on all but health status and medical care affordability. However, they declined on the spending on non-necessities and percent without functional limitations.

In the next section of the report, we discuss each of the indicators in more detail.



- Almost three-quarters (73 percent) of the “youngest” group (50 to 64) were confident that they would have enough money to live comfortably throughout their retirement years, **substantially higher than we found last year, when confidence among pre-retirees stood at only 63 percent.**

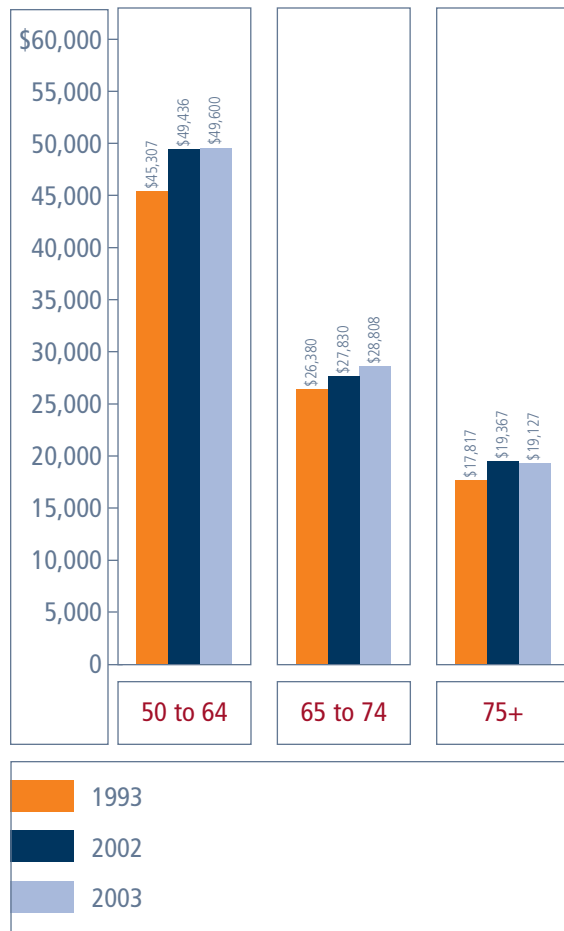
Economic Indicators

1

Median family income is perhaps the most basic measure of economic well-being. In general, the median family income of the “youngest” (50 to 64) age group, most of whom are working, is 75 percent larger than that of the “middle” age group (65 to 74 year-olds), and over two-and-one-half times that of the “oldest” (75+) age group, reflecting the loss of wage income after retirement. Partially offsetting these income differentials is the smaller size of age 65+ families, which are less likely to have dependent children at home.

Median family income for the 50 to 64 and 65 to 74 age groups increased by about eight percent (after inflation) over the past decade, while income for the 75+ age group increased just six percent. While these are modest improvements, there has been no real net increase in income since at least 1999 in any of the three age subgroups. In the case of the “youngest” (50 to 64) group, their 2003 income (\$49,600) was below their 1998 income level (\$51,235) in 2003 dollars. For the 65 to 74 year-olds, their 2003 income of \$28,808 was below their 1999 level of \$29,050. And for those age 75+, their 2003 income of \$19,127 was even below their 1997 income level of \$19,170. Moreover, the sluggish economy still lingers in that family income for the “youngest” (50 to 64) age group adjusted for inflation barely increased in real terms, while income for the “oldest” population (age 75+) declined by 1.2 percent between 2002 and 2003. However, income grew in the past year for the 65 to 74 age group by a healthy 3.5 percent.

Median family income (\$2003)



Source: U.S. Bureau of the Census, Annual Demographic Survey, March Supplement, Current Population Survey, 1994, 2003, 2004

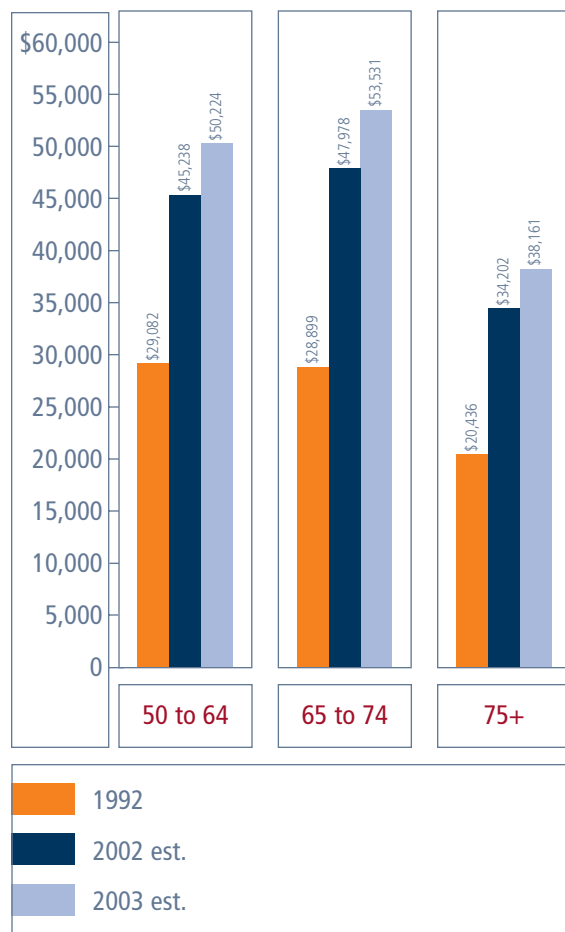
Median financial assets⁷

(the financial wealth of the family in the exact middle of the wealth distribution) is a measure of the liquid (i.e., close to cash) wealth held by families age 50 and older. It excludes housing and other real estate, as well as vehicles and business property. We report wealth data based on the Federal Reserve's Survey of Consumer Finances (SCF), a triennial survey whose most recent available results are for 2001. Despite the lack of current data, the importance of this indicator argued for developing at least a crude estimate for the years between the surveys. We did so using the Federal Reserve's aggregate wealth data, the Flow of Funds Accounts, assuming that median assets in each age group changed at the same rate as aggregate changes in financial assets.

When adjusted for inflation, median financial assets increased by nearly 75 percent between 1992 and 2003 for the "youngest" age group, and by more than 85 percent for both the "middle" and "oldest" age groups. The improvement was largely driven by the boom in equity markets in the late 1990s and the spread of stock ownership, thanks mostly to 401(k) plans. The crash of the stock market after 2000 caused dramatic losses in equity shares, which plunged in value from \$17 trillion to \$10 trillion between 1999 and 2002. The losses were understandably heavier among people age 50 and older, because they hold nearly three-fourths of all financial assets in the U.S.

According to the September 2004 Federal Reserve Flow of Funds Accounts, total financial assets declined from \$32.3 trillion to \$30 trillion between 2001 and 2002, nearly eight percent, but had recovered to \$34.3 trillion by the end of 2003, an increase of more than 14 percent.

Median financial assets (\$2003)



Sources: Federal Reserve Board, Survey of Consumer Finances, 1992, 2001; Federal Reserve Board, Flow of Funds Accounts, September 16, 2004.

Applying the same method to 2003 as we did last year, we estimate that median financial assets for the "youngest" age group in 2003 were \$50,224 in 2003 dollars, compared with \$53,531 for the "middle" age group, and \$38,161 for the "oldest" group. Although these figures represent solid growth in financial assets, the median amounts of financial assets are not sufficient to guarantee a comfortable retirement, which would require replacement of between 60 to 80 percent of pre-retirement income, underscoring the need for Social Security as the most stable source of income in retirement.

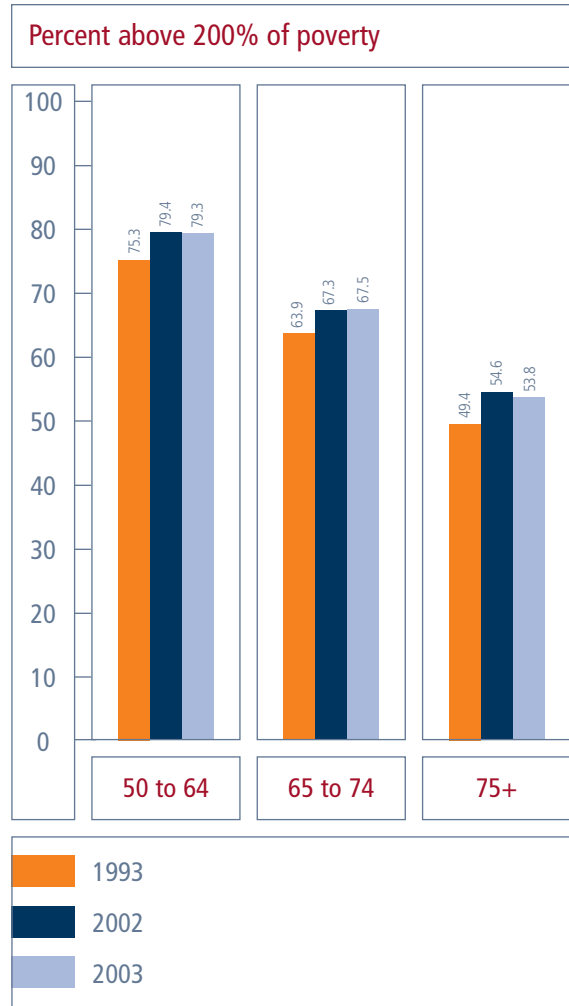
3

The percent of the population above 200 percent of poverty

is a rough indicator of the percentage of people with an adequate standard of living. The poverty line, which was established more than 40 years ago, is indexed to general increases in prices. But prices have generally grown more slowly than the level of wages in the economy, which better reflects the living standard. To illustrate, between 2002 and 2003 the poverty threshold increased 2.3 percent compared to a 3.8 percent increase in the median wage level. Therefore, the poverty line has fallen farther and farther behind the standard of living. For that reason we have selected two times the poverty line as a better reflection of a minimum standard of adequacy than the current poverty threshold.

When it was created, the poverty threshold was set at a lower level for people age 65+ than it was for the rest of the population because of putative differences in nutrition requirements, and those dollar differences in the poverty thresholds still remain today (\$8,825 in 2003 for the 65+ population and \$9,573 for those under 65). This difference in poverty level means that the older population must be poorer than younger age groups to be considered poor for statistical purposes.⁸

More progress against poverty has been made among the 75+ group than among the younger groups over the past two decades, but still nearly half of the oldest group fall below our standard of adequacy. The percent of people above 200 percent of poverty increased by four percentage points in the past decade to nearly 80 percent for the “youngest” age group and by 3.6 percentage points to 67.5 percent for the “middle” age group, a favorable trend.



Source: U.S. Bureau of the Census, Annual Demographic Survey, March Supplement, Current Population Survey, 1994, 2003, 2004.

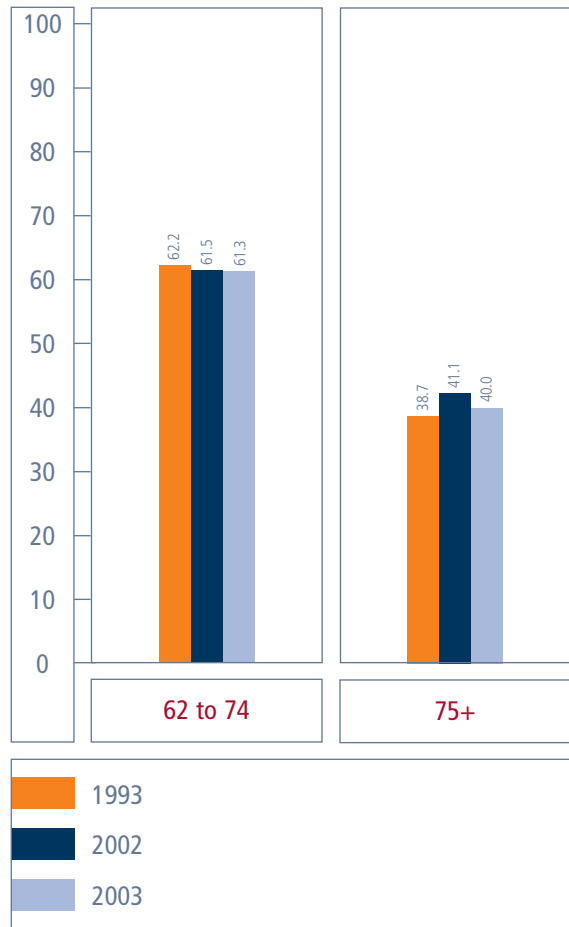
The percent of the population age 62 and older who receive more than half of their income from sources other than Social Security indicates the relative dependence on sources of income other than Social Security. Having diverse sources of income generally means higher incomes and less vulnerability to income loss from any one source. Social Security was not intended to be the sole source of income for retirees. The higher this indicator, other things being equal, the better off beneficiaries are.

Nearly half (49.5 percent) of the population age 62 and older received more than half their income from sources other than Social Security in 2003, a slight decline from the past year and more than a percentage point decline over the past decade. The percentage also declined for both 62 to 74 year-olds and 75+ subgroups over the past year and for 62 to 74 year-olds over the past 10 years.

These trends may be the result of higher benefit levels for new beneficiaries (due to past earnings) outpacing the slow or non-existent income growth from other sources which we have seen earlier. It also underscores the continued importance of Social Security as the mainstay of retirement income for a majority of retirees, despite increased participation in equity markets and the growing wealth of America's seniors. Many have not benefited from the growth in wealth that is indicated in mean and median estimates of net worth and assets.

One possible flaw in our interpretation that reduced reliance on Social Security represents an improvement in well being is that reduced reliance could also occur as a result of reductions in Social Security benefits. Thus the importance of the caveat, "other things equal" when we stated the higher the indicator the better.

Percent of the population 62 and older who receive more than 50% of income from sources other than Social Security



Source: U.S. Bureau of the Census, Annual Demographic Survey, March Supplement, Current Population Survey, 1994, 2003, 2004.

Reductions in Social Security that increase the relative importance of other income sources would obviously leave people worse off.

5

The pension coverage rate

indicates the percentage of all workers who currently are covered by a pension. For roughly half the workforce, including part-time workers, a large part of ongoing saving for retirement occurs through participation in a pension plan.

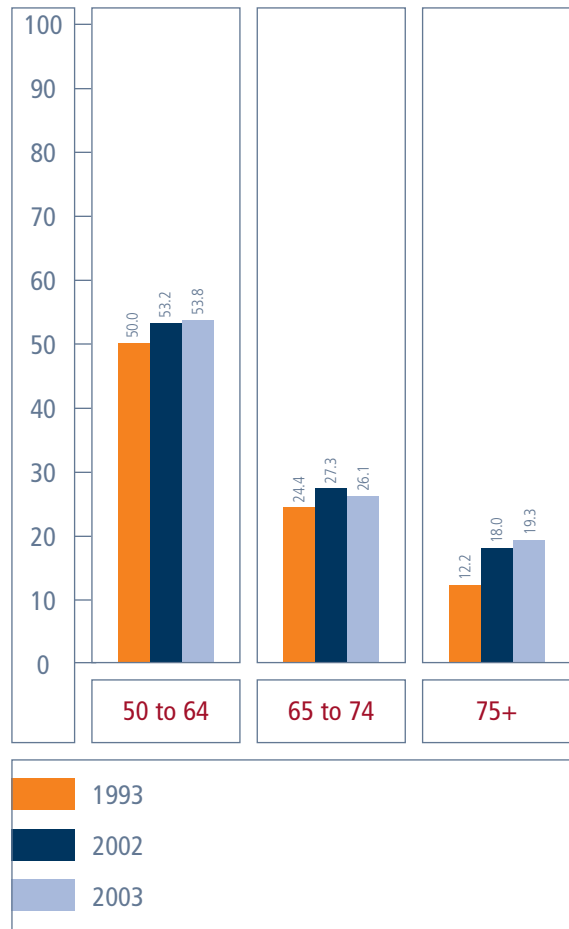
The long-term trend has been that only half of adult workers at any given time have pension coverage through their current employer. Even though the shift in coverage from predominantly defined benefit to defined contribution plans has lowered employers' risk by shifting it to workers, the rate of coverage has still remained locked at around 50 percent.

This measure does not count as covered those workers who may have already earned pensions from earlier jobs or who have coverage under a spousal pension plan. These factors would increase coverage rates. Coverage rates would be higher still if only full-time, year round workers were included.

The pension coverage rate for the “youngest” age group was 53.8 percent in 2003, up nearly four percentage points from a decade earlier. Coverage for the “youngest” group is more of a concern because workers at this age would normally be in career jobs and would need to be building wealth in their pension plans, whereas the “middle” and “oldest” age groups may already have earned a pension on another job so that coverage may not be as critical for them.

Lower coverage rates for workers age 65 and older in general reflect the fact that these workers are no longer in career jobs and are more likely to have transitional “bridge jobs,” which often provide few benefits. These rates also reflect the complete withdrawal from the labor force of those eligible to receive a pension. However, the percent of workers in the “middle” age group with coverage

Pension coverage rate



Source: U.S. Bureau of the Census, Annual Demographic Survey, March Supplement, Current Population Survey, 1994, 2003, 2004.

increased from 24.4 percent to 26.1 percent over the decade, and the largest increase in pension coverage—7.1 percentage points—was for workers in the “oldest” age group. This increase may suggest a spreading of 401(k) availability through the working population, or it may merely indicate a trend toward individuals who work well into their 70s in career jobs being the type of workers who have pension coverage.

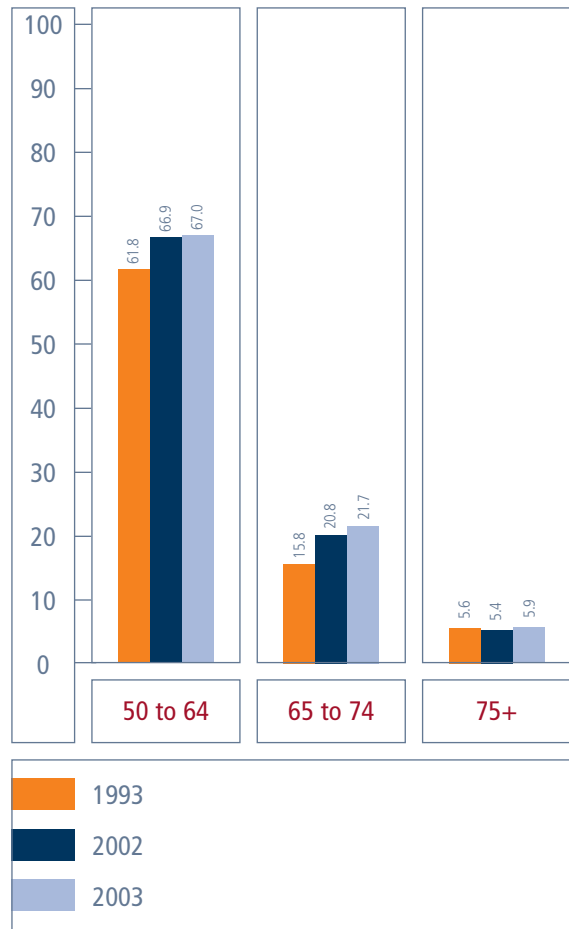
In the past year, the percent with coverage increased slightly from 53.2 percent to 53.8 percent for the 50 to 64 age group. However, there was a decline for the “middle” age group. The “oldest” age group of workers realized the highest increase in pension coverage—1.3 percentage points.

6

The **employment rate** is the percent of people in the population or a particular age group who are working (it is often referred to as the employment-to-population ratio).⁹ Compared to a decade before, the employment rate was up by 5.2 percentage points by 2003 for the “youngest” age group—age 50 to 64 and by nearly 6 percentage points for the “middle” age group. For those age 75+, the rate increased a bare 0.3 percentage points. These increases in employment reinforce other evidence of a long-term shift toward lengthening of working lives.

However, the near-term trend has not been so favorable. The 2001 recession and its aftermath caused more than two million jobs to be lost among workers of all ages. Older workers were not immune from these losses. The unemployment rates for the “oldest” workers have risen. In the past year, the employment rate remained virtually unchanged for the “youngest” (50 to 64) age group (from 66.9 percent to 67 percent), and it increased by less than a percentage point (0.9) for the “middle” age group. These small increases are consistent with the trend of a sluggish recovery in the larger economy, where job growth has been anemic.

Employment rate



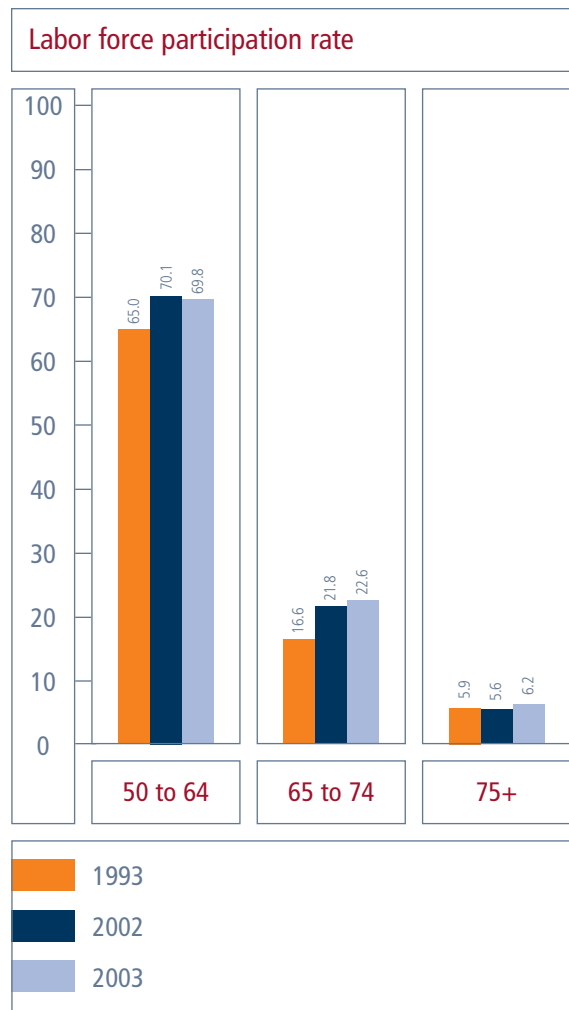
Source: U.S. Bureau of the Census, Annual Demographic Survey, March Supplement, Current Population Survey, 1994, 2003, 2004.

The labor force participation rate is the ratio of those *employed* and those *without a job and looking for work* to the adult civilian noninstitutional population.

The labor force participation rate of the 50+ population increased slowly and steadily over the past two decades, a development that masks two opposing trends—an increase in the participation rate for women, as growing numbers of middle-aged and older women remained in, or entered, the labor force, and a decrease in the participation rate for men age 55 to 64. Although the trend toward ever-earlier retirement seems to have come to an end, many men still leave the labor force in their 50s to mid-60s.

Nevertheless, the overall labor force participation rate continued its rise to 69.8 percent for people age 50 to 64 in 2003, up nearly five percentage points from a decade ago. The rate was 22.6 percent for those age 65 to 74, up 6 percentage points in the past decade. There was negligible change in the labor force participation rate for the 75+ age group over the last decade. Nearly 80 percent of baby boomers say they expect to work at least part time in retirement.¹⁰ Other surveys also reveal high percentages of older workers planning to work in retirement, most often because they want to remain active, or be productive, or do something fun. Many, however, say they need the money or access to health insurance.

In the past year, labor force participation has continued to rise for workers age 65 and older, despite the continued weak employment situation relative to previous recoveries. Labor force participation in the past year grew slightly from 21.8 percent to 22.6 percent for the 65 to 74 age group, and



Source: U.S. Bureau of the Census, Annual Demographic Survey, March Supplement, Current Population Survey, 1994, 2003, 2004.

from 5.6 to 6.2 percent for the 75+ group. The “youngest” workers’ participation rate declined slightly in the past year, from 70.1 percent to 69.8 percent.

The percent better off economically than a year earlier

is a measure derived from the AARP Aging Indicators Study. The results appear to mirror the mixed economic picture that prevailed through 2004. About one-fifth (19 percent) of the “youngest” group considered their economic situation better than 12 months before, but an almost equal percentage (17 percent) regarded themselves as worse off. Almost two-thirds (63 percent) said they were about the same.

The “youngest” age group more frequently judged themselves better off than did the “middle” age group (12 percent), and the “youngest” were three times as likely to perceive themselves as better off than the “oldest” group (6 percent).

The 50 to 64 and 65 to 74 age groups (“youngest” and “middle”) were about equally likely to see no change from the previous year (63 percent vs. 64 percent). However, only six percent of those 75+ said they were better off last year compared to 21 percent who said they were worse off.

Percent who say they are better off economically than last year

| | 2003 | 2004 |
|----------|------|------|
| 50 to 64 | 23% | 19% |
| 65 to 74 | NA | 12% |
| 75+ | NA | 6% |

Source: AARP Aging Indicators Study, 2003 and 2004.

The percent confident in their retirement future,

like the previous measure, is a subjective and summary measure of well-being, but one that focuses more specifically on future retirement prospects. This indicator showed a substantial increase across-the-board compared with last year. More than three-quarters (76 percent) of those 50+ were confident (either very confident or somewhat confident) that they would have enough money to live comfortably throughout their retirement years, compared with only two-thirds who expressed this level of confidence last year. An even greater proportion (81 percent) of the 65+ population expressed this level of optimism about their retirement future—up from 73 percent in last year’s survey.

Almost three-quarters (73 percent) of the “youngest” group (50 to 64) were confident that they would have enough money to live comfortably throughout their retirement years, substantially higher than we found last year, when confidence among pre-retirees stood at only 63 percent.

More than three-fourths of the “middle” age group (78 percent) were confident that they would have enough money to live comfortably throughout their retirement, and the 75+ population had the highest level of confidence in their retirement future (83 percent) in 2004. The high levels of confidence among the oldest group may reflect renewed optimism after the 2003 recovery of the stock market from the crash of 2000–2002, or it may merely suggest that retirees learn to adjust their expectations to their resources.

Men were more confident than women and whites were significantly more confident than African Americans. Also, those who were retired were more likely to express confidence than those who

| Percent confident in their retirement future | | |
|--|------|------|
| | 2003 | 2004 |
| 50 to 64 | 63% | 73% |
| 65 to 74 | NA | 78% |
| 75+ | NA | 83% |

Source: AARP Aging Indicators Survey, 2003 and 2004.

were still working. Those without substantial medical bills were much more likely to be confident than those indicating medical bills were a financial problem.

The percent reporting no increase in personal debt

is a new indicator this year, a self-reported measure of current total debt status as compared to the previous year. Currently, there is much discussion about the debt load of Americans, especially boomers nearing retirement, when compared to earlier cohorts.

Respondents to the AARP 2004 Aging Indicators Study were asked whether their total debt (including all mortgage debt, credit cards, installment loans) had increased, remained the same, or decreased from the previous year, or whether they had no debt at all. One third of persons 50 and older reported having no debt at all. Another one-third (32 percent) reported that their debt load had remained about the same, while approximately equal numbers reported their debt load increased and decreased (16 and 18 percent, respectively). In sum, 83 percent of all persons 50 and older reported no increase in debt. This percentage increased directly with age.

Persons in the “youngest” age group were three times more likely than those in the “oldest” group to report their debt had increased (22 percent and seven percent, respectively) and only one-third as likely as the “oldest” group to report being without debt in the last 12 months (20 percent and 59 percent, respectively).

There is growing concern that medical expenses contribute to older persons’ debt. One-third (34 percent) of respondents to the AARP 2004 Aging Indicators Study who reported that their debt increased also reported having financial problems with medical bills. One-fifth (20 percent) of survey respondents age 50+ reported medical bills to be a problem—this was doubled (42 percent) for persons whose debt had increased.

Percent reporting no increase in personal debt

| | 2004 |
|----------|------|
| 50 to 64 | 78% |
| 65 to 74 | 87% |
| 75+ | 91% |

Source: AARP Aging Indicators Study, 2004.

African Americans were less likely than whites to be debt-free. Men were more likely than women to have reported their debt had decreased (23 percent and 13 percent, respectively).



- The slight increase between 2001 and 2002 in the percent of people age 50 and older who regularly engage in physical activity was due entirely to the increase among the 75+ age group (1.2 percentage points).

Health Indicators

11

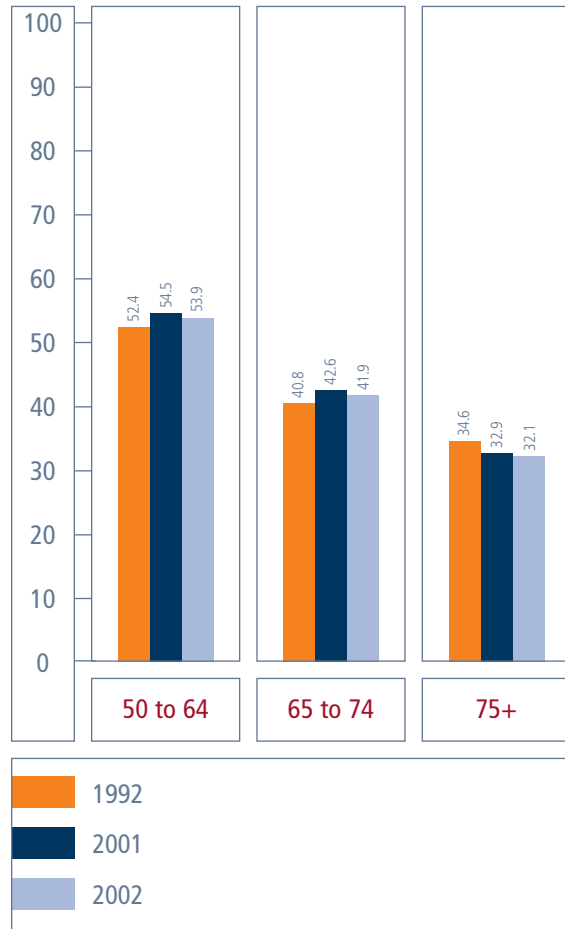
The percent reporting their health as “excellent” or “very good” is one of the most widely used measures of health around the world. Although subjective, self-assessed health has been found to correlate strongly with objective measures of physical and mental health,¹¹ and is a predictor of health outcomes such as mortality, functional status, and health services use.¹²

According to the National Health Interview Survey, in 2002, 46.8 percent of the 50+ population reported their health as “very good” or “excellent” on a scale consisting of poor, fair, good, very good, and excellent. The results for the 50+ population mask fairly dramatic differences within the group, ranging from 53.9 percent of 50 to 64 year-olds to 32.1 percent of those age 75+ reporting “excellent” or “very good” health.

Between 1992 and 2002, the direction of change was positive by only 1.2 percentage points for the entire 50+ age group, but results differed by age. The portion of the population that reported excellent or very good health status increased by 1.5 percentage points and 1.1 percentage points for persons in the “youngest” and “middle” age groups, respectively, while it decreased by 2.5 percentage points for the age 75+ group.

Between 2001 and 2002, the most recent years for which there are data, the percent reporting “excellent” or “very good” health declined slightly (less than one percentage point) among all 50+ age subgroups.

Percent reporting health as “excellent” or “very good”



Source: National Center for Health Statistics, National Health Interview Survey, 1992, 2001, 2002.

The percent of noninstitutional Medicare beneficiaries (including disabled beneficiaries of all ages) with prescription drug coverage throughout the year increased slightly in the most recent year to 57.4 percent in 2001 from 56.7 percent in 2000, and from 51.1 percent in 1995. Although coverage levels increased more than six percentage points between 1995 and 2001, the change from 2000 to 2001 represents the continuation of small year-to-year changes in recent years in Medicare beneficiaries' drug coverage levels.

Medicare beneficiaries age 75 and older are less likely than those age 65 to 74 to have had full-year drug coverage in 2001 (55.2 percent vs. 57.9 percent, respectively). However, coverage levels increased slightly among beneficiaries age 75+ between 2000 and 2001, while decreasing slightly among beneficiaries age 65 to 74 for the same period. (Separate estimates were not available for Medicare beneficiaries under age 65, who are enrolled in the program on the basis of disability.)

The relative plateau in the overall rate of full-year drug coverage in the past year is no surprise given the decline in two key sources of supplemental coverage for Medicare beneficiaries—employer-sponsored plans and Medicare private plans. Although legislation establishing a benefit for outpatient prescription drugs in Medicare was signed in 2003, the benefit does not take effect until 2006 and is voluntary.

Percent of noninstitutional Medicare beneficiaries with prescription drug coverage throughout the year, 65+ or disabled

| | 1995 | 2000 | 2001 |
|-----------------|-------|-------|-------|
| 65+ or disabled | 51.1% | 56.7% | 57.4% |
| 65 to 74 | NA | 58.4% | 57.9% |
| 75+ | NA | 54.8% | 55.2% |

Source: Analysis of Medicare Current Beneficiary Survey by the Peter Lamy Center for Drug Therapy and Aging at the University of Maryland.¹³

The percent of population 50 to 64 with health insurance from any source for any length of time during the year

is a vitally important measure because of the key role of health insurance in economic security. People with health insurance have a reduced risk of health problems and premature death compared with their peers who lack health insurance.

The percentages with coverage in 2003 are not directly comparable with estimates prior to 1999 because in March 2000 the Census Bureau changed the way the Current Population Survey counts the uninsured population.¹⁴ Therefore, any change between a pre-1999 year and 2003 could reflect either the change in method or a real change in health coverage for this age group. From 1999 to 2003, the period since the survey methodology changed, the number of people in the 50 to 64 age group grew 18.3 percent nationally while the number in this age group without coverage grew more rapidly than those with coverage.

The portion of 50 to 64 year-olds who had health insurance at any time during 2003 dropped to 86.5 percent from 86.9 percent in 2002. This translated to almost 357,000 fewer adults in this age group with insurance in 2003, and raised the number of uninsured 50 to 64 year-olds to 6.4 million.

Those in the 50 to 64 age group are insured at a higher rate than younger age groups, but these recent trends indicate that the coverage rate among those 50 to 64 is weakening.

Percent of population 50 to 64 with health insurance from any source during the year

| | 1999 | 2002 | 2003 |
|----------|-------|-------|-------|
| 50 to 64 | 87.1% | 86.9% | 86.5% |

Source: U.S. Bureau of the Census, Annual Demographic Survey, March Supplement, Current Population Survey, 2000, 2003, 2004.

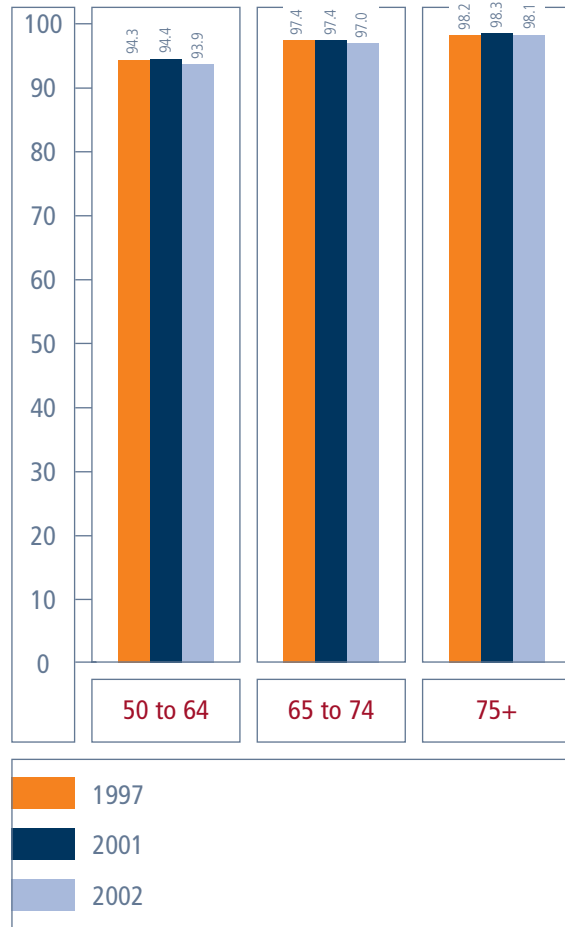
The percent able to afford medical care when needed during the past 12 months

declined slightly between 2001 and 2002 for the 50+ population and all subgroups. There had been no change from 1997 to 2001, which was reversed in 2002. The decline in 2002 put this indicator below the level it reached back in 1997, but the differences are small in all cases.

Although the differences between age subgroups are small, individuals age 50 to 64 were most likely to have been unable to afford needed medical care due to financial barriers in the previous 12 months. Put differently, of those in the “youngest” age group, 93.9 percent were able to obtain needed medical care, compared with 97.0 percent of those age 65 to 74 and 98.1 percent of those age 75+. This finding may point to one of the advantages of being able to depend on the Medicare program for health coverage. While certain disabled persons under age 65 also have coverage through Medicare, most younger persons must obtain health insurance elsewhere (for example, through an employer). Millions of persons under age 65, however, lack any health insurance, which creates potential financial barriers to receiving medical care.

It is important to note that among individuals of all ages who received needed care, there may be some who were only able to “afford it” by accepting money from family or friends or by going into debt. As we reported above concerning Indicator 10, one-third (34 percent) of respondents who reported that their debt increased also reported having a financial problem with medical bills.

Percent able to afford medical care when needed during past 12 months



Source: National Center for Health Statistics, National Health Interview Survey, 1997, 2001, 2002.

The percent who engage in leisure time physical activity

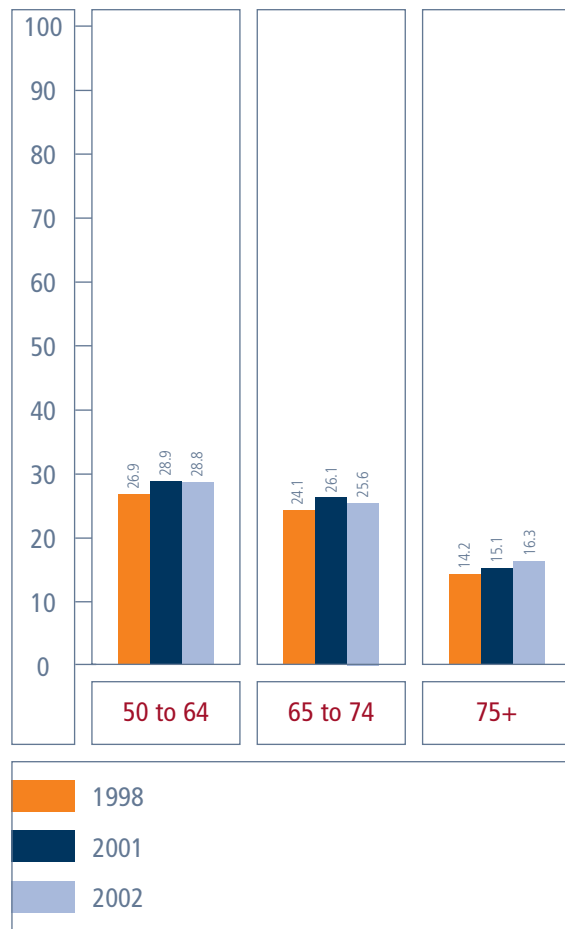
provides an important indicator of a healthy lifestyle. Older adults can achieve significant health benefits from moderate physical activity performed on a regular basis. For example, physical activity helps maintain the ability to live independently and reduces the risk of falling and fracturing bones. In addition, physical activity reduces the risk of dying from heart disease, and of developing conditions like high blood pressure, colon cancer, and diabetes. Other benefits include decreased anxiety and depression and an improved overall feeling of well-being.

According to the National Health Interview Survey, in 2002, barely one quarter of the 50+ population engaged in some type of leisure time physical activity. Regular leisure time physical activity is defined as engaging in light to moderate activity for 30 or more minutes five or more times a week; or engaging in vigorous activity for 20 minutes or more three times a week. Physical activity was much less common among the population age 75 and older (16.3 percent) than either the “middle” or “youngest” age groups (25.6 and 28.8 percent, respectively).

Between 1998 and 2002, the direction of change was positive for the entire 50+ age group, with all age subgroups showing an increase by of at least 1.5 percentage points. However, the most significant increase occurred among the “oldest” age group which showed a 2.1 percentage point increase over the four-year period.

The slight increase between 2001 and 2002 in the percent of people age 50 and older who regularly engage in physical activity was due entirely to the increase among the 75+ age group (1.2 percentage

Percent who are physically active



Source: National Center for Health Statistics, National Health Interview Survey, 1998, 2001, 2002.

points). There was a slight decline in physical activity among the “youngest” (0.1 percentage point) and “middle” (0.5 percentage point) age groups.

The percent who are not overweight and not obese

is another new indicator on our “report card” and an important measure of whether persons are maintaining body weight at a level that lowers their risk for certain chronic illnesses, such as diabetes, heart disease, high blood pressure, osteoarthritis, and certain cancers. Persons are considered not overweight and/or not obese if their body mass index (BMI), a measure of weight in relationship to height, is less than 25.

According to the Behavioral Risk Factor Surveillance System, in 2003, the 75+ age group had the highest percent of the 50+ population who were *not* overweight and not obese (47.0 percent), while the percent among the other 50+ age groups was relatively low by comparison (about one-third).

The entire 50+ population experienced a significant and disturbing drop—from 39.7 to 35.4 percent—in the percentage who were *not* overweight and not obese over the 5 year period between 1998 and 2003. This finding is consistent with the Surgeon General’s recent warning that overweight and obesity have reached epidemic proportions among the general population. The age 75+ subgroup showed a somewhat larger decline (5.3 percentage points) than other 50+ age groups.

It is encouraging that, most recently, the percent *not* overweight and not obese among the 50+ age group increased slightly between 2002 and 2003. Unfortunately, this improvement does not reflect positive changes for all age groups: the 75+ age group is responsible for all of the improvement (a 1.2 percentage point increase), while the “youngest” age group and the “middle” age group experienced slight declines.

Non-obese and non-overweight BMIs



Source: Centers for Disease Control and Prevention, Behavioral Risk Factor Surveillance System, 1998, 2002, 2003.

The percent without possible signs of depression

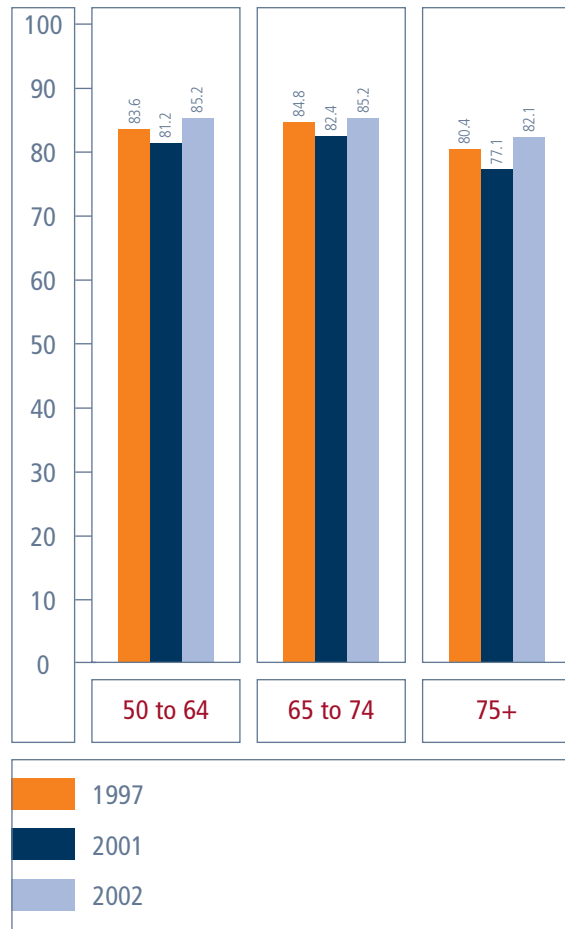
expands this report's attention to the health of the 50+ population by considering mental health status in addition to the physical health indicators already addressed. When left untreated, mental disorders can be just as serious and disabling as physical conditions. Furthermore, depression, the most common mental disorder, is a risk factor for suicide, by which older adults—particularly men age 85 and over—are disproportionately likely to die.¹⁵ In contrast to the normal emotional experiences of sadness, grief, loss or passing mood states, symptoms of depression include feeling sad, worthless or hopeless for weeks at a time.¹⁶

According to the National Health Interview Survey, in 2002, 84.6 percent of the 50+ population did not experience feelings of hopelessness, worthlessness, or sadness (to the extent that nothing cheered them up) some, most, or all of the time. The 50 to 64 and 65 to 74 year-old age groups were most likely to be free of these possible signs of depression during the previous month (85.2 percent each), while the 75+ age group was least likely (82.1 percent).

Compared to 1997, the earliest year for which comparable data are available, the 50+ population experienced a 1.3 percentage point improvement in the portion of people who did not experience these possible signs of depression in the last month.

Due to a six-year low on this indicator in 2001, even larger changes than between 1997 and 2002 occurred between 2001 and 2002 in the share of the older population who did not experience these possible signs of depression in the previous month. The percentage of the 50+ age group rose 4.0 percentage points from a low of 80.6 percent over this one

Percent without possible signs of depression



Source: National Center for Health Statistics, National Health Interview Survey, 1997, 2001, 2002.

year period. Improvement in this mental health indicator was most dramatic for the 75+ age group (with an increase of 5.0 percentage points from a low of 77.1 percent).



→ While 70 percent of the “youngest” age group say they use the Internet, less than half the “middle” age group report that they use the Internet and less than one-quarter of the 75+ age group do.

The percent of expenditures for “non-necessities”¹⁷

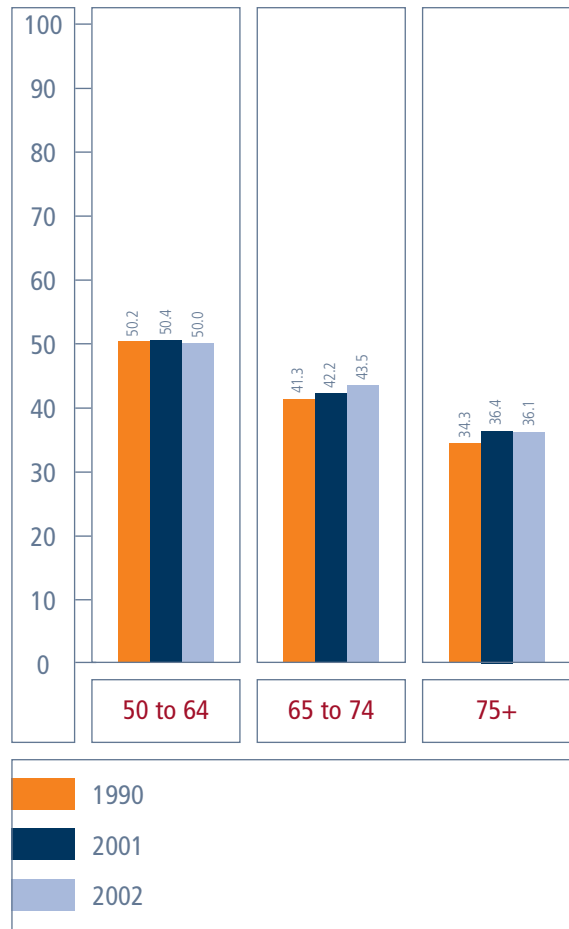
suggests the degree of flexibility or “slack” in family budgets, or the percent of budgets that is discretionary. The greater the flexibility or discretion, the greater sense of security one might experience and the less anxiety. It also provides greater ability to save for emergencies, for long-term investments such as children’s education, and for retirement.

The portion of family budgets spent on “non-necessities” increased from 45.9 percent in 1990 to 46.7 percent in 2002 for the 50+ population overall. Change over that period was negative but very slight for the “youngest” age group, which went from 50.2 percent to 50.0 percent on discretionary items over the period. The discretionary share of spending increased for the other age groups, from 41.3 percent to 43.5 percent for the “middle” age group and from 34.3 percent to 36.1 percent for the “oldest.”

In the most recent year, discretionary spending went from 46.3 percent (2001) to 46.7 percent (2002) for those age 50+, with a slight decrease for the “youngest” and “oldest” groups and an increase for the “middle” group (1.3 percentage points). In fact the percent spent on more discretionary items has changed relatively little over the past decade for the overall 50+ population or the subgroups.

There was a seven to eight percentage point difference between the non-necessity spending share of each age subgroup—50 percent for 50 to 64 year-olds, compared with 42 percent for persons age 65 to 74, and 34 to 36 percent for the 75+ age group. These percentages were stable even when measured over a decade.

Percent of expenditures for “non-necessities”



Source: Bureau of Labor Statistics, Consumer Expenditure Survey, 1990, 2001, 2002.

The percent who use the Internet.

The percent of the population who use the Internet provides one measure of the degree of connection with the outside world. Americans over age 50 rely increasingly on the Internet to communicate with friends and family, keep abreast of the news, search for health and medical information, pay bills, make online purchases, track investments, engage in work-related activities, and more. For this age group, the Internet is rapidly becoming an essential tool of modern life.

While 70 percent of the “youngest” age group say they use the Internet, less than half the “middle” age group report that they use the Internet and less than one-quarter of the 75+ age group do. Nonetheless, Internet use is growing rapidly among Americans age 50 and older.

In last year’s report, our data came from a survey conducted by UCLA that asked about Internet access from home. Because we were interested in actual use of the Internet from anywhere, we included a question in the AARP Aging Indicators Study concerning Internet use from anywhere. A comparable question has been asked by the Bureau of the Census in a supplement to the Current Population Survey. Our results are derived from the latter two surveys. Between 1998 and 2004, the proportion of people age 50+ who say they use the Internet increased from just under 20 percent to 53 percent. During the same time period, the percentage of Internet users more than doubled among the youngest age group, from 31.3 percent to 70 percent, it grew from 12.3 to 45 percent among the “middle” age group and from 4.3 to 23 percent among those age 75+.

Percent who use the Internet

| | 1998 | 2004 |
|----------|-------|------|
| 50 to 64 | 31.3% | 70% |
| 65 to 74 | 12.3% | 45% |
| 75+ | 4.3% | 23% |

Source: AARP Aging Indicators Study, 2004; U.S. Bureau of the Census, Current Population Survey, Internet and Computer Use Supplement, 1998.

The percent very satisfied with amount of contact with family, friends, and neighbors.

Satisfaction with the amount of contact with family, friends, and neighbors is an important component of social well-being. For instance, research has shown that social contact with friends and neighbors can positively affect the physical and mental health of older Americans. Ties with family and friends are also a critical way to help alleviate feelings of isolation, an important issue for many older Americans. Finally, family, friends, and neighbors are important sources of informal assistance and support for older persons.

Overall, seven in 10 persons age 50 or older were very satisfied with the amount of contact with family, friends, and neighbors, with relatively minor variation among the three age subgroups. The percent very satisfied with the amount of contact with family, friends and neighbors was highest for the “middle” age group (77 percent) and somewhat lower for the “youngest” (69 percent) and “oldest” (70 percent) age groups.

Two similar questions were asked in last year’s report—one concerning contact with family members and one which asked about friends and neighbors. Although two separate questions were asked last year and therefore were not directly comparable to this year’s survey, we obtain similar results if we add up the “very satisfied” responses to *either* question for the two age groups we analyzed in last year’s report. Of those age 50 to 64, 75 percent responded “very satisfied” in last year’s survey about their contacts with *either* family or friends and neighbors, compared with 69 percent in this year’s survey. Of those age 65 and older, 84 percent responded

Percent very satisfied with the amount of contact with family, friends, and neighbors

| | 2004 |
|----------|------|
| 50 to 64 | 69% |
| 65 to 74 | 77% |
| 75+ | 70% |

Source: AARP Aging Indicators Study, 2004.

“very satisfied” about the contacts with family or friends and neighbors, compared with 73 percent this year.

In this year’s survey, women were more likely than men to be “very satisfied” (76 vs. 65 percent), as were persons/spouses without a reported disability relative to those who did report disability (74 vs. 63 percent). And homeowners were much more likely to report being “very satisfied” (72 percent) than renters (57 percent), perhaps because owners have on average lived in their communities longer and have developed more extensive ties in the community.

The percent who say their quality of life has improved during the past 12 months.

Quality of life encompasses many aspects of well-being, with their relative importance varying from person to person and as one ages or one's circumstances change. For most people, quality of life includes finances, health, living situation, employment and other activities, and relationships to friends and family.

In responding to a question about whether quality of life has improved, declined, or stayed the same compared to 12 months ago, each person may be responding to changes in one or more of these aspects of life quality.

Among everyone age 50 and over, 14 percent said their quality of life had improved since last year, and 13 percent said that it had declined. Most people (72 percent) said their quality of life was about the same as it was a year ago. Among those in the “youngest” age group (50 to 64), 18 percent reported their quality of life had improved and 11 percent said it had declined, while those in the “oldest” group, ages 75 and above, were more than twice as likely to report a decline than an improvement (eight percent reported an improvement and 18 percent reported a decline). There was no significant difference between men and women in either of these age groups.

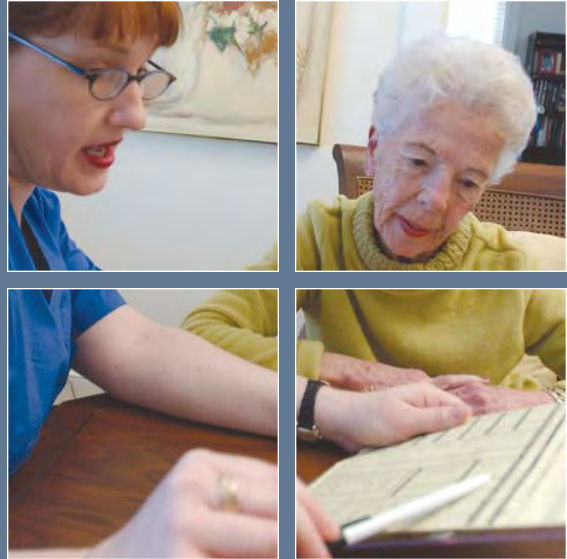
Approximately the same percent of those in the “middle” (65 to 74) age group reported a decline (13 percent) as an improvement (12 percent). However, there were significant gender differences. Men in this age group were similar to men age 50 to 64, with many more reporting an improvement in quality of life, while women in this age group were similar to women in the 75+ group, with many more reporting a decline.

Percent who report their quality of life “improved” in the past 12 months

| | 2004 |
|----------|------|
| 50 to 64 | 18% |
| 65 to 74 | 12% |
| 75+ | 8% |

Source: AARP Aging Indicators Study, 2004.

The percentage responses to the “quality of life” question were very similar to those we found for Indicator 8, which asked whether people were better off economically than last year, but not so similar that we would regard these as equivalent questions.

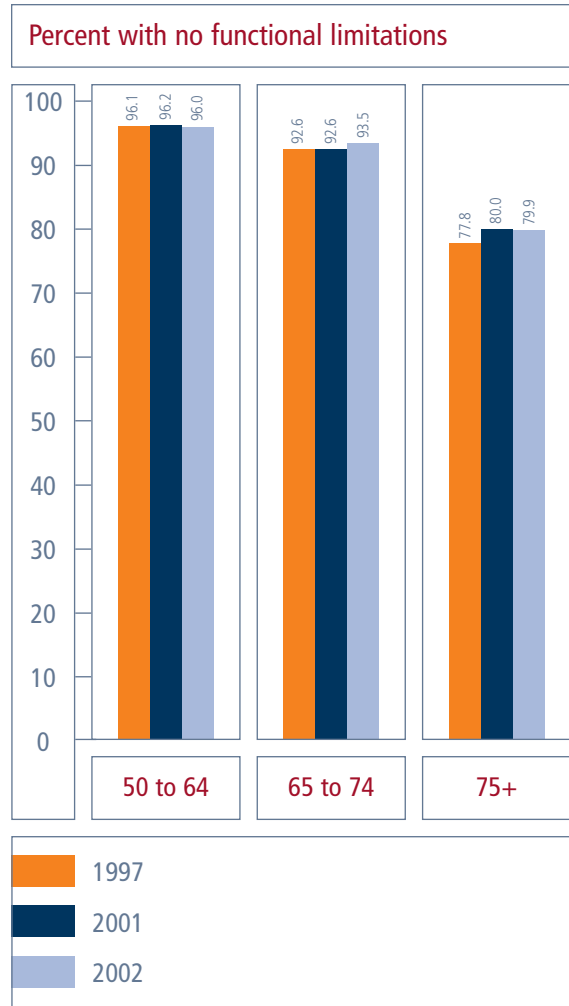


→ In 2004, 41 percent of persons 50 and older reported providing unpaid help to a relative or friend age 50 or older—such as help with personal needs or chores, arranging for services, or visiting regularly to see how they are doing.



The percent with no functional limitations requiring assistance from another person measures the independence of the population, which generally correlates with a sense of control and empowerment. This measure of disability includes persons with at least one chronic condition who do not need the help of another person with either very personal needs, such as bathing or dressing, or in handling routine needs, such as everyday household chores or shopping.¹⁸ Persons who do need such help typically receive assistance from family or other unpaid caregivers, from paid caregivers, such as aides from home care agencies, or from both unpaid and paid caregivers. Other individuals with disabilities may not need human assistance, but make extensive use of special equipment and technologies, such as wheelchairs and computers, as well as services in their communities, such as accessible public transportation, in order to maintain independence.

The proportion of persons who do not need any human assistance with functional limitations declines with age, especially among persons age 75 and older. About 96 percent of persons in the “youngest” age group, 93 percent of persons in the “middle” age group, and 80 percent of persons 75 and older do not need such assistance. Over the period since 1997, the percent of the “youngest” group having no functional limitation changed little, but the percent of the “middle” and “oldest” age groups having no functional limitations increased by one and two percentage points, respectively, both favorable changes.



Source: National Center for Health Statistics, National Health Interview Survey, 1997, 2001, 2002.

The percent of caregivers with no substantial caregiving burdens.

The great majority of the assistance received by persons with disabilities in the U.S. is provided by family and friends rather than by paid caregivers through formal, paid sources, such as home care aides or in assisted living or nursing home settings. The assistance provided can range from visiting on a regular basis to occasional help with chores to providing intense personal care for many years. We have defined substantial caregiving burdens as one of the following: spending more than 20 hours per week providing care or experiencing a decrease in pay or benefits as a result of caregiving.¹⁹ The percent of caregivers with neither of these burdens may experience less physical, financial, and emotional stress compared with their counterparts who *do* provide more intense levels of care.

In 2004, 41 percent of persons 50 and older reported providing unpaid help to a relative or friend age 50 or older—such as help with personal needs or chores, arranging for services, or visiting regularly to see how they are doing—down substantially from 46 percent in 2003. At the same time, there was a substantially lower proportion of caregivers in 2004 (67 percent) than in 2003 (78 percent) who did not have substantial caregiving burdens, although this difference may be due to the different format of the question.²⁰ For the “middle” age group the figure was 58 percent without significant burdens, and for the “oldest” age group it was 67 percent.

The percent of caregivers in the 50 to 64 and 65+ age subgroups without substantial burdens was similarly lower in this year’s survey than last year. In 2004, 70 percent of 50 to 64 year-old caregivers had no substantial caregiving burden, compared

Percent of caregivers with no substantial caregiving burdens

| | 2003 | 2004 |
|----------|------|-------|
| 50 to 64 | 77%* | 70% |
| 65 to 74 | NA | 58.0% |
| 75+ | NA | 67.0% |

Source: AARP Aging Indicators Study, 2003 and 2004.
*See end note 5.

with 77 percent in last year’s survey. And only 61 percent of the 65+ caregivers in 2004 had no substantial burdens, compared with 81 percent of the 65+ caregivers in 2003. Again, these differences may be due to the different format of the questions. Caregivers who do not experience substantial burdens are less likely to say that medical and prescription drug bills are a financial problem.

Unpaid caregiving is more common among persons in the 50 to 64 year-old age group (49 percent) than the 65 to 74 year-old age group (35 percent), or the 75+ age group (27 percent). Not surprisingly, the 75+ age group is more likely than 50 to 64 year-olds to report receiving unpaid care. Older caregivers, both those ages 65 to 74 and 75+, are more likely to say the person they are helping lives in their home, possibly because caring for a spouse is more common at older ages.

Helping older relatives often involves money as well as time. For example, over half (52 percent) of caregivers ages 50 to 64 say that caregiving has resulted in an increase in their expenses. In addition, one out of five persons age 50 to 64 provides cash to older relatives to help them maintain their independence.

The percent who rarely or never miss something away from their residence due to lack of transportation.

The percentage of individuals 50+ who rarely or never miss doing something due to a lack of transportation indicates the proportion of older individuals whose mobility needs and wants are being met. Transportation is the means by which individuals access the goods, services, and social opportunities that contribute to maintaining independence and quality of life. When mobility needs are *not* being met, individuals are likely to be isolated. Research shows that isolation contributes to impaired mental and physical health.

The percent whose transportation needs are being met (according to our indicator) is generally high but decreases with age. Individuals in the “youngest” (95 percent) and “middle” age groups (92 percent) are least likely to miss things because of a lack of transportation, while individuals in the 75+ age group are most likely (88 percent). There is a strong correlation between whether individuals drive a privately owned automobile and whether their transportation needs are being met; while more than nine out of ten individuals 50+ who drive themselves rarely or never miss doing something because they do not have transportation, over half (56 percent) of those who rely on others for rides rarely or never miss doing things because of not having transportation.

Percent who rarely or never miss doing something because they lack transportation

| | 2004 |
|----------|------|
| 50 to 64 | 95% |
| 65 to 74 | 92% |
| 75+ | 88% |

Source: AARP Aging Indicators Study, 2004.

The percent who rate their community as excellent in terms of how safe they feel.

A sense of personal safety and security is an important element of successful aging, and influences how willing and able older persons are to conduct everyday errands and to participate in the social life of their community. Fear of crime contributes to isolation, and perceptions of neighborhood crime can ultimately affect property values. Furthermore, older persons are sometimes perceived as vulnerable and become a target for crime.

Fortunately, most persons 50 and older have positive perceptions of neighborhood safety. Nearly nine out of 10 rate their community as good or excellent in terms of how safe they feel when walking in their neighborhood during the evening, with no significant variation across age subgroups.

However, there were significant differences for minorities age 50 and older. In particular, white persons age 50 and older were more likely than African Americans age 50 and older to view neighborhood safety as “excellent” (90 vs. 77 percent). Similarly, 20 percent of persons age 50 and older with under \$25,000 in household income viewed neighborhood safety as “fair” or “poor”, compared to only 5 percent of those earning \$50,000 or more. Notably, urban areas were perceived more unfavorably than other areas for safety, with 20 percent of persons 50 and older indicating only “fair” or “poor” safety and security (compared to seven to eight percent in the suburbs and rural areas). Persons/spouses with a disability and renters were also more likely to respond “fair” or “poor” to this question.

| Perceived neighborhood safety | |
|-------------------------------|------|
| | 2004 |
| 50 to 64 | 89% |
| 65 to 74 | 86% |
| 75+ | 87% |

Source: AARP Aging Indicators Study, 2004.

The Biggest Challenges: Health Care Costs, Coverage, Access and Quality

At the start of the 21st century, America has a health care system characterized by paradoxes. We spend more on health care than any other industrial nation, yet the system's performance is uneven. Scientific advancements offer improved treatments and other interventions, yet these are often not employed to improve care or the quality of life. The complex, fragmented delivery “non-system” represents almost 15 percent of the nation's economy,²¹ yet it remains disorganized, inefficient, and wasteful.

These paradoxes present a major challenge: how to harness the benefits of modern health care while making the best use of the resources available to pay for it. Purchasers of health care—employers, governments, and individuals—are struggling with how to restrain the growth in their health spending while getting value for their spending. In recent years, there has been a push to make individual consumers more cost conscious and more responsible for their use of the health care system. This takes a variety of forms and includes efforts to educate consumers about the links between their behaviors and their health; impose more financial risk on consumers for the cost and quality of their choices (e.g., tiered cost-sharing, high deductibles, different benefits for care by high quality providers); and give consumers information about providers and treatment options to help them find the best quality care.

Because health problems become more prevalent with age, the 50+ population has a major stake in both the problems confronting our health care system and their resolution.

System-Wide Health Spending: The Tell-Tale Signs

Health care spending has accelerated in recent years, growing 9.3 percent in 2002 and is expected to continue growing at a relatively high rate over the next decade

(i.e., over seven percent per year between 2003 and 2013). By comparison, average annual spending growth was 5.3 percent between 1993 and 1998.²² Health care cost increases affect individuals, business, and government in numerous ways, including growth in health insurance premiums, declining offers of retiree health benefits, and more people without health coverage.

In 2004, health insurance premiums increased 11.2 percent, the fourth double-digit increase in as many years, and continued to outstrip general inflation and wage growth.²³ The growth in health costs has led to a major decrease in the percent of employers offering health benefits to future retirees—from 66 percent of large firms in 1988 to 36 percent in 2004.²⁴ This trend has particular importance for the 50+ population since access to health benefits affects the timing of retirement²⁵ as well as individual financial planning for health expenses in retirement. Loss of employer subsidies puts additional financial responsibility on individual retirees.

The rising cost of health coverage also affects the size of the uninsured population. The 45 million Americans who were uninsured in 2003 outnumbered those entitled to Medicare. Between 2000 and 2003, the ranks of uninsured 50 to 64 year-olds grew from 5.2 million to 6.4 million, or from 13 percent of the 39 million uninsured to 14 percent of the 45 million uninsured.²⁶ (See Indicator 13.) The implications of this situation are especially serious for older Americans, as research shows both that (a) adults in late middle age who lack or lose health coverage are particularly susceptible to deteriorations of function and health status, and (b) they have a higher risk of dying.²⁷

Health Care Costs: The Squeeze on Individuals

In the fall of 2004, AARP conducted a survey to explore, among other issues, how the 50+ population is experiencing aspects of the cost, coverage, access and quality problems in our health care system. The AARP survey finds that, over the last year, medical bills (including prescription drugs) have been a financial problem for one-fifth of adults age 50 and older. Of those age 65+, 22 percent report that medical bills have been a financial problem, compared with 18 percent of those age 50 to 64 and 17 percent of those age 25 to 49.

During the last 12 months, medical bills have had dramatic effects on many families' budgets. While 26 percent of survey respondents age 50+ report having to cut back on discretionary spending (e.g., dining out, movies) due to medical expenses, 19 percent report having used savings that were supposed to be for other non-medical items, and seven percent report that their medical bills have caused them to cut back on basic necessities like food or housing. Moreover, nine percent of respondents borrowed or went into debt, and one percent filed for bankruptcy as a result of their medical bills. Experiences were similar across age subgroups within the 50+ population.

Although the main reason for buying health coverage is to insure against catastrophic or unpredictable health expenses, coverage does not necessarily protect everyone from high health care costs. Premiums and cost-sharing have been rising, and individuals pay out of pocket for care and treatment frequently not covered by their insurance, such as dental care, eye glasses, hearing aids, long-term care, and prescription drugs. At least until 2006, when the Medicare program will offer a voluntary drug

benefit, lack of coverage for prescription drugs is a particular issue among people age 65 and older.

While, among respondents age 50+, the uninsured were most likely to have had financial problems from medical bills in the past year (36 percent), Medicare beneficiaries and other insured respondents were not insulated (24 percent for those with Medicare and 13 percent with other coverage had financial problems). In addition to the uninsured age 50+, the disabled (43 percent), those with incomes less than \$25,000 (35 percent), and African Americans (33 percent) were the most likely subgroups of the 50+ population to report problems with medical bills. These categories of individuals typically also were most likely to describe medical bills as a major problem.

Health Coverage: The Challenge of Holding On

Changes in financial burden are one reason that health coverage can be unstable over time. In addition, as a result of changes in employment and family status, those with coverage today may not have had consistent coverage in past years and may not always have it in the future. Of AARP's survey respondents age 50 to 64 who were not on Medicare, roughly two in five reported not always having health coverage in their adult life: four percent had rarely or never had coverage, another 9 percent reported being covered only sometimes, and 26 percent reported being covered most—but not all—of their adult life.

If not all members of a household have health insurance, there is additional risk. Among respondents age 50+ with coverage, 6 percent reported another person in their household was uninsured at the time of the survey. This could reflect younger spouses who were covered as dependents but lost that coverage when

the older partner became entitled to Medicare, or other factors affecting access to health coverage such as affordability of individual or employer coverage options.

Access to Care: Cost and Coverage Drive Delays

The ability to access needed care is closely related to health care coverage. While 6 percent of respondents age 65+ report that they had delayed getting health care in the last 12 months or decided not to get health care when they thought they needed it, 17 percent of those age 50 to 64—and 21 percent of those age 25 to 49—did so.

These results underscore the importance of Medicare in insuring older Americans and the relative success of the program in allowing age 65+ to access needed care.

However, as other surveys have found, certain subgroups tend to be more susceptible than others to access problems.²⁸

Among the 50+ population, these include African Americans, those with household income under \$25,000, and those with a disability. Also, the uninsured are much more likely than those with insurance to report access problems.

The cost of health care is another key factor that affects a person's ability to access needed care in a timely manner. Of those survey respondents age 50+ who delayed or did not get health care when they thought they needed it, two-thirds (66 percent) cite lack of affordability as a reason. Other factors related to whether an older adult delayed or had to forgo needed health care include insurance-related reasons (60 percent), inability to get to the doctor or health care provider (13 percent), physical barriers that prevent them from getting around the building (seven percent), and communication problems such as language differences or hearing difficulties (three percent).

Because most persons surveyed—89 percent of those age 50+—received at

least one prescription for drugs from a doctor in the last 12 months, paying for prescription drug costs has the potential to create particular access problems.

Eleven percent of those age 50+ (or their spouse) did not fill a prescription due to the cost of drugs, and 16 percent delayed having a prescription filled. Fourteen percent skipped doses or cut pills to make their medicine last longer, and 15 percent had to sacrifice buying something else they needed. Certain subgroups within the 50+ population—the uninsured, those with incomes under \$25,000, and minorities—reported using these strategies to cope with drug costs at about twice the rate of the overall 50+ population. In addition, younger persons (i.e., those age 50 to 64 and 25 to 49) are slightly more likely than persons age 65+ to have responded to their drug costs in these ways.

Quality of Care: Consumers Recognize Some Problems

In addition to the cost, coverage, and access problems described above, the 50+ population faces large and pervasive deficits in quality of care. Among people age 50 and older, nearly six in ten are generally dissatisfied with the quality of health care in this country.²⁹ Moreover, 48 percent of those between the ages of 50 to 64 and 39 percent of those age 65 and over believe that health care quality has gotten worse over the past five years.³⁰ In addition, close to 40 percent of those between the age of 50 to 64 and over 20 percent of people age 65 and over report being personally involved in a situation where a preventable medical error was made in their own or their family's care.³¹ Of those who experienced these medical mistakes, seven in ten reported that the doctor or health professional involved did not reveal that an error had occurred.³²

In stark contrast, when asked about the quality of the care they personally

received over the past two years, almost two-thirds of persons age 65 and older are extremely or very satisfied.³³ Younger people (age 45 to 64) are somewhat less satisfied (57 percent) as are those who are non-white (44 percent) and those whose annual incomes are \$35,000 or less (49 percent).

Informed Decision-Making by Consumers: Not Yet a Reality

In an environment where consumers are increasingly asked to take more responsibility for the cost and quality of their care, some policymakers and purchasers believe that, by coupling financial incentives with information, consumers can be encouraged to include quality as factor in their health care decision making. Although consumers, by necessity, may respond to the financial incentives, many are somewhat skeptical that such information will improve the quality of doctors and hospitals. People age 45 to 64 are more likely than those age 65 and older (52 percent vs. 38 percent, respectively) to believe that access to this information will help to improve care.³⁴ Similarly, 57 percent of those age 45 to 64 and 38 percent of those age 65 and over believe that the quality of care they receive would improve if they had access to more information on the effectiveness of treatment options.³⁵

In spite of the fact that many consumers do not appear to be persuaded that information will improve the quality of care, experts and consumer advocates assert that useful and meaningful information that informs coverage, provider, and treatment choices is critical because the risk of making a bad choice could cause financial or personal harm. However, if consumers are to benefit from published information about health care quality (e.g., through report cards on health plans), it must be accessible and

formatted in ways that help the user to easily interpret the data. According to the AARP Aging Indicators Study, only about one-third of persons age 50 and older have seen comparative information about health plans and hospitals. Roughly one in five individuals who saw hospital information used it to make a decision, while about one in three who saw the health plan information used it to choose a health plan.

Consumers cite several reasons for not using information on the quality of hospitals and health plans: the information is not available when they need to choose, not specific to their health concerns, or not specific to the facility or health plan choices offered to them.³⁶ In addition, 10 percent of respondents who did not use comparative information on hospitals and 23 percent who did not use information on health plans found it too confusing.³⁷

With regard to physicians, AARP's Aging Indicators Study found that only 12 percent of adults age 50+ have seen comparative information on doctors. Of those who have, about 34 percent used the information to decide on doctors. The vast majority of respondents age 50 and over (92 percent) report they are confident that they have enough information to choose the best doctors for themselves or family members. However, except in a few locations, very little information is available that actually compares physicians' performance. Even the information in physician directories is lacking³⁸ because it typically consists only of descriptive information such as the name and address of the physician.

Furthermore, objective sources are not necessarily being used by consumers when they select a physician. For example, most consumers age 50 and older are likely to consult their current physicians (85 percent) or family and friends (79 percent). Adults between the

age of 50 and 64 are more inclined than their age 65+ counterparts (55 percent vs. 40 percent, respectively) to obtain guidance on physician selection from their health insurance plans. Interestingly, when choosing a doctor, consumers age 65 and older are more likely to look for information in the yellow pages (14 percent) than to obtain this information from government agencies (13 percent) or the Internet (8 percent). Nevertheless, consumers appear to be increasingly recognizing that family and friends are not an objective source of information. The proportion of people reporting that family and friends do not have enough knowledge and experience to provide good information about health plans increased from 27 percent in 1996 to 36 percent in 2004.³⁹

Financial Future Regarding Health Care: Not Considered Secure

All of these factors play into individuals' confidence about their long-term ability to handle health-related costs in their retirement. Over one quarter of survey respondents (27 percent) age 50+ reported that they are not confident about their ability to pay for health and long-term care expenses throughout their retirement years. The findings vary by age: nearly a third of those age 50 to 64 and those age 25 to 49 express concerns about their ability to pay for future health expenses, in contrast to 23 percent of those age 65 to 74 and 16 percent of those age 75+. Heightened concerns among midlife and younger adults may reflect uncertainty about how changes in employer and retiree benefits may affect them, what Medicare will be like in the future, and what their income will be in retirement. But given the growth in the 50+ population in coming years, their experiences with and concerns about health care point to a system urgently in need of attention.

Commentary



Peter V. Lee

AARP's State of 50+ America report provides optimism for the future of health care and the role of activated consumers, but also raises issues of grave concern. Its findings must be cautiously interpreted to inform policymaking efforts and value purchasing strategies.

The optimism that may be construed from the year-over-year increase in median income for working seniors (50 to 64) is also sounding an important alarm. Sadly, the impact of escalating health care costs means that consumers are paying a larger proportion of bigger numbers. The real story for working seniors is that if their income is reduced by the average increase in health care spending, income did not go up in 2003 by the \$164 cited in the report—it went down by almost \$200 (based on Kaiser Family Foundation/HRET Survey results).

While it's true that the proportion of health care costs being directly borne by consumers is lower today than it was ten years ago, the health care tab is far higher. And, of even greater concern is the fact that in far too many cases, both public and private purchasers are not thoughtfully sharing costs in ways that will encourage consumers to get the right care at the right time—too often they are blindly shifting costs in ways that may discourage individuals from getting needed care. Private purchasers and Medicare must move to linking consumer information tools with thoughtful cost-sharing to encourage consumers to make better choices at every level of the health care system: health plan, hospital, physician and treatment.

Despite advances in the ability of physicians and other health care professionals to treat a range of conditions and new technologies that hold huge promise, the likelihood of the average insured American actually getting the right care at the right time is in the range of 50 percent, according to a recent RAND study. Taken with the documented problems of medical errors and the huge variation in both the quality and cost-effectiveness with which care is delivered, we truly do have a system in crisis.

Fortunately, this report sheds light on a trend that, although understated here, represents an important opportunity—the sea change in consumers using comparative performance information. Disagreeing with the report's observation that “only” about one-third of persons age 50 and older have seen comparative information about health plans and hospitals, and that far fewer have used that information is not a mere case of quibbling over whether consumers' use of this information is a cup “half-full” or “half-empty.” Rather, it misconstrues both the magnitude of opportunity for consumer use of this information and its potential to transform health care.

At the hospital level alone, the data presented mean that over 26 million Americans over 50 years old saw comparative performance information and over 5 million used that information to select a hospital. Making valid and reliable performance information public is about giving consumers tools to make better-informed decisions, but even more importantly, it is about encouraging

hospitals (or providers at every other level) to improve. We are making headway toward a “tipping point” where informed consumer choice will drive provider improvement. This report also affirms that increasingly the “tracks are being laid” to get performance information into the hands of seniors. Not only do 70 percent of those 50 to 64 regularly use the Internet; about a quarter of those over 75 do on a regular basis. The movement to greater performance transparency is one from which there is no turning back. Consumers deserve and are demanding valid information so they can make better choices; purchasers deserve that information to be clear what we’re paying for and providers need that information to make the improvements that we all need.

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Mr. Lee is a member of the boards of the National Committee on Quality Assurance (NCQA) and the National Business Coalition on Health. He also serves as the co-chair of the Consumer/Purchaser Disclosure Project, a national effort to promote better transparency of health care providers’ performance. Mr. Lee has served on numerous national and statewide bodies, such as the Institute of Medicine’s Crossing the Quality Chasm Summit Committee and the State of California’s Managed Health Care Improvement Task Force. Prior to joining PBGH, Mr. Lee was

the Executive Director of the Center for Health Care Rights. Previously, Mr. Lee was an attorney with the Los Angeles firm of Tuttle & Taylor. He received his law degree from the University of Southern California and his undergraduate degree from the University of California at Berkeley.



Alice M. Rivlin

No dramatic changes from last year are revealed in AARP's second annual report on the well-being of the older population, but stability is to be expected in a population that is mostly retired. Indeed, big changes from one year to the next would lead a statistician to suspect there was something wrong with the sample. Some new features have been added, and the on-going project promises to be an increasingly rich source of information on the changing economic and health status of senior citizens.

A new feature this year—breaking out older seniors (75 and older) from younger seniors (aged 65 to 74 years)—reveals big differences between the two groups. Not surprisingly, younger seniors have higher household incomes and assets and are more likely to be working. It is worrisome that almost half of older seniors have incomes below twice the poverty line, which the report regards as a minimally adequate standard of living. About a third of younger seniors also fall in this category. It is encouraging, however, that 80 percent of older seniors report no functional limitations, and 23 percent say they stay connected via the Internet (up from 13 percent in 2001).

As President Bush and the new congress take on reform of Social Security and Medicare, they would do well to keep in mind two facts that emerge clearly from the AARP's status report. First, dependence on Social Security is remarkably high, especially for older seniors. Sixty percent of older seniors report receiving more than half their income from Social

Security, as do nearly 40 percent of those 65 to 74. As the ratio of older people to those in the prime working ages increases over the next several decades, we should find a way to reduce dependence on Social Security in retirement and increase reliance on pensions and private savings. But this transition will take time and must be structured to protect low-income retirees, who rely heavily on their Social Security checks.

Second, Medicare has been remarkably successful in helping seniors cope with the rising costs of needed medical care. An astonishing 97.5 percent of seniors 65 and over report that they were "able to afford medical care when needed during the past 12 months." Although some of them were assisted by Medicaid, charity, family contributions, or going into debt, Medicare is a vital piece of the coverage story. As we struggle to find ways to reduce the future cost of Medicare, it is important not to undermine the success of the program in ensuring that almost all seniors can pay for the care they need.

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the District of Columbia Financial Management Assistance Authority (1998–2001).

Dr. Rivlin was the founding Director of the Congressional Budget Office (1975–1983). She was director of the Economic Studies Program at Brookings (1983–1987). She also served at the Department of Health, Education and Welfare as Assistant Secretary for Planning and Evaluation (1968–69).

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Dr. Rivlin was born in 1931 in Philadelphia, Pennsylvania and grew up in Bloomington, Indiana. She received a B.A. in economics from Bryn Mawr College in 1952; and in 1958 a Ph.D. from Radcliffe College (Harvard University) in economics. She is married to economist Sidney G. Winter, who is a professor at the University of Pennsylvania. She has three children and four grandchildren.



Gail R. Wilensky

AARP has provided an important service to the country with its second annual “report card” on the quality of life for Americans over the age of 50. Looking at over 25 indicators of economic and health security as well as lifestyle and long-term care, the AARP report attempts to provide information about how seniors have fared over a “rolling decade” and how they have fared over the past year.

For the most part, their findings are in the expected directions. The over 50 population has experienced real economic improvement over the last decade, although less so in the last five years and not equally by all of the over 50 population groups. To no surprise, since the economy has been coming out of a recession with a two year period of slow job growth, the report card showed signs of improvement in the most recent year. In what I regard as an important positive sign for the future, more of those over 50 are employed than there were ten years ago.

The health indicators examine changes in physical health, mental health, health coverage, the ability to afford health care and the relationship between increasing debt and medical expenditures. This represents an important component of a “report card” on the quality of life for Americans over the age of 50. Most of the findings are not surprising. A few are cause for concern.

Most of the health indicators show some improvement, including a new mental health measure. Two that did not, the numbers with health insurance for the 50 to 64 age group and the numbers who are

overweight or obese, are disturbing. The economy may help the uninsured rate. The obesity rate will be more difficult to resolve and appears to be a more significant problem for the 50 to 64 year olds than for the older groups. This is a problem that the country will have to resolve for its younger populations as well or face significant health and economic consequences.

The yearly change measures were taken at the end of a recession and it is not surprising to see some small declines in insurance coverage or in the percent able to afford needed health care. Many of the measures used in this section were not available for a full decade, and it was sometimes difficult to put the changes in much context.

The surprising finding is that the number with drug coverage increased slightly in the most recent year and more substantially over the 6-year period reported. I’m not surprised it stabilized in the years reported (2000 and 2001); I’m surprised it was not declining.

An additional indicator that would be very useful is the number of people who have disabilities that limit their activities. This information would put in better context several of the measures reported in the health section and also the indicator on employment rates. If one had to be discarded, I would eliminate the percent with drug coverage. With the new Medicare benefit, this measure is less critical.

Gail Wilensky is a Senior Fellow at Project HOPE, an international health education foundation, where she analyzes and

develops policies relating to health reform and to ongoing changes in the medical marketplace. Dr. Wilensky testifies frequently before Congressional committees, acts as an advisor to members of Congress and other elected officials, and speaks nationally and internationally before professional, business and consumer groups. From 2001 to 2003, she co-chaired the President's Task Force to Improve Health Care Delivery for Our Nation's Veterans, which covered health care for both veterans and military retirees. From 1997 to 2001, she chaired the Medicare Payment Advisory Commission, which advises Congress on payment and other issues relating to Medicare, and from 1995 to 1997, she chaired the Physician Payment Review Commission. Previously, she served as Deputy Assistant to President (GHW) Bush for Policy Development, advising him on health and welfare issues. Prior to that, she was Administrator of the Health Care Financing Administration, overseeing the Medicare and Medicaid programs.

Dr. Wilensky is an elected member of the Institute of Medicine of The National Academies and its Governing Council; Vice Chair of the Maryland Health Care Commission; and serves as a trustee of the Combined Benefits Fund of the United Mineworkers of America, the American Heart Association, and on the Advisory Board of the National Institute of Health Care Management. She is an advisor to the Robert Wood Johnson Foundation and the Commonwealth Fund, immediate past chair of the Board of Directors of Academy Health and is a director on several corporate boards.

Dr. Wilensky received a bachelor's degree in psychology and a Ph.D. in economics at the University of Michigan.

Endnotes

- ¹ AARP, Beyond 50.01 through Beyond 50.04, see http://research.aarp.org/general/beyond_50.html.
- ² Instead of basing it on the unemployment rate, which has as the denominator those in the labor force, we have calculated it as those employed over the total population, which includes many not seeking employment. Because of the larger denominator, the employment rate will be much lower (44.7 percent this year compared with 95 percent last year).
- ³ Last year's report cited Internet *access* at home, whereas this year we are measuring the *use* of the Internet anywhere, including work or home.
- ⁴ Contact with family and with friends and neighbors were two separate indicators last year. Because the results were so similar, we opted to combine them into a single indicator this year. But in addition, we attempted this year to determine not only the amount of contact but the level of satisfaction with that contact as well.
- ⁵ In both this year's and last year's report, we asked whether people were providing unpaid help to a relative or friend age 50 or older, such as help with personal needs or chores, arranging for services, or visiting regularly. Last year, we also asked whether caregiving resulted in either a loss of pay or employment, a loss of savings, or required 20 or more hours per week, which gave us a measure of substantial burdens. This year, we chose to divide this question into two questions: (1) On average, does caregiving require 20 or more hours per week of your time? And (2) Has caregiving resulted in a decrease in your pay or benefits during employment? The idea was to differentiate among the types of burdens but still be able to estimate the percent having a substantial burden. Because the questions are different, they are not precisely comparable.
- ⁶ AARP Aging Indicators Study 2004, conducted for AARP by Southeastern Institute for Research (SIR), Richmond, VA, in October of 2004. SIR conducted a survey with a nationally representative sample of 1201 respondents age 25 and older. The survey oversampled those age 75+ (300 respondents). We reported all results based on the AARP Aging Indicators Study and did not discriminate between statistically significant or insignificant changes. All sample values have a margin of error of plus or minus 2.8 percentage points. Upon request, we will provide information about specific changes. Please contact us at ppi.aarp.org with requests.
- ⁷ Financial assets include the following assets derived from the Federal Reserve Survey of Consumer Finances (SCF): checking, savings, and money market accounts; certificates of deposit; mutual funds; stocks; defined contribution pension balances; IRA and Keogh account balances; savings bonds; cash value of life insurance; annuities; trust funds; and other financial assets. The most important asset that is excluded is housing wealth, which is the largest single asset for most households. Housing (and other tangible property) is not liquid (easily converted to cash), so it cannot readily be accessed for short-term retirement needs. The SCF data also exclude wealth held in traditional defined benefit pensions (because it is not readily measurable). The indicator does include wealth held in defined contribution plans, such as 401(k) plans, and in Individual Retirement Accounts (IRAs), however.
- ⁸ The poverty index was originally based on food consumption, which was thought to be one-third of family

budgets, but because older people consumed less, their poverty thresholds were accordingly lower.

⁹ This is a change from the indicator we used in last year's report, which was simply one minus the unemployment rate. Because the latter is measured as a percentage of those in the labor force, our measure of employment was very high—between 95 and 96 percent of those actually in the labor market. We have moved to the official definition of employment, which is based on the total population. Therefore the percentages are substantially lower than a year ago.

¹⁰ AARP, *Baby Boomers Envision Retirement II* (2004).

¹¹ Ofstedal, Mary Beth, et al. *A Comparison of Self-Assessed Health Expectancy Among Older Adults in Several Asian Settings*, unpublished draft paper prepared for presentation at the 2002 meeting of the Gerontological Society of America. Abstract available on the web at www.gsa-tag.org/2002/2SRH.PDF.

¹² Office of Public Health and Science, U.S. Department of Health and Human Services, *Healthy People 2010 Objectives: Draft for Public Comment*, September 15, 1998.

¹³ Beneficiaries who were enrolled in the program for only part of the year (i.e., people who entered the program because of age or disability status or who died during the year) are counted as not having full-year coverage, regardless of whether or not they had drug coverage during the entire time that they were enrolled in Medicare. As a result, these estimates may understate the share of Medicare beneficiaries with coverage during the full year.

1995 estimates by age as well as 2000 and 2001 estimates for the under age

65 population were not included due to time limitations either in accessing data that are archived (i.e., 1995) or in exploring possible anomalies in the data (i.e., a reported six percentage point increase between 2000 and 2001 in the share of under-65 beneficiaries who had full-year drug coverage, which is not consistent with other evidence about drug coverage among this population).

¹⁴ 1993 data for this measure are available (i.e., 86.6 percent of this population had health insurance) but are not directly comparable to 2003 data because insurance status in 1993 was estimated using a different method than in 2003. Specifically, the March 2000 Current Population Survey (CPS) added a health insurance “verification” question that has remained in subsequent surveys. Therefore, comparability with 2003 is only possible beginning in 1999.

¹⁵ National Institute of Mental Health, “Older Adults: Depression and Suicide Facts,” NIH Publication No. 03-4593, Revised May 2003. Accessed October 31, 2004 at <http://www.nimh.nih.gov/publicat/elderlydepsuicide.cfm>.

¹⁶ National Institute of Mental Health, “Depression,” Updated August 17, 2004. Accessed October 31, 2004 at <http://www.nimh.nih.gov/healthinformation/depressionmenu.cfm>.

¹⁷ Necessities are defined as food, housing, health care, and utilities, and non-necessities represent the difference between total expenditures and expenditures on necessities. This measure suggests the degree of flexibility or “slack” in family budgets, which provides a sense of security and reduces anxiety. It also provides greater ability to save for emergencies, for long-term investments such as children's education and retirement.

- ¹⁸ Personal care needs include eating, bathing, dressing, and getting around inside the house; Routine needs include everyday household chores, doing necessary business, shopping, and getting around for other purposes.
- ¹⁹ See endnote 5.
- ²⁰ The questions asked in 2003 and 2004 were similar but not the same. Hence differences between the two years may be due to differences in the questions—see endnote 5.
- ²¹ Stephen Heffler, et al. February 11, 2004. “Health Spending Projections Through 2013.” *Health Affairs* Web Exclusive.
- ²² Ibid.
- ²³ Kaiser Family Foundation and HRET, *Employer Health Benefits: 2004 Annual Survey*.
- ²⁴ Ibid. A large employer is defined as having 200 or more workers.
- ²⁵ Gruber, J. and Madrian, B. *Health Insurance, Labor Supply, and Job Mobility: A Critical Review of the Literature*, NBER Working Paper 8817, 2002.
- ²⁶ U.S. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States; 2003*, Table C-1.
- ²⁷ Institute of Medicine, *Care Without Coverage: Too Little, Too Late*, Washington, D.C., 2002, pp.81–82.
- ²⁸ Medicare Payment Advisory Commission. March 2004. *Report to the Congress: Medicare Payment Policy*.
- ²⁹ Kaiser Family Foundation/Agency for Healthcare Research and Quality/Harvard School of Public Health, *National Survey on Consumers’ Experiences with Patient Safety and Quality Information*, November 2004.
- ³⁰ Ibid.
- ³¹ Ibid.
- ³² Ibid.
- ³³ Employee Benefit Research Institute and Mathew Greenwald & Associates, 2004 Health Confidence Survey, November 2004.
- ³⁴ Ibid.
- ³⁵ Ibid.
- ³⁶ Kaiser Family Foundation/Agency for Healthcare Research and Quality/Harvard School of Public Health, *National Survey on Consumers’ Experiences with Patient Safety and Quality Information*, November 2004.
- ³⁷ Ibid.
- ³⁸ Stone, E., Jerilyn Heinold, Lydia Ewing, and Stephen Schoenbaum. *Accessing Physician Information on the Internet*, The Commonwealth Fund, Field Report, January 2002.
- ³⁹ Kaiser Family Foundation/Agency for Healthcare Research and Quality/Harvard School of Public Health, *National Survey on Consumers’ Experiences With Patient Safety and Quality Information*, November 2004.

AARP is a nonprofit, nonpartisan membership organization that helps people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We produce *AARP The Magazine*, published bimonthly; *AARP Bulletin*, our monthly newspaper; *AARP Segunda Juventud*, our bimonthly magazine in Spanish and English; *NRTA Live & Learn*, our quarterly newsletter for 50+ educators; and our Web site, www.aarp.org. AARP Foundation is our affiliated charity that provides security, protection, and empowerment to older persons in need with support from thousands of volunteers, donors, and sponsors. We have staffed offices in all 50 states, the District of Columbia, Puerto Rico, and the U.S. Virgin Islands.



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