

# Health Care

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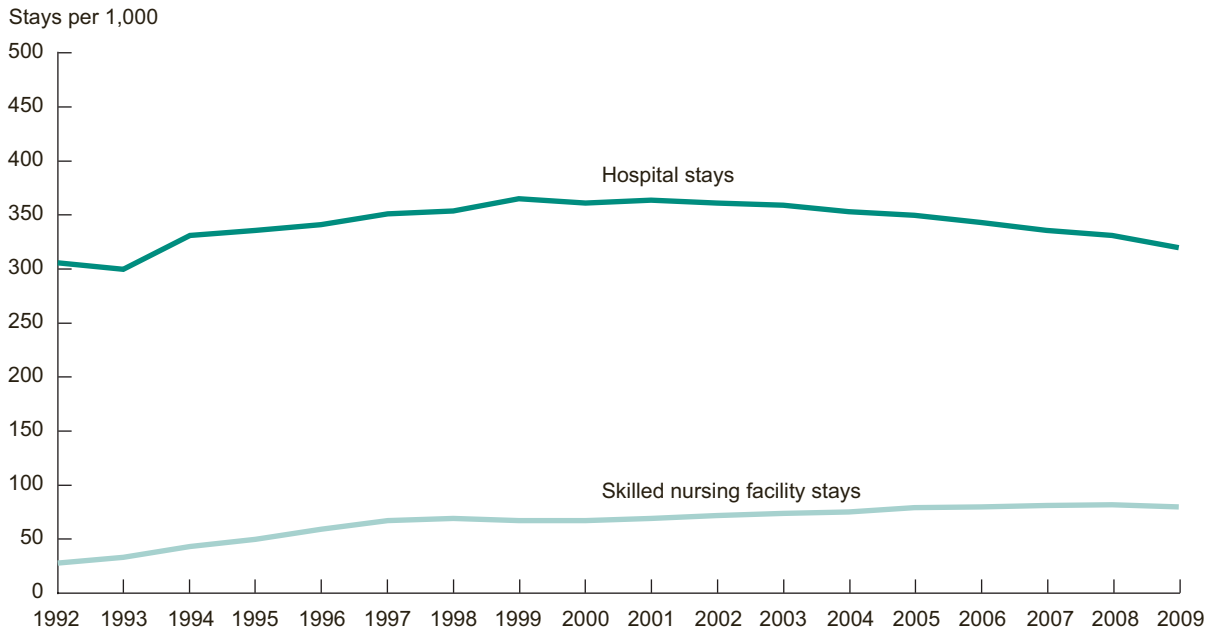
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## INDICATOR 29 Use of Health Care Services

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

### Medicare-covered hospital and skilled nursing facility stays per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992–2009



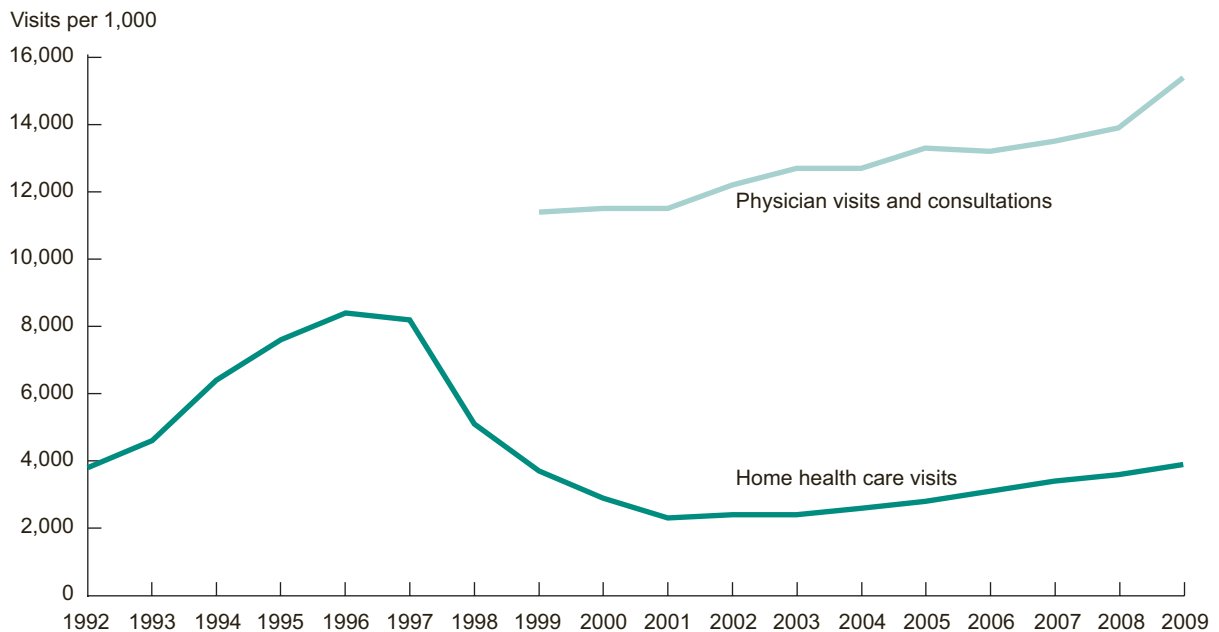
NOTE: Data are for Medicare enrollees in fee-for-service only. Beginning in 1994, managed care enrollees were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care enrollees were included in the denominators; they comprised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

Reference population: These data refer to Medicare enrollees.

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

- Between 1992 and 1999, the hospitalization rate increased from 306 hospital stays per 1,000 Medicare enrollees to 365 per 1,000. The rate then decreased to 320 per 1,000 enrollees in 2009. The average length of a hospital stay decreased from 8.4 days in 1992 to 5.4 days in 2009.
- Skilled nursing facility stays increased significantly from 28 per 1,000 Medicare enrollees in 1992 to 80 per 1,000 in 2009. Much of the increase occurred from 1992 to 1997.

## Medicare-covered physician and home health care visits per 1,000 Medicare enrollees age 65 and over in fee-for-service, 1992–2009



NOTE: Data are for Medicare enrollees in fee-for-service only. Physician visits and consultations include all settings, such as physician offices, hospitals, emergency rooms, and nursing homes. The data base used to generate rates of physician visits and consultations in previous *Older American* reports is no longer available. This chart uses a different data base that begins with 1999 data and yields slightly different rates. Therefore, this chart uses the new data base to estimate rates of physician visits and consultations for all years between 1999 and 2009 to get a consistently defined trend. Beginning in 1994, managed care enrollees were excluded from the denominator of all utilization rates because utilization data are not available for them. Prior to 1994, managed care enrollees were included in the denominators; they comprised 7 percent or less of the Medicare population.

Reference population: These data refer to Medicare enrollees.

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

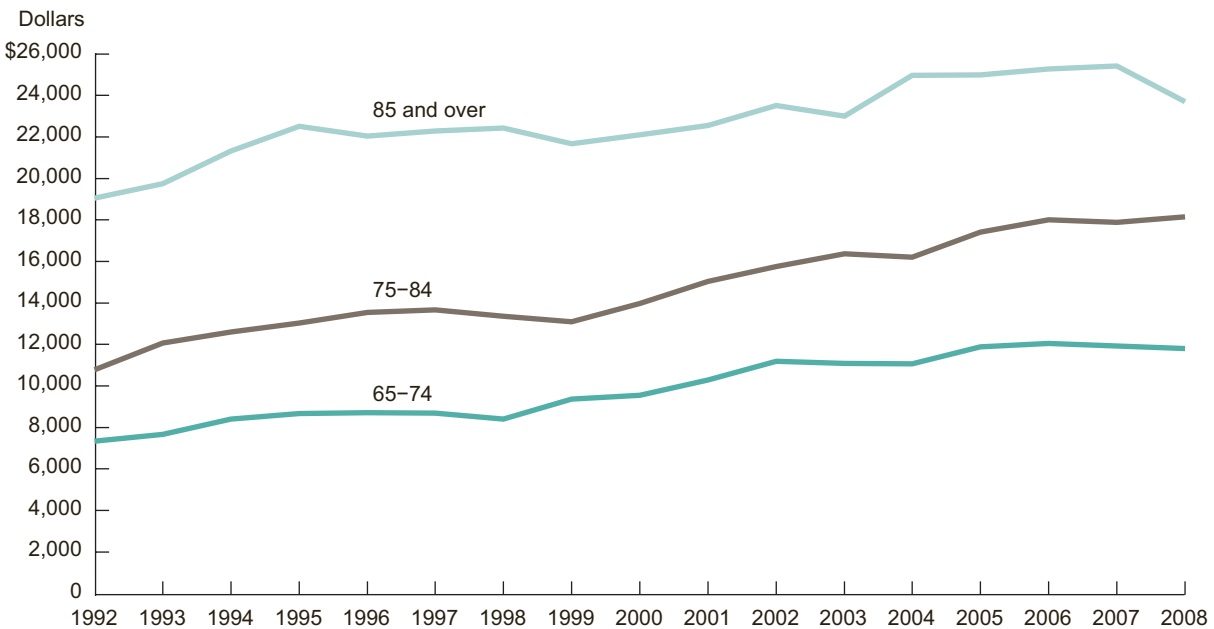
- The number of physician visits and consultations increased from 11,395 per 1,000 Medicare enrollees in 1999 to 15,437 per 1,000 in 2009.
- The number of home health care visits per 1,000 Medicare enrollees increased from 3,822 in 1992 to 8,376 in 1996. Home health care use increased during this period in part because of an expansion in the coverage criteria for the Medicare home health care benefit.<sup>35</sup> Home health care visits declined after 1997 to 2,295 per 1,000 enrollees in 2001. The decline coincided with changes in Medicare payment policies for home health care resulting from implementation of the Balanced Budget Act of 1997. The visit rate increased thereafter to 3,864 per 1,000 enrollees in 2009.
- Use of skilled nursing facility and home health care increased with age. In 2009, there were about 33 skilled nursing facility stays per 1,000 Medicare enrollees age 65–74, compared with about 222 per 1,000 enrollees age 85 and over. Home health care agencies made 1,896 visits per 1,000 enrollees age 65–74, compared with 8,974 per 1,000 for those age 85 and over.

*Data for this indicator's charts and bullets can be found in Tables 29a and 29b on page 134.*

## INDICATOR 30 Health Care Expenditures

Older Americans use more health care per capita than any other age group. Health care costs per capita are increasing at the same time the “Baby Boom” generation is approaching retirement age.

**Average annual health care costs for Medicare enrollees age 65 and over, by age group, 1992–2008**



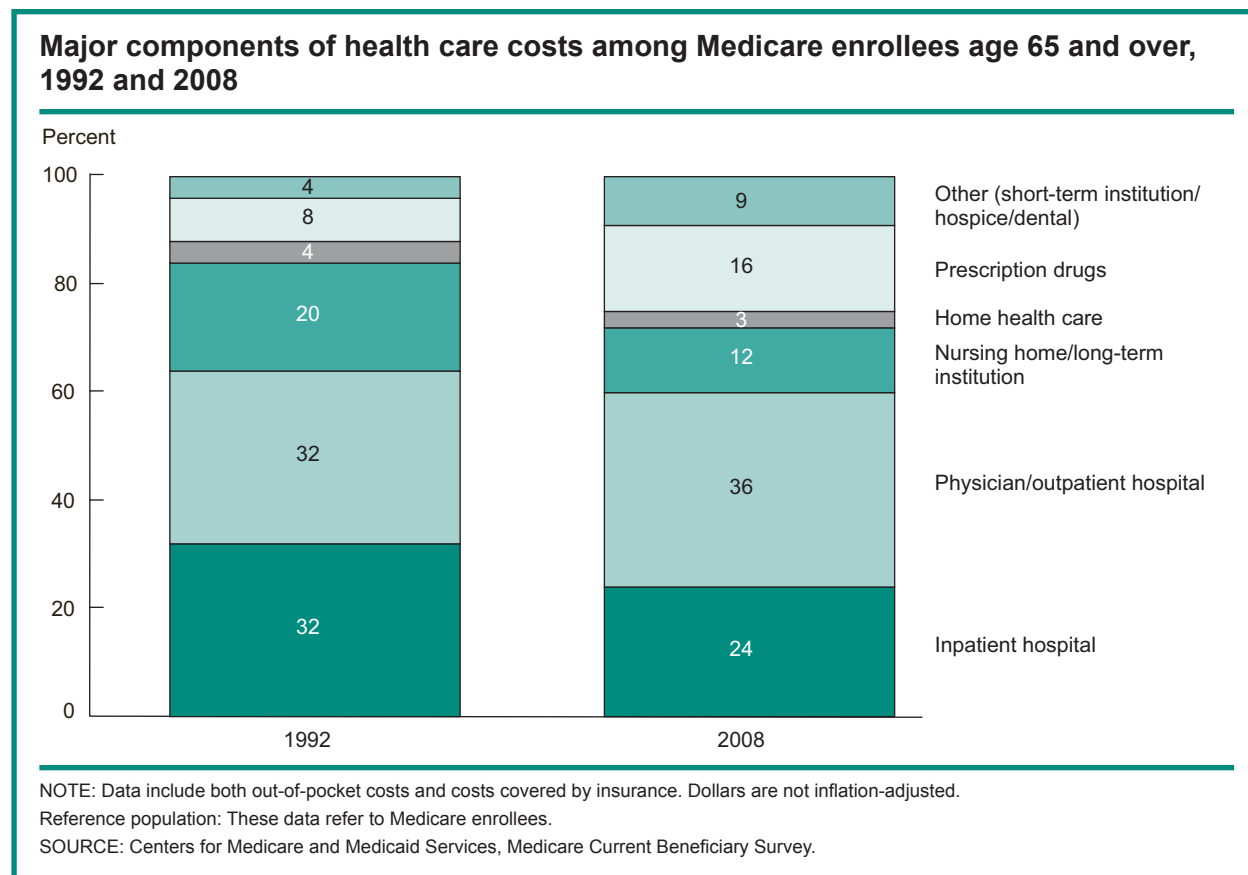
NOTE: Data include both out-of-pocket costs and costs covered by insurance. Dollars are inflation-adjusted to 2008 using the Consumer Price Index (Series CPI-U-RS).

Reference population: These data refer to Medicare enrollees.

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

- After adjusting for inflation, health care costs increased significantly among older Americans between 1992 and 2006, but did not increase in 2007 or 2008. Average costs were substantially higher at older ages.
- Average health care costs varied by demographic characteristics. Average costs among non-Hispanic Blacks were \$19,839 in 2008, compared with \$15,362 among Hispanics. Low-income individuals incurred higher health care costs; those with less than \$10,000 in income averaged \$21,924 in health care costs whereas those with more than \$30,000 in income averaged only \$13,149.
- Costs also varied by health status. Individuals with no chronic conditions incurred \$5,520 in health care costs on average. Those with five or more conditions incurred \$24,658. Average costs among residents of long-term care facilities were \$61,318, compared with only \$13,150 among community residents.
- Access to health care is determined by a variety of factors related to the cost, quality, and availability of health care services. The percentage of older Americans who reported they delayed getting care because of cost declined from about 10 percent in 1992 to about 5 percent in 1997 and remained relatively constant thereafter. The percentage who reported difficulty obtaining care varied between 2 and 3 percent.

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



- Hospital and physician services are the largest components of health care costs. Long-term care facilities accounted for 12 percent of total costs in 2008. Prescription drugs accounted for 16 percent of health care costs.
- The mix of health care services changed between 1992 and 2008. Inpatient hospital care accounted for a lower share of costs in 2008 (24 percent compared with 32 percent in 1992). Prescription drugs increased in importance from 8 percent of costs in 1992 to 16 percent in 2008. “Other” costs (short-term institutions, hospice and dental care)

also increased as a percentage of all costs (4 percent to 9 percent).

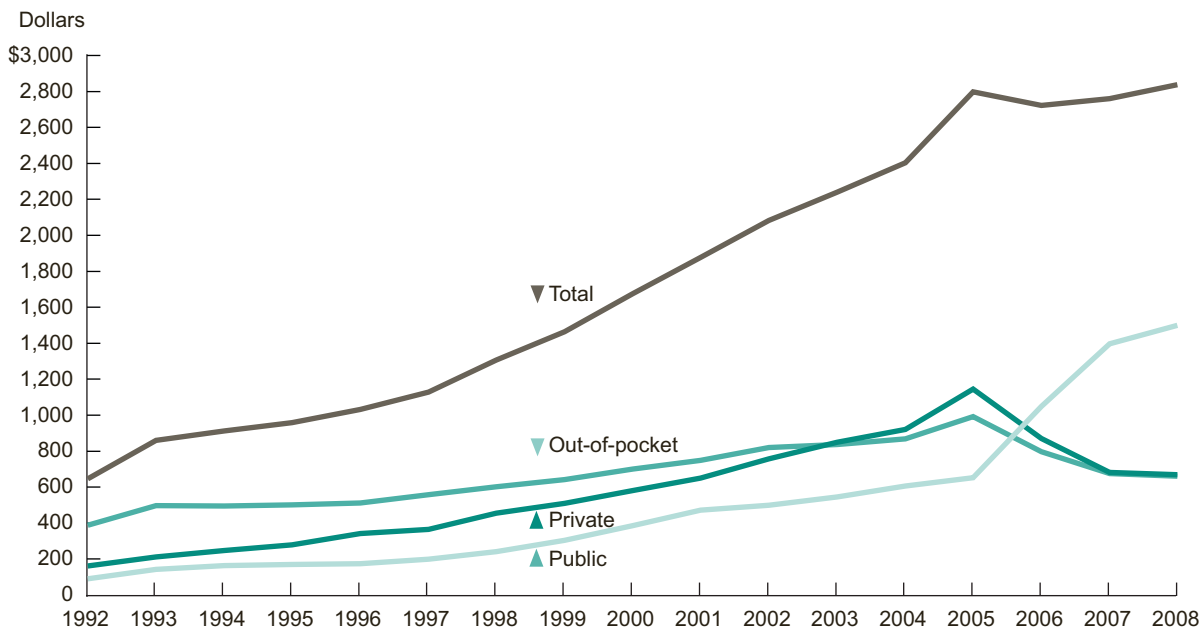
- The mix of services varied with age. The biggest difference occurred for long-term care facility services; average costs were \$6,594 among people age 85 and over, compared with just \$526 among those age 65–74. Costs of home health care and “other” services also were higher at older ages.

*Data for this indicator’s charts and bullets can be found in Tables 30a through 30e on pages 135–137.*

## INDICATOR 31 Prescription Drugs

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

### Average prescription drug costs among noninstitutionalized Medicare beneficiaries age 65 and over, by sources of payment, 1992–2008



NOTE: Dollars have been inflation-adjusted to 2008 using the Consumer Price Index (Research Series). Reported costs have been adjusted to account for underreporting of prescription drug use. The adjustment factor changed in 2006 with the initiation of the Medicare Part D prescription drug program. Public programs include Medicare, Medicaid, Department of Veterans Affairs, and other State and Federal programs.

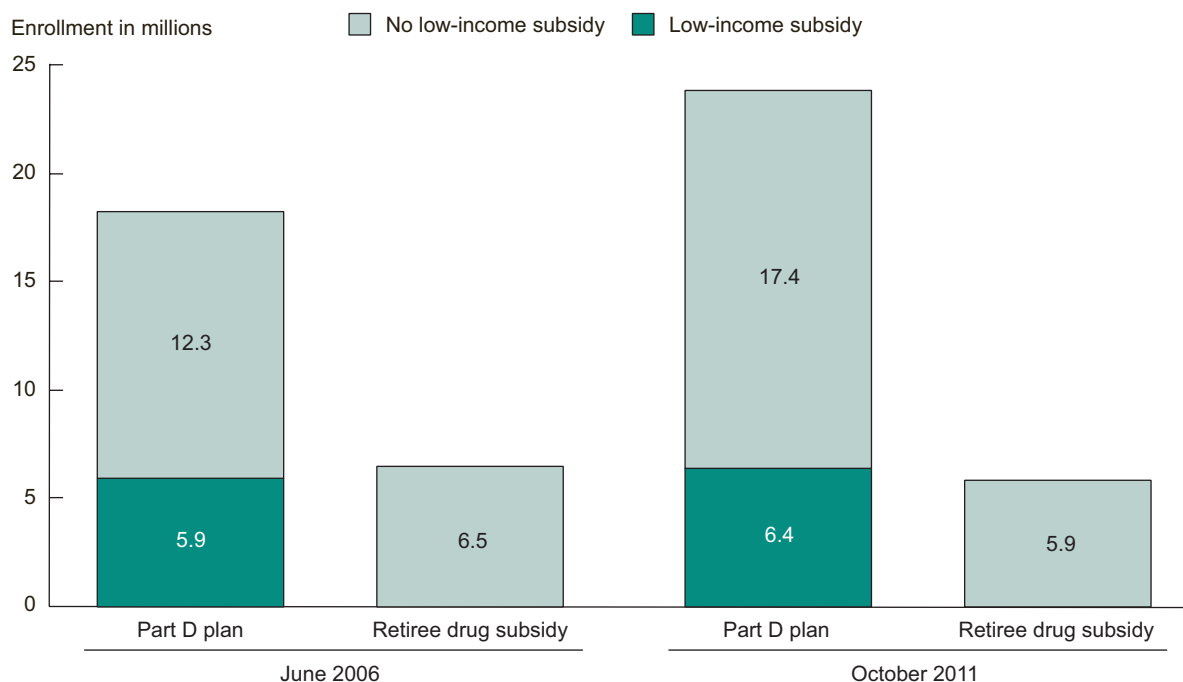
Reference population: These data refer to Medicare beneficiaries.

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

- Average prescription drug costs for older Americans increased rapidly for many years but were relatively stable from 2005 to 2008. Average costs per person were \$2,834 in 2008.
- Average out-of-pocket costs and costs covered by private insurance decreased after the introduction of the Medicare Part D prescription drug program in 2006. There was a corresponding increase in drug costs covered by public insurance. Older Americans paid 60 percent of prescription drug costs out-of-pocket in 1992, compared with 23 percent in 2008. Private insurance covered 24 percent of prescription drug costs in 2008; public programs covered 53 percent.
- Costs varied significantly among individuals. Approximately 6 percent of older Americans incurred no prescription drug costs in 2008. About 15 percent incurred \$5,000 or more in prescription drug costs that year.
- Chronic conditions are associated with high prescription drug costs. In 2008, older Americans with no chronic conditions incurred average prescription drug costs of \$1,230. Those with five or more chronic conditions incurred \$5,300 in prescription drug costs on average.

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

### Number of Medicare beneficiaries age 65 and over who enrolled in Part D prescription drug plans or who were covered by retiree drug subsidy payments, June 2006 and October 2011



Reference population: These data refer to Medicare beneficiaries.

SOURCE: Centers for Medicare and Medicaid Services, Management Information Integrated Repository.

- The number of Medicare beneficiaries enrolled in Part D prescription drug plans increased from 18.2 million (51 percent of beneficiaries) in June 2006 to 23.8 million (58 percent of beneficiaries) in October 2011. In October 2011, 60 percent of plan enrollees were in stand-alone plans and 40 percent were in Medicare Advantage plans. Approximately 5.9 million beneficiaries were covered by the retiree drug subsidy. Eleven million beneficiaries who were not in Part D plans and not covered by the retiree drug subsidy either had drug coverage through another source (e.g., TRICARE, Federal Employees

Health Benefits plan, Department of Veterans' Affairs, current employer) or did not have drug coverage.

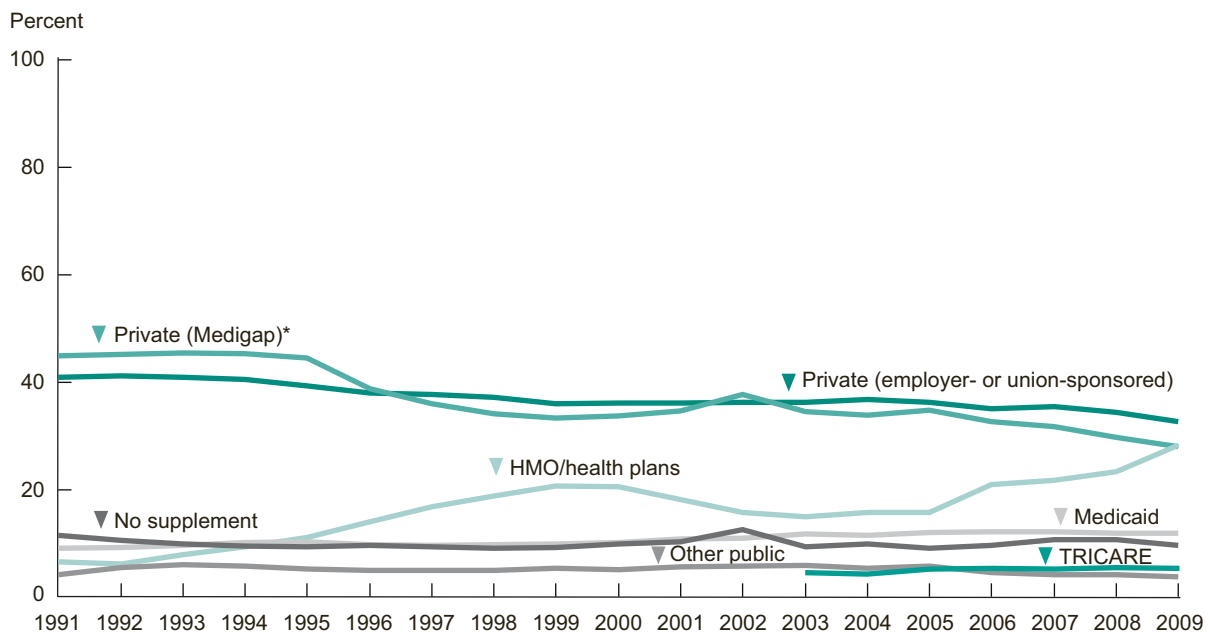
- In October 2011, 6.4 million Part D enrollees were receiving low-income subsidies. Many of these beneficiaries had drug coverage through the Medicaid program prior to enrollment in Part D.

*Data for this indicator's charts and bullets can be found in Tables 31a through 31d on pages 138–139.*

## INDICATOR 32 Sources of Health Insurance

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

**Percentage of noninstitutionalized Medicare enrollees age 65 and over with supplemental health insurance, by type of insurance, 1991–2009**



\* Includes people with private supplement of unknown sponsorship.

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

Reference population: These data refer to Medicare enrollees.

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

- Most Medicare enrollees have a private insurance supplement, either provided by a former employer or purchased as a Medigap policy. The percentage with Medicaid coverage has increased from 10 percent in 2000 to 12 percent in 2009. Between 1991 and 2009, enrollment in Medicare HMOs and other health plans, which are usually equivalent to Medicare supplements because they offer extra benefits, varied between 6 percent and 28 percent. About 9 percent of Medicare enrollees reported having no health insurance supplement in 2009.
- While almost all older Americans have health insurance via Medicare, a significant proportion of people younger than age 65 have no health insurance. In 2010, about 13 percent of people age 55–64 were uninsured. The percentage of people not covered by health insurance varied by poverty status. In 2010, about 31 percent of people age 55–64 who lived either below the poverty level or below 200 percent of the poverty threshold had no health insurance compared with 7 percent of people who had incomes greater than or equal to 200 percent of the poverty threshold.

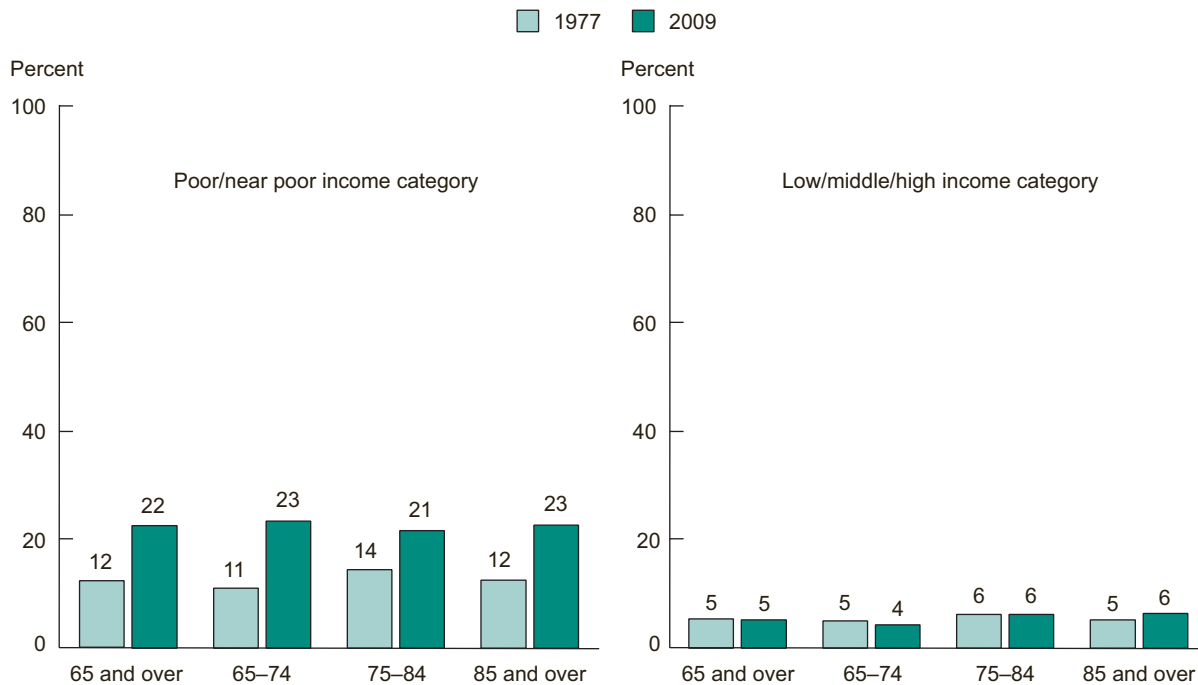
*Data for this indicator's charts and bullets can be found in Tables 32a and 32b on page 140.*



## INDICATOR 33 Out-of-Pocket Health Care Expenditures

Large out-of-pocket expenditures for health care service use have been shown to encumber access to care, affect health status and quality of life, and leave insufficient resources for other necessities.<sup>36,37</sup> The percentage of household income that is allocated to health care expenditures is a measure of health care expense burden placed on older people.

**Out-of-pocket health care expenditures as a percentage of household income, among people age 65 and over, by age group and income category, 1977 and 2009**



NOTE: Out-of-pocket health care expenditures exclude personal spending for health insurance premiums. Including expenditures for out-of-pocket premiums in the estimates of out-of-pocket spending would increase the percentage of household income spent on health care. People are classified into the "poor/near poor" income category if their household income is below 125 percent of the poverty level; otherwise, people are classified into the "low/middle/high" income category. The poverty level is calculated according to the U.S. Census Bureau guidelines for the corresponding year. The ratio of a person's out-of-pocket expenditures to their household income was calculated based on the person's per capita household income. For people whose ratio of out-of-pocket expenditures to income exceeded 100 percent, the ratio was capped at 100 percent. For people with out-of-pocket expenditures and with zero income (or negative income) the ratio was set at 100 percent. For people with no out-of-pocket expenditures the ratio was set to zero. These methods differ from what was used in *Older Americans 2004*, which excluded persons with no out-of-pocket expenditures from the calculations (17 percent of the population 65 and over in 1977, and 4.5 percent of the population age 65 and over in 2004).

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

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

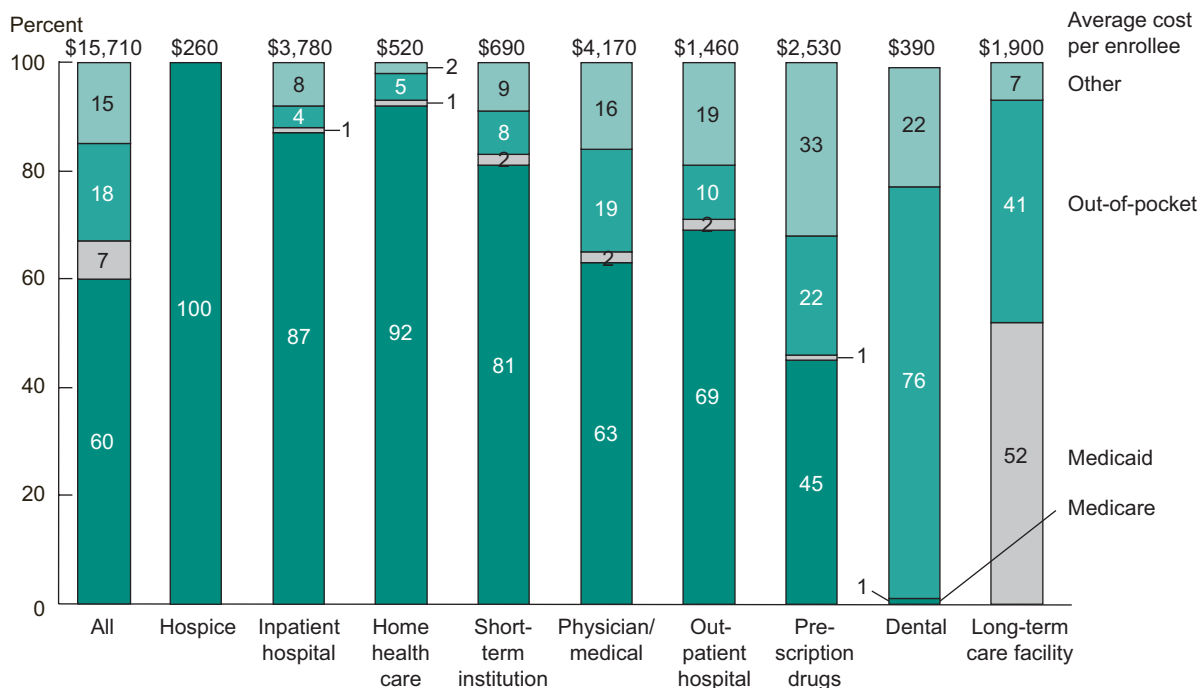
- The percentage of people age 65 and over with out-of-pocket spending for health care services increased between 1977 and 2009 (from 83 percent to 94 percent).
- From 1977 to 2009 the percentage of household income that people age 65 and over allocated to out-of-pocket spending for health care services increased among those in the poor/near poor income category from 12 percent to 22 percent, whereas for the low/middle/high income category the percentages were lower (5 percent) for both years.
- In 2009, over two-fifths (41 percent) of out-of-pocket health care spending by people age 65 and over was used to purchase prescription drugs. The percentage of out-of-pocket spending for prescription drugs increased from 2000 to 2004 (54 percent to 61 percent, respectively) and then decreased starting in 2005.
- In 2009, people age 85 and over spent a lower proportion of out-of-pocket dollars than people age 65-74 on dental services, office-based medical provider visits, and prescription drugs but a higher proportion on hospital care and other health care (primarily home health care).

Data for this indicator's charts and bullets can be found in Tables 33a through 33c on pages 141-145.

## INDICATOR 34 Sources of Payment for Health Care Services

Medicare covers a little over one-half of the total health care costs of Medicare enrollees age 65 and over. Medicare's payments are focused on acute care services such as hospitals and physicians. Historically, nursing home care, prescription drugs, and dental care have been primarily financed out-of-pocket or by other payers. Medicare coverage of prescription drugs began in January 2006, including a low-income subsidy.

**Sources of payment for health care services for Medicare enrollees age 65 and over, by type of service, 2008**



NOTE: "Other" refers to private insurance, Department of Veterans Affairs, and other public programs.

Reference population: These data refer to Medicare enrollees.

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

- Medicare paid for 60 percent of the health care costs of Medicare enrollees age 65 and over in 2008. Medicare financed all of their hospice costs and most hospital, physician, home health care, and short-term institution costs.
- Medicaid covered 7 percent of health care costs of Medicare enrollees age 65 and over, and other payers (primarily private insurers) covered another 15 percent. Medicare enrollees age 65 and over paid 18 percent of their health care costs out-of-pocket, not including insurance premiums.
- In 2008, about 52 percent of long-term care facility costs for Medicare enrollees age 65 and over were covered by Medicaid; another 41 percent of these costs were paid out-of-pocket. Forty-five percent of prescription drug costs for Medicare enrollees age 65 and over were covered by Medicare, 33 percent

were covered by third-party payers other than Medicare and Medicaid (consisting mostly of private insurers), and 22 percent were paid out-of-pocket. Seventy-six percent of dental care received by older Americans was paid out-of-pocket.

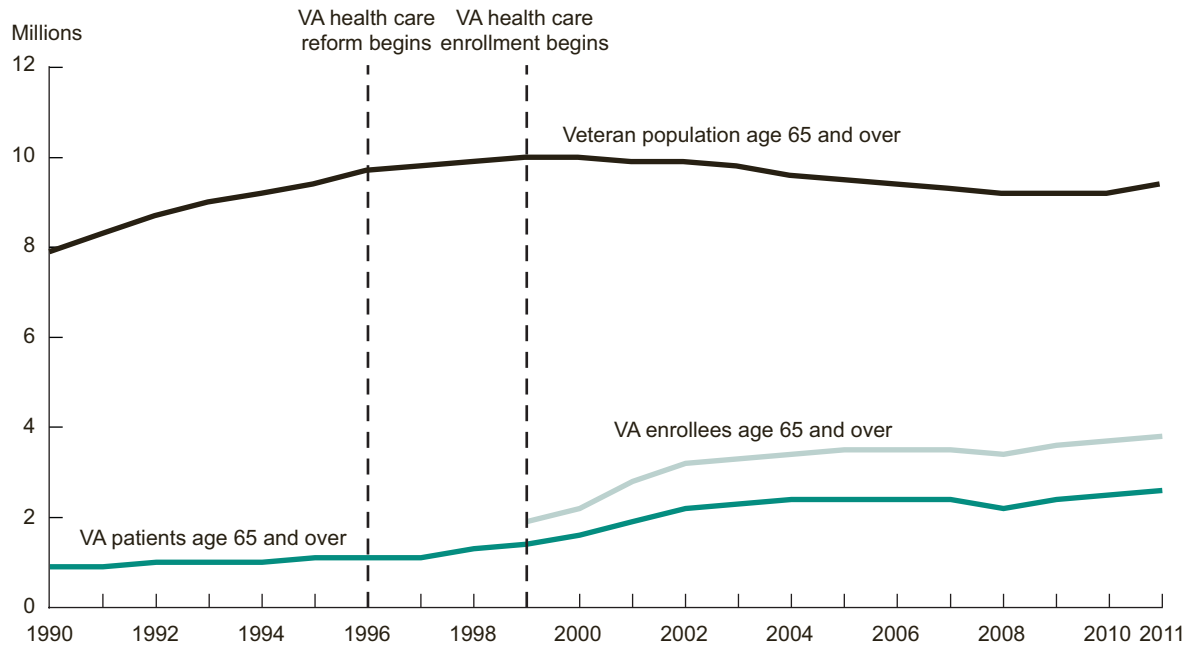
- Other than Medicare, sources of payment for health care varied by income. Individuals with lower incomes relied heavily on Medicaid; those with higher incomes relied more on private insurance. As shown in Indicator 33 (Out-of-Pocket Health Care Expenditures), people in the poor/near poor income category spent a higher percentage of their household income on health care services than people in the low/middle/high income category.

*Data for this indicator's charts and bullets can be found in Tables 34a and 34b on page 146.*

## INDICATOR 35 Veterans' Health Care

The number of veterans age 65 and over who receive health care from the Veterans Health Administration (VHA), within the Department of Veterans Affairs (VA), has been steadily increasing. This increase may be because VHA fills important gaps in older veterans' health care needs not currently covered or fully covered by Medicare such as long-term care (nursing home care for eligible veterans and community-based care for all enrolled veterans) and specialized services for the disabled, including acute mental health services. In addition, as the largest integrated health care system in the country, VHA provides broad geographic access to these important services in rural and highly rural communities.

### Veterans age 65 and over who are enrolled in or are receiving care from the Veterans Health Administration, 1990–2011



NOTE: Department of Veterans Affairs (VA) enrollees are veterans who have signed up to receive health care from the Veterans Health Administration (VHA). VA patients are veterans who have received care each year through VHA, including those who received care but were not enrolled in VA.

Reference population: These data refer to the total veteran population, VHA enrollment population, and VHA patient population.

SOURCE: Department of Veterans Affairs, Veteran Population Projections; Office of the Assistant Deputy Under Secretary for Health for Policy and Planning, Fiscal 2011 Year-end Enrollment file linked with VHA Vital Status data (including data from VA, Medicare, and SSA).

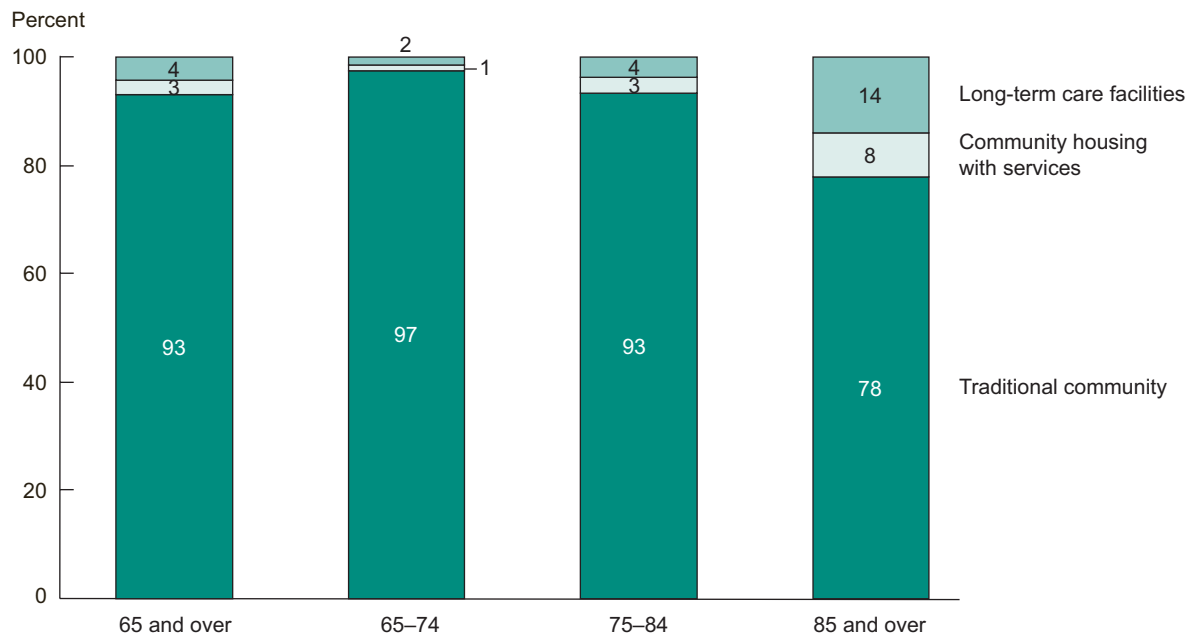
- In 2011, approximately 2.6 million veterans age 65 and over received health care from the VHA. An additional 1.2 million older veterans were enrolled to receive health care from the VHA but did not use its services in 2011.
- Older veterans continue to turn to VHA for their health care needs, despite their eligibility for other sources of health care. VHA estimates that about 38 percent of its enrollees age 65 and over are enrolled in Medicare Part D. Approximately 23 percent of enrollees age 65 and over have some form of private insurance. About 15 percent are enrolled in TRICARE for Life, and 14 percent are eligible for Medicaid. In contrast, about 5 percent of VHA enrollees age 65 and over report having no other public or private coverage.<sup>38</sup>
- In rural and highly rural areas, the number of VHA enrollees age 65 and over has increased to about 47 percent of all enrollees. About 70 percent of older enrollees in these areas used VHA health care in 2011. To further enable veterans to receive quality health care services within or near their home communities, VHA has expanded Home-Based Primary Care, telehealth and mobile clinic services, transportation and outreach services, and Project Access Received Closer to Home (ARCH).

*Data for this indicator's charts and bullets can be found in Table 35 on page 147.*

## INDICATOR 36 Residential Services

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

**Percentage of Medicare enrollees age 65 and over in selected residential settings, by age group, 2009**



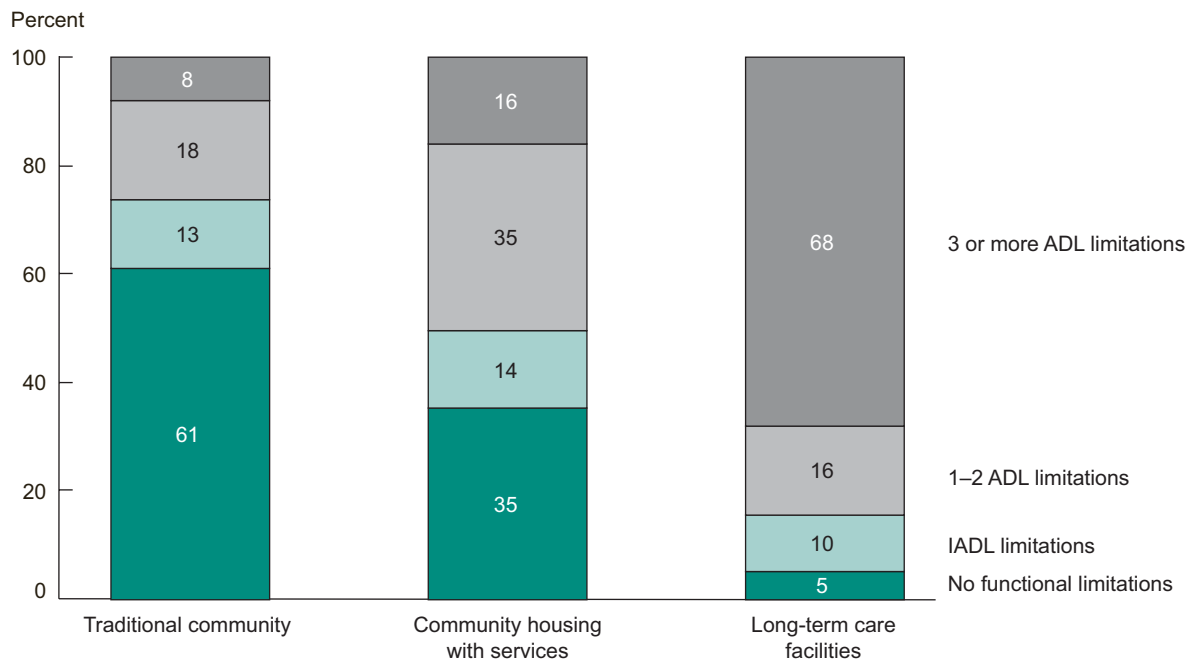
NOTE: Community housing with services applies to respondents who reported they lived in retirement communities or apartments, senior citizen housing, continuing care retirement facilities, assisted living facilities, staged living communities, board and care facilities/homes, and similar situations,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

Reference population: These data refer to Medicare beneficiaries.

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

- In 2009, about 3 percent of the Medicare population age 65 and over resided in community housing with at least one service available. Four percent resided in long-term care facilities. The percentage of people residing in community housing with services and in long-term care facilities was higher for the older age groups; among individuals age 85 and over, 8 percent resided in community housing with services, and 14 percent resided in long-term care facilities. Among individuals age 65–74, about 97 percent resided in traditional community settings.
- Among residents of community housing with services, 84 percent reported access to meal preparation services; 80 percent reported access to housekeeping/cleaning services; 73 percent reported access to laundry services; and 48 percent reported access to help with medications. These numbers reflect percentages reporting availability of specific services, but not necessarily the number that actually used these services.
- Sixty-two percent of residents in community housing with services reported that there were separate charges for at least some services.

## Percentage of Medicare enrollees age 65 and over with functional limitations, by residential setting, 2009



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

Reference population: These data refer to Medicare beneficiaries.

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

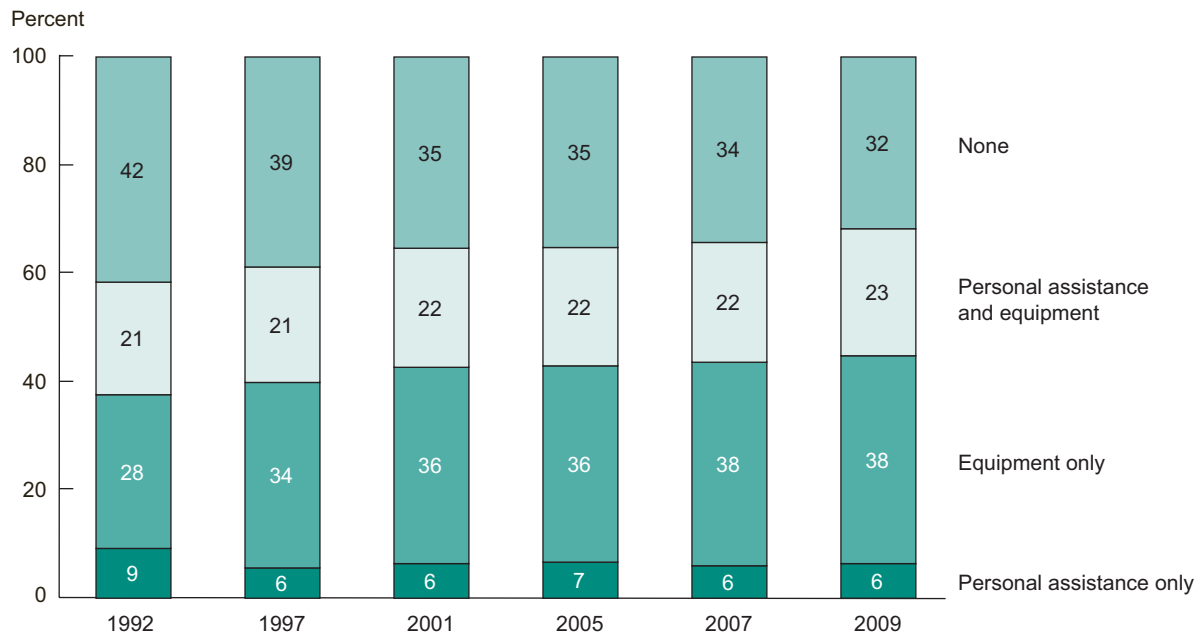
- People living in community housing with services had more functional limitations than traditional community residents, but not as many as those living in long-term care facilities. Fifty-one percent of individuals living in community housing with services had at least one activity of daily living (ADL) limitation compared with 26 percent of traditional community residents. Among long-term care facility residents, 84 percent had at least one ADL limitation. Thirty-five percent of individuals living in community housing with services had no ADL or instrumental activities of daily living (IADL) limitations.
- The availability of personal services in residential settings may explain some of the observed decline in nursing home use.
- Residents of community housing with services tended to have somewhat lower incomes than traditional community residents, and higher incomes than long-term care facility residents. Forty-one percent of long-term care facility residents had incomes of \$10,000 or less in 2009, compared with 11 percent of traditional community residents and 17 percent of residents of community housing with services.
- Over one-half (53 percent) of people living in community housing with services reported they could continue living there if they needed substantial care.

*Data for this indicator's charts and bullets can be found in Tables 36a through 36e on pages 148-149.*

## INDICATOR 37 Personal Assistance and Equipment

As the proportion of the older population residing in long-term care facilities has declined (see “Indicator 20: Functional Limitations”), the use of personal assistance and/or special equipment among those with limitations has increased. This assistance helps older people living in the community maintain their independence.

**Percent distribution of noninstitutionalized Medicare enrollees age 65 and over who have limitations in activities of daily living (ADLs), by types of assistance, selected years 1992–2009**



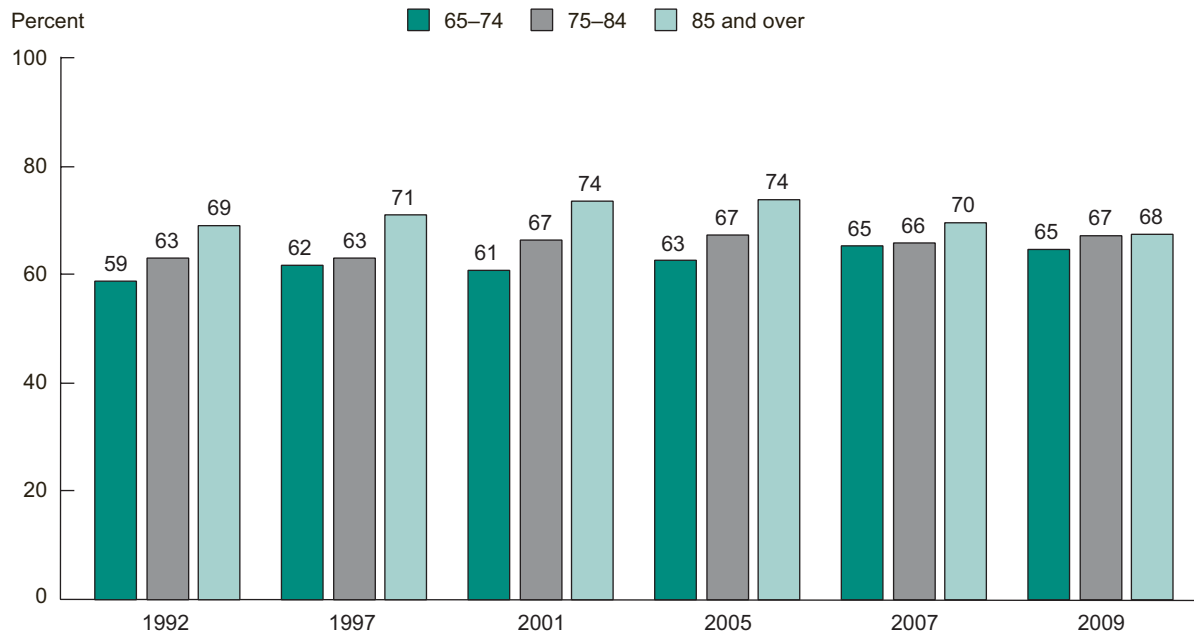
NOTE: ADL limitations refer to difficulty performing (or inability to perform for a health reason) one or more of the following tasks: bathing, dressing, eating, getting in/out of chairs, walking, or using the toilet. Respondents who report difficulty with an activity are subsequently asked about receiving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

Reference population: These data refer to noninstitutionalized Medicare enrollees who have limitations with one or more ADLs.

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

- Between 1992 and 2009, the age-adjusted proportion of people age 65 and over who had difficulty with one or more ADLs and who did not receive personal assistance or use special equipment with these activities decreased from 42 percent to 32 percent. More people were using equipment only—the percentage increased from 28 percent to 38 percent. The percentage of people who used personal assistance only decreased from 9 percent to 6 percent.
- In 2009, slightly more than two-thirds of people who had difficulty with one or more ADLs received personal assistance or used special equipment: 6 percent received personal assistance only, 38 percent used equipment only, and 23 percent used both personal assistance and equipment.
- In 2009, there were no significant differences in the percent of women and men with limitations in ADLs who received personal assistance only. However, men were more likely than women to receive no assistance with their limitations.

**Percentage of noninstitutionalized Medicare enrollees age 65 and over who have limitations in instrumental activities of daily living (IADLs) and who receive personal assistance, by age group, selected years 1992–2009**



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

Reference population: These data refer to noninstitutionalized Medicare enrollees who have limitations with one or more IADLs.

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

- In 1992, persons 85 and over who had difficulty with IADLs were more likely to receive personal assistance than those with IADL limitations, ages 65–74. In 2009, the percentages between these two groups were similar.
- Men age 75–84 were more likely than women of the same age group to receive personal assistance with their IADLs in 2009.
- In 2009, two-thirds of people age 65 and over who had difficulty with one or more IADLs received personal assistance.

*Data for this indicator's charts and bullets can be found in Tables 37a through 37d on page 150.*