Health, United States, 2014

In Brief

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Introduction

Monitoring the health of the American people is an essential step in making sound health policy and setting research and program priorities. In a Chartbook and detailed tables, *Health, United States* provides an annual picture of the health of the entire nation. *Health, United States, 2014*—which includes a Special Feature on Adults Aged 55–64—is the 38th report on the health status of the nation and is submitted by the Secretary of the Department of Health and Human Services to the President and the Congress of the United States in compliance with Section 308 of the Public Health Service Act. This report was compiled by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS).

Health, United States, 2014: In Brief is provided as a companion to the full report. This short report contains summary information on the health of the American people, including mortality and life expectancy, morbidity and risk factors such as cigarette smoking and overweight and obesity, health insurance coverage, access to and utilization of health care, and health expenditures. An At a Glance table and Highlights summarize some of these key indicators at the national level and are followed by 29 figures from *Health, United States, 2014*, that focus on these topics in addition to this year's Special Feature on the health of adults aged 55–64.

The full report—*Health, United States, 2014: With Special Feature on Adults Aged 55–64*—is available at http://www.cdc.gov/nchs/hus.htm. On this website, users can find:

- The full searchable report in PDF format, consisting of a Preface, the At a Glance table and Highlights, the Chartbook with 29 figures including the Special Feature, 123 detailed Trend Tables, Data Sources, Definitions and Methods, and an Index.

- The Chartbook and Trend Tables available as downloadable PDFs and spreadsheet files.

- Additional years of data for selected Trend Tables, in spreadsheet format.

- Updated data for Trend Tables when available.

- Standard errors for selected estimates in the spreadsheets.

- All charts in PowerPoint format.

- Charts and tables conveniently grouped by specific topics, such as older adults, racial and ethnic groups, and state data.

- *Health, United States, 2014: In Brief* in PDF format.

- Previous editions of *Health, United States*, beginning with 1975.

Health, United States, 2014: At a Glance

	Value (year)			Health, United States, 2014 Figure/Table No.
Life Expectancy and Mortality				
Life Expectancy, in years				Table 16
At birth	76.8 (2000)	78.8 (2012)	78.8 (2013)	
Infant deaths per 1,000 live births				Figure 2/Table 12
All infants	6.91 (2000)	5.98 (2012)	5.96 (2013)	
Deaths per 100,000 population, age-adjusted				Table 18
All causes	869.0 (2000)	732.8 (2012)	731.9 (2013)	
Heart disease	257.6 (2000)	170.5 (2012)	169.8 (2013)	
Cancer	199.6 (2000)	166.5 (2012)	163.2 (2013)	
Chronic lower respiratory diseases	44.2 (2000)	41.5 (2012)	42.1 (2013)	
Unintentional injuries	34.9 (2000)	39.1 (2012)	39.4 (2013)	
Stroke	60.9 (2000)	36.9 (2012)	36.2 (2013)	
Alzheimer's disease	18.1 (2000)	23.8 (2012)	23.5 (2013)	
Diabetes	25.0 (2000)	21.2 (2012)	21.2 (2013)	
Influenza and pneumonia	23.7 (2000)	14.4 (2012)	15.9 (2013)	
Nephritis, nephrotic syndrome and nephrosis	13.5 (2000)	13.1 (2012)	13.2 (2013)	
Suicide	10.4 (2000)	12.6 (2012)	12.6 (2013)	
Morbidity and Risk Factors				
Fair or poor health, percent				Table 50
All ages	8.9 (2000)	10.3 (2012)	10.2 (2013)	
65 years and over	26.9 (2000)	22.7 (2012)	23.1 (2013)	
Heart disease (ever told), percent				Table 42
18 years and over	11.3 (2000–2001)	11.6 (2010–2011)	11.4 (2012–2013)	
65 years and over	30.9 (2000–2001)	30.5 (2010–2011)	29.8 (2012–2013)	
Cancer (ever told), percent				Table 42
18 years and over	5.0 (2000–2001)	6.3 (2010–2011)	6.4 (2012–2013)	
65 years and over	15.2 (2000–2001)	18.5 (2010–2011)	18.4 (2012–2013)	
Hypertension,[1] percent				Table 60
20 years and over	30.2 (1999–2002)	32.1 (2003–2006)	32.2 (2009–2012)	
Diabetes,[2] percent				Table 44
20 years and over	9.8 (1999–2002)	10.9 (2003–2006)	12.3 (2009–2012)	
Hypercholesterolemia,[3] percent				Table 61
20 years and over	25.0 (1999–2002)	28.0 (2003–2006)	29.5 (2009–2012)	
Obese, percent				Figure 10/ Tables 64 and 65
Obese,[4] 20 years and over	30.5 (1999–2002)	33.5 (2003–2006)	35.5 (2009–2012)	
Obese (BMI at or above sex- and age-specific 95th percentile):				
2–5 years	10.3 (1999–2002)	12.5 (2003–2006)	10.2 (2009–2012)	
6–11 years	15.9 (1999–2002)	17.0 (2003–2006)	17.9 (2009–2012)	
12–19 years	16.0 (1999–2002)	17.6 (2003–2006)	19.4 (2009–2012)	
Cigarette smoking, percent				Table 52
18 years and over	23.2 (2000)	18.1 (2012)	17.8 (2013)	
Aerobic activity and muscle strengthening,[5] percent meeting both guidelines				
18 years and over	15.1 (2000)	20.3 (2012)	20.4 (2013)	Table 63

[1]Having measured high blood pressure (systolic pressure of at least 140 mm Hg or diastolic pressure of at least 90 mm Hg) and/or respondent report of taking antihypertensive medication.

[2]Includes physician-diagnosed and undiagnosed diabetes (fasting plasma glucose of at least 126 mg/dL or a hemoglobin A1c of at least 6.5%).

[3]Having high serum total cholesterol of 240 mg/dL or greater and/or respondent report of taking cholesterol-lowering medication.

[4]Obesity is a body mass index (BMI) greater than or equal to 30 for adults. Height and weight are measured rather than self-reported.

[5]Federal guidelines recommend at least 150 minutes of moderate-intensity or 75 minutes of vigorous-intensity aerobic physical activity a week and muscle-strengthening activities at least twice a week.

	Value (year)			Health, United States, 2014 Figure/Table No.
Health Care Utilization				
No health care visit in past 12 months, percent				Table 71
Under 18 years	12.3 (2000)	8.1 (2012)	8.2 (2013)	
18–44 years	23.4 (2000)	24.7 (2012)	24.8 (2013)	
45–64 years	14.9 (2000)	15.1 (2012)	15.2 (2013)	
65 years and over	7.4 (2000)	6.1 (2012)	6.4 (2013)	
Emergency room visit in past 12 months, percent				Tables 79 and 80
Under 18 years	20.3 (2000)	17.8 (2012)	17.6 (2013)	
18–44 years	20.5 (2000)	19.4 (2012)	18.5 (2013)	
45–64 years	17.6 (2000)	18.0 (2012)	17.6 (2013)	
65 years and over	23.7 (2000)	22.2 (2012)	21.3 (2013)	
Dental visit in past year, percent				Table 84
2–17 years	74.1 (2000)	82.3 (2012)	83.0 (2013)	
18–64 years	65.1 (2000)	61.6 (2012)	61.7 (2013)	
65 years and over	56.6 (2000)	61.8 (2012)	60.6 (2013)	
Prescription drug in past 30 days, percent				Table 85
Under 18 years	20.5 (1988–1994)	23.8 (1999–2002)	23.5 (2009–2012)	
18–44 years	31.3 (1988–1994)	35.9 (1999–2002)	38.1 (2009–2012)	
45–64 years	54.8 (1988–1994)	64.1 (1999–2002)	67.2 (2009–2012)	
65 years and over	73.6 (1988–1994)	84.7 (1999–2002)	89.8 (2009–2012)	
Hospitalization in past year, percent				Table 87
18–44 years	7.0 (2000)	6.1 (2012)	6.1 (2013)	
45–64 years	8.4 (2000)	8.0 (2012)	7.8 (2013)	
65 years and over	18.2 (2000)	15.9 (2012)	15.3 (2013)	
Health Insurance and Access to Care				
Uninsured, percent				Table 114
Under 65 years	17.0 (2000)	16.9 (2012)	16.7 (2013)	
Under 18 years	12.6 (2000)	6.6 (2012)	6.6 (2013)	
18–44 years	22.4 (2000)	24.8 (2012)	24.2 (2013)	
19–25 years	32.3 (2000)	26.3 (2012)	26.7 (2013)	
45–64 years	12.6 (2000)	15.6 (2012)	15.4 (2013)	
Delay or nonreceipt of needed medical care in past 12 months due to cost, percent				Table 69
Under 18 years	4.6 (2000)	3.2 (2012)	3.1 (2013)	
18–44 years	9.5 (2000)	12.7 (2012)	11.9 (2013)	
45–64 years	8.8 (2000)	14.0 (2012)	13.2 (2013)	
65 years and over	4.5 (2000)	4.1 (2012)	4.2 (2013)	
Health Care Resources				
Patient care physicians per 10,000 population[6]				Table 92
United States	22.7 (2000)	26.1 (2011)	26.9 (2012)	
Highest state	54.5 (DC) (2000)	68.3 (DC) (2011)	65.9 (DC) (2012)	
Lowest state	14.4 (ID) (2000)	17.7 (ID) (2011)	18.0 (ID,MS) (2012)	
Community hospital beds per 1,000 population[7]				Table 99
United States	2.9 (2000)	2.6 (2011)	2.6 (2012)	
Highest state	6.0 (ND) (2000)	5.9 (DC) (2011)	5.7 (DC) (2012)	
Lowest state	1.9 (NM,NV,OR,UT,WA) (2000)	1.7 (WA) (2011)	1.7 (OR) (2012)	
Health Care Expenditures				
Personal health care expenditures, in dollars				Table 104
Total, in trillions	$1.2 (2000)	$2.4 (2012)	$2.5 (2013)	
Per capita	$4,129 (2000)	$7,597 (2012)	$7,826 (2013)	

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[7]Copyright 2014. Used with permission of Health Forum LLC, an affiliate of the American Hospital Association.

NOTES: Estimates in this table are taken from the PDF, printed, or spreadsheet versions of the cited tables. For more information and the spreadsheet versions of the tables, see the complete report, *Health, United States, 2014*, available from: http://www.cdc.gov/nchs/hus.htm.

Highlights

This section presents selected data from this year's Special Feature on the health of the population aged 55–64 and from the four major areas included in the report: health status and determinants, utilization of health resources, health care resources, and health care expenditures and payers. The section focuses on topics of public health importance and illustrates the breadth of material included in *Health, United States*. Each highlight includes a reference to the detailed trend table, spreadsheet file, or figure where more information can be obtained.

Special Feature on Adults Aged 55–64

All-cause death rates in 2013 for those aged 55–64 were 6% lower for men and 11% lower for women than in 2003, driven by decreases in death rates for cancer and heart disease (Figure 20).

In 2012–2013, 18.1% of noninstitutionalized adults aged 55–64 were current cigarette smokers, 8% lower than the percentage in 2002–2003 (19.7%) (Figure 23).

For adults aged 55–64, the percentage with private health insurance was lower for all family income groups in 2012–2013 compared with 2002–2003, with the largest loss of private coverage occurring for those with family income below 200% of the poverty level (Figure 25).

In 2009–2012, the percentage of adults aged 55–64 who took no, 1–4, or 5 or more prescription drugs in the past 30 days was similar to levels in 1999–2002; use of prescription cholesterol-lowering drugs was 54% higher among 55- to 64-year-olds in 2009–2012 (31.8%) compared with 1999–2002 (20.6%) (Figure 28).

Health Status and Determinants

Life Expectancy and Mortality

In 2013, life expectancy at birth in the United States for the total population was 78.8 years—76.4 years for males and 81.2 years for females (Table 16).

Between 2003 and 2013, life expectancy at birth increased 1.9 years for males and 1.5 years for females. The gap in life expectancy between males and females narrowed from 5.2 years in 2003 to 4.8 years in 2013 (Table 16).

Between 2003 and 2013, life expectancy at birth increased more for the black than for the white population, thereby narrowing the gap in life expectancy between these two racial groups. In 2003, life expectancy at birth for the white population was 5.3 years longer than for the black

population; by 2013, the difference had narrowed to 3.6 years (Table 16).

Between 2003 and 2013, the infant mortality rate decreased 13%, from 6.85 to 5.96 deaths per 1,000 live births. In 2003, the infant mortality rate for white mothers was 5.72, compared with 14.01 for black mothers; by 2013, the infant mortality rate declined to 5.07 among white mothers and 11.22 among black mothers (Table 12).

In 2013, the 10 leading causes of death were heart disease, cancer, chronic lower respiratory diseases, unintentional injuries, stroke, Alzheimer's disease, diabetes, influenza and pneumonia, nephritis, and suicide. These 10 causes of death accounted for 74% of the 2.6 million deaths in 2013 (Table 20).

Between 2003 and 2013, the age-adjusted heart disease death rate decreased 28%, from 236.3 to 169.8 deaths per 100,000 population. In 2013, 24% of all deaths in the United States were from heart disease (Tables 20 and 24).

Between 2003 and 2013, the age-adjusted cancer death rate decreased 15%, from 190.9 to 163.2 deaths per 100,000 population. In 2013, 23% of all deaths in the United States were from cancer (Tables 20 and 26).

Between 2003 and 2013, the age-adjusted suicide death rate increased 17%, from 10.8 to 12.6 deaths per 100,000 population. In 2013, 17% of deaths among those aged 15–24 and 11% of deaths among those aged 25–44 were from suicide (Tables 21 and 33).

Between 2003 and 2013, the age-adjusted drug poisoning death rate involving opioid analgesics increased from 2.9 to 5.1 deaths per 100,000 population. In 2013, the drug poisoning death rate involving opioid analgesics was highest among those aged 45–54 (10.6), followed by those aged 35–44 (8.6), 25–34 (7.5), and 55–64 (7.5) (Table 30).

Fertility and Natality

Between 2003 and 2013, the birth rate among teenagers aged 15–19 fell 36%, from 41.1 to 26.5 live births per 1,000 females—a record low for the United States (Table 3).

The percentage of low-birthweight births (infants weighing less than 2,500 grams [5.5 pounds] at birth) was 8.02% in 2013, down 3% from the recent high of 8.26% in 2006 (Table 6).

Health Risk Factors

Children

In 2009–2012, the prevalence of obesity among children aged 2–5 years was 10.2%, 17.9% among children aged 6–11, and 19.4% among adolescents aged 12–19 (Table 65 and Figure 10).

In 2013, 16.3% of 12th graders, 9.1% of 10th graders, and 4.5% of 8th graders had smoked cigarettes in the past 30 days. Smoking prevalence declined for all grades from 2003 levels, when 24.4% of 12th graders, 16.7% of 10th graders, and 10.2% of 8th graders reported smoking cigarettes in the past 30 days (Table 56).

In 2013, 24.7% of students in grades 9–12 reported they were in a physical fight during the past year, and the percentage was higher among male students (30.2%) than female students (19.2%) (Table 57).

In 2013, 21.9% of students in grades 9–12 rode in a car in the past 30 days with a driver who had been drinking alcohol, down from 30.2% in 2003 (Table 57).

Adults

In 2013, 20.4% of adults aged 18 and over met the 2008 federal physical activity guidelines for both aerobic activity and muscle strengthening (Table 63).

Between 1988–1994 and 2009–2012, the percentage of adults aged 20 and over with grade 1 obesity (a body mass index [BMI] of 30.0–34.9) increased from 14.8% to 20.4%. Those with grade 2 obesity (BMI of 35.0–39.9) rose from 5.2% to 8.6%, and those with grade 3 or higher obesity (BMI of 40 or higher) doubled, from 3.0% to 6.3% (percentages are age-adjusted) (Table 64).

In 2013, 17.8% of noninstitutionalized adults aged 18 and over were current cigarette smokers, a decline from 2000 (23.2%). Men (20.5%) were more likely than women (15.3%) to be current cigarette smokers (Table 52).

Measures of Health and Disease Prevalence

In 2011–2013, 5.3% of children under age 18 had an asthma attack in the past year, and 5.6% had a food allergy (Table 39).

Among children aged 5–17, 10.1% were diagnosed with attention deficit/hyperactivity disorder and 5.5% had serious emotional or behavioral difficulties in 2011–2013 (Table 39).

In 2013, the percentage of noninstitutionalized adults who reported their health as fair or poor ranged from 6.2% of those aged 18–44 to 27.6% of those aged 75 and over (Table 50).

In 2013, 58.9% of noninstitutionalized adults aged 65 and over reported having at least one basic actions difficulty (e.g., movement, emotional, sensory [seeing or hearing], or cognitive difficulty) and 32.0% of noninstitutionalized adults aged 65 and over reported having at least one complex activity limitation (e.g., self-care, social, or work limitation) (Table 47).

In 2012–2013, 12.1% of noninstitutionalized adults aged 45–64 and 29.8% of noninstitutionalized adults aged 65 and over had ever been told by a physician or other health professional that they had heart disease (Table 42).

In 2012–2013, 6.7% of noninstitutionalized adults aged 45–64 and 18.4% of noninstitutionalized adults aged 65 and over had ever been told by a physician or other health professional that they had cancer (excluding squamous and basal cell skin cancers) (Table 42).

The prevalence of diabetes increases with age. In 2009–2012, 3.7% of adults aged 20–44, 16.2% of adults aged 45–64, and 26.8% of adults aged 65 and over had diabetes (physician-diagnosed and undiagnosed) (Table 44 and Figure 6).

In 2009–2012, nearly one-third (32.2%) of adults aged 20 and over had hypertension (diagnosed and undiagnosed). Of adults aged 20 and over with hypertension (diagnosed and undiagnosed), nearly one-half (47.4%) continued to have uncontrolled high blood pressure (Table 60 and Figure 9).

Utilization of Health Resources

Use of Health Care Services

In 2013, 15.8% of persons had no health care visits in the past year, 47.0% had 1–3 health care visits, 24.5% had 4–9 visits, and 12.7% had 10 or more visits. Health care visits for illness, preventive care, or an injury include visits to see a health care provider at physician offices, emergency departments, clinics, or some other place, and home visits by health care professionals (Table 71).

In 2011, there were 126 million visits to hospital outpatient departments and 136 million visits to hospital emergency departments (Table 82).

In 2013, 83.0% of children aged 2–17 years, 61.7% of adults aged 18–64, and 60.6% of adults aged 65 and over had visited a dentist in the past year (Table 84).

The percentage of the population taking at least one prescription drug during the past 30 days increased from 39.1% in 1988–1994 to 47.3% in 2009–2012. During the same period, the percentage taking three or more prescription drugs rose from 11.8% to 20.6%, and the percentage taking five or more drugs more than doubled, from 4.0% to 10.1% (percentages are age-adjusted) (Table 85).

Use of Preventive Medical Care Services

In 2013, 70% of children aged 19–35 months had completed the combined series of childhood vaccinations (at least 4 doses of diphtheria/tetanus/pertussis vaccine, 3 doses of polio vaccine, 1 dose of measles-containing vaccine, 3 or 4 doses of *Haemophilus influenzae* type b vaccine depending on product type, 3 doses of hepatitis B vaccine, 1 dose of varicella vaccine, and 4 doses of pneumococcal conjugate vaccine) (Table 72 and Figure 13).

In 2013, 41.0% of noninstitutionalized adults aged 18 and over had received an influenza vaccination in the past year. Influenza vaccination increased with age, with 29.6% of those aged 18–49, 46.6% of those aged 50–64, and 67.9% of those aged 65 and over reporting an influenza vaccination in the past year (Table 74 and Figure 12).

In 2013, 59.7% of noninstitutionalized adults aged 65 and over ever had a pneumococcal vaccination (Table 75 and Figure 12).

In 2013, two-thirds of women aged 40 and over had a mammogram in the past 2 years. Between 2003 and 2013, mammography use decreased 7% among women aged 40–49 (to 59.6% in 2013), 6% among those 50–64 (to 71.4%), and 7% among those 75 and over (to 56.5%), while remaining steady among those aged 65–74 (75.3% in 2013). Recommendations regarding which age groups should have screening mammograms have changed over time (Table 76).

In 2013, almost 7 of 10 women aged 18 and over had a Pap smear in the past 3 years (69.4%). Those aged 65 and over were less likely to have had a recent Pap smear (42.7%) than those aged 18–44 (77.2%) and 45–64 (73.9%). Currently, the U.S. Preventive Services Task Force does not recommend Pap smear screening for women aged 65 and over at low risk for cervical cancer (Table 77).

In 2013, almost 6 of 10 adults aged 50–75 had the recommended colorectal cancer screening tests (57.8%). Those aged 50–75 with at least some college education were more likely to have been screened (63.1%) than those with only a high school diploma or GED (53.4%) or those without a high school diploma (43.5%). Currently, the U.S. Preventive Services Task Force recommends colorectal cancer screening for those aged 50–75 (Table 78).

Nonreceipt of Needed Medical Care, Prescription Drugs, and Dental Care Due to Cost

In 2013, among noninstitutionalized persons, 9.1% reported not receiving or delaying needed medical care due to cost, 6.4% reported not receiving needed prescription drugs due to cost, and 11.1% reported not receiving needed dental care due to cost (Table 69).

Among adults aged 18–64, the percentage who reported not receiving or delaying seeking needed medical care due to cost in the past 12 months increased during 2003–2010, then was stable during 2010–2013. Among adults aged 18–64, the percentage who reported not receiving needed prescription drugs due to cost in the past 12 months increased during 2003–2010, then declined during 2010–2013. Among adults aged 18–64, the percentage who reported not receiving needed dental care due to cost in the past 12 months increased during 2003–2010, then was stable through 2013 (Table 69).

Health Care Resources

In 2012, there were 26.9 physicians in patient care per 10,000 population in the United States. The number of patient care physicians per 10,000 population ranged from 18.0 in Idaho and Mississippi to 41.3 in Massachusetts and 65.9 in the District of Columbia (Table 92).

In 2012, the United States had 4,999 community hospitals and 800,566 community hospital beds. Community hospital occupancy averaged 63.4% in 2012, similar to the levels in 2010 and 2011 (Table 98).

In 2013, there were 15,663 certified nursing homes with 1,697,484 nursing home beds. U.S. nursing home occupancy averaged 80.8% in 2013. Nursing home occupancy rates were highest in North Dakota (92.9%) and the District of Columbia (92.9%) in 2013 (Table 101).

Health Care Expenditures and Payers

Health Care Expenditures

In 2013, personal health care expenditures in the United States totaled $2.5 trillion, a 3.8% increase from 2012. The per capita personal health care expenditure for the total U.S. population was $7,826 in 2013, up from $7,597 in 2012 (Table 102).

Expenditures for hospital care accounted for 38.0% of all personal health care expenditures in 2013. Physician and clinical services accounted for 23.8% of total personal health care expenditures, prescription drugs for 11.0%, and nursing care facilities and continuing care retirement communities for 6.3%; the remainder of spending was for other types of care (Table 103).

In 2013, prescription drug expenditures totaled $271.1 billion, up from $264.4 billion in 2012 (Table 103).

In 2012, the average inflation-adjusted cost for the entire hospitalization involving a heart valve procedure was $52,625, a coronary artery bypass graft procedure was $40,142, cardiac pacemaker or defibrillator insertion or replacement was $35,028, and spinal fusion was $28,190 (Table 105).

Health Care Payers

In 2013, 34.3% of all personal health care expenditures were paid by private health insurance, 22.3% were paid by Medicare, and 16.6% by Medicaid; consumers paid 13.7% out of pocket; and the remainder was paid by other types of insurance, payers, and programs (Table 104).

In 2011, children under age 21 accounted for 47.2% of Medicaid recipients but only 19.6% of Medicaid expenditures. The aged and blind and persons with disabilities accounted for 20.3% of Medicaid recipients and 60.6% of Medicaid expenditures (Table 118).

In 2013, the Medicare program had 52.3 million enrollees and expenditures of $582.9 billion, up from 50.9 million enrollees and $574.2 billion expenditures the previous year. Expenditures for the Medicare drug program (Part D) were $69.7 billion in 2013 (Table 116).

Health Insurance Coverage

Between 2003 and 2013, the percentage of adults aged 18–64 who were uninsured increased 6% from 19.3% to 20.5% (Table 114).

Based on preliminary data, from 2013 to the second quarter of 2014 (April–June), the percentage of adults aged 18–64 who were uninsured declined 24%, to 15.6% (preliminary data; Martinez ME, Cohen RA. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2014. NCHS; 2014. Available from: http://www.cdc.gov/nchs/data/nhis/earlyrelease/ Quarterly_estimates_2010_2014_Q12.pdf).

Between 2003 and 2010, the percentage of adults aged 19–25 who were uninsured was stable at 31%–34%, and then decreased to 26.7% in 2013 (Table 114).

Based on preliminary data, from 2013 to the second quarter of 2014 (April–June), the percentage of adults aged 19–25 who were uninsured declined 28%, to 19.2% (preliminary data; Martinez ME, Cohen RA. Health insurance coverage: Early release of estimates from the National Health Interview Survey, January–June 2014. NCHS; 2014. Available from: http://www.cdc.gov/nchs/data/nhis/earlyrelease/ insur201412.pdf and unpublished data).

Between 2003 and 2013, the percentage of the population under age 65 with private health insurance obtained through the workplace declined from 64.4% to 56.6% (Table 112).

Between 2003 and 2013, among children in families with income of 100%–199% of poverty, the percentage of uninsured children under age 18 dropped from 15.6% to 11.1%, while Medicaid or the Children's Health Insurance Program (CHIP) coverage among children in families with income of 100%–199% of poverty increased from 41.7% to 60.1% (Tables 113 and 114).

In 2013, Massachusetts (4.4%), the District of Columbia (7.1%), Puerto Rico (7.7%), Vermont (8.1%), and Hawaii (8.3%) had the lowest percentages of persons uninsured (i.e., without public or private coverage) among those under 65, while Nevada (23.4%), Florida (24.2%), and Texas (24.5%) had the highest percentages (Table 123, a new table in the 2014 edition).

Mortality
Life Expectancy at Birth

Figure 1. Life expectancy at birth, by selected characteristics: United States, 1980–2013
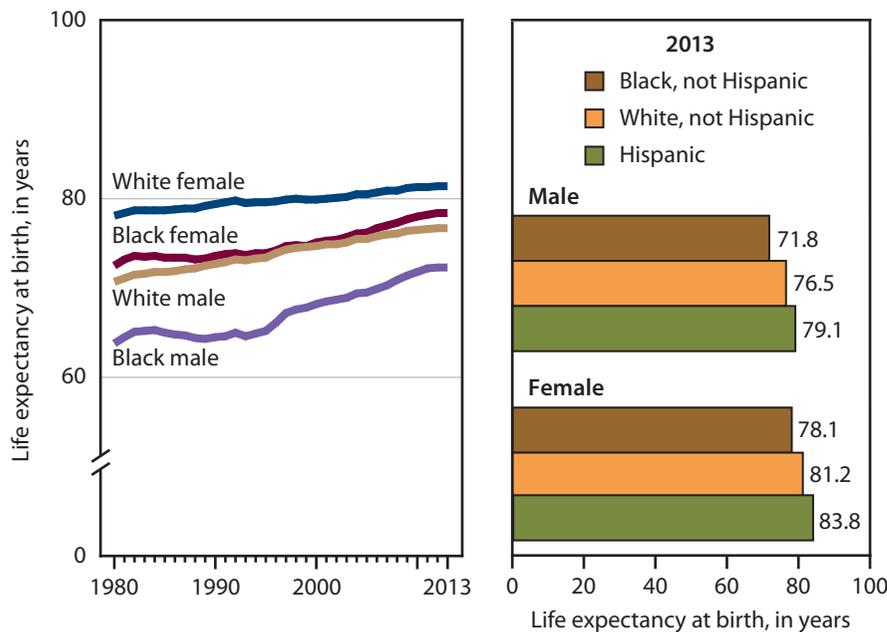
Between 2003 and 2013, life expectancy at birth increased for white females (1.2 years), white males (1.6 years), black females (2.7 years), and black males (3.4 years).

Life expectancy is a measure often used to gauge the overall health of a population (1). Between 1980 and 2013, life expectancy at birth in the United States increased from 70.0 to 76.4 years for males and from 77.4 to 81.2 years for females. Racial disparities in life expectancy at birth persisted for both males and females in 2013 but continue to narrow. Life expectancy at birth was 6.2 years longer for white males than for black males in 2003, and 4.4 years longer for white males than for black males in 2013. In 2003, life expectancy at birth was 4.5 years longer for white females than for black females; by 2013, life expectancy at birth was 3.0 years longer for white females than for black females. In 2013, Hispanic males and females had longer life expectancy at birth than non-Hispanic white or non-Hispanic black males and females.

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig01
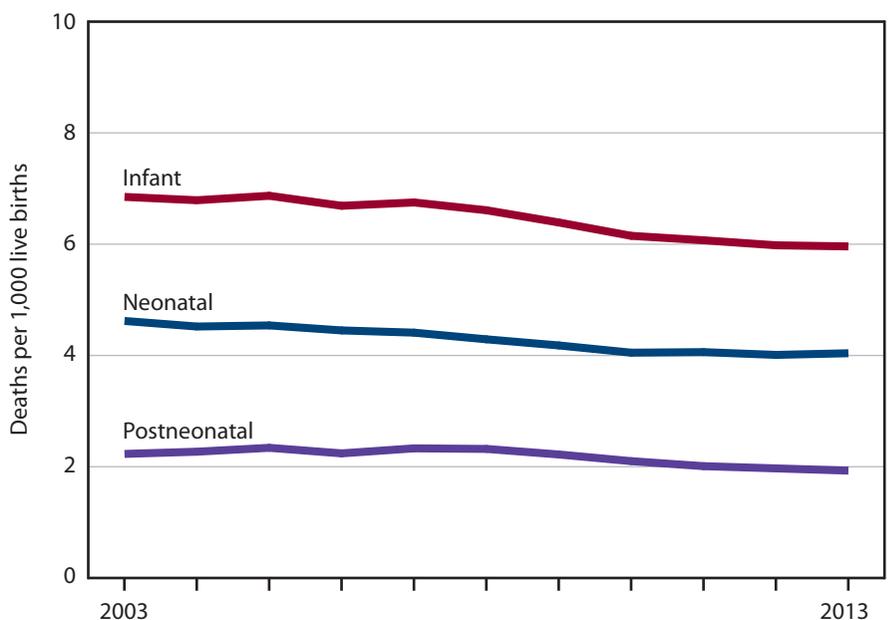
Mortality
Infant Mortality

Infant, neonatal, and postneonatal mortality rates declined 13% between 2003 and 2013.

The infant mortality rate is the risk of death during the first year of life (1). The 2013 infant mortality rate of 5.96 per 1,000 live births—a historical low—was 13% lower than in 2003. During the same period, the neonatal mortality rate (death rate among infants under 28 days, a subset of infant mortality) decreased 13% to 4.04 per 1,000 live births, and the postneonatal mortality rate (death rate among infants 28 days through 11 months, a subset of infant mortality) declined 13% to 1.93 per 1,000 live births.

Figure 2. Infant, neonatal, and postneonatal mortality rates: United States, 2003–2013

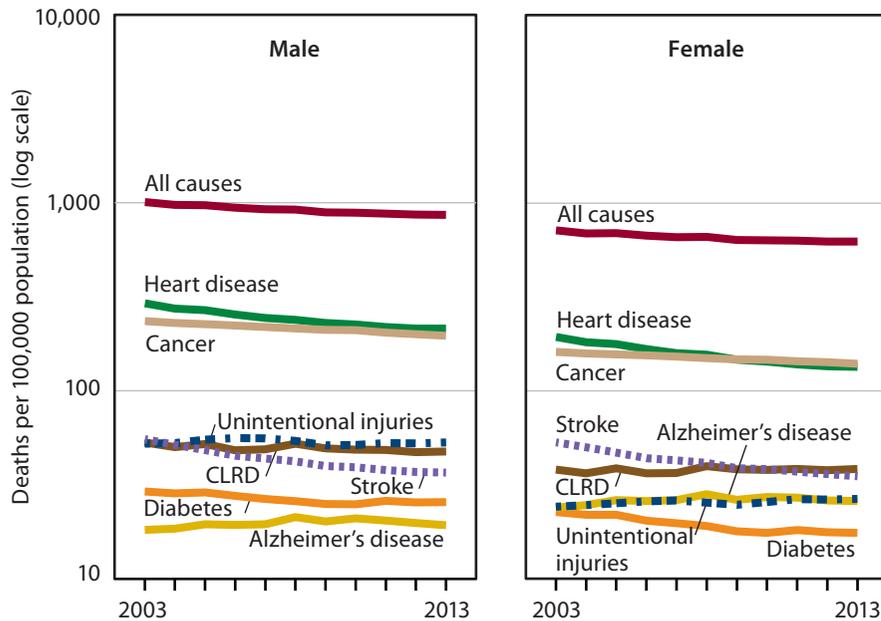*Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig02*

Mortality
Selected Causes of Death

Figure 3. Age-adjusted death rates for selected causes of death for all ages, by sex: United States, 2003–2013

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig03

Between 2003 and 2013, the all-cause age-adjusted death rate decreased 15% among males and 13% among females.

During this 10-year period, age-adjusted death rates among males declined 34% for stroke, 27% for heart disease, 17% for cancer, and 11% for chronic lower respiratory diseases, while the age-adjusted death rate for Alzheimer's disease increased 6%, and the age-adjusted death rate for unintentional injuries was stable. Among females, age-adjusted death rates declined 34% for stroke, 31% for heart disease, and 14% for cancer, while the age-adjusted death rates increased 8% for Alzheimer's disease and 10% for unintentional injuries. In 2013, age-adjusted death rates were higher for males than females for heart disease, cancer, chronic lower respiratory diseases, diabetes, and unintentional injuries; were similar for stroke; and were higher among females than males for Alzheimer's disease.

NOTES: CLRD is chronic lower respiratory diseases. A change in the coding rules for nephritis, nephrotic syndrome and nephrosis, caused an increase in the number of deaths attributed to diabetes beginning with 2011 data. The trend for diabetes death rates should be interpreted with caution.
SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 18. Data from the National Vital Statistics System (NVSS).

Mortality
Suicide

In 2013, suicide rates were highest for males aged 45–64 (29.0) and 65 and over (30.9); rates were substantially lower for females aged 45–64 (9.4) and 25–44 (6.8).

Suicide was the 10th leading cause of death in the U.S., with more than 40,000 deaths in 2013 (Table 20). Suicide deaths take a large emotional toll on family and friends (2,3). Biological, social, psychological, and cultural factors affect an individual's risk of suicide (3). Suicide rates differ by demographic and other factors (2,3).

Suicide rates were 3.7 times as high for males (20.3 deaths per 100,000 population in 2013) as females (5.5) overall (age-adjusted; Table 33), and were higher for males than females in each age group. Among males in 2013, suicide rates were highest for those aged 45–64 (29.0) and 65 and over (30.9). Among females, rates were highest among those aged 45–64 (9.4) and 25–44 (6.8). Between 2003 and 2013, suicide rates increased among females aged 15–24 (50%), 25–44 (19%), 45–64 (36%), and 65 and over (21%). Among males, rates increased 23% for those aged 45–64 and 9% or less for the other male age groups.

SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 33. Data from the National Vital Statistics System (NVSS).

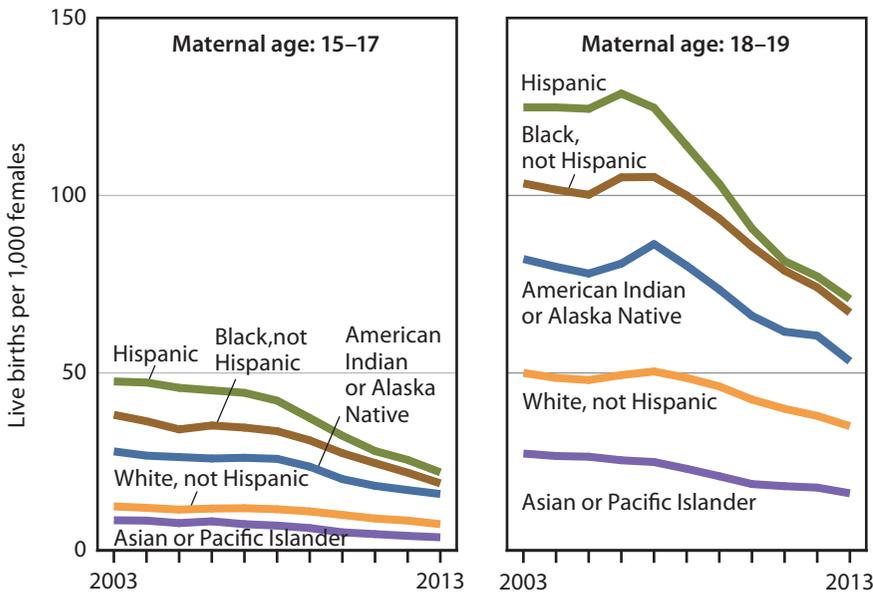**Figure 4. Suicide death rates, by sex and age: United States, 2003–2013**

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig04
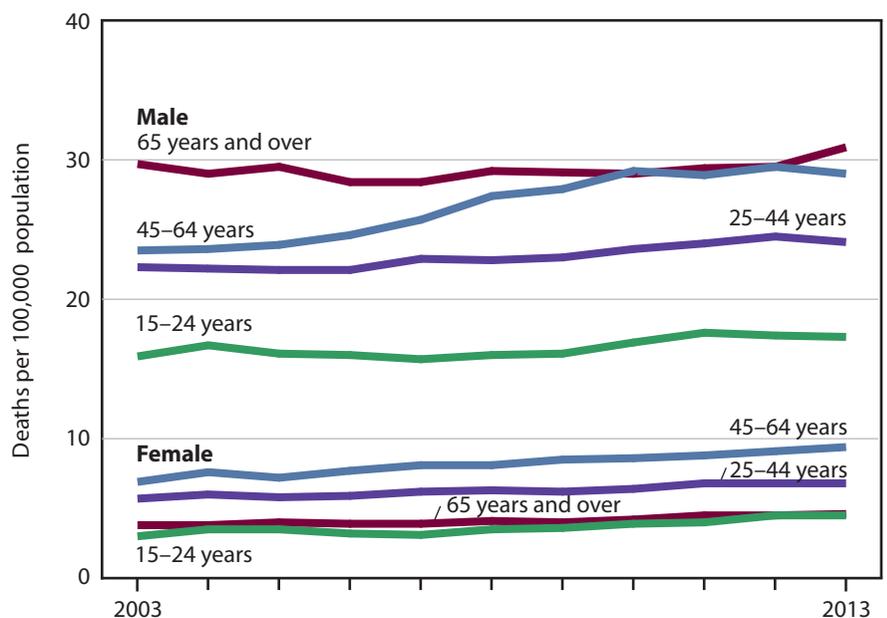
Natality
Teenage Childbearing

Figure 5. Teenage childbearing, by maternal age and race and Hispanic origin: United States, 2003–2013

Between 2003 and 2013, teenage birth rates declined among all racial and ethnic groups.

Teen childrearing often limits the mother's educational and occupational opportunities, and babies born to teen mothers are more likely to also become teen mothers (4). In 2013, 2.0% of births were to teenagers under age 18 and 5.0% were to women aged 18–19 (Table 4). Between 2003 and 2013, birth rates declined 45% for teenagers aged 15–17 and 32% for those aged 18–19 (Table 3). Birth rates were higher among Hispanic and non-Hispanic black teenagers than among other racial and ethnic groups. Since 2003, birth rates have decreased 54% for Hispanic teenagers aged 15–17 and 51% for non-Hispanic black teenagers in the same age group. Also during this period, birth rates for those aged 18–19 decreased 43% for Hispanic teenagers and 35% for non-Hispanic black teenagers.

SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 3. Data from the National Vital Statistics System (NVSS).

Excel and PowerPoint: *http://www.cdc.gov/nchs/hus/contents2014.htm#fig05*

Morbidity
Diabetes Prevalence

In 2009–2012, 26.8% of those aged 65 and over had diabetes (diagnosed or undiagnosed), compared with 16.2% of those aged 45–64 and 3.7% of those aged 20–44.

Diabetes is a complex chronic condition requiring ongoing medical care and active patient self-management (5,6). Long-term complications of diabetes include heart disease and renal, nerve, and retinal damage. In 2013, diabetes was the 7th leading cause of death in the U.S. (Table 20). Between 1988–1994 and 2009–2012, diabetes prevalence among adults aged 20 and over increased from 8.8% to 11.7% (age-adjusted; Table 44). The increase occurred only for those aged 20–44 and 65 and over.

In 2009–2012, the prevalence of diabetes increased with age among adults from 3.7% of those 20–44 to 16.2% of those 45–64, and 26.8% of those 65 and over. Although diabetes prevalence is lowest among adults aged 20–44, the undiagnosed share is larger than in other age groups.

Figure 6. Diagnosed and undiagnosed diabetes prevalence among adults aged 20 and over, by age: United States 1988–1994 and 2009–2012

NOTE: The components of diabetes may not sum to the total due to rounding.
SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 44. Data from the National Health and Nutrition Examination Survey (NHANES).

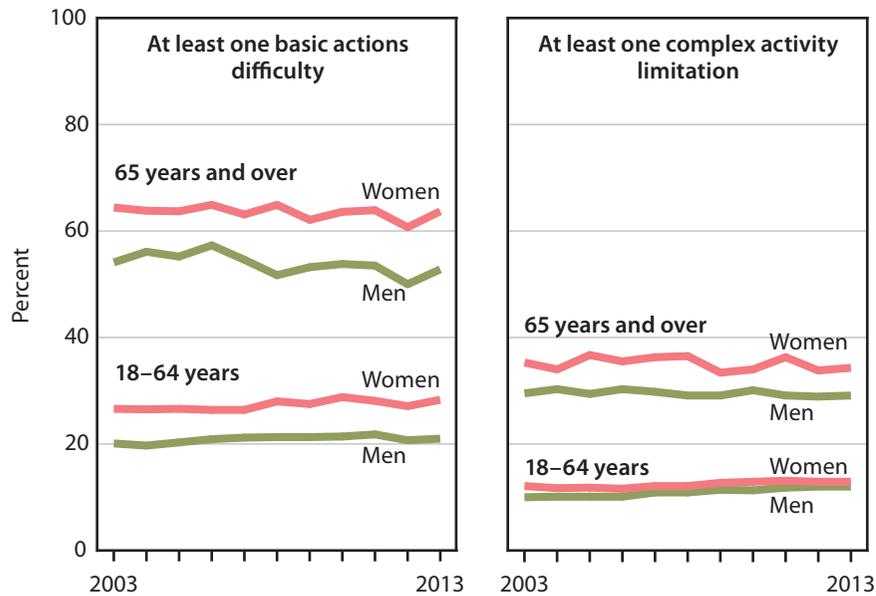Excel and PowerPoint: *http://www.cdc.gov/nchs/hus/contents2014.htm#fig06*
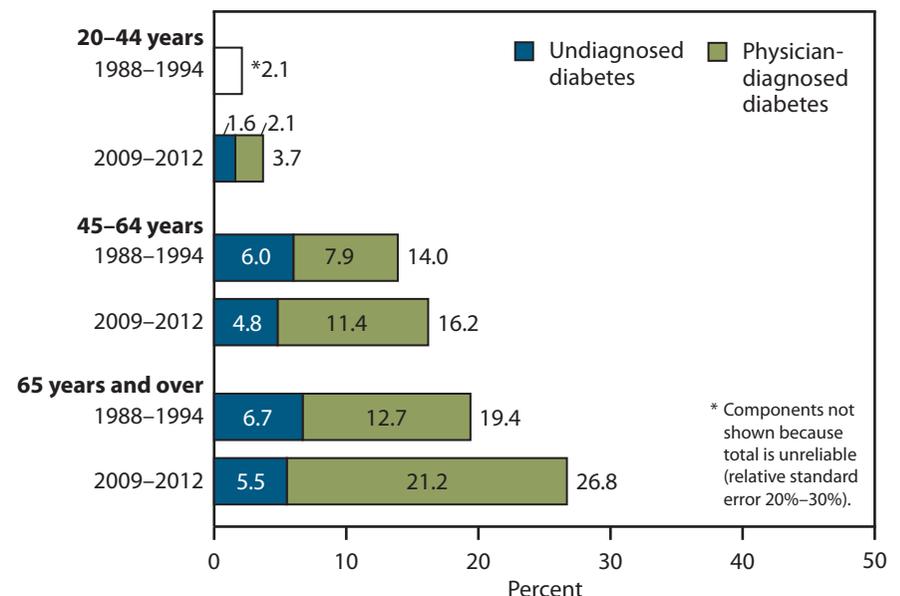
Disability Measures

Basic Actions Difficulty and Complex Activity Limitation

Figure 7. Basic actions difficulty and complex activity limitation among adults aged 18 and over, by sex and age: United States, 2003–2013

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig07

The prevalence of basic actions difficulty is higher among those aged 65 and over than those aged 18–64; the prevalence of complex activity limitation also is higher among those aged 65 and over compared with those aged 18–64.

Basic actions difficulty and complex activity limitation are two constructs to measure disability (7). Basic actions difficulty captures at least one limitation in movement, emotional, sensory, or cognitive functioning associated with a health problem. Complex activity limitation is a limitation in at least one selected social role, such as living independently or working. In 2013, the prevalence of basic actions difficulty was higher among those aged 65 years and over (58.9%) compared with those aged 18–64 (24.7%). The prevalence of complex activity limitation also was higher among those aged 65 and over (32.0%) compared with those aged 18–64 (12.4%) in 2013 (Table 47). In 2013, the prevalence of each disability measure was higher for women than for men in the same age group, except for complex activity limitation among those aged 18–64, where the prevalence was similar.

SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 47. Data from the National Health Interview Survey (NHIS).

Health Risk Factors

Current Cigarette Smoking

During 2003–2013, cigarette smoking prevalence declined among high school seniors and among adults aged 18–44 and adults aged 45–64.

Smoking is associated with an increased risk of heart disease, stroke, lung and other types of cancers, and chronic lung diseases (8). Between 2003 and 2013, cigarette smoking among high school seniors (students in grade 12) decreased from 26.2% to 18.4% for male students and from 22.1% to 13.2% for female students. During 2003–2013, the percentage of adults who smoked cigarettes declined for men and women aged 18–44 and aged 45–64, while remaining stable for men and women aged 65 and over. In 2013, 20.5% of adult men aged 18 and over and 15.3% of adult women were current cigarette smokers (Table 52).

SOURCE: CDC/NCHS, *Health, United States, 2014*, Tables 52 and 56. Data from the National Health Interview Survey (NHIS) and the Monitoring the Future (MTF) Study.

Figure 8. Current cigarette smoking among high school seniors and adults aged 18 and over, by sex and age: United States, 2003–2013
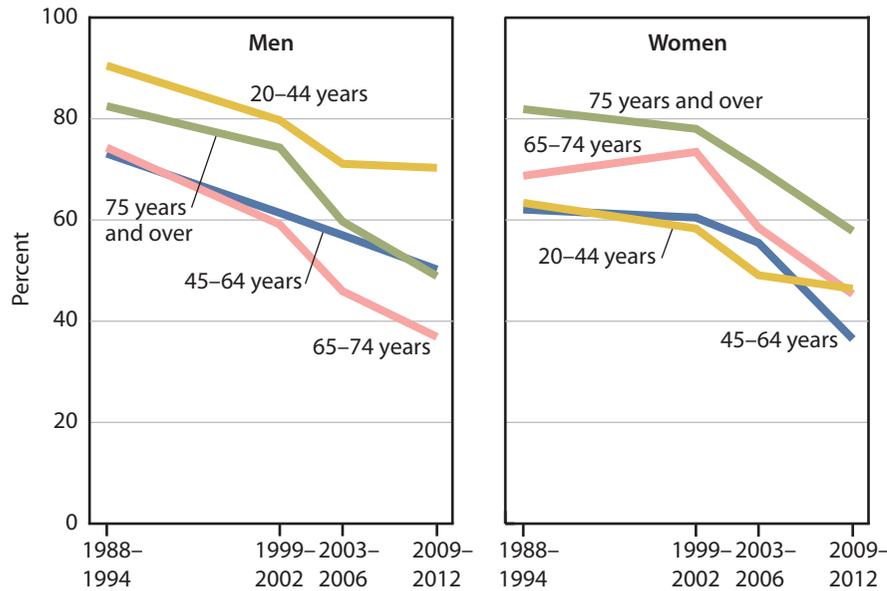

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig08
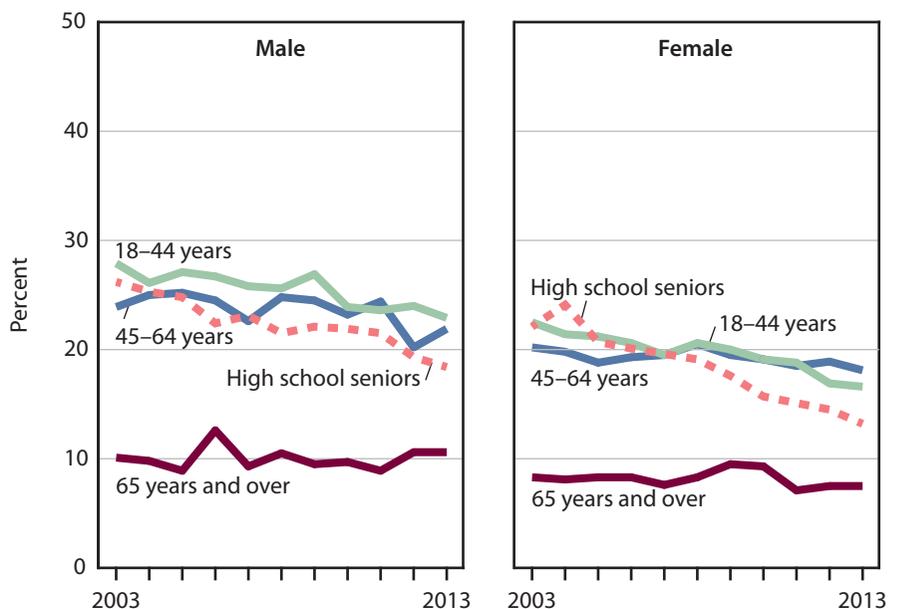
Health Risk Factors
Uncontrolled High Blood Pressure

Figure 9. Uncontrolled high blood pressure among adults aged 20 and over with hypertension, by sex and age: United States, 1988–1994 through 2009–2012

Although control of high blood pressure has improved since 1988–1994, nearly one-half of adults with hypertension had uncontrolled high blood pressure in 2009–2012.

Hypertension increases the risk for cardiovascular disease, including heart attack and stroke (9). Between 1988–1994 and 2009–2012, the prevalence of uncontrolled high blood pressure (defined as an average systolic blood pressure of 140 mm Hg or higher, or an average diastolic pressure of 90 mm Hg or higher, among those with hypertension) declined for all age groups for men and women. However, nearly one-half (47.4%) of adults aged 20 and over with hypertension had uncontrolled high blood pressure in 2009–2012 (Table 60).

SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 60. Data from the National Health and Nutrition Examination Survey (NHANES).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig09

Health Risk Factors
Obesity Among Children and Adolescents

In 2009–2012, the prevalence of obesity was higher among boys and girls aged 6–19, compared with those aged 2–5.

Excess body weight in children is associated with excess morbidity in childhood and excess body weight in adulthood (10,11). Obesity among children is defined as a body mass index at or above the sex- and age-specific 95th percentile of the CDC growth charts (12). In 2009–2012, obesity prevalence was higher among children aged 6–11 (17.9%) and adolescents aged 12–19 (19.4%), compared with 2- to 5-year-olds (10.2%). The prevalence of obese boys aged 6–11 and 12–19 was higher than for boys aged 2–5. The prevalence of obese girls aged 6–11 and 12–19 was higher than among girls aged 2–5. Within each age group, the prevalence of obesity did not differ for boys and girls. From 2003–2004 to 2011–2012, there was no significant change in obesity prevalence among children aged 2–19 overall, but there was a decrease in obesity prevalence among children aged 2–5 (13).

SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 65. Data from the National Health and Nutrition Examination Survey (NHANES).

Figure 10. Obesity among children and adolescents, by sex and age: United States, 2009–2012

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig10
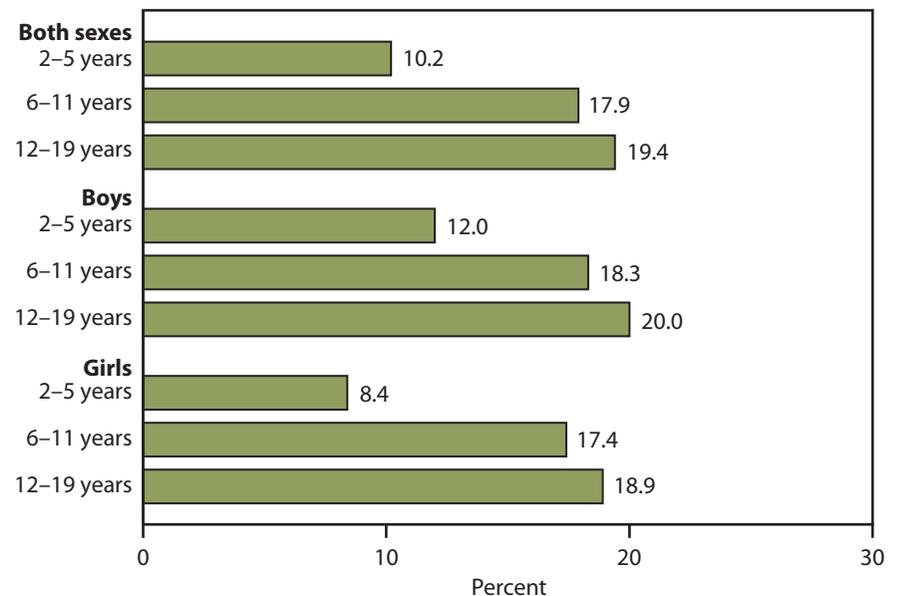
Health Risk Factors
Overweight and Obesity Among Adults

Figure 11. Overweight and obesity among adults aged 20 and over, by sex: United States, 1988–1994 through 2009–2012

Excel and PowerPoint: *http://www.cdc.gov/nchs/hus/contents2014.htm#fig11*
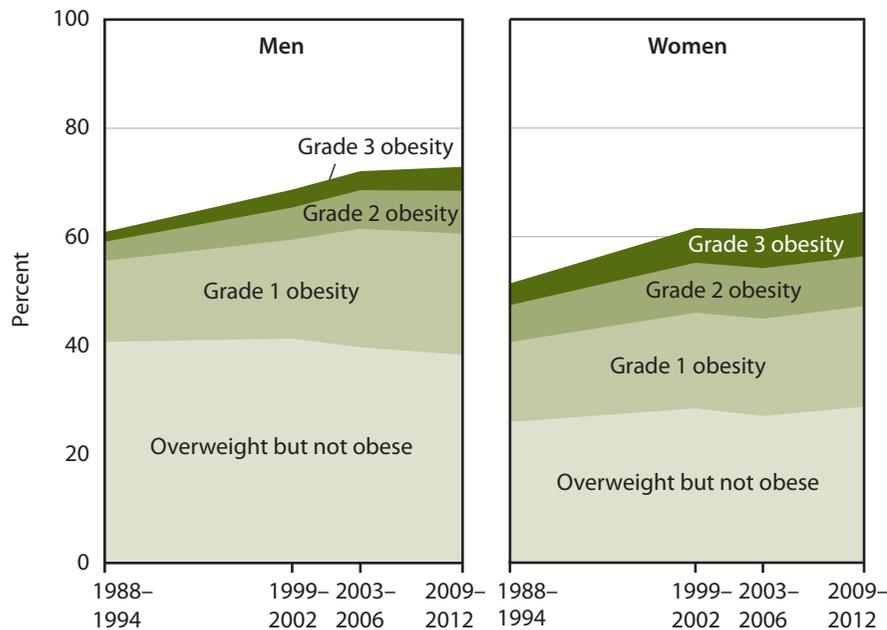
Between 1988–1994 and 2009–2012, the prevalence of men and women with Grades 1, 2, and 3 obesity increased while the prevalence of men and women aged 20 and over who were overweight but not obese was stable.

Reducing the prevalence of obesity is a public health priority because obesity is correlated with excess morbidity and mortality (14–16). In particular, Grade 2 or higher obesity (a body mass index [BMI] of 35 or higher) significantly increases the risk of death (17). Between 1988–1994 and 2009–2012, the percentage of adults aged 20 and over with Grade 1 obesity (BMI greater than or equal to 30 but less than 35), Grade 2 obesity (BMI greater than or equal to 35 but less than 40), and Grade 3 obesity (BMI of 40 or higher) increased among both men and women. During this period, the percentage of men and women aged 20 and over who were overweight but not obese (BMI greater than or equal to 25 but less than 30) was stable. In 2009–2012, 4.4% of men and 8.2% of women aged 20 and over had Grade 3 obesity.

SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 64. Data from the National Health and Nutrition Examination Survey (NHANES).

Prevention
Influenza and Pneumococcal Vaccination

During 2003–2013, influenza vaccination in the past 12 months increased among adults under age 75, while remaining stable among those aged 75 and over. The percentage of adults aged 65 and over who had ever received a pneumococcal vaccination increased during this period.

Vaccination against influenza and invasive pneumococcal disease is an important public health strategy (18). During 2003–2013, influenza vaccination in the past 12 months for noninstitutionalized adults increased among those aged 18–49 and 50–74 but was stable among those aged 75 and over. Decreases in influenza vaccination coverage in 2005 were related in part to a vaccine shortage (19). During 2003–2013, the percentage of non-institutionalized adults who had ever received pneumococcal vaccination was stable among high-risk persons aged 18–64, and increased among those aged 65–74 and 75 and over.

NOTE: The pneumococcal high-risk group includes persons who reported diabetes; cancer; heart, lung, liver, or kidney disease; or cigarette smoking.
SOURCE: CDC/NCHS, *Health, United States, 2014*, Tables 74 and 75. Data from the National Health Interview Survey (NHIS).

Figure 12. Influenza and pneumococcal vaccination among noninstitutionalized adults aged 18 and over, by type of vaccination and age: United States, 2003–2013
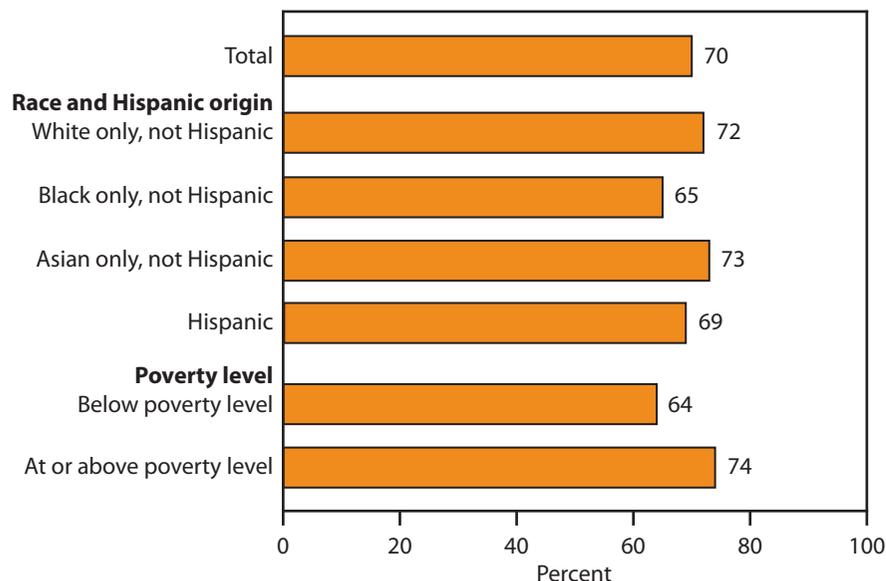

Excel and PowerPoint: *http://www.cdc.gov/nchs/hus/contents2014.htm#fig12*
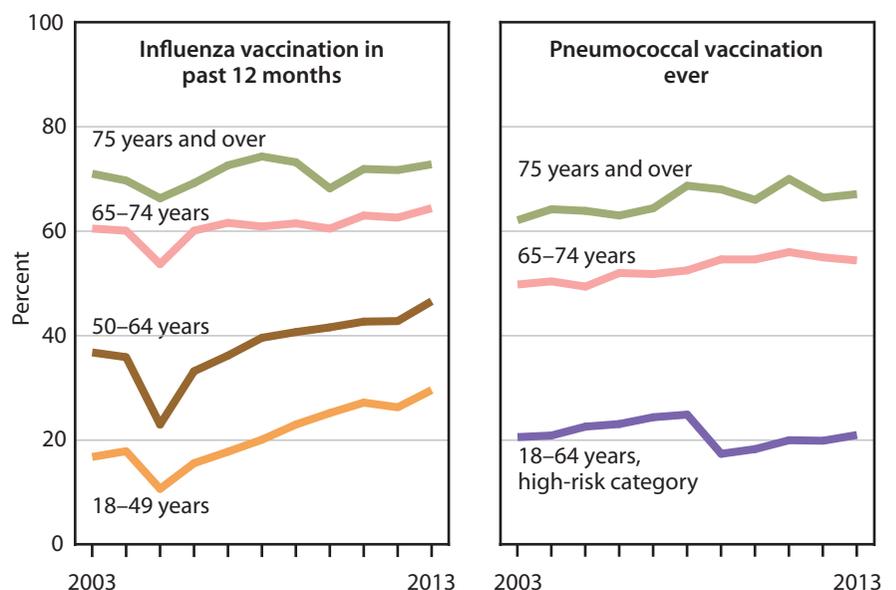
Prevention
Vaccination Coverage Among Children Aged 19–35 Months

Figure 13. Vaccination coverage for combined series (4:3:1:3*:3:1:4) among children aged 19–35 months, by race and ethnicity and poverty level: United States, 2013

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig13

In 2013, 70% of children aged 19–35 months had received the combined vaccine series, which includes diphtheria, tetanus, and polio vaccines.

Vaccination can prevent or lessen the severity of disease and is one of the greatest public health advances (20). For children aged 19–35 months, a series of vaccinations is recommended (18). To evaluate how many children are meeting the guidelines, the combined vaccine series (4:3:1:3*:3:1:4) is used. This measure includes the recommended doses of vaccines against diphtheria, tetanus, and pertussis; polio; measles; *Haemophilus influenzae* type b; hepatitis B; varicella; and pneumococcus (18). Childhood immunization prevents 40,000 deaths and 20 million cases of disease for each birth cohort (21).

In 2013, 70% of children aged 19–35 months had the combined series. Children living below the poverty level had lower coverage (64%) than children living at or above the poverty level (74%). Non-Hispanic black children had lower coverage (65%) than non-Hispanic white (72%) or Asian (73%) children. Poverty level accounts for most of the differences by race and Hispanic origin (22).

SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 72. Data from the National Center for Immunization and Respiratory Diseases, National Immunization Survey.

Prevention
Colorectal Tests and Procedures

Between 2003 and 2013, colorectal cancer tests and procedures increased 48% among noninstitutionalized adults aged 50–75, to 57.8% in 2013.

Among men and women, colorectal cancer is the third leading cause of cancer deaths responsible for more than 50,000 deaths a year (1,23). The U.S. Preventive Services Task Force recommends colorectal cancer screening for those aged 50–75 (24). A variety of colorectal tests are recommended (Table 78). Increased screening can reduce colorectal cancer incidence because the tests can find precancerous growths that can be removed before they progress to cancer. Screening also increases the likelihood that colorectal cancer will be detected at an earlier and thus, more treatable stage (23).

Between 2003 and 2013, the percentage of adults aged 50–75 who reported having colorectal tests and procedures increased from 39.1% to 57.8%, and increased among all racial and ethnic groups. In 2013, Hispanic and Asian adults were less likely than non-Hispanic white and non-Hispanic black adults to have had colorectal tests and procedures.

SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 78. Data from the National Health Interview Survey (NHIS).

Figure 14. Colorectal tests and procedures among adults aged 50–75, by race and ethnicity: United States, 2003 and 2013

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig14
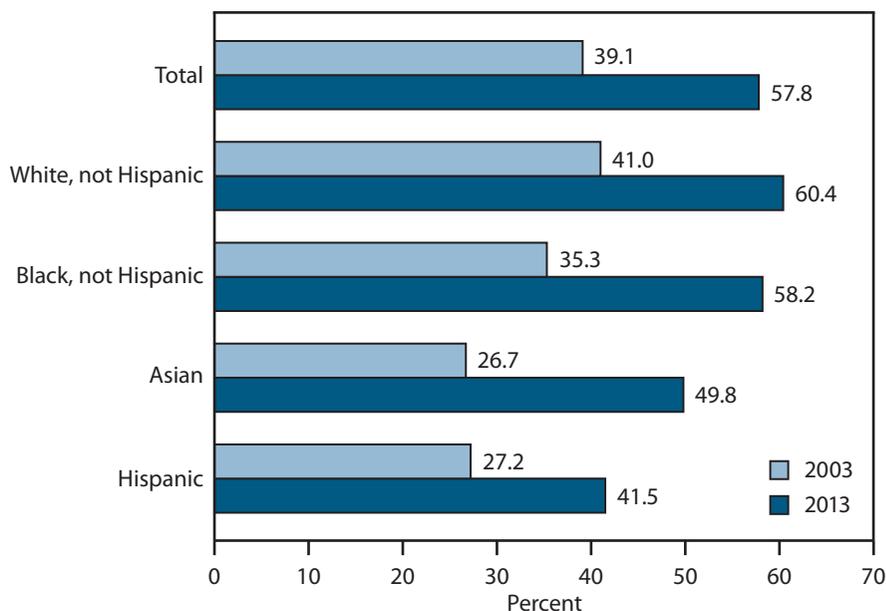
Health Insurance
Coverage Among Adults Aged 18–64

Figure 15. Health insurance coverage among adults aged 18–64, by type of coverage: United States, 2003–2013
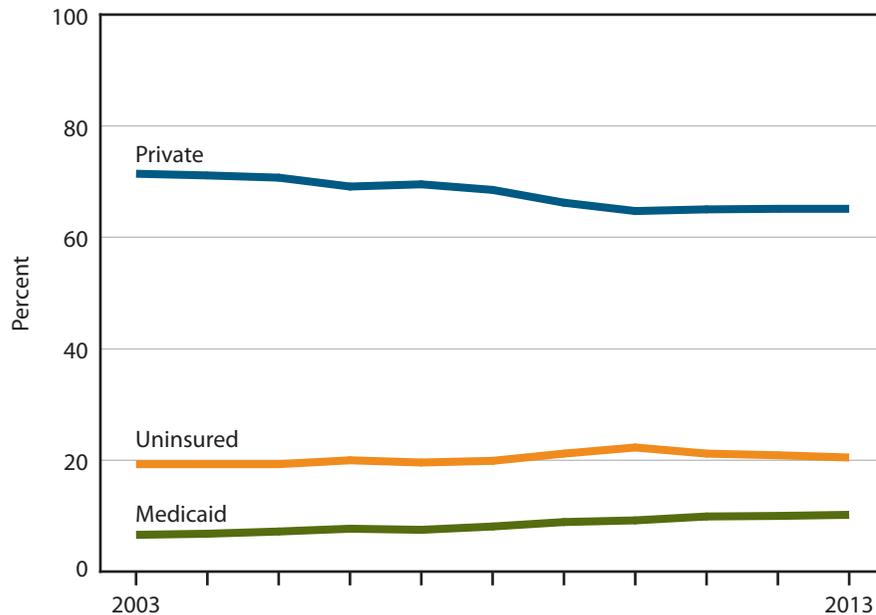
During 2003–2013, the percentage of adults aged 18–64 with private health insurance coverage decreased, and the percentage with Medicaid and the percentage uninsured increased.

Health insurance is a major determinant of access to health care (25). Among adults aged 18–64, the percentage with private coverage declined from 2003 (71.4%) through 2013 (65.1%) (Table 111). The percentage with Medicaid coverage increased from 2003 (6.6%) through 2013 (10.2%) (Table 113). The percentage of adults 18–64 who were uninsured increased from 19.3% in 2003 to 20.5% in 2013 (Table 114).

Preliminary data from NHIS' Early Release show that between 2013 and the second quarter of 2014 (April–June), private coverage for those aged 18–64, increased to 67.7% (26,27). Among adults aged 18–64, 5.7 million were covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges as of the second quarter (26). The percentage uninsured for those aged 18–64 declined between 2013 and the second quarter of 2014, to 15.6% (26).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig15

SOURCE: CDC/NCHS, *Health, United States, 2014*, Tables 111, 113, and 114. Data from the National Health Interview Survey (NHIS).

Health Insurance
Coverage Among Adults Aged 19–25

Between 2010 and 2013, the percentage of uninsured adults aged 19–25 decreased from 33.8% to 26.7%.

Adults aged 19–25 have had high levels of uninsurance (Table 114). The percentage with private coverage declined from 57.8% in 2003 to 51.8% in 2010 and then rose to 58.9% in 2013 (Table 111). Between 2003 and 2010, the percentage uninsured was stable at 31%–34%, and then decreased to 26.7% in 2013. The ACA allows most young adults to remain on their parent's coverage until age 26 (fully effective in 2011) (28–30). The percentage with Medicaid increased from 8.8% in 2003 to 12.1% in 2013 (Table 113).

Preliminary data from NHIS' Early Release show that between 2013 and the second quarter of 2014 (April–June), private coverage for adults aged 19–25, increased to 62.4% (27,31). Among adults aged 19–25, 0.7 million were covered by private plans obtained through the Health Insurance Marketplace or state-based exchanges as of the second quarter (31). The percentage uninsured for those 19–25 declined 28% between 2013 and the second quarter of 2014, to 19.2% (27,31).

SOURCE: CDC/NCHS, *Health, United States, 2014*, Tables 111, 113, and 114. Data from the National Health Interview Survey (NHIS).

Figure 16. Health insurance coverage among adults aged 19–25, by type of coverage: United States, 2003–2013

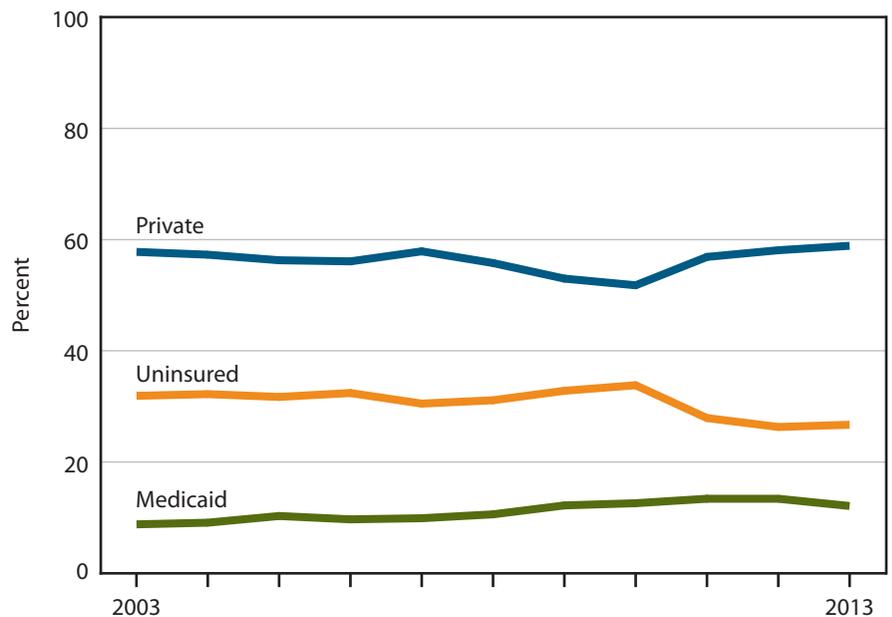*Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig16*

Utilization and Access
Emergency Department Use

Figure 17. One or more emergency department visits in the past 12 months, by age and type of coverage: United States, 2003–2013
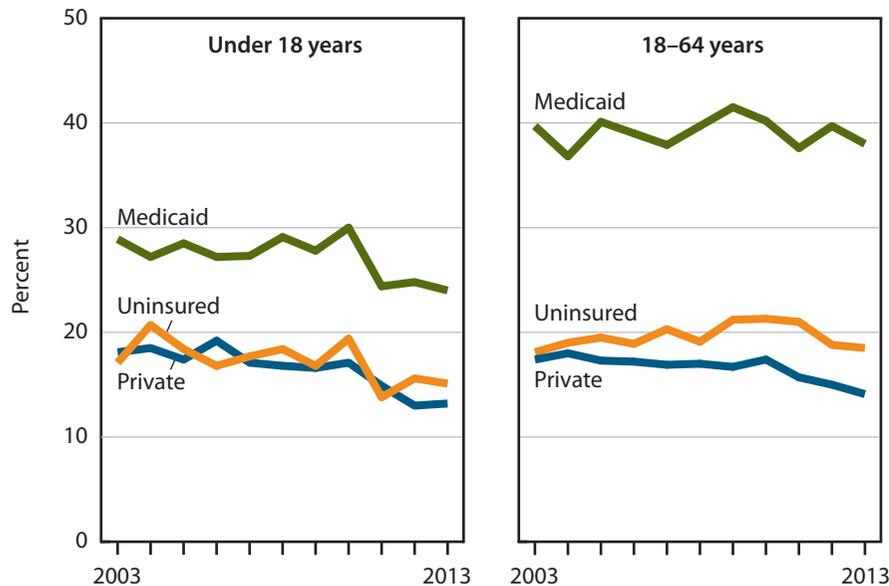
During 2003–2013, children and adults aged 18–64 with Medicaid coverage were more likely to have had at least one emergency department visit in the past year, compared with the uninsured and those with private coverage.

During 2003–2013, the percentage of children under age 18 with at least one emergency department (ED) visit in the past year declined for those with Medicaid coverage while remaining stable for uninsured children. For children with private coverage, the percentage with an ED visit was stable through 2010 and then declined during 2010–2013. In 2013, 24.0% of children with Medicaid, 15.1% of uninsured children, and 13.2% of children with private coverage had an ED visit in the past year. During 2003–2013, the percentage of adults aged 18–64 with at least one ED visit was stable for those with Medicaid and for the uninsured. For adults with private coverage, the percentage with an ED visit was stable during 2003–2010, and then declined during 2010–2013.

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig17

Utilization and Access
Delay or Nonreceipt of Needed Medical Care or Nonreceipt of Needed Dental Care Due to Cost

During 2003–2013, the percentage of adults aged 18–64 who delayed or did not receive needed medical care, and those who did not receive needed dental care, in the past 12 months due to cost was higher for those living below 200% of the poverty level than for those in higher income groups.

During 2003–2013, the percentage of adults aged 18–64 who delayed or did not receive needed medical care in the past 12 months due to cost was higher for adults living below 200% of the poverty level than for those with higher family income. During 2003–2010, the percentage increased for all poverty levels, then declined during 2010–2013 for those in families at 200%–399% of the poverty level while remaining stable for other poverty levels.

During 2003–2013, nonreceipt of needed dental care due to cost was higher for adults living below 200% of the poverty level than for those with higher family income. During 2003–2010, the percentage increased for all poverty levels, then declined during 2010–2013 for those in families at 200%–399% of the poverty level while remaining stable for other poverty levels.

Figure 18. Delay or nonreceipt of needed medical care or nonreceipt of needed dental care in the past 12 months due to cost among adults aged 18–64, by percent of poverty level: United States, 2003–2013
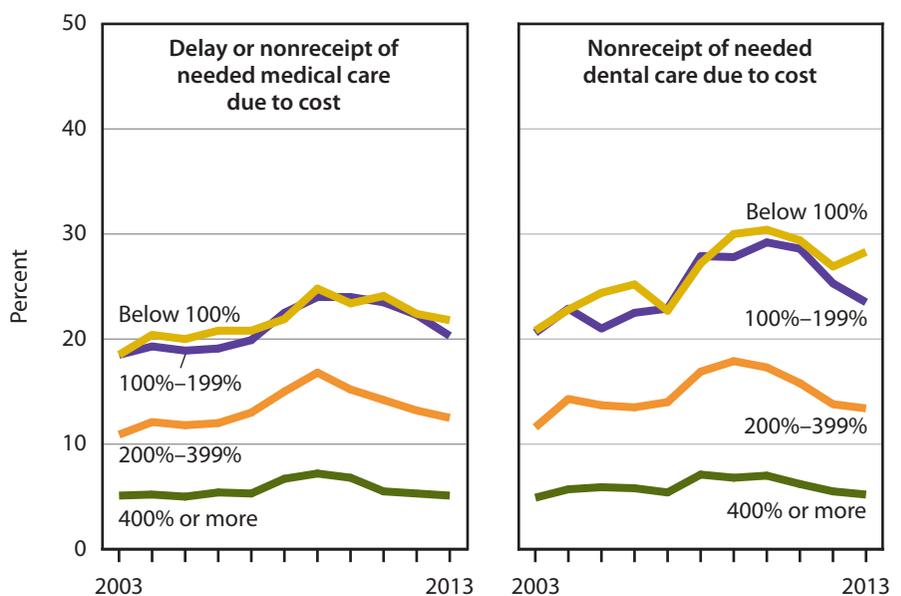
Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig18

Personal Health Care Expenditures

Major Source of Funds

Figure 19. Personal health care expenditures, by source of funds: United States, 2003–2013
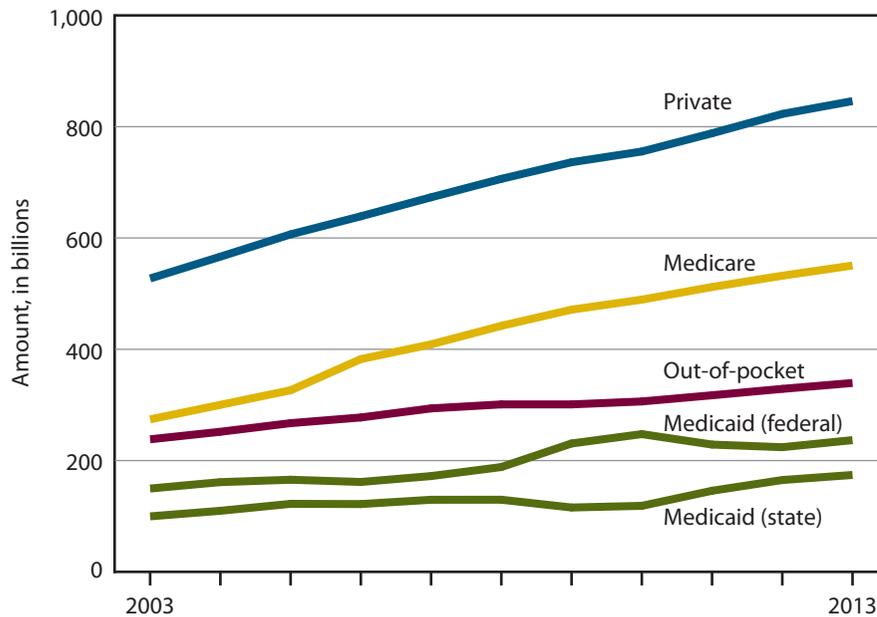
Out-of-pocket spending for personal health care expenditures grew less rapidly than Medicare, federal and state Medicaid, and private insurance spending between 2003 and 2013.

Between 2003 and 2013, total personal health care expenditures grew from $1.5 trillion to $2.5 trillion (Table 104). During this period, the average annual growth in Medicare expenditures was 7.2%; for Medicaid (federal) it was 4.7%, for Medicaid (state) 5.7%, for private health insurance 4.8%, and for out-of-pocket spending 3.6%. In 2013, private health insurance spending for personal health care expenditures was $846.0 billion; Medicare spending $550.5 billion, out-of-pocket spending $339.4 billion, Medicaid (federal) spending $236.7 billion, and Medicaid (state) spending $174.1 billion. The remainder was paid by other types of insurance, payers, and programs (Table 104) (32).

NOTE: Average annual percent change was computed from estimates shown in Table 104.
SOURCE: CDC/NCHS, *Health, United States, 2014*, Table 104. Data from the Centers for Medicare & Medicaid Services, National Health Expenditure Accounts (NHEA).

Special Feature on Adults Aged 55–64

Introduction

Each year, *Health, United States* examines a topic of importance to the health care system and this year's special feature explores the health of the 55–64 age group. Born during the Cold War, raised in the Sixties, and now with many of its members close to retirement, this group—the heart of the so-called "Baby Boom" generation—will have a significant effect on our health care system (33). The health of the 55–64 group merits review for several reasons. Within 10 years nearly all of this 55–64 age group will be covered by Medicare—a payer under financial pressure to serve current and future enrollees (34). Additionally, age 55–64 is a period of life increasingly influenced by chronic conditions, which are leading causes of death and disability in the United States (Tables 20 and 21) (35,36). As the 55–64 age group approaches the Medicare years, a relevant question for policymakers and health care administrators is how does the health of the current 55–64 age group compare with the health of those who were aged 55–64 ten years ago? Changes in the health status and well-being of today's 55- to 64-year-olds could have implications for future Medicare enrollment, utilization, and expenditures.

Between 2003 and 2013, the U.S. population aged 55–64 grew from 28 to 39 million (Table 1). In 2003, the 55–64 age group accounted for 9.7% of the population; by 2013, this share had increased to 12.4%. By 2030, the 55–64 age group will likely decrease to 10.8% as the Baby Boomers pass through this age group and swell the ranks of the 65–74 and 75–84 age groups (33). Nearly all of the current 55–64 age group reside in noninstitutionalized settings—about 0.4% of this age group lived in nursing homes and 0.4% were in correctional facilities in 2012 (37). For this reason, this examination of the 55–64 age group will focus on those in the civilian noninstitutionalized population.

Understanding the demographic and socioeconomic composition of the 55–64 age group is important because these characteristics are associated with health risk factors, disease prevalence, and access to care, which in turn drive health care utilization and expenditures (see Profile). The profile of the 55–64 group in 2012–2013 indicates that current 55- to 64-year-olds are more racially and ethnically diverse than their counterparts a decade earlier. Between 2002–2003 and 2012–2013, non-Hispanic white adults decreased from close to 79% of the 55–64 group to just under 74%, while non-Hispanic black adults rose from 9.5% to 10.9% and Hispanic adults aged 55–64 grew from 7.5% to almost 10%. Although educational attainment increased among 55- to 64-year-olds over the two time periods, the percentage with family income at or above 400% of the poverty level was lower in 2012–2013 than in 2002–2003. Fewer 55- to 64-year-olds reported being retired in 2012–2013 (14.6%) than in the earlier period (17.0%), while the

percentage not employed due to disability rose from 11.5% to 12.7%, and the percentage employed remained the same at approximately 60%. Those aged 55–64 in 2012–2013 were less likely to be married, and more likely to report cohabiting, than 55- to 64-year-olds 10 years previously. The current 55–64 group was almost twice as likely to report never marrying compared with their counterparts in 2002–2003 (7.3% compared with 4.4%).

Chronic conditions can begin at any age, including childhood. However, the prevalence of chronic conditions typically begins to rise in midlife and accumulates with advancing age (Tables 42, 44, 45, and 60) (Figure 21). By age 55–64, a significant segment of the civilian noninstitutionalized population has two or more chronic conditions (Table 43). Managing multiple chronic conditions can be a complex process involving visits to, and coordination among, numerous health care providers and specialists, taking multiple prescription drugs, and having many diagnostic tests, procedures, and surgeries (38). Chronic conditions are leading causes of death, with cancer and heart disease together accounting for over one-half of deaths among those aged 55–64 [55.0% in 2013 (39)].

Having affordable, comprehensive health insurance is important for the 55–64 age group because of the need to access the health care system to manage acute and chronic conditions, to obtain recommended prevention and screening, and to treat injuries (40,41). Lack of coverage (42,43) and underinsurance (44) are major barriers to access, and have been long-standing policy concerns for those aged 55–64 (45,46). For those aged 55–64, employer-sponsored health insurance is the major source of coverage, but the percentage with employer-sponsored coverage has been declining (Table 112 and Figure 25) (47). In addition, there is concern that those aged 55–64 who are currently employed will not be able to carry employer-sponsored coverage into retirement as employers increasingly change, reduce, or eliminate retiree coverage as an employee benefit (48).

Within the next 10 years, nearly all those currently aged 55–64 will be covered by Medicare. Being uninsured at 55–64 may have an impact on future use of Medicare benefits. A recent study found that Medicare use for those who were uninsured at age 55–64, in terms of total expenditures or number of hospitalizations, did not differ from those who were previously privately insured at age 55–64 (49). However, the previously uninsured used Medicare services differently with fewer office-based physician visits and more emergency and hospital outpatient department visits than those 55- to 64-year-olds who had private insurance prior to obtaining Medicare coverage.

This Special Feature explores recent trends in important health issues for the 55–64 age group. The charts that follow provide detailed comparisons on key measures of mortality, health status, health care access, and utilization between those aged 55–64 in 2002–2003 and the current 55- to 64-year group. Differences by gender, socioeconomic status, and racial and ethnic group within this age group are also presented. Featured charts include leading causes of death; prevalence of chronic physical and mental health conditions; health behavior patterns (specifically, current cigarette smoking and participation in leisure-time physical activity); health insurance coverage; utilization of various sectors of the health care system, prescription drugs, and prevention-related services; and finally, an examination of problems accessing the health care system due to financial considerations. Together, the special feature charts provide an overview of the health and well-being of the current 55–64 group as they approach retirement age and enrollment in the Medicare program, noting similarities and differences with 55- to 64-year-olds a decade ago, who are now enrolled in Medicare.

Health, United States, 2014: Profile of the 55–64 age group

Characteristic	2002–2003		2012–2013	
	Percent distribution	SE	Percent distribution	SE
Sex				
Men	48.0	0.3	48.0	0.3
Women	52.0	0.3	52.0	0.3
Race/ethnicity[1]				
Hispanic	7.5	0.2	9.6	0.3
Not Hispanic:				
White only.	78.9	0.5	73.6	0.5
Black only.	9.5	0.4	10.9	0.3
Education[2]				
Less than high school diploma.	16.1	0.4	11.7	0.3
High school diploma or GED	31.8	0.5	27.4	0.4
Some college	25.0	0.4	29.6	0.4
Bachelor's degree or higher	27.1	0.5	31.3	0.5
Percent of poverty level[3]				
Below 100%.	9.3	0.3	10.0	0.3
100%–199%.	13.7	0.4	14.7	0.4
200%–399%.	27.9	0.5	28.1	0.4
400% or more.	49.1	0.6	47.2	0.6
Employment status in past week[4]				
Employed	60.0	0.5	61.4	0.4
Not employed due to retirement.	17.0	0.4	14.6	0.3
Not employed due to disability	11.5	0.3	12.7	0.3
Other	11.5	0.3	11.3	0.2
Marital Status				
Married	71.7	0.5	67.6	0.4
Divorced or separated	14.6	0.3	16.5	0.3
Widowed	6.8	0.2	4.7	0.2
Never married.	4.4	0.2	7.3	0.2
Cohabitating.	2.5	0.2	3.9	0.2

SE is standard error.

[1]Does not sum to 100% because all racial and ethnic groups are not presented.

[2]GED is General Educational Development high school equivalency diploma. See Appendix II, Education.

[3]Percent of poverty level is based on family income and family size and composition, using U.S. Census Bureau poverty thresholds. Missing family income data were imputed.

[4]Employment status was assessed by asking respondents what they were doing last week. If they responded they had a job but were not working or not working and not looking for work, a followup question was asked that probed the main reason they were not working last week. Other includes adults who were looking for work, or those who were not working and not looking for work (excluding those who responded they were not looking for work because they were retired or disabled).

NOTES: The detailed Trend Tables contained in *Health, United States, 2014* provide additional data for the 55–64 age group: population numbers (Table 1), death rates (Tables 23–34), morbidity measures (Tables 42, 43, 46, 48–50, 51, 52, 58, 60, 61, 63, and 64), health care access and utilization of health care (Tables 68, 69, 71, 77, 80, 82, 83, 87, and 88), and health insurance coverage (Tables 111–114).

SOURCE: CDC/NCHS, National Health Interview Survey, family core questionnaire. See Appendix I, National Health Interview Survey (NHIS).

Leading Causes of Death

In 2013, all-cause death rates for adults aged 55–64 were lower for both men and women compared with 2003, driven by decreases in death rates for the top two leading causes of death for this group—cancer and heart disease.

Death rates are one summary measure of population health and well-being. Variation in death rates between groups is associated with underlying distributions of health determinants and risk factors, access to and use of health services, and public health efforts aimed at health promotion and disease prevention (50).

All-cause death rates in 2013 for those aged 55–64 were 6% lower for men and 11% lower for women than in 2003. In both time periods, all-cause death rates were higher for men aged 55–64 than for women (68% higher in 2013).

For men aged 55–64, the death rate for cancer—the leading cause of death in both periods—was 14% lower in 2013 than in 2003, and the death rate for heart disease was 19%

lower. In contrast, unintentional injury death rates were 31% higher in 2013, driven by a more than threefold increase in drug poisoning death rates (39); chronic liver disease death rates were 33% higher than in 2003. Compared with 2003, death rates among men aged 55–64 in 2013 were lower for chronic lower respiratory diseases (CLRD) (6%) and diabetes (7%).

For women aged 55–64, the death rate for cancer—the leading cause of death in both periods—was 18% lower in 2013 than in 2003, heart disease death rates were 24% lower, and CLRD death rates were 6% lower. Unintentional injury death rates were 35% higher, driven by a more than threefold increase in drug poisoning death rates (39). Both diabetes and stroke death rates were lower in 2013 than in 2003 (22% and 25% lower, respectively).

Figure 20. Death rates for leading causes of death among adults aged 55–64, by sex: United States, 2003–2013
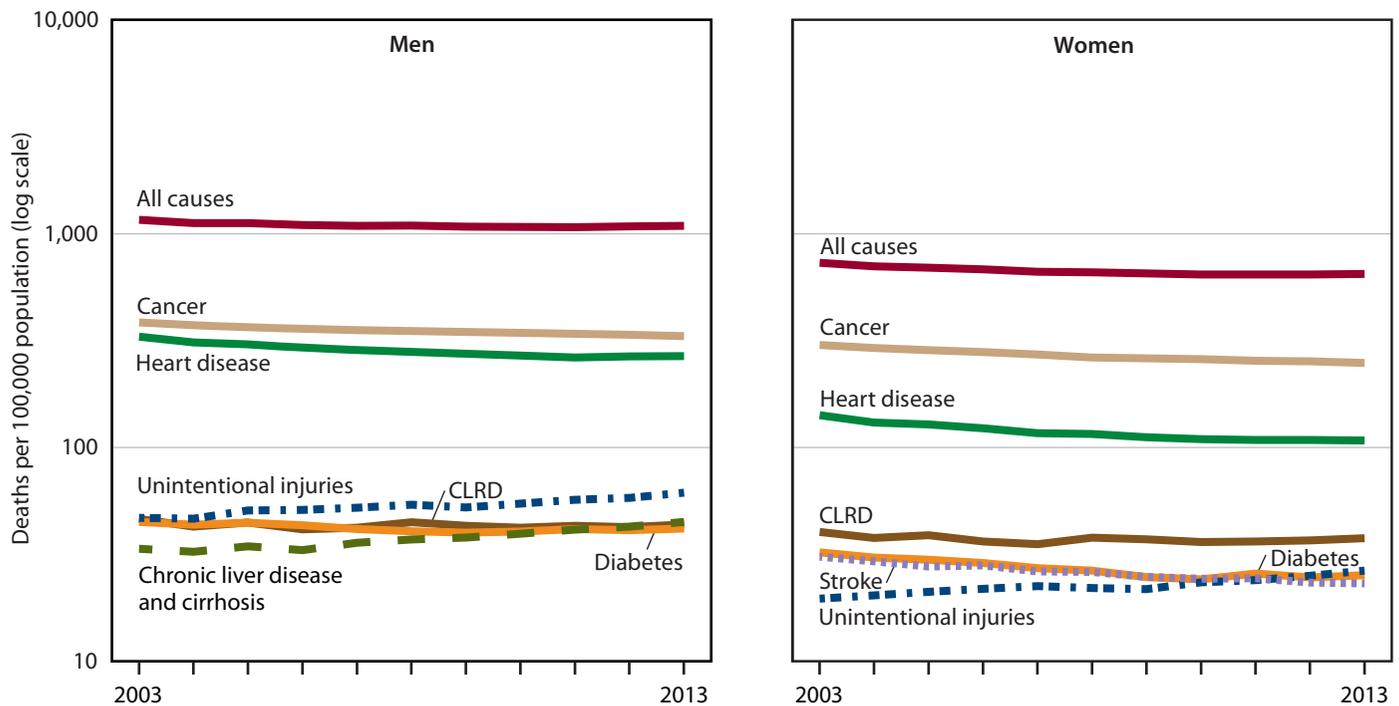
NOTES: CLRD is chronic lower respiratory diseases. Diabetes coding rules changed starting in 2011 resulting in an increased number of deaths coded to this cause. See data table for Figure 20.

SOURCE: CDC/NCHS, National Vital Statistics System. See Appendix I, National Vital Statistics System (NVSS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig20

Selected Chronic Conditions

For adults aged 55–64, the percentage with hyper-cholesterolemia was higher in 2009–2012 (50.1%) than in 1999–2002 (39.1%), while the prevalence of other selected chronic conditions was similar in both time periods.

Chronic conditions are common among those aged 55–64 and necessitate periodic contact with the health care system for monitoring, treatment, and control to promote optimum health and wellness. Obesity increases the risk of heart disease, stroke, diabetes, certain cancers, kidney disease, and osteoarthritis (51). Diabetes increases the risk of heart disease, stroke, kidney disease, blindness, and peripheral nerve disease (52,53). High serum cholesterol levels increase the risk of heart disease and stroke (54). High blood pressure also increases the risk of heart disease and stroke (55).

In 2009–2012, about 2 in 10 (18.9%) of those aged 55–64 had diabetes[a], and 4 in 10 were obese[b] (40.6%), similar to

the levels in 1999–2002. In 2009–2012, one-half (50.1%) of those aged 55–64 had hypercholesterolemia[c] (defined as taking cholesterol-lowering medication or having a measured serum total cholesterol level of at least 240 mg/dL), up from 39.1% in 1999–2002. The percentage with measured high cholesterol was stable, but the percentage taking cholesterol-lowering drugs increased (Table 61) (56). Additionally, one-half (51.4%) of those aged 55–64 in 2009–2012 had hypertension[d], similar to the level in 1999–2002.

Increases in the prevalence of chronic conditions may be related to a variety of factors, including higher incidence (new cases), longer duration with the condition, and increased diagnosis.

Figure 21. Selected chronic conditions among adults aged 55–64: United States, 1999–2002 and 2009–2012
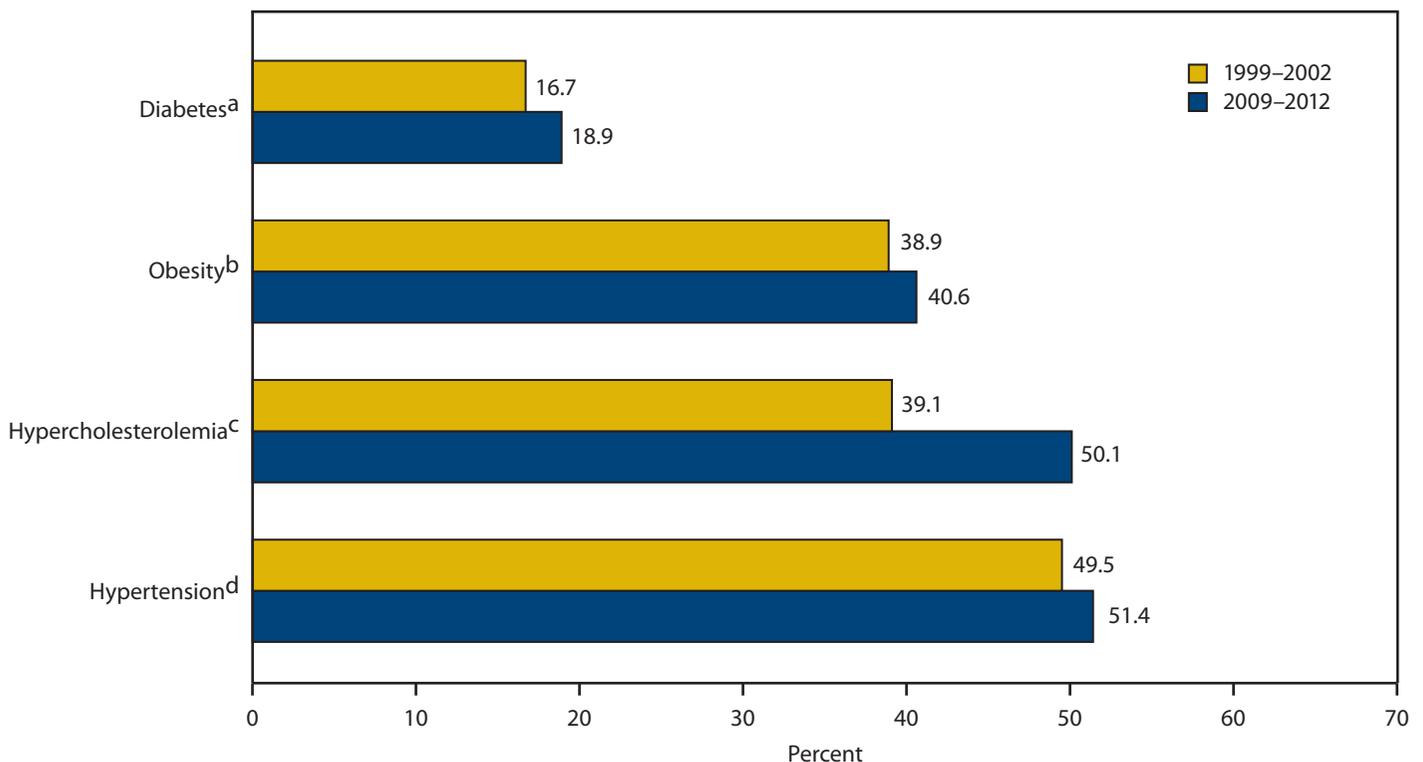
[a]Defined as respondent report of physician-diagnosed diabetes, or undiagnosed diabetes (measured fasting plasma glucose of at least 126 mg/dL or a hemoglobin A1c of at least 6.5%).
[b]Defined as body mass index greater than or equal to 30.
[c]Defined as reporting taking cholesterol-lowering medication or having a measured serum total cholesterol level of at least 240 mg/dL.

[d]Defined as reporting taking antihypertensive medication or having a measured systolic blood pressure of at least 140 mm Hg or a measured diastolic blood pressure of at least 90 mm Hg.

NOTE: See data table for Figure 21.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey. See Appendix I, National Health and Nutrition Examination Survey (NHANES).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig21

Health, United States, 2014: In Brief ■ Complete report available from: http://www.cdc.gov/nchs/hus.htm.

Psychological Distress: Serious or Mild-moderate

The prevalence of serious psychological distress for those aged 55–64 was 22% higher in 2012–2013 (4.4%) than in 2002–2003 (3.6%), while the prevalence of mild-moderate psychological distress for those aged 55–64 was similar in both periods (7.1% and 6.4%, respectively).

Mental health is a key component of overall health and well-being (57). Mental illnesses and conditions are serious, disabling, and costly (2,58–62). Two measures of psychological distress (serious and mild-moderate) are explored based on respondents' responses to a series of six questions—the K6 scale—that asks how frequently they experienced symptoms of general psychological distress within the past 30 days (see data table for Figure 22) (63–66).

For adults aged 55–64, 4.4% had serious psychological distress (SPD) in the past 30 days in 2012–2013, 22% higher than in 2002–2003 (3.6%). The percentage with SPD was higher in 2012–2013 than in 2002–2003 for men and for non-Hispanic white persons. The percentage who

experienced SPD varied by gender, racial and ethnic group, and family income for those aged 55–64. In 2012–2013, SPD prevalence was higher for women (5.0%) than for men (3.7%) and was higher for Hispanic adults (5.7%) than non-Hispanic black adults (3.6%). The prevalence of SPD was more than nine times as high for those living below poverty (14.5%) as for those at 400% or more of poverty (1.5%).

In 2012–2013, 7.1% of adults aged 55–64 experienced mild-moderate psychological distress (MMPD) in the past 30 days, similar to the percentage for the 55–64 group in 2002–2003 (6.4%). As with SPD, MMPD varied by gender, racial and ethnic group, and family income. In 2012–2013, prevalence of MMPD was higher for women (7.8%) than men (6.3%) and for Hispanic adults (9.9%) than non-Hispanic white (6.7%) adults. The prevalence of MMPD was more than five times as high for those living below poverty (17.1%) as for those at 400% or more of poverty (3.1%) in 2012–2013.

Figure 22. Serious or mild-moderate psychological distress in the past 30 days among adults aged 55–64, by selected characteristics: United States, average annual 2002–2003 and 2012–2013
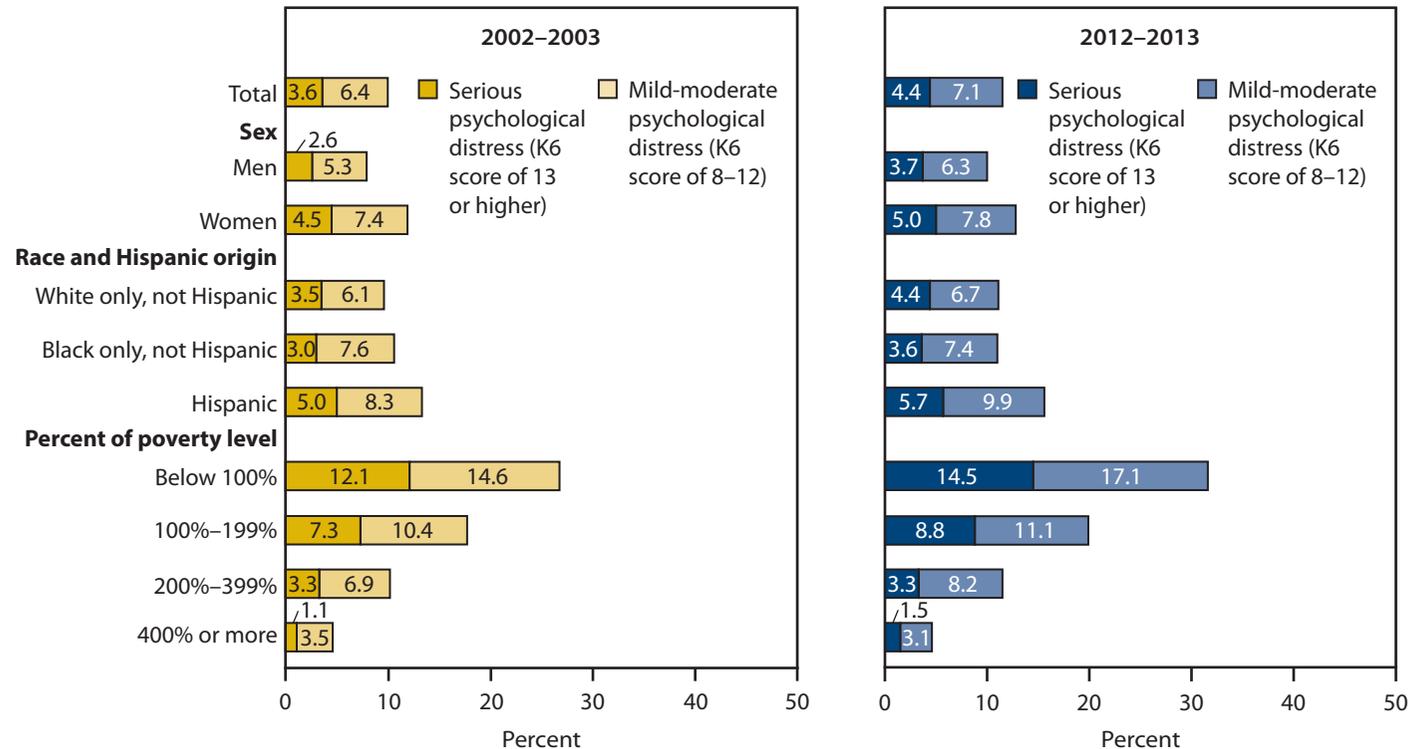
NOTE: See data table for Figure 22.

SOURCE: CDC/NCHS, National Health Interview Survey. See Appendix I, National Health Interview Survey (NHIS).

Excel and PowerPoint: *http://www.cdc.gov/nchs/hus/contents2014.htm#fig22*

Current Cigarette Smoking

In 2012–2013, 18.1% of adults aged 55–64 were current cigarette smokers, 8% lower than the percentage in 2002–2003 (19.7%); cigarette smoking prevalence varied by sociodemographic group.

Tobacco use remains the leading preventable cause of death in the United States, resulting in about 480,000 deaths across all ages for each year during 2005–2009 (67). Tobacco use is associated with death from many types of cancer, heart disease, diabetes, stroke, and chronic obstructive pulmonary disease (67–69)—all of which are major causes of death for those 55–64 (Figure 20). Quitting smoking has immediate health benefits, and in the long-term, the risks of smoking-related diseases decrease (67,70–72).

In 2012–2013, 18.1% of adults aged 55–64 were current cigarette smokers, which was 8% lower than the percentage for 55- to 64-year-olds in 2002–2003 (19.7%). The percentage of adults aged 55–64 who were current smokers in 2012–2013 was lower than in 2002–2003 for women, Hispanic persons, and those living at 400% or more of poverty.

Cigarette smoking varies by gender, racial and ethnic group, and family income for those aged 55–64. In 2012–2013, men (20.7%) were more likely than women (15.7%), and non-Hispanic white (18.8%) and non-Hispanic black (21.5%) adults were more likely than Hispanic (10.1%) adults to be current smokers. Those living below poverty (32.4%) were nearly three times as likely to be current smokers as those at 400% or more of poverty (11.2%) in 2012–2013.

Figure 23. Current cigarette smoking among adults aged 55–64, by selected characteristics: United States, average annual 2002–2003 and 2012–2013
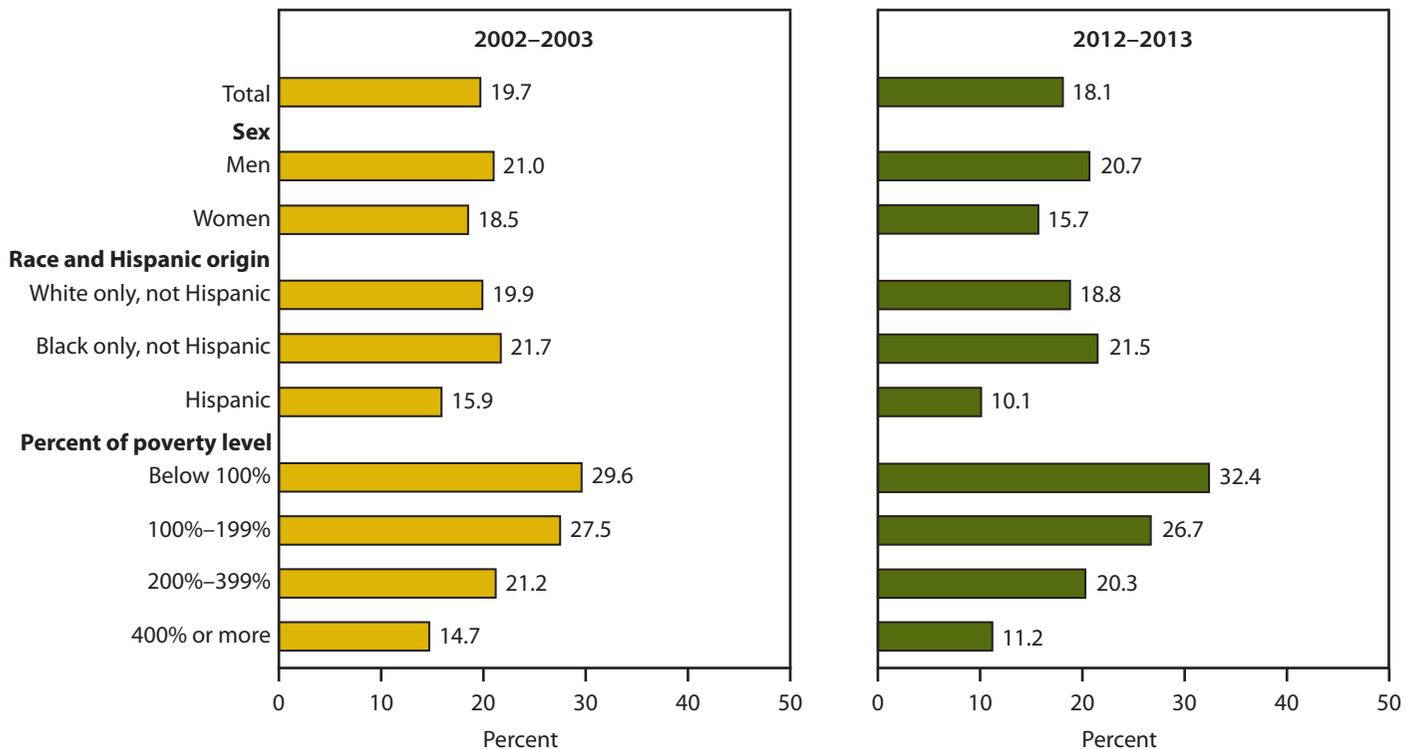
NOTE: See data table for Figure 23.

SOURCE: CDC/NCHS, National Health Interview Survey. See Appendix I, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig23

Leisure-time Physical Activity

In 2012–2013, the percentage of adults aged 55–64 who engaged in leisure-time aerobic and muscle-strengthening activities at levels sufficient to meet federal guidelines was 23% higher than in 2002–2003; participation in leisure-time aerobic and muscle-strengthening activities varied by sociodemographic group.

Physical activity has many positive health benefits, including assisting with weight control, reducing the risk for many chronic conditions including heart disease and some cancers, strengthening bones and musculature, improving mental health, and decreasing the risk of premature death (16,73–77). The *2008 Physical Activity Guidelines for Americans* recommend adults perform at least 150 minutes a week of moderate-intensity, or 75 minutes a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity (77). Aerobic activity should be performed in episodes of at least 10 minutes. In addition, adults should perform muscle-strengthening activities that are of

moderate or high intensity and involve all major muscle groups on 2 or more days a week.

In 2012–2013, 15.7% of adults aged 55–64 met both the aerobic activity and muscle-strengthening (AAMS) guidelines, 23% higher than in 2002–2003 when 12.8% met the guidelines. For adults aged 55–64, the percentage who met AAMS guidelines was higher in 2012–2013 compared with 2002–2003 for all sociodemographic groups examined, except among Hispanic persons and those living at 100%–199% of poverty, where percentages were similar to the earlier period.

Participation in AAMS varies by gender, racial and ethnic group, and family income for adults aged 55–64. In 2012–2013, men (17.2%) were more likely than women (14.2%), and non-Hispanic white (17.0%) adults were more likely than non-Hispanic black (12.3%) and Hispanic (10.2%) adults to have met AAMS guidelines. In 2012–2013, adults aged 55–64 living below 200% of the poverty level were less likely to have met both AAMS guidelines than those with higher family income.

Figure 24. Participation in recommended levels of leisure-time aerobic and muscle-strengthening activities among adults aged 55–64, by selected characteristics: United States, average annual 2002–2003 and 2012–2013
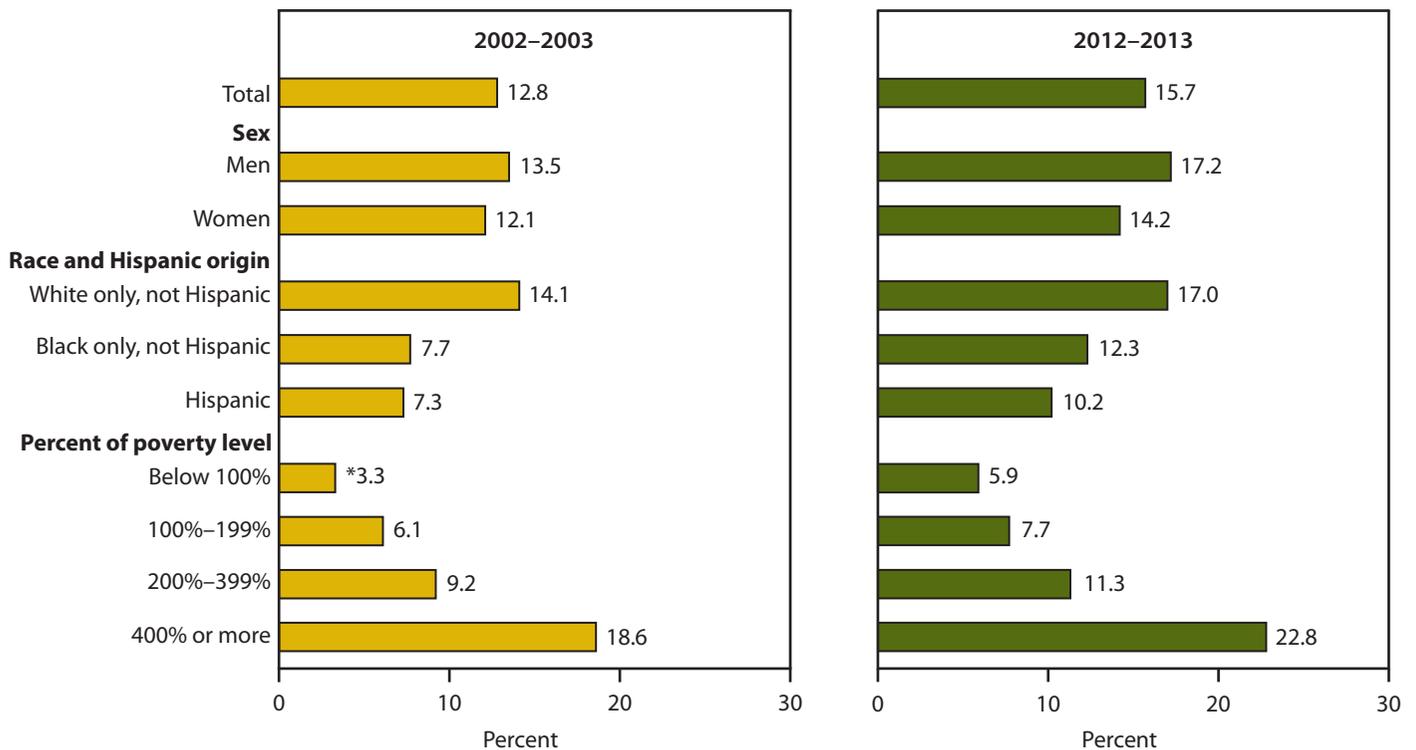
* Estimate is considered unreliable and has a relative standard error of 20%–30%.
NOTES: Participants met the *2008 Physical Activity Guidelines for Americans* for aerobic activity and muscle strengthening. See data table for Figure 24.

SOURCE: CDC/NCHS, National Health Interview Survey. See Appendix I, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig24

Health Insurance Coverage

For adults aged 55–64, the percentage with private health insurance was lower for all family income groups in 2012–2013 compared with 2002–2003, with the largest loss of private coverage occurring for those with family income below 200% of the poverty level.

Health insurance coverage is a major determinant for access to the health care system and influences both health care utilization patterns and health outcomes (78).

Across all income groups, the percentage of adults aged 55–64 with any private coverage—and private workplace coverage—was lower in 2012–2013 than in 2002–2003, while the percentage with only public coverage was higher in 2012–2013 than in the earlier period. The percentage of adults aged 55–64 who were uninsured was higher in 2012–2013 than in 2002–2003 for all income groups below 400% of poverty.

For adults aged 55–64 living below 100% of the poverty level, the percentage with private coverage in 2012–2013 (15.5%) was 43% lower than in 2002–2003 (27.3%), and the percentage with private coverage through the workplace (10.4% in 2012–2013)

was nearly 50% lower than in 2002–2003 (20.5%). For those living below 100% of the poverty level, the percentage with only public coverage was 17% higher and the percentage uninsured was 14% higher in 2012–2013 (32.0%) than in 2002–2003 (28.0%). Similarly, for those at 100%–199% and 200%–399% of the poverty level, the percentage with private coverage and workplace coverage was lower in 2012–2013 than in the earlier period, and the percentage with only public coverage and the percentage uninsured was higher. For those in the highest family income group, the percentage with private coverage was 2% lower in 2012–2013 (90.8%) than in 2002–2003 (92.5%), the percentage with only public coverage was 53% higher (5.5% compared with 3.6%), and the percentage uninsured was similar (about 4%).

In 2012–2013, a strong gradient persisted between family income and type of health insurance coverage. As family income decreased, the share with private coverage and private workplace coverage decreased, and the share with only public coverage, and the uninsured increased.

Figure 25. Health insurance coverage among adults aged 55–64, by percent of poverty level and type of coverage: United States, average annual 2002–2003 and 2012–2013

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig25

Health Care Utilization

For those aged 55–64, there were few changes in health care utilization in 2012–2013 compared with 2002–2003; utilization of the health care system varied by type of care.

Over the past few years, the United States has grappled with the issues of health reform and insurance coverage including how to ensure access and provide high-quality, safe, affordable, and appropriate care and how to pay for that care (42,44,48,79,80). The final charts in this Special Feature focus on the intertwined issues of health care access and utilization. Better understanding of recent utilization patterns is key for future planning because the aging of the historically large Baby Boom generation threatens to impact the capacity of the health care system and the sufficiency of the supply of health care workers (33,81,82).

In 2012–2013, 86.7% of adults aged 55–64 had at least one doctor visit in the past 12 months, 1% lower than in 2002–2003 (87.9%). The percentage of those aged 55–64

who had 1–3 doctor visits in the past 12 months was 10% higher in 2012–2013 (43.3%) than in 2002–2003 (39.5%), while the percentage with 4 or more doctor visits in the past 12 months was 10% lower in 2012–2013 (43.4%) when compared with visits in 2002–2003 (48.4%).

In 2012–2013, about one in five (18.1%) of those aged 55–64 had at least one emergency department visit in the past 12 months, similar to the percentage in 2002–2003. In 2012–2013, 10.1% of those aged 55–64 had at least one hospital stay in the past 12 months, 14% lower than in 2002–2003 (11.7%). In 2012–2013, 12.6% of those aged 55–64 did not have any doctor visits, emergency department visits, or hospitalizations in the past 12 months, which was 13% higher than in 2002–2003 (11.2%). Less than 1% of those aged 55–64 had an emergency department visit or a hospitalization, but no doctor visits, in 2012–2013 (data table for Figure 26).

Figure 26. Health care utilization in the past 12 months among adults aged 55–64, by type of visit: United States, average annual 2002–2003 and 2012–2013
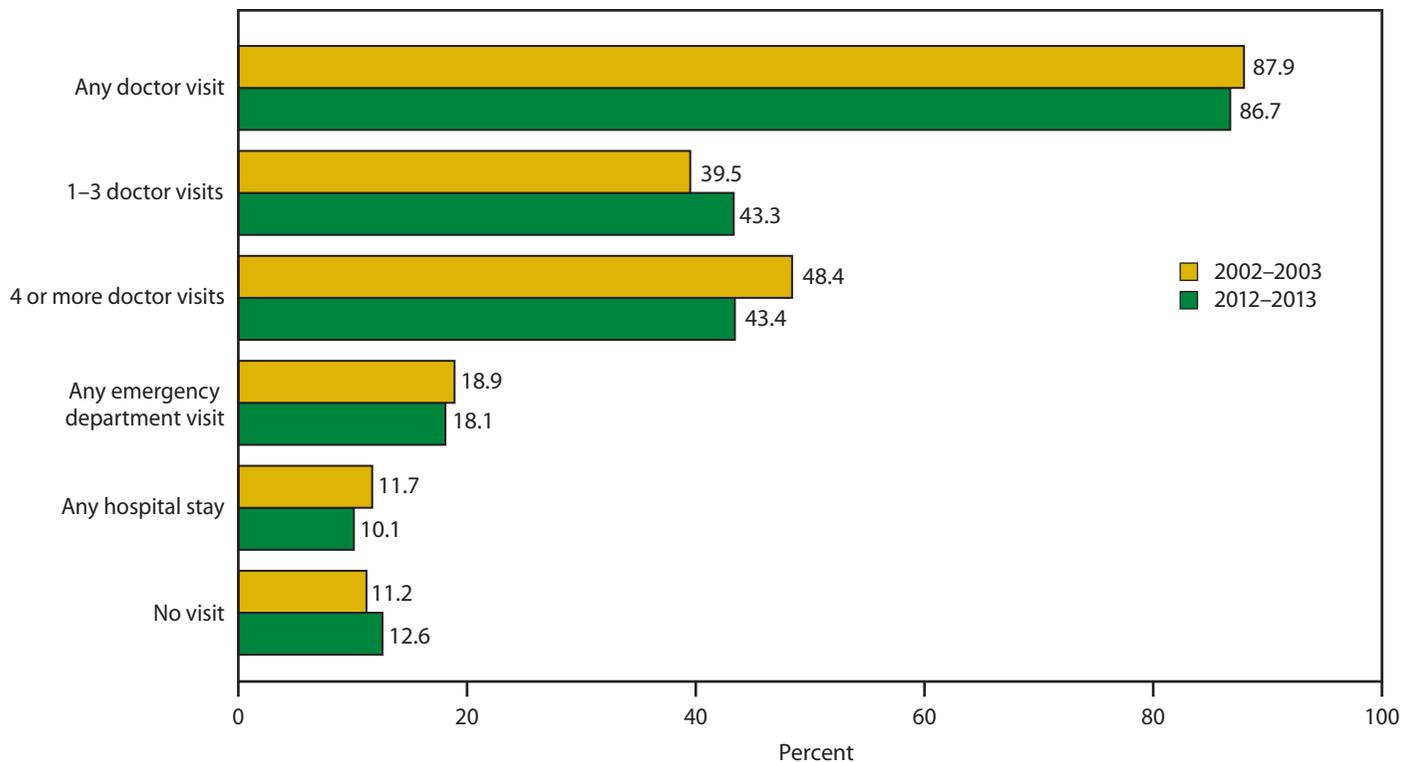
NOTES: No visit is no doctor visit, emergency department visit, or hospital stay, in the past 12 months. See data table for Figure 26.

SOURCE: CDC/NCHS, National Health Interview Survey. See Appendix I, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig26

Use of Preventive Services and Screening

For adults aged 55–64, utilization of annual influenza vaccination and colorectal procedures was higher in 2013 than in 2003, while use of pneumococcal vaccination for high-risk groups was at similar levels, and use of mammograms and Pap smears was lower than in the earlier period.

In addition to utilizing the health care system to diagnose, manage, and control acute and chronic conditions and treat injuries, adults aged 55–64 require access to address prevention and screening recommendations (24,83,84). CDC recommends annual influenza vaccination for all adults and pneumococcal vaccination for adults under age 65 in high-risk categories (83). The U.S. Preventive Services Task Force recommends periodic colorectal screening for those aged 50–75, breast cancer screening for women aged 50–74, and cervical cancer screening for women aged 21–65 (24). However, screening guidelines and frequencies differ for those in high-risk categories, have changed over time, and vary by recommending organization (85,86).

In 2013, 49.9% of adults aged 55–64 had an influenza vaccination in the past 12 months, 24% higher than in 2003 (40.4%). The percentage of adults aged 55–64 in high-risk groups who had ever received a pneumococcal vaccination was similar in the two periods (35.2% and 32.5%, respectively).

Utilization of colorectal, breast, and cervical cancer procedures can occur for routine screening or for diagnostic reasons. In 2013, 58.3% of adults aged 55–64 had a colorectal test or procedure, 46% higher than 2003 (40.0%) (see data table for Figure 27 for definition of colorectal test or procedure). In 2013, 71.3% of women aged 55–64 had a mammogram in the past 2 years, 7% lower than 2003 (76.9%). In 2013, 75.9% of women aged 55–64, who had not had a hysterectomy, had a Pap smear in the past 3 years, 11% lower than in 2000, when 85.5% of women aged 55–64 had a Pap smear.

Figure 27. Use of preventive services and screening among noninstitutionalized adults aged 55–64: United States, 2003 and 2013
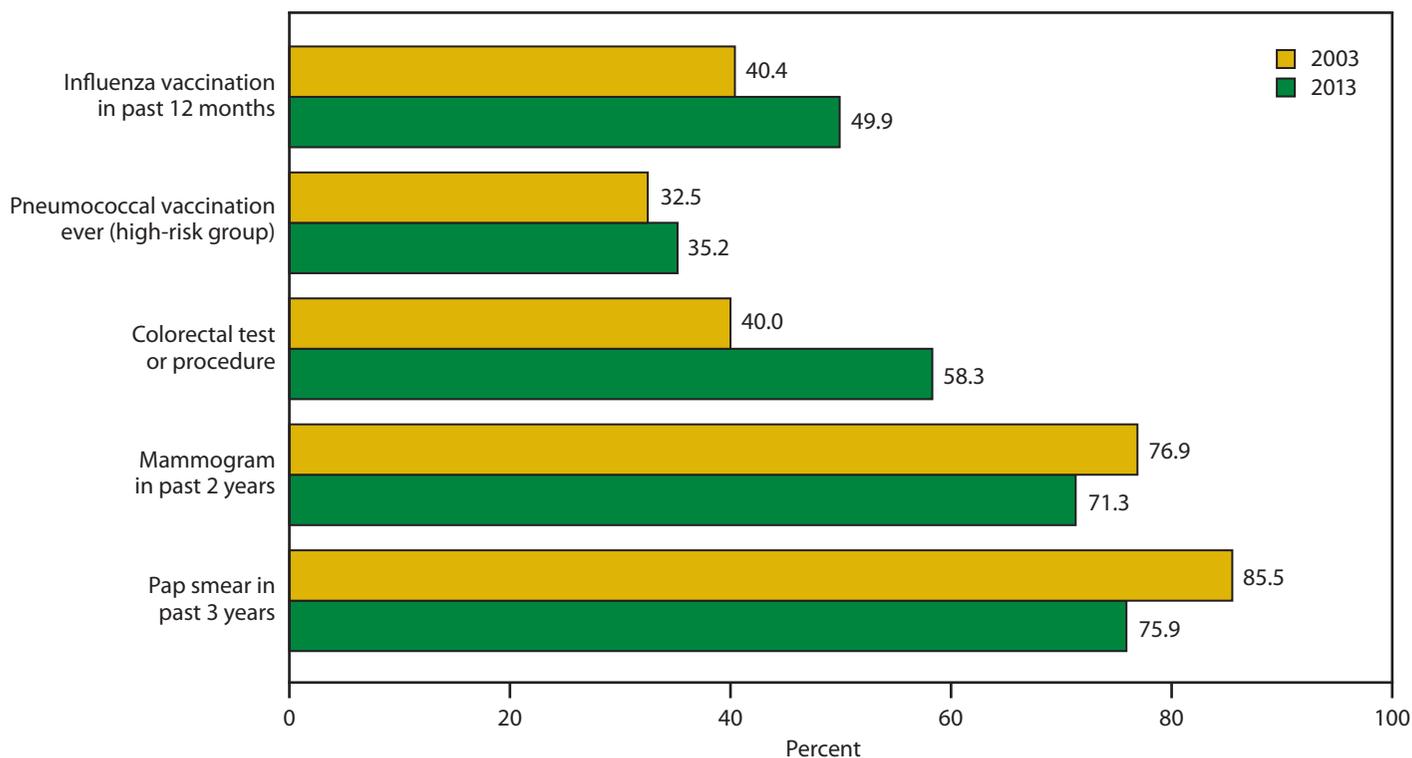
NOTES: The pneumococcal high-risk group includes persons who reported diabetes; cancer; heart, lung, liver, or kidney disease; or cigarette smoking. Colorectal test or procedure is fecal occult blood test (FOBT) in the past year, sigmoidoscopy in the past 5 years with FOBT in the past 3 years, or colonoscopy in the past 10 years.

Data shown for Pap smear were for 2000 and 2013 and were for women who have not had a hysterectomy. See data table for Figure 27.

SOURCE: CDC/NCHS, National Health Interview Survey. See Appendix I, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig27

Prescription Drug Use

In 2009–2012, the percentage of adults aged 55–64 who took no, 1–4, or 5 or more prescription drugs in the past 30 days was similar to levels in 1999–2002; use of prescription cholesterol-lowering drugs was 54% higher among 55- to 64-year-olds in 2009–2012 compared with 1999–2002.

Prescription drugs play an important role in preventing, treating, ameliorating, and curing health conditions and disease for those aged 55–64 (87). Major technological advances resulting in more drugs coming to market combined with increases in clinical recommendations for tighter control of chronic conditions, which often affect those aged 55–64 (Figure 21), have contributed to the use of prescription drugs (88,89).

In 2009–2012, 24.2% of adults aged 55–64 did not use any prescription drugs in the past 30 days, 55.6% used 1–4 prescription drugs, and 20.3% used 5 or more prescription drugs in the past 30 days, which was similar to levels in 1999–2002.

In 2009–2012 compared with 1999–2002, the percentage of adults aged 55–64 who took selected prescription drugs in the past 30 days was 54% higher for cholesterol-lowering drugs, 78% higher for gastric reflux drugs, 40% higher for antidepressant drugs, and 29% higher for antidiabetic drugs. In contrast, the percentage of adults aged 55–64 who took prescription cardiovascular agents (which include heart, blood pressure, and kidney drugs) and the percentage who took prescription analgesics were similar to the levels in 1999–2002.

In 2009–2012, nearly one-half (45.0%) of adults aged 55–64 took a prescription cardiovascular drug in the past 30 days, nearly one-third (31.8%) took a prescription cholesterol-lowering drug, and 16.0% used prescription gastric reflux medications (for anti-acid reflux and stomach ulcers). Fifteen percent of those aged 55–64 used prescription analgesics (narcotics, nonsteroidal anti-inflammatory drugs, and aspirin), and 14.4% used prescription antidepressants in the past 30 days. Antidepressant drugs can be prescribed for a wide variety of clinical reasons (90,91). In 2009–2012, 12.9% of those aged 55–64 used prescription antidiabetic agents in the past 30 days.

Figure 28. Prescription drug use in the past 30 days among adults aged 55–64, by number of drugs and selected drug class: United States, 1999–2002 and 2009–2012
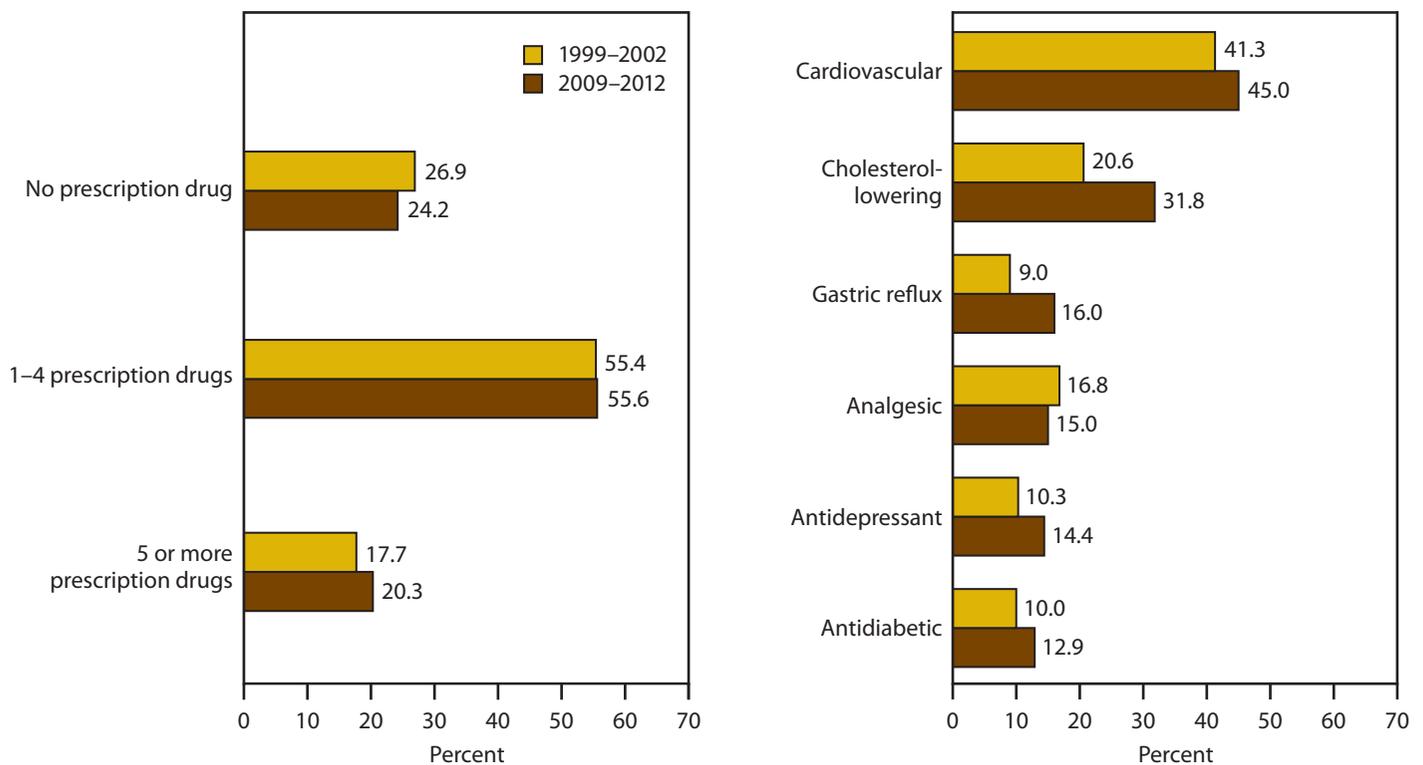
NOTE: See data table for Figure 28 for indications and conditions for which drug classes are commonly prescribed.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey. See Appendix I, National Health and Nutrition Examination Survey (NHANES).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig28

Delay or Nonreceipt of Medical Care or Nonreceipt of Prescription Drugs Due to Cost

For adults aged 55–64, the percentage who delayed or did not receive needed medical care due to cost in the past 12 months, or who did not receive needed prescription drugs due to cost in the past 12 months, was higher in 2012–2013 than in 2002–2003 and varied by insurance coverage.

Forgoing or delaying needed health care can have serious health effects (92). Access to care is a complex process that addresses the extent to which a population can connect with health care and reflects the affordability, availability, and acceptability of health services (93). Health insurance facilitates access to health care by connecting individuals to health care providers and by covering a portion of the cost of care (94).

In 2012–2013, 13.2% of adults aged 55–64 delayed or did not receive needed medical care in the past 12 months due to cost, 39% higher than in 2002–2003 (9.5%). For adults aged 55–64 who were insured for the entire past year, the percentage who delayed or did not receive needed medical care due to cost was 32% higher in 2012–2013 (7.8%) than in 2002–2003 (5.9%). The percentage of adults aged 55–64 who were uninsured for all or some of the past year and who

delayed or did not receive needed medical care due to cost was 14% higher in 2012–2013 (44.2%) compared with 2002–2003 (38.7%).

In 2012–2013, 8.8% of adults aged 55–64 did not receive needed prescription drugs in the past 12 months due to cost, 26% higher than in 2002–2003 (7.0%). For adults who were insured for the entire past year, the percentage who did not receive needed prescription drugs due to cost was 25% higher in 2012–2013 (5.5%) than in 2002–2003 (4.4%). For those who were uninsured for all or part of the year, 26.7% did not receive needed prescription drugs due to cost in 2012–2013, similar to the level in 2002–2003.

An association exists between not receiving needed medical care and prescription drugs due to cost and insurance status. In 2012–2013, for adults aged 55–64, those who were uninsured for some or all of the past year were 5.7 times as likely to delay or not receive needed medical care due to cost and 4.9 times as likely to not receive needed prescription drugs due to cost as those who were continuously insured in the past year.

Figure 29. Adults aged 55–64 who delayed or did not receive needed medical care or needed prescription drugs due to cost in the past 12 months, by insurance status: United States, average annual 2002–2003 and 2012–2013

Delay or nonreceipt of needed medical care due to cost in past 12 months

	2002–2003	2012–2013
Total	9.5	13.2
Insured all year	5.9	7.8
Uninsured all or part of past year	38.7	44.2

Nonreceipt of needed prescription drugs due to cost in past 12 months

	2002–2003	2012–2013
Total	7.0	8.8
Insured all year	4.4	5.5
Uninsured all or part of past year	27.5	26.7
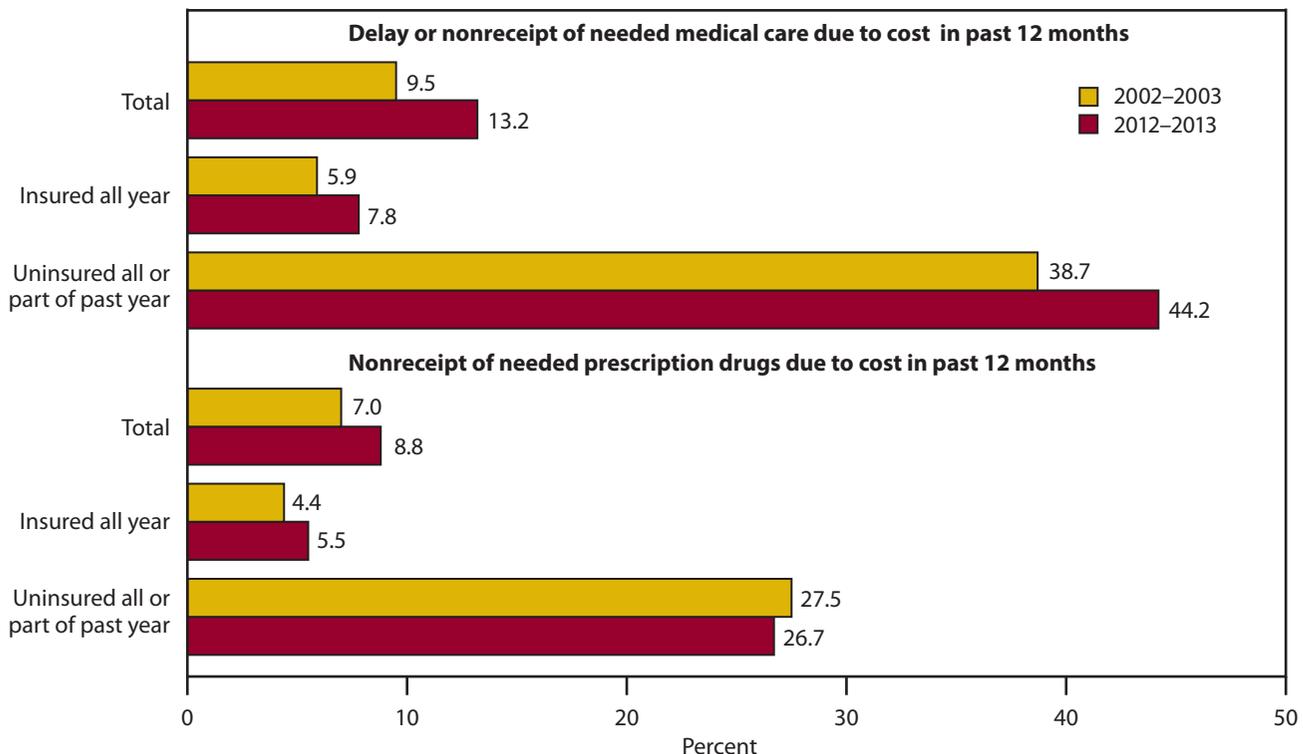
NOTE: See data table for Figure 29.

SOURCE: CDC/NCHS, National Health Interview Survey. See Appendix I, National Health Interview Survey (NHIS).

Excel and PowerPoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig29

Health, United States, 2014: In Brief ■ Complete report available from: http://www.cdc.gov/nchs/hus.htm.

Data table for Figure 20. Death rates for leading causes of death among adults aged 55–64, by sex: United States, 2003–2013

Excel and Powerpoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig20

Sex and underlying cause of death[1]	Rank 2013	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Both sexes						Deaths per 100,000 population						
All causes	. . .	937.3	903.2	898.5	881.3	866.7	867.1	856.7	851.9	849.4	854.2	860.0
Malignant neoplasms (Cancer).	1	341.6	330.8	323.9	317.7	311.4	304.7	301.7	300.1	295.8	293.2	288.2
Diseases of heart	2	232.3	217.1	212.8	205.1	197.8	195.3	190.0	186.6	183.2	184.6	184.6
Unintentional injuries.	3	32.7	32.9	35.4	35.8	36.8	37.4	36.5	38.4	39.8	41.0	43.4
Chronic lower respiratory diseases (CLRD) . . .	4	43.1	40.1	41.6	38.8	38.6	41.1	40.0	39.0	39.5	39.4	40.5
Diabetes[2]	5	38.3	36.8	36.9	35.8	34.1	33.3	32.1	32.0	33.3	32.5	33.2
Chronic liver disease and cirrhosis	6	22.9	22.4	23.3	22.6	24.2	25.0	25.9	26.8	28.2	29.1	30.4
Cerebrovascular diseases (Stroke).	7	35.5	34.0	32.7	32.9	31.7	30.6	29.7	29.3	29.4	28.7	28.9
Suicide	8	13.7	13.7	13.7	14.4	15.3	16.0	16.4	17.5	17.1	18.0	18.1
Septicemia	9	13.0	12.8	12.8	12.6	12.8	13.3	13.1	12.6	13.0	12.9	13.6
Nephritis, nephrotic syndrome and nephrosis[2]	10	13.6	13.5	13.5	13.7	13.4	14.1	13.5	13.9	12.5	12.3	12.6
Men												
All causes	. . .	1,159.9	1,119.2	1,119.8	1,097.5	1,086.5	1,089.8	1,078.4	1,075.5	1,071.1	1,080.2	1,088.4
Malignant neoplasms (Cancer)	1	384.9	373.5	365.8	359.4	353.9	349.3	345.9	344.9	340.4	336.9	331.3
Diseases of heart	2	330.0	310.1	303.9	293.4	285.1	280.8	274.1	269.5	263.6	266.4	267.3
Unintentional injuries	3	46.9	46.5	50.8	51.0	52.3	54.0	52.5	54.6	56.9	58.1	61.5
Chronic liver disease and cirrhosis	4	33.6	32.5	34.5	33.1	35.9	37.1	37.9	39.5	41.3	42.7	44.8
Chronic lower respiratory diseases (CLRD) . . .	5	46.3	42.7	44.6	41.4	42.1	44.7	43.1	42.2	43.0	42.4	43.7
Diabetes[2]	6	44.8	43.6	44.5	43.3	41.6	40.6	40.0	40.5	41.5	41.0	41.8
Cerebrovascular diseases (Stroke).	7	40.6	39.1	38.2	38.3	37.5	35.5	35.0	34.7	34.9	34.5	35.1
Suicide	8	22.1	21.9	22.0	22.5	23.9	25.8	26.1	27.7	27.3	28.7	28.3
Septicemia	9	14.0	13.7	14.0	13.9	13.8	14.7	14.3	13.9	14.4	14.5	15.3
Nephritis, nephrotic syndrome and nephrosis[2]	10	15.3	15.0	15.9	15.9	15.5	16.2	15.9	16.4	14.7	14.5	14.8
Women												
All causes	. . .	730.5	702.4	692.4	680.0	661.8	659.6	650.1	643.5	642.9	643.8	647.4
Malignant neoplasms (Cancer)	1	301.4	291.2	284.8	278.9	271.8	263.3	260.6	258.5	254.1	252.5	248.1
Diseases of heart	2	141.5	130.6	128.0	122.8	116.4	115.6	111.6	109.3	108.4	108.4	107.5
Chronic lower respiratory diseases (CLRD) . . .	3	40.2	37.7	38.8	36.3	35.2	37.8	37.1	36.1	36.3	36.7	37.6
Unintentional injuries	4	19.6	20.3	21.1	21.8	22.4	22.0	21.7	23.4	23.9	25.1	26.5
Diabetes[2]	5	32.3	30.5	29.8	28.8	27.2	26.5	24.7	24.1	25.7	24.6	25.2
Cerebrovascular diseases (Stroke).	6	30.8	29.3	27.7	28.0	26.3	26.1	24.8	24.3	24.4	23.3	23.1
Chronic liver disease and cirrhosis	7	13.0	13.1	12.8	12.8	13.2	13.7	14.6	14.9	16.0	16.5	17.0
Septicemia	8	12.1	11.9	11.6	11.4	11.8	12.1	11.9	11.4	11.7	11.4	12.0
Nephritis, nephrotic syndrome and nephrosis[2]	9	12.0	12.1	11.3	11.7	11.4	12.0	11.4	11.6	10.4	10.3	10.5
Influenza and pneumonia	10	9.4	8.8	9.0	7.7	7.4	8.8	9.9	8.0	8.9	8.1	10.0

See footnotes at end of table.

Data table for Figure 20. Death rates for leading causes of death among adults aged 55–64, by sex: United States, 2003–2013—Con.

Sex and underlying cause of death[1]	Rank 2013	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Both sexes						Standard error						
All causes	...	1.83	1.76	1.71	1.66	1.62	1.59	1.56	1.53	1.49	1.49	1.48
Malignant neoplasms (Cancer)	...	1.10	1.06	1.03	1.00	0.97	0.94	0.92	0.91	0.88	0.87	0.86
Diseases of heart	...	0.91	0.86	0.83	0.80	0.77	0.76	0.73	0.72	0.69	0.69	0.69
Unintentional injuries	...	0.34	0.34	0.34	0.34	0.33	0.33	0.32	0.32	0.32	0.33	0.33
Chronic lower respiratory diseases (CLRD)	...	0.39	0.37	0.37	0.35	0.34	0.35	0.34	0.33	0.32	0.32	0.32
Diabetes[2]	...	0.37	0.35	0.35	0.33	0.32	0.31	0.30	0.30	0.30	0.29	0.29
Chronic liver disease and cirrhosis	...	0.29	0.28	0.28	0.27	0.27	0.27	0.27	0.27	0.27	0.27	0.28
Cerebrovascular diseases (Stroke)	...	0.36	0.34	0.33	0.32	0.31	0.30	0.29	0.28	0.28	0.27	0.27
Suicide	...	0.22	0.22	0.21	0.21	0.21	0.22	0.22	0.22	0.21	0.22	0.21
Septicemia	...	0.22	0.21	0.20	0.20	0.20	0.20	0.19	0.19	0.18	0.18	0.19
Nephritis, nephrotic syndrome and nephrosis[2]	...	0.22	0.21	0.21	0.21	0.20	0.20	0.20	0.20	0.18	0.18	0.18
Men												
All causes	...	2.93	2.82	2.75	2.67	2.61	2.57	2.51	2.47	2.42	2.41	2.40
Malignant neoplasms (Cancer)	...	1.69	1.63	1.57	1.53	1.49	1.46	1.42	1.40	1.36	1.35	1.32
Diseases of heart	...	1.56	1.48	1.43	1.38	1.34	1.31	1.27	1.24	1.20	1.20	1.19
Unintentional injuries	...	0.59	0.57	0.59	0.58	0.57	0.57	0.55	0.56	0.56	0.56	0.57
Chronic liver disease and cirrhosis	...	0.50	0.48	0.48	0.46	0.47	0.47	0.47	0.47	0.47	0.48	0.49
Chronic lower respiratory diseases (CLRD)	...	0.59	0.55	0.55	0.52	0.51	0.52	0.50	0.49	0.48	0.48	0.48
Diabetes[2]	...	0.58	0.56	0.55	0.53	0.51	0.50	0.48	0.48	0.48	0.47	0.47
Cerebrovascular diseases (Stroke)	...	0.55	0.53	0.51	0.50	0.48	0.46	0.45	0.44	0.44	0.43	0.43
Suicide	...	0.41	0.39	0.39	0.38	0.39	0.40	0.39	0.40	0.39	0.39	0.39
Septicemia	...	0.32	0.31	0.31	0.30	0.29	0.30	0.29	0.28	0.28	0.28	0.28
Nephritis, nephrotic syndrome and nephrosis[2]	...	0.34	0.33	0.33	0.32	0.31	0.31	0.30	0.31	0.28	0.28	0.28
Women												
All causes	...	2.24	2.15	2.09	2.03	1.96	1.93	1.88	1.85	1.81	1.79	1.78
Malignant neoplasms (Cancer)	...	1.44	1.38	1.34	1.30	1.26	1.22	1.19	1.17	1.14	1.12	1.10
Diseases of heart	...	0.99	0.93	0.90	0.86	0.82	0.81	0.78	0.76	0.74	0.74	0.73
Chronic lower respiratory diseases (CLRD)	...	0.53	0.50	0.49	0.47	0.45	0.46	0.45	0.44	0.43	0.43	0.43
Unintentional injuries	...	0.37	0.37	0.36	0.36	0.36	0.35	0.34	0.35	0.35	0.35	0.36
Diabetes[2]	...	0.47	0.45	0.43	0.42	0.40	0.39	0.37	0.36	0.36	0.35	0.35
Cerebrovascular diseases (Stroke)	...	0.46	0.44	0.42	0.41	0.39	0.38	0.37	0.36	0.35	0.34	0.34
Chronic liver disease and cirrhosis	...	0.30	0.29	0.28	0.28	0.28	0.28	0.28	0.28	0.29	0.29	0.29
Septicemia	...	0.29	0.28	0.27	0.26	0.26	0.26	0.25	0.25	0.24	0.24	0.24
Nephritis, nephrotic syndrome and nephrosis[2]	...	0.29	0.28	0.27	0.27	0.26	0.26	0.25	0.25	0.23	0.23	0.23
Influenza and pneumonia	...	0.25	0.24	0.24	0.22	0.21	0.22	0.23	0.21	0.21	0.20	0.22

. . . Category not applicable.

[1]Underlying cause of death was coded according to the 10th Revision of the *International Classification of Diseases*. See Appendix II, Cause of death; Table IV.

[2]Starting with 2011 data, the rules for selecting Renal failure as the underlying cause of death were changed, affecting the number of deaths in the Nephritis, nephrotic syndrome and nephrosis and Diabetes categories. These changes directly affect deaths with mention of Renal failure and other associated conditions, such as Diabetes mellitus with renal complications. The result is a decrease in the number of deaths for Nephritis, nephrotic syndrome and nephrosis and an increase in the number of deaths for Diabetes mellitus. Therefore, trend data for these two causes of death should be interpreted with caution. For more information, see Technical Notes in Deaths: Preliminary data for 2011, available from: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf.

NOTES: Death rates for 2003–2009 were calculated using intercensal population estimates based on the 2000 and 2010 censuses. For 2010, population estimates were based on bridged-race April 1 census counts. Rates for 2011 and beyond were computed using 2010-based postcensal estimates. See Appendix I, Population Census and Population Estimates. Due to space limitations, the six leading causes of death are graphed in Figure 20.

SOURCE: CDC/NCHS, National Vital Statistics System: numerator data from annual public-use Mortality Files; denominator data from national population estimates. See Appendix I, National Vital Statistics System (NVSS).

Data table for Figure 21. Selected chronic conditions among adults aged 55–64: United States, 1999–2002 and 2009–2012

Chronic condition	1999–2002		2009–2012	
	Percent	SE	Percent	SE
Diabetes[1]	16.7	1.9	18.9	2.7
Obesity[2]	38.9	2.0	40.6	2.6
Hypercholesterolemia[3]	39.1	1.6	50.1	2.0
Hypertension[4]	49.5	1.6	51.4	2.0

SE is standard error.

[1]Defined as respondent report of physician-diagnosed diabetes, or undiagnosed diabetes (measured fasting plasma glucose of at least 126 mg/dL or a hemoglobin A1c of at least 6.5%). See Appendix II, Diabetes.

[2]Defined as body mass index greater than or equal to 30. See Appendix II, Body mass index.

[3]Defined as reporting taking cholesterol-lowering medication or having a measured serum total cholesterol level of at least 240 mg/dL. See Appendix II, Cholesterol.

[4]Defined as reporting taking antihypertensive medication or having a measured systolic blood pressure of at least 140 mm Hg or a measured diastolic blood pressure of at least 90 mm Hg. See Appendix II, Blood pressure, high.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey. See Appendix I, National Health and Nutrition Examination Survey (NHANES).

Data table for Figure 22. Serious or mild-moderate psychological distress in the past 30 days among adults aged 55–64, by selected characteristics: United States, average annual 2002–2003 and 2012–2013

Characteristic	Level of psychological distress[1]							
	Serious				Mild-moderate			
	2002–2003		2012–2013		2002–2003		2012–2013	
	Percent	SE	Percent	SE	Percent	SE	Percent	SE
Total age 55–64	3.6	0.2	4.4	0.2	6.4	0.3	7.1	0.3
Sex								
Men.	2.6	0.3	3.7	0.3	5.3	0.4	6.3	0.4
Women	4.5	0.3	5.0	0.3	7.4	0.5	7.8	0.4
Race and Hispanic origin[2]								
White only, not Hispanic	3.5	0.3	4.4	0.3	6.1	0.4	6.7	0.4
Black only, not Hispanic.	3.0	0.5	3.6	0.5	7.6	0.9	7.4	0.7
Hispanic or Latino.	5.0	0.8	5.7	0.7	8.3	1.0	9.9	1.1
Asian only	*	*	*	*	*	*	*4.2	1.0
Percent of poverty level[3]								
Below 100%.	12.1	1.4	14.5	1.2	14.6	1.4	17.1	1.3
100%–199%.	7.3	1.0	8.8	0.8	10.4	1.0	11.1	0.9
200%–399%.	3.3	0.4	3.3	0.4	6.9	0.6	8.2	0.7
400% or more	1.1	0.2	1.5	0.2	3.5	0.4	3.1	0.3

SE is standard error.

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error (RSE) of 20%–30%. Data not shown have an RSE greater than 30%.

[1]Two measures of psychological distress are presented for those aged 55–64 in the noninstitutionalized population: serious and mild-moderate psychological distress. These measures are based on respondent's responses to a series of six questions—the K6 scale—that asks how frequently they experienced symptoms of nonspecific psychological distress within the past 30 days. See Appendix II, Serious psychological distress. Scores on the K6 scale range from 0 to 24 with scores of 13 to 24 classified as probable serious mental illness and scores of 8 to 12 as probable mild–moderate mental illness based on K6 validation studies. See: Kessler RC, Galea S, Gruber MJ, Sampson NA, Ursano RJ, Wessely S. Trends in mental illness and suicidality after Hurricane Katrina. Molecular Psychiatry 2008;13:374–84. Available from: http://www.nature.com/mp/journal/v13/n4/full/4002119a.html. Serious psychological distress as measured by the K6 indicates a high probability of serious mental illness with serious impairment in functioning. Mild-moderate psychological distress also indicates a high probability of a mental illness diagnosable according to the the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM–IV), but accompanying difficulties in functioning are less severe. Scores on the K6 do not provide specific psychiatric diagnoses.

[2]The race group, Asian only, includes persons of Hispanic and non-Hispanic origin. Persons of Hispanic origin may be of any race. Race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* and are not strictly comparable with estimates for earlier years. The single-race categories shown in the table conform to the 1997 Standards and are for persons who reported only one racial group. Starting with 2003 data, race responses of other race and unspecified multiple race were treated as missing, and then race was imputed if these were the only race responses. Almost all persons with a race response of other race were of Hispanic origin. See Appendix II, Hispanic origin; Race.

[3]Based on family income and family size and composition using U.S. Census Bureau poverty thresholds. Missing family income data were imputed. See Appendix II, Family income; Poverty; Table VI.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 23. Current cigarette smoking among adults aged 55–64, by selected characteristics: United States, average annual 2002–2003 and 2012–2013

Characteristic	Current cigarette smoker[1]			
	2002–2003		2012–2013	
	Percent	SE	Percent	SE
Total age 55–64	19.7	0.5	18.1	0.5
Sex				
Men	21.0	0.7	20.7	0.7
Women	18.5	0.7	15.7	0.6
Race and Hispanic origin[2]				
White only, not Hispanic	19.9	0.6	18.8	0.6
Black only, not Hispanic	21.7	1.4	21.5	1.1
Hispanic or Latino	15.9	1.5	10.1	0.9
Asian only	*12.0	2.9	11.8	2.0
Percent of poverty level[3]				
Below 100%	29.6	1.7	32.4	1.7
100%–199%	27.5	1.4	26.7	1.3
200%–399%	21.2	1.0	20.3	0.9
400% or more	14.7	0.7	11.2	0.6

SE is standard error.

* Estimate is considered unreliable. Data preceded by an asterisk have a relative standard error of 20%–30%.

[1]Current cigarette smokers smoked 100 cigarettes in their lifetime and smoke now every day or some days. See Appendix II, Cigarette smoking.

[2]The race group, Asian only, includes persons of Hispanic and non-Hispanic origin. Persons of Hispanic origin may be of any race. Race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* and are not strictly comparable with estimates for earlier years. The single-race categories shown in the table conform to the 1997 Standards and are for persons who reported only one racial group. Starting with 2003 data, race responses of other race and unspecified multiple race were treated as missing, and then race was imputed if these were the only race responses. Almost all persons with a race response of other race were of Hispanic origin. See Appendix II, Hispanic origin; Race.

[3]Based on family income and family size and composition using U.S. Census Bureau poverty thresholds. Missing family income data were imputed. See Appendix II, Family income; Poverty; Table VI.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 24. Participation in recommended levels of leisure-time aerobic and muscle-strengthening activities among adults aged 55–64, by selected characteristics: United States, average annual 2002–2003 and 2012–2013

Excel and Powerpoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig24

| | Met both aerobic activity and muscle-strengthening guidelines[1] | | | |
| | 2002–2003 | | 2012–2013 | |
Characteristic	Percent	SE	Percent	SE
Total age 55–64	12.8	0.5	15.7	0.5
Sex				
Men	13.5	0.7	17.2	0.7
Women.	12.1	0.6	14.2	0.6
Race and Hispanic origin[2]				
White only, not Hispanic.	14.1	0.5	17.0	0.6
Black only, not Hispanic	7.7	1.0	12.3	1.1
Hispanic or Latino	7.3	1.3	10.2	1.1
Asian only.	*7.2	2.1	14.1	1.9
Percent of poverty level[3]				
Below 100%	*3.3	0.9	5.9	0.8
100%–199%	6.1	1.0	7.7	0.8
200%–399%	9.2	0.8	11.3	0.7
400% or more.	18.6	0.8	22.8	0.9

SE is standard error.

* Estimates are considered unreliable. Data preceded by an asterisk have a relative standard error of 20%–30%.

[1]The federal *2008 Physical Activity Guidelines for Americans* recommend that for substantial health benefits adults perform at least 150 minutes a week of moderate-intensity, or 75 minutes a week of vigorous-intensity aerobic physical activity, or an equivalent combination of moderate- and vigorous-intensity aerobic activity. In addition, adults should perform muscle-strengthening activities that are moderate or high intensity and involve all major muscle groups on 2 or more days a week. See Appendix II, Physical activity, leisure-time.

[2]The race group, Asian only, includes persons of Hispanic and non-Hispanic origin. Persons of Hispanic origin may be of any race. Race-specific estimates are tabulated according to the 1997 *Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity* and are not strictly comparable with estimates for earlier years. The single-race categories shown in the table conform to the 1997 Standards and are for persons who reported only one racial group. Starting with 2003 data, race responses of other race and unspecified multiple race were treated as missing, and then race was imputed if these were the only race responses. Almost all persons with a race response of other race were of Hispanic origin. See Appendix II, Hispanic origin; Race.

[3]Based on family income and family size and composition using U.S. Census Bureau poverty thresholds. Missing family income data were imputed. See Appendix II, Family income; Poverty; Table VI.

NOTE: Data reported are for leisure-time physical activity and do not include physical activity performed for work, transportation, or other non-leisure-time activities.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 25. Health insurance coverage among adults aged 55–64, by percent of poverty level and type of coverage: United States, average annual 2002–2003 and 2012–2013

Percent of poverty level and type of coverage[1,2]	2002–2003		2012–2013	
	Percent	SE	Percent	SE
Total age 55–64				
Any private, including workplace	76.7	0.4	69.8	0.4
Private through workplace only	69.5	0.5	62.0	0.5
Public only	12.1	0.3	16.9	0.3
Uninsured	11.2	0.3	13.4	0.3
Below 100%				
Any private, including workplace	27.3	1.6	15.5	1.0
Private through workplace only	20.5	1.5	10.4	0.9
Public only	44.7	1.7	52.5	1.2
Uninsured	28.0	1.2	32.0	1.2
100%–199%				
Any private, including workplace	51.1	1.3	37.3	1.0
Private through workplace only	42.0	1.3	29.7	1.0
Public only	25.2	1.2	34.8	1.0
Uninsured	23.7	1.1	27.8	1.0
200%–399%				
Any private, including workplace	77.7	0.8	70.5	0.7
Private through workplace only	69.0	0.9	61.5	0.7
Public only	9.8	0.6	14.0	0.6
Uninsured	12.5	0.7	15.5	0.6
400% or more				
Any private, including workplace	92.5	0.4	90.8	0.4
Private through workplace only	86.8	0.5	83.4	0.5
Public only	3.6	0.3	5.5	0.3
Uninsured	3.8	0.3	3.7	0.3

SE is standard error.

[1]Percent of poverty level is based on family income and family size and composition using U.S. Census Bureau poverty thresholds. Missing family income data were imputed. See Appendix II, Family income; Poverty; Table VI.

[2]Information on health insurance coverage is collected at the time of interview. The categories any private, public only, and uninsured are mutually exclusive, but may not sum to 100% due to rounding. Any private coverage includes those with coverage through the workplace, or other sources of private coverage, and includes a small percentage of adults aged 55–64 with both private and public coverage (3.2% in 2012–2013). Any private workplace coverage includes coverage obtained through a present or former employer, union, self-employment, or a professional association and is a subset of the any private category. Public only includes Medicaid, Children's Health Insurance Program (CHIP), Medicare, military health care (TRICARE/VA/CHAMP–VA), state-sponsored health plans, and other government programs. Adults aged 55–64 in the public only category may have more than one source of public coverage, but they do not have any private coverage. Persons not covered by private or public coverage were considered to be uninsured. See Appendix II, Health insurance coverage.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 26. Health care utilization in the past 12 months among adults aged 55–64, by type of visit: United States, average annual 2002–2003 and 2012–2013

Excel and Powerpoint: *http://www.cdc.gov/nchs/hus/contents2014.htm#fig26*

Visits in the past 12 months[1]	2002–2003		2012–2013	
	Percent	SE	Percent	SE
Any doctor visit	87.9	0.4	86.7	0.4
1–3 doctor visits	39.5	0.6	43.3	0.6
4 or more doctor visits	48.4	0.6	43.4	0.6
Any emergency department visit	18.9	0.5	18.1	0.5
Any hospital stay	11.7	0.4	10.1	0.3
No visit	11.2	0.4	12.6	0.4

SE is standard error.

[1]Respondents were asked a series of questions about their health care contacts in the past 12 months: "Have you seen a doctor or other health care professional about your own health at a doctor's office, a clinic, or some other place? Do not include times you were hospitalized overnight, visits to hospital emergency departments, home visits, or telephone calls"; "During the past 12 months how many times have you gone to a hospital emergency room about your own health?" (This includes emergency room visits that resulted in a hospital admission.) In 2002–2003, respondents were asked "During the past 12 months were you a patient in a hospital overnight?"; in 2012–2013, respondents were asked "During the past 12 months were you a patient in a hospital overnight?" (Do not include an overnight stay in the emergency room.) Less than 1% of those aged 55–64 had an emergency department visit or a hospitalization, but no doctor visits, in 2012–2013. No visit is no doctor visit, emergency department visit, or hospital stay, in the past 12 months.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 27. Use of preventive services and screening among noninstitutionalized adults aged 55–64: United States, 2003 and 2013

Excel and Powerpoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig27

Health care utilization	2003		2013	
	Percent	SE	Percent	SE
Influenza vaccination in past 12 months[1]	40.4	0.9	49.9	0.9
Pneumococcal vaccination ever (high-risk group)[2]	32.5	1.4	35.2	1.2
Colorectal test or procedure[3]	40.0	0.9	58.3	0.9
Mammogram in past 2 years[4]	76.9	1.0	71.3	1.0
Pap smear in past 3 years[5]	85.5	1.1	75.9	1.2

SE is standard error.

[1]Respondents were asked about influenza vaccination in the past 12 months. See Appendix II, Vaccination.

[2]Respondents were asked, "Have you ever had a pneumonia shot? This shot is usually given only once or twice in a person's lifetime and is different from the flu shot. It is also called the pneumococcal vaccine." High-risk group membership is based on recommendations of CDC's Advisory Committee on Immunization Practices (ACIP). The high-risk group includes persons who reported diabetes; cancer; heart, lung, liver, or kidney disease. Starting in 2009, this definition was expanded to include persons who reported asthma or cigarette smoking, to be consistent with the revised ACIP recommendation. Starting with data year 2012, the survey questionnaire was changed to ask respondents a new question on chronic obstructive pulmonary disease (COPD), and this information was added to the list of lung diseases used to construct the high-risk category. For more information on high-risk groups, see the 2009 ACIP recommendation available from: http://www.cdc.gov/mmwr/pdf/wk/mm5934.pdf.

[3]Colorectal test or procedure is defined as fecal occult blood test (FOBT) in the past year, sigmoidoscopy in the past 5 years with FOBT in the past 3 years, or colonoscopy in the past 10 years. See Appendix II, Colorectal tests or procedures.

[4]Questions concerning use of mammography differed slightly on the National Health Interview Survey across the years for which data are shown. See Appendix II, Mammography.

[5]Estimates are for women who have not had a hysterectomy. Questions concerning use of Pap smears and hysterectomy status differed slightly on the National Health Interview Survey across the years for which data are shown. Hysterectomy status was not assessed in 2003; therefore, data shown for Pap smear were for 2000 and 2013 when hysterectomy status was available. See Appendix II, Pap smear.

NOTE: Utilization of colorectal, cervical, and breast cancer procedures can occur for routine screening or for diagnostic reasons.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Data table for Figure 28. Prescription drug use in the past 30 days among adults aged 55–64, by number of drugs and selected drug class: United States, 1999–2002 and 2009–2012

Characteristic	1999–2002		2009–2012	
	Percent	SE	Percent	SE
Number of prescription drugs in past 30 days[1]				
No prescription drugs.	26.9	1.5	24.2	1.4
1–4 prescription drugs	55.4	1.8	55.6	1.4
5 or more prescription drugs.	17.7	1.7	20.3	1.3
Prescription drug use in past 30 days, by selected Multum Lexicon Plus therapeutic drug class (common indications for use)[2]				
Cardiovascular (heart, blood pressure, and kidney disease).	41.3	2.0	45.0	2.2
Cholesterol-lowering (high cholesterol).	20.6	1.7	31.8	1.7
Gastric reflux (gastroesophageal reflux disease [GERD], anti-acid reflux, ulcers)	9.0	1.6	16.0	1.2
Analgesic (pain, inflammation, blood clot prevention).	16.8	1.4	15.0	1.7
Antidepressant (depression, anxiety, perimenopausal symptom, pain).	10.3	1.2	14.4	1.2
Antidiabetic (high glucose [blood sugar])	10.0	1.1	12.9	0.9

SE is standard error.

[1]Respondents were asked if they had taken a prescription drug in the past 30 days. Those who answered "yes" were asked to show the interviewer the medication containers for all prescriptions. If no container was available, the respondent was asked to verbally report the name of the medication. Each drug's complete name was recorded and classified.

[2]The December 2012 Multum Lexicon Plus database was used for processing and editing the National Health and Nutrition Examination Survey prescription drug data. Lexicon Plus, a proprietary database of Cerner Multum, Inc. (Denver, CO), is used to assist with collection, editing, and release of drug data. Lexicon Plus is a comprehensive database of all prescription and some nonprescription drug products available in the U.S. drug market. See: http://www.multum.com/. Lexicon Plus provides a three-level nested category system that assigns a therapeutic classification to each drug reported. Not all drugs have three classification levels; some may only have two classification levels, and others only have one classification level. For more information, see: http://wwwn.cdc.gov/nchs/nhanes/1999-2000/RXQ_DRUG.htm. Up to four different therapeutic classes can be assigned to each drug. Drugs classified into more than one class were counted in each therapeutic class. Respondents taking more than one drug in a specific drug class were counted once; respondents taking drugs in different drug classes were counted in both classes. The therapeutic drug class identifies the therapeutic effect(s) of the drug as a whole and for multi-ingredient drugs differs from a classification scheme based on drug ingredients. In this analysis, cardiovascular drugs (including ACE inhibitors, beta blockers, calcium channel blockers, and diuretics) are level 1, class 40; cholesterol-lowering drugs are level 2, class 19; antidepressant drugs are level 2, class 249; analgesic drugs are level 2, class 58; gastric reflux drugs (including proton pump inhibitors) are level 2, class 272, and H_2 antagonists are level 2, class 94; and antidiabetic drugs are level 2, class 99. The therapeutic drug classes proton pump inhibitors (272) and H_2 antagonists (94) were combined because of their similar indications for use. See Appendix II, Drug; Multum Lexicon Plus therapeutic drug class.

SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey. See Appendix I, National Health and Nutrition Examination Survey (NHANES).

Data table for Figure 29. Adults aged 55–64 who delayed or did not receive needed medical care or needed prescription drugs due to cost in the past 12 months, by insurance status: United States, average annual 2002–2003 and 2012–2013

Excel and Powerpoint: http://www.cdc.gov/nchs/hus/contents2014.htm#fig29

Characteristic	2002–2003		2012–2013	
	Percent	SE	Percent	SE
Delay or nonreceipt of needed medical care due to cost in the past 12 months				
Total age 55–64	9.5	0.3	13.2	0.3
Insurance status[1]:				
Insured all year	5.9	0.2	7.8	0.2
Uninsured all or part of past year	38.7	1.3	44.2	1.0
Nonreceipt of needed prescription drugs due to cost in the past 12 months				
Total age 55–64	7.0	0.3	8.8	0.3
Insurance status[1]:				
Insured all year	4.4	0.3	5.5	0.3
Uninsured all or part of past year	27.5	1.6	26.7	1.3

SE is standard error.

[1]This table presents health insurance coverage over the past year. Insured respondents had coverage continuously for the year prior to interview, while those categorized as uninsured for all or part of the past year had some period of time without insurance during the year prior to interview.

NOTE: The percentage who delayed or did not receive medical care and the percentage who did not receive prescription drugs were determined independently of each other.

SOURCE: CDC/NCHS, National Health Interview Survey. Family core and sample adult questionnaires. See Appendix I, National Health Interview Survey (NHIS).

Technical Notes

Data Sources and Comparability

Data for the *Health, United States, 2014* Chartbook come from many surveys and data systems and cover a broad range of years. Detailed descriptions of the data sources included in the Chartbook are provided in Appendix I. Data Sources. Additional information clarifying and qualifying the data are included in the table notes and in Appendix II. Definitions and Methods.

Data Presentation

Many measures in the Chartbook are shown for people in specific age groups because of the strong effect of age on most health outcomes. Age-adjusted estimates use the age distribution of the 2000 standard population; where this has been done, it is noted in the data tables that accompany the charts. Age-adjusted rates are computed to eliminate differences in observed rates that result from age differences in population composition (see Appendix II, Age adjustment). For some charts, data years are combined to increase sample size and the reliability of the estimates. Some charts present time trends, and others focus on differences in estimates among population subgroups for the most recent time point available. Trends are generally shown on a linear scale to emphasize absolute differences over time. The time trends for the overall mortality measures are shown on a logarithmic (log) scale to emphasize the rate of change and to enable measures with large differences in magnitude to be shown on the same chart. Point estimates and standard errors for Figures 1–19 are available in the Trend Table and Excel spreadsheet specified in the note below the chart. Data tables with point estimates and standard errors accompany Figures 20–29. Some data tables contain additional data that were not graphed because of space considerations.

Statistical Testing

Data trends can be described in many ways. For trend analyses presented in the Chartbook, increases or decreases in the estimates during the entire time period shown are measured by the annual percent change using the weighted least squares regression method. Statistically significant changes in the trend are assessed at the 0.05 level using the National Cancer Institute's Joinpoint software, and permitting up to one joinpoint (change in inflection). For more information on Joinpoint, see: http://srab.cancer.gov/joinpoint. For analyses that show two time periods, differences between the two periods

were assessed for statistical significance at the 0.05 level using two-sided significance tests (z-tests) without correction for multiple comparisons. Data tables include point estimates and standard errors for users who would like to perform additional statistical tests.

Terms such as "similar," "stable," and "no difference" used in the text indicate that the statistics being compared were not significantly different. Lack of comment regarding the difference between statistics does not necessarily suggest that the difference was tested and found to be not significant. Because statistically significant differences or trends are partly a function of sample size (the larger the sample, the smaller the change that can be detected), they do not necessarily have public health significance (95). Testing and comparisons use the estimates and standard errors in the trend and data tables.

Overall estimates generally have relatively small sampling errors, but estimates for certain population subgroups may be based on small numbers and have relatively large sampling errors. Numbers of deaths obtained from the National Vital Statistics System represent complete counts and therefore are not subject to sampling error. They are, however, subject to random variation, which means that the number of events that actually occur in a given year may be considered as one of a large series of possible results that could have arisen under the same circumstances. When the number of events is small and the probability of such an event is small, considerable caution must be observed in interpreting the conditions described by the charts. Estimates that are unreliable because of large sampling errors or small numbers of events have been noted with an asterisk. The criteria used to designate or suppress unreliable estimates are indicated in the notes to the applicable tables or charts.

For NCHS surveys, point estimates and their corresponding variances were calculated using the SUDAAN software package, which takes into consideration the complex survey design (96). Standard errors for other surveys or data sets were computed using the methodology recommended by the programs providing the data, or were provided directly by those programs.

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Trend Tables in *Health, United States, 2014*

The Chartbook section of *Health, United States, 2014* is followed by 123 Trend Tables organized around four major subject areas: health status and determinants, utilization of health resources, health care resources, and health care expenditures and payers. Trend Tables present data for selected years, to highlight major trends in health statistics. A key criterion used in selecting topics for the Trend Tables is the availability of comparable national data over a period of several years. A summary of the Trend Table topics for the 2014 edition is given below. Earlier editions of *Health, United States* may present data for additional years that are not included in the current printed report. Where available, these additional years of data are provided in spreadsheet files on the *Health, United States* website at: http://www.cdc.gov/nchs/hus.htm.

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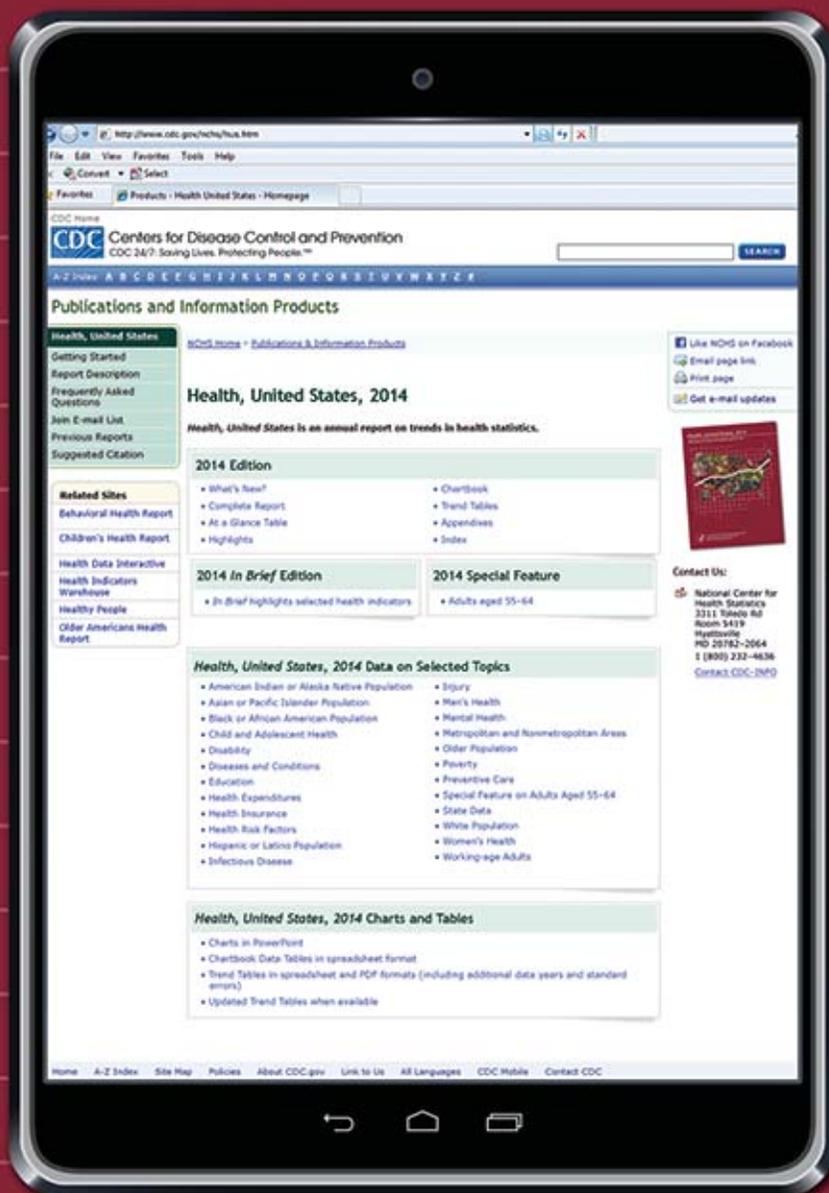## State Health Expenditures and Health Insurance Tables 121–123

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