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When Should Medicare Coverage Begin?

By Richard W. Johnson

Summary

Lowering the Medicare eligibility age to 62 would result in near universal health care coverage among 62 to 64 year olds. People who purchase individual insurance in the market as well as the uninsured could benefit from Medicare coverage. The change would reduce employer costs for retiree health benefits and lower both retiree and employer costs for COBRA continuation coverage. Lowering the automatic eligibility age to 62 would increase Medicare spending by about $5.4 billion a year (in 2000 dollars). Net federal spending would be about $5.0 billion higher, because Medicare would pick up some costs currently paid by Medicaid. State Medicaid outlays would fall by about $0.3 billion.

For more than 35 years, Medicare has provided subsidized health insurance coverage to virtually all Americans when they turn 65. Younger adults can receive Medicare benefits only if they are disabled.

In recent years, various experts, policymakers, and advocates for elderly people have recommended changing the age of eligibility. Growing concerns about health insurance coverage for near elderly adults have recently prompted calls to lower the eligibility age, while increases in the normal retirement age for Social Security and concerns about Medicare's financial health, particularly as the population ages, have led others to suggest delaying it.

This brief reviews the available evidence on how changes to the age of Medicare eligibility might affect government costs and rates of health insurance coverage and employment for near elderly adults (aged 55 to 64) and young elderly adults (aged 65 to 66). It explores the tradeoffs between protecting the health and income security of older adults, containing government spending, and encouraging work. It devotes special attention to the potential impact of changes to the age of eligibility on vulnerable older Americans with limited incomes and health problems.

Current Coverage Rates for Near Elderly Adults

Like other adults, near elderly people obtain health insurance from a mix of public and private sources. In 1998, about 44 percent of adults aged 55 to 64 received coverage from their own current employers (see Figure 1). About 12 percent of the near elderly population received health benefits from former employers.

Many large private firms and most public sector employers provide retired employees with subsidized retiree health insurance (RHI) benefits, which generally continue until age 65, when Medicare coverage begins. RHI sometimes supplement Medicare benefits after age 65. Other retirees obtain unsubsidized continuation

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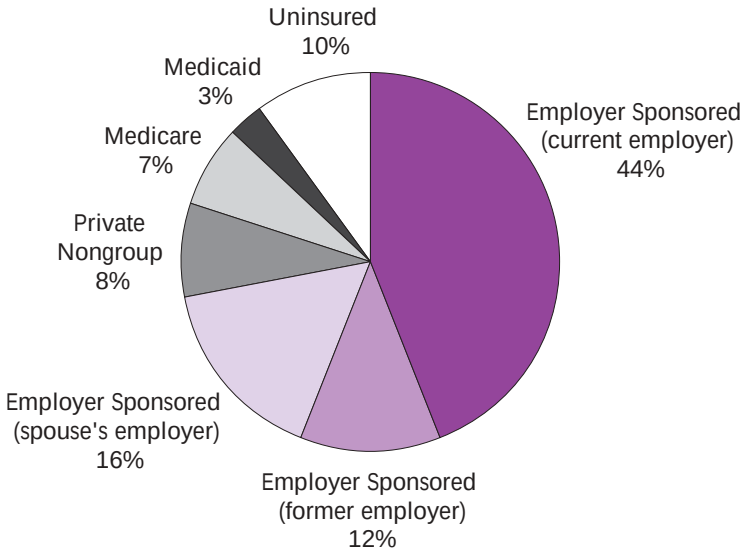
coverage from their former employers under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which requires employers with health plans and 20 or more employees to offer coverage to separating workers for up to 18 months (or 29 months if the worker is disabled), but which allows them to charge enrollees 102 percent of the group rate. In addition, 16 percent of the near elderly population (and almost one-quarter of near elderly women) received coverage from their spouses' current or former employers. In all, 72 percent of near elderly adults had workplace coverage in 1998.

Near elderly adults who lack job-related health benefits have limited insurance options. Before age 65, adults can qualify for Medicare or Medicaid benefits only if they are blind or disabled. In addition, Medicaid benefits are subject to strict income and asset tests, and Medicare benefits do not begin until at least 29 months after the onset of disability. In 1998, about 10 percent of adults aged 55 to 64 received public benefits through the Medicare or Medicaid programs (Figure 1).

Figure 1
Health Insurance Coverage at Ages 55 to 64, 1998



Source: Johnson (2003), based on data from the 1998 Health and Retirement Study.
Note: Coverage is determined by the following hierarchy: employer-sponsored (current, former, spouse), private nongroup, Medicare, Medicaid, uninsured.

Many near elderly adults without coverage from employers turn to the private nongroup market. In 1998 about 8 percent of adults aged 55 to 64 purchased nongroup coverage, almost twice the rate for those at ages 35 to 54. Relying upon the private nongroup market at older ages has drawbacks, including the high price of coverage (especially for those in poor health), the limited benefits provided by many plans, and the possibility that coverage may be denied altogether.

Just under 10 percent of the near elderly population was uninsured in 1998.[1] Estimated rates of uninsurance differ across surveys, but virtually all agree that near elderly people are less likely to lack coverage than younger adults. For example, in the Urban Institute's National Survey of American Families, 13 percent of respondents aged 35 to 54 were uninsured in 1997, compared with 10 percent of those aged 55 to 64 (Brennan 2000).

Concern about uninsurance among near elderly adults arises from the importance of coverage at older ages, not from especially low coverage rates. As individuals reach their late 50s and 60s, they become increasingly likely to develop health problems, raising health care expenses and the demand for health insurance. Average health care expenditures are twice as high for those between the ages of 55 and 64 than for those 35 to 44 (General Accounting Office 1998).

At all ages, those without insurance are less likely to seek routine and preventive care, which can lead to a variety of preventable and potentially costly health episodes. Because the incidence of many serious

1 This estimate of the uninsurance rate is lower than widely cited rates derived from the Current Population Survey (CPS). For example, Shea, Short, and Powell (2001) report that 14 percent of CPS respondents aged 50 to 64 lacked coverage in 1998. Differences in survey design may account for the discrepancy. Until recently, the CPS asked a series of questions about insurance coverage and then assumed that any respondent who did not report coverage was uninsured. The HRS adds a question that verifies whether respondents who appear not to have coverage are, in fact, uninsured. HRS estimates are consistent with those from other sources, including the National Survey of American Families.

health problems increases with age, foregoing routine care can be especially hazardous in later life.

Many of the uninsured have low incomes and health problems. In 1998, just over half (54 percent) of the uninsured were poor or near poor, with family incomes below 200 percent of the poverty line, compared with only 18 percent of the insured population (see Figure 2). In addition, just over one-third of near elderly adults without insurance reported fair or poor health, compared with slightly less than one-quarter of those with coverage. Fully 22 percent of the uninsured had health problems *and* limited incomes.

Because many of the uninsured have few economic resources, initiatives such as tax credits that aim to increase coverage by encouraging older adults to purchase private insurance are likely to be ineffective unless they include substantial subsidies. Otherwise, private insurance options will remain unaffordable for many uninsured near elderly adults.

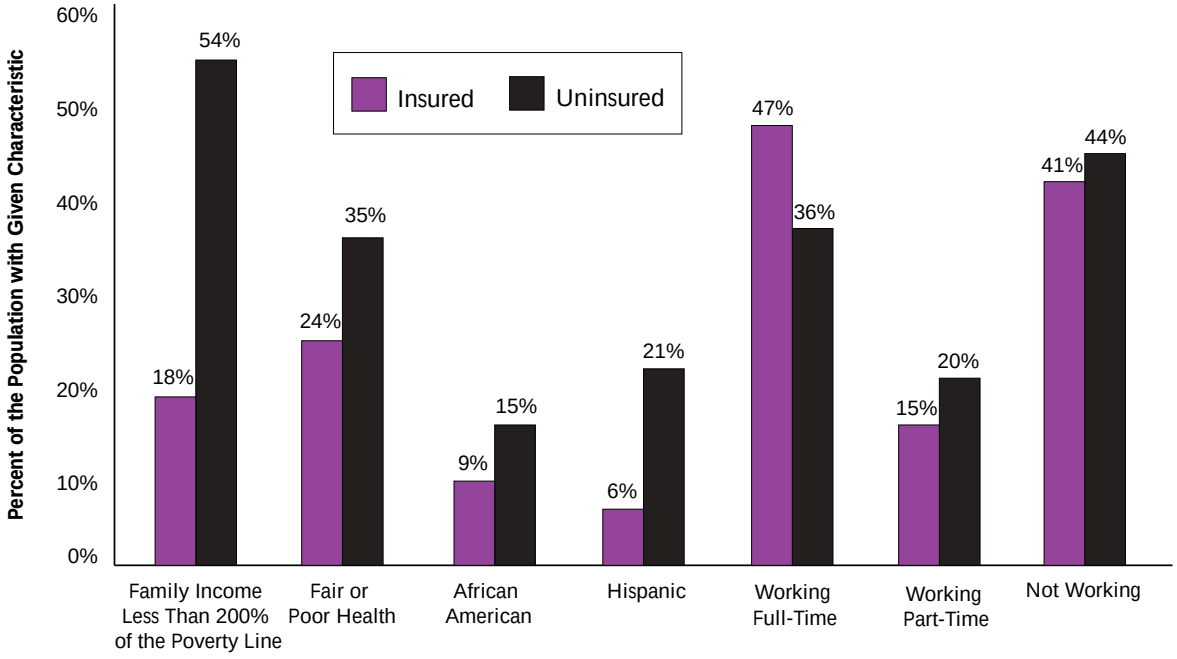
Lowering the Age of Medicare Eligibility

One way to improve coverage for some near elderly people would be to expand Medicare benefits to nondisabled adults younger than 65. Lowering the age of automatic eligibility for Medicare would virtually eliminate uninsurance at ages 62 to 64. It would also benefit those who rely on the expensive and risky individual insurance market. In addition, the expansion of Medicare coverage would reduce employer costs for retiree health benefits and both retiree and employer costs for COBRA continuation coverage. Because COBRA beneficiaries tend to use more health services than active workers, they raise costs for employers, even though they pay premiums themselves (Fronstin 2001).

Lowering the automatic eligibility age to 62 would be expensive. Automatic eligibility for those age 62 to 64 would cost the Medicare program about $5.4 billion per year (in 2000 dollars). The net cost to the federal government would total about $5.0 billion, because the expanded Medicare program would pick up some costs currently paid by Medicaid (Johnson 2003). State Medicaid outlays would fall by about $0.3 billion.

A less costly approach would be to create a buy-in plan through which near elderly people could purchase Medicare coverage. These plans would in effect lower the age of Medicare eligibility, although partici-

Figure 2
Composition of the Insured and Uninsured Population Aged 55 to 64, 1998



Source: Johnson (2003), based on data from the 1998 Health and Retirement Study.

pants would pay higher premiums than older beneficiaries who qualify for automatic coverage. The Clinton administration first proposed a buy-in plan in 1998 that would charge premiums approximately equal to the cost of services, and Democratic lawmakers introduced similar legislation in Congress in 2002. These proposals limited benefits to adults aged 62 to 64 (and displaced workers aged 55 to 61).

Studies of the Clinton buy-in proposal predict that about 9 percent of adults aged 62 to 64 would participate in a plan priced at $300 per month with no supplemental payments after age 65 (Johnson, Moon, and Davidoff 2002; Sheils and Chen 2001). This represents about 37 percent of adults eligible for the buy-in plan, because only those without access to other types of public insurance or employer-sponsored health benefits would qualify for the buy-in plan. However, participation rates would be much higher among those who would otherwise purchase private coverage than among those who would be uninsured, so the plan would not help the uninsured much. Simulations indicate that it would reduce the size of the uninsured population aged 62 to 64 by only about 6 to 12 percent. Nonetheless, the Clinton buy-in plan would lower premium costs and improve the quality of coverage for many adults who would otherwise purchase individual coverage; the buy-in would reduce the number of adults with expensive individual policies by more than half, to less than 6 percent of the population aged 62 to 64.

A buy-in plan could better raise coverage rates if it were subsidized, particularly for low-income adults. In 2000 the Clinton administration modified its plan to include a 25 percent tax credit for premiums paid by participants. If the credits were refundable, so that all enrollees would receive the full value of the tax credit even when it exceeded their total tax liabilities, the effective price of the buy-in plan would fall to 25 percent below the average cost of services provided for all prospective participants. Low-income participants would not receive larger subsidies than high-income participants. If the tax credit is nonrefundable, low income people would receive little or no subsidy.

Health policy experts have proposed several alternative buy-in plans that would relate premiums to income. Sheils and Chen (2001), for example, suggest capping the buy-in premium at either 5 or 10 percent of the enrollee's income. Varying premiums in these ways would substantially reduce costs for those with limited incomes while eliminating subsidies for high-income participants. The researchers estimate that limiting premiums to 5 percent of enrollee's income would reduce uninsurance rates at ages 62 to 64 by more than 38 percent.

Relating buy-in premiums to income could substantially improve coverage rates for those with low incomes. Johnson, Moon, and Davidoff (2002) compare the impact of a buy-in plan that charged a flat premium of $300 per month for all participants to a plan priced at $43.80 per month (the monthly Medicare Part B premium in 1998) for those with family incomes below 150 percent of the poverty level and $300 per month for everyone else.[2] They find that the flat pricing scheme would have no effect on uninsurance rates for the poor or near poor. However, a buy-in plan with subsidies for low-income adults would reduce uninsurance rates from 28 percent to 12 percent for poor near elderly adults and from 22 percent to 12 percent for near poor adults (see Figure 3).

Loprest and Moon (1999) suggest a buy-in plan that would fully subsidize premiums for those with incomes below the poverty level. The subsidy would gradually fall as income rises, disappearing completely for those with incomes above 200 percent of the poverty level. Their plan would also set premiums at the community rate that would prevail if all adults aged 62 to 64 enrolled, which they estimate would be about $270 per month. Loprest and Moon estimate that their plan could reduce uninsurance among the poor by as much as 75 percent.

Shea, Short, and Powell (2001) proposed an extension of the Loprest and Moon proposal. They would provide low-income adults with subsidized vouchers that could be used to buy into the Medicare program. The plan would base eligibility for the vouchers on lifetime earnings, not current income, reducing the

2 This plan imposes a large tax on those with incomes just above 150 percent of the poverty level, leaving them potentially worse off than others with less income and creating powerful work disincentives for those with incomes near that level. A better plan design would be to phase out subsidies gradually as income rises.

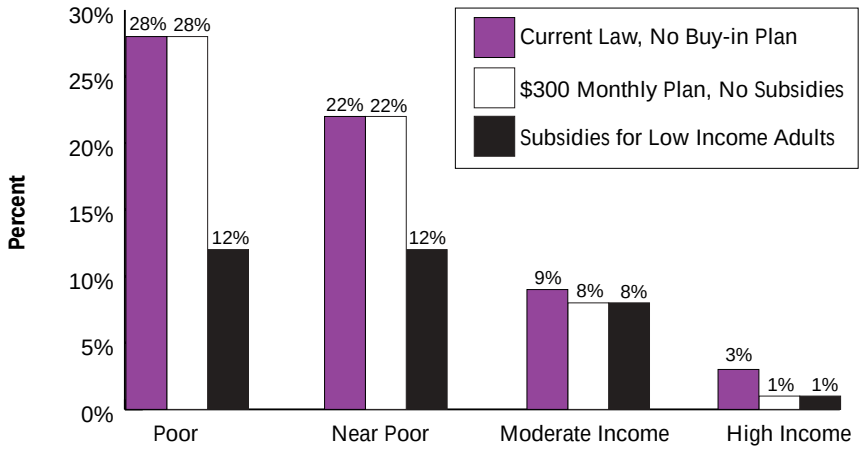
incentive to cut back on work hours at older ages to qualify for low-cost health insurance. They would also create a tax deferred saving program in which the middle class could accumulate funds to purchase Medicare coverage when they reach age 62. The vouchers and savings accounts could also be used to purchase private nongroup coverage or to participate in employer-sponsored plans.

Although subsidies would improve the effectiveness of the buy-in plans, they inevitably increase program costs. Annual costs for a buy-in plan at ages 62 to 64 could reach $525 million (in 2000) for a buy-in plan that subsidized premiums for all participants by 25 percent (Sheils and Chen 2001), $791 million for the Loprest and Moon (1999) plan, and $2.7 billion for a plan that capped premiums at 5 percent of income (Sheils and Chen 2001). Costs would run even higher if the buy-in program were extended to those as young as 55.

Even if policymakers did not intend to subsidize benefits, they would find it almost impossible to design a cost-neutral, buy-in program, because the plan would disproportionately attract participants who expect to use many services. Relating premiums to income raises the cost of administrating the program.

Another drawback of extending Medicare benefits to non-disabled adults younger than 65, either by lowering the eligibility age outright or allowing near elderly adults to buy into the Medicare program, is that it would probably encourage some workers to retire early. By reducing or even eliminating the period during which early retirees without RHI benefits would need to purchase expensive private non-group coverage to avoid becoming uninsured, extending Medicare coverage would lower the costs of retiring. Policies that encourage retirement heighten concerns about the ability of the economy to support the growing retired population. At the same time, lowering the age of eligibility could allow older workers the freedom to leave their job and pursue a second career or become self-employed, without worrying about the availability of health insurance coverage.

Figure 3
Simulated Uninsurance Rates at Ages 62 to 64 Under Current Law and Alternative Buy-In Plans, by Income



Note: The subsidized plan sets premiums at $43.80 per month for those for those with incomes below 150 percent of the poverty level and at $300 per month for everyone else. Plans do not charge supplemental premiums after age 65. Individuals are classifed as poor if family income falls below the poverty level, as near poor if it falls between 100% and 200% of the poverty level, as moderate income if it falls between 200% and 400% of the poverty level, and as high income if it exceeds 400% of the poverty level.
Source: Johnson, Moon, and Davidoff (2002).

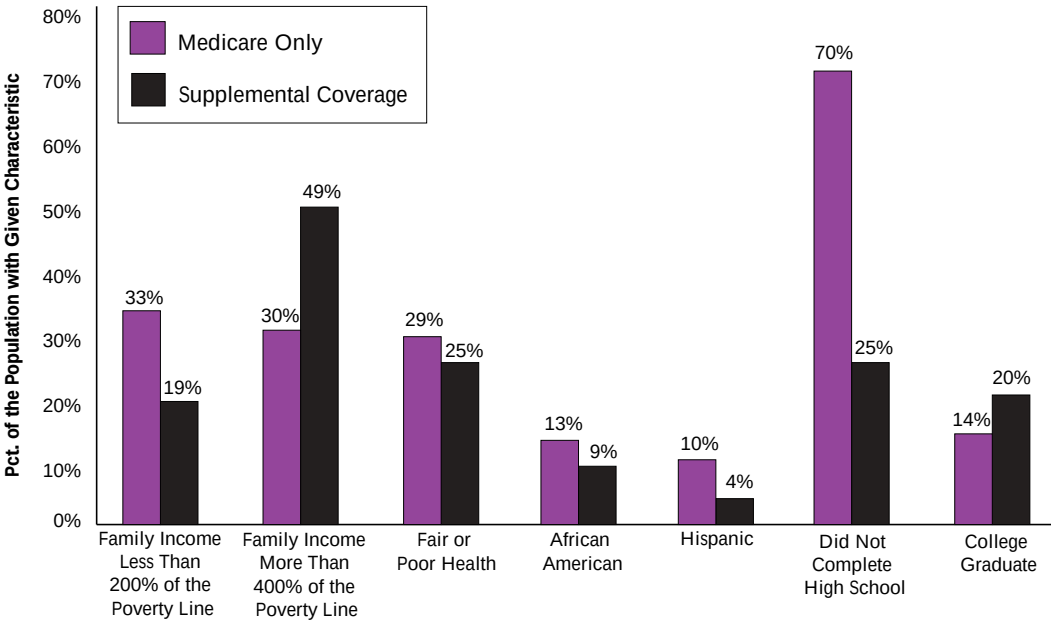
Recent estimates suggest that lowering the automatic age of Medicare eligibility to 62 would raise overall annual retirement rates among full-time workers aged 51 to 61 from 6.9 percent to 7.4 percent, a relative increase of about 7 percent (Johnson, Davidoff, and Perese 2003). The introduction of a buy-in program priced at $300 per month would raise overall retirement rates by only about 2 percent.

Raising the Age of Medicare Eligibility

Despite concerns about the number of uninsured older adults too young to qualify for Medicare, proposals to increase the age of Medicare eligibility continue to attract attention. Proponents argue that raising the eligibility age would reduce Medicare costs

and improve the solvency of the Medicare trust fund. In addition, it would bring the age of Medicare eligibility in line with the normal retirement age for Social Security, and might encourage some individuals to remain at work and delay retirement, an increasingly important policy goal as the aging of the population reduces the share of adults below the traditional retirement age who can support the growing elderly population and pay for other government services. Opponents of an increase in the eligibility age argue that it would leave many near elderly adults uninsured or with inadequate insurance.

Figure 4
Composition of the Population of Medicare Beneficiaries Aged 65 to 66 With and Without Supplemental Coverage, 1998



Source: Johnson (2003), based on data from the 1998 Health and Retirement Study.

Many Medicare beneficiaries supplement their Medicare coverage with additional types of insurance, which generally pay at least part of the deductibles, co-payments, and premiums that Medicare charges, and which sometimes covers services excluded from Medicare, such as prescription drugs. In 1998, 31 percent of Medicare beneficiaries aged 65 to 66 received RHI benefits from their former employers, and another 23 percent purchased individual Medigap coverage (Johnson 2003). In addition, 7 percent received Medicaid benefits, which are available to elderly adults with low income and limited assets. These rates of supplemental coverage suggest that many near elderly adults could probably maintain some type of coverage if they no longer qualified for Medicare, although some Medigap policy holders may encounter problems purchasing primary individual plans.

The remaining 31 percent of young elderly Medicare beneficiaries relied on Medicare coverage alone in 1998.[3] Many young elderly adults without additional types of insurance may have difficulty finding coverage if they lose Medicare eligibility, especially because many of those without supplemental coverage have limited economic resources. Among Medicare beneficiaries aged 65 to 66 in 1998, 33 percent of those without supplemental coverage were poor or near poor (see Figure 4). The comparable figure is only 19 percent for those with supplemental coverage. Thus, many near elderly beneficiaries may be unable to afford private alternatives to Medicare. High school dropouts, African Americans, Hispanics, and those in fair or poor health also make up disproportionate shares of the near elderly population without supplemental health insurance coverage.

Nonetheless, recent estimates of the impact of raising the age of Medicare eligibility to 67 indicate that 91 percent of near elderly adults would find some type of alternative coverage (Davidoff and Johnson 2003). More than half would receive employer-sponsored coverage from their own workplace or their spouse's workplace (see Figure 5). Employer-sponsored coverage for the near elderly would increase relative to

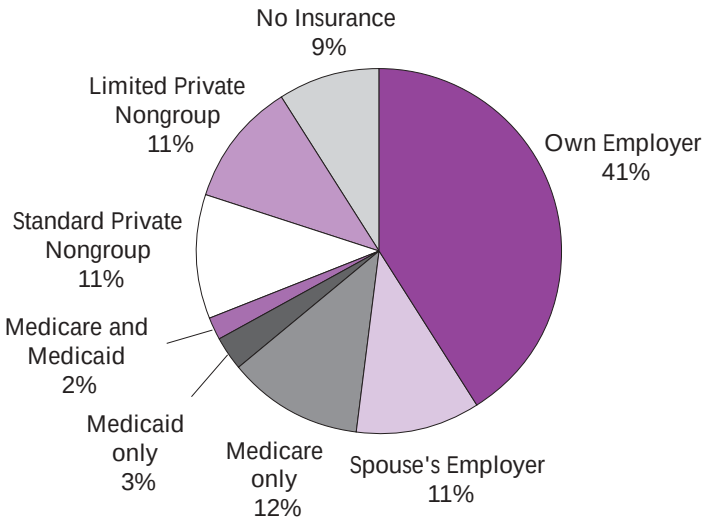
3 Some, however, belonged to managed care plans, which often cover more services than the traditional fee-for-service Medicare program.

current rates primarily because the delay in Medicare eligibility would discourage some workers with health benefits on the current job from retiring. An increase in the age of Medicare eligibility to 67 would reduce annual retirement rates for workers aged 55 to 64 by about 5 percent (from 10.7 percent to 10.2 percent), higher than some estimates of the impact of increasing the normal retirement age for Social Security (Johnson 2002).

Rates of employer-sponsored coverage would also rise because more retirees would receive RHI benefits. In some retiree health plans, coverage ceases when beneficiaries become eligible for Medicare coverage, so more near elderly adults would qualify for RHI benefits if Medicare eligibility did not begin until age 67. Estimates of the impact of raising the Medicare age to 67 assume that employers would continue the terms of the insurance coverage they offer to retirees or to active workers. In particular, the estimates assume that employers would pick up the additional costs of extending retiree health benefits to 65- and 66-year-olds until Medicare began at age 67. Costs would rise even for employers whose RHI plans continue after Medicare coverage begins, because they would be providing primary coverage for near elderly retirees, not the supplemental wrap-around coverage that they currently provide.

With an increase in the eligibility age, 17 percent of adults ages 65 and 66 would receive public health benefits. About 2 percent would continue to qualify for Medicare coverage because of disabilities and for Medicaid benefits because of their low income and assets or high medical costs. Another 12 percent would receive only Medicare coverage and 3 percent would receive only Medicaid benefits. Delaying Medicare eligibility would decrease Medicaid coverage by about 2 percentage points among near elderly people because they would no longer qualify for the Medicare Savings Program, a government initiative that pays Medicare deductibles, premiums, and copayments through Medicaid for low-income Medicare beneficiaries with too much income to qualify for full Medicaid coverage. Despite the slight drop in coverage, delaying Medicare eligibility would raise Medicaid costs, because Medicaid would provide primary coverage for near elderly enrollees, not supplemental coverage for Medicare beneficiaries.

Figure 5
Simulated Coverage Rates at Ages 65 and 66 if the Age of Medicare Eligibility Were 67, With No Medicare Buy-In Plan, 1998



Source: Davidoff and Johnson (2003).
Note: Coverage is determined by the following hierarchy: public insurance, own employer, spouse employer, and private nongroup.

About one in five near elderly adults would purchase individual coverage if the age of Medicare eligibility were raised to 67 (Davidoff and Johnson 2003). However, the high cost of these individual policies would create financial difficulties for many near elderly adults, especially those in poor health. For a standard PPO plan with a $500 deductible and a 20 percent coinsurance rate, mean monthly premiums in 1998 for those aged 63 to 64 with two or more serious health conditions ranged from $540 to $791 for women and from $790 to $908 for men, depending on whether the policyholder smoked. These estimates are based on price quotes collected through an insurance website from insurers throughout the country (see Table One).

Because virtually everyone goes on Medicare when they turn 65, reliable premium data for individual primary coverage for adults aged 65 and older do not exist. However, assuming that premiums would increase with age at the same rate after age 65 as before, the quotes obtained for adults in their early

Table 1
Estimated Monthly Nongroup Premiums in 1998

Age	Number of Serious Health Problems	Men		Women	
		Non-Smoker	Smoker	Non-Smoker	Smoker
57–59	Zero	$358	$420	$224	$361
	One	536	630	336	541
	Two or more	716	840	448	721
60–62	Zero	377	451	268	386
	One	565	676	401	579
	Two or more	753	902	535	771
63–64	Zero	395	454	270	396
	One	593	681	405	593
	Two or more	790	908	540	791
65–66	Zero	414	457	273	406
	One	622	686	409	609
	Two or more	829	915	546	811

Note: A serious health problem is defined as diabetes, cancer, chronic lung disease, heart problems, or stroke.
Source: Johnson and Davidoff (2000), based on data collected from an online insurance service.

60s imply that mean monthly premiums at ages 65 and 66 for those with two or more chronic conditions would range from $546 to $811 for women and from $829 to $915 for men. Because individual coverage is so expensive, almost half of the near elderly people who would purchase individual policies after a delay in the age of Medicare eligibility, or about 9 percent of the overall population ages 65 and 66, could only afford policies that provided limited coverage, leaving them vulnerable to high out-of-pocket expenses in the event of illness or injury.

An increase in the age of Medicare eligibility would leave 9 percent of the young elderly population uninsured. This estimate assumes that private insurers would offer individual policies to all adults ages 65 and 66 who could afford and were willing to pay the premium costs. However, some adults with health problems are unable to find coverage at any price, and those who can obtain coverage are often offered policies that exclude pre-existing conditions (Chollet and Kirk 1998; Pollitz, Sorian, and Thomas 2001). Nonetheless, the simulated uninsurance rate among the young elderly population seems plausible, since it equals the actual level of uninsurance among those aged 62 to 64, and insurers are probably not that much less willing to cover those aged 65 to 66 than those aged 62 to 64.

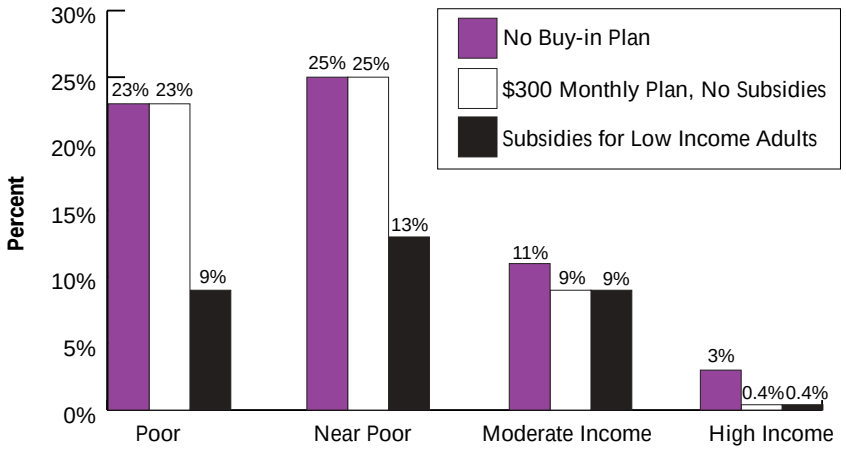
Raising the age of eligibility would hit those with limited incomes especially hard. For example, almost one in four poor and near poor near elderly adults would lack coverage (see Figure 6). Creating a Medicare buy-in plan for the near elderly would mitigate the adverse effects of an increase in the automatic age of eligibility, but it would not reduce uninsurance rates for low-income adults unless premiums were heavily subsidized. For example, if Medicare premiums for adults ages 65 and 66 were set at $300 per month—a price that many experts agree would just cover the cost of services provided—a buy-in plan would not reduce uninsurance rates at all for the poor or near poor, because most could not afford to purchase Medicare coverage. However, the buy-in plan could cut uninsurance rates to only 9 percent for the poor and 13 percent for the near poor if premiums were set at about $45 per month for those with incomes below 150 percent of the poverty line.

An increase in the age of eligibility could generate substantial savings for Medicare. By 2022, annual savings could reach $28 billion (in 2000 dollars), compared to what the program would pay out under

current rules (Wittenburg, Stapleton, and Scrivner 2000). The reduction in the total cost of public insurance would be somewhat lower, because some near elderly people would move from Medicare to Medicaid.

Medicare enrollment would fall faster than costs, because many of the most expensive beneficiaries—including the oldest old and those with disabilities—would remain in the program. According to one study, raising the age of eligibility would reduce Medicare enrollment by 11 percent and Medicare expenditures by 4.3 percent (Wittenburg, Stapleton, and Scrivner 2000).

Figure 6
Simulated Uninsurance Rates at Ages 65 and 66 if the Age of Medicare Eligibility Were 67, Under Alternative Medicare Buy-In Plans, by Income, 1998



Note: The subsidized plan sets premiums at $43.80 per month for those with incomes below 150 percent of the poverty level and at $300 per month for everyone else. Individuals are classified as poor if family income falls below the poverty level, as near poor if it falls between 100% and 200% of the poverty level, as moderate income if it falls between 200% and 400% of the poverty level, and as high income if it exceeds 400% of the poverty level.
Source: Davidoff and Johnson (2003).

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Conclusions

Setting the age for Medicare eligibility is necessarily arbitrary. Although a clear consensus exists in this country for providing universal health benefits to older adults (Kaiser Family Foundation 1998), it is not clear when an individual becomes old. Finding the appropriate age involves trade-offs. Lowering the age of Medicare eligibility would improve health and income security for some adults younger than 65, especially those with health problems and limited incomes. But it would raise costs and encourage some workers to retire early, exacerbating concerns about the ability of the economy to support the growing retired population. Raising the age of Medicare eligibility would reduce program costs and encourage workers to remain in the labor force, but at the expense of the health and income security of some older Americans. Most would find alternative sources of coverage, but many of the most vulnerable Americans—those in or near poverty and those with health problems who do not qualify for disability-related Medicare coverage—would be left uninsured or underinsured. Health insurance costs for employers and older consumers would rise.

Many adults could benefit from an option to buy into the Medicare program at younger ages. Similar to the early retirement option for Social Security, the buy-in program would permit individuals to receive limited subsidized benefits before the full entitlement age. The buy-in option would be particularly important to vulnerable populations, especially if plan premiums varied with the ability to pay.

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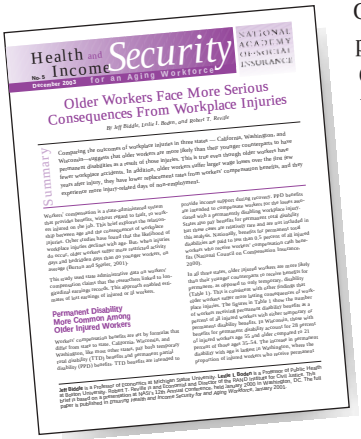
No.5 Older Workers Face More Serious Consequences From Workplace Injuries

by Jeff Biddle, Leslie I. Boden, and Robert T. Reville

December 2003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for an Aging Workforce
NATIONAL ACADEMY OF SOCIAL INSURANCE
Older Workers Face More Serious Consequences From Workplace Injuries
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Summary

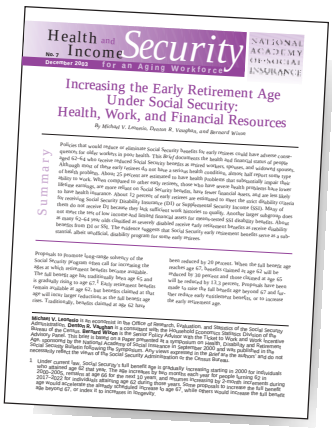
Comparing the outcomes of workplace injuries in three states—California, Washington, and Wisconsin—suggests that older workers are more likely than their younger counterparts to have permanent disabilities as a result of those injuries. This is true even though older workers have fewer workplace accidents. In addition, older workers suffer larger wage losses over the first few years after injury, they have lower replacement rates from workers' compensation benefits, and they experience more injury-related days of non-employment.

No.7 Increasing the Early Retirement Age Under Social Security: Health, Work, and Financial Resources

by Michael V. Leonesio, Denton R. Vaughan, and Bernard Wixon

December 2003

Policies that would reduce or eliminate Social Security benefits for early retirees could have adverse consequences for older workers in poor health. This Brief documents the health and financial status of people aged 62–64 who receive reduced Social Security benefits as retired workers, spouses, and widowed spouses. Although most of these early retirees do not have a serious health condition, almost half report some type of health problem. About 25 percent are estimated to have health problems that substantially impair their ability to work. When compared to other early retirees, those who have severe health problems have lower lifetime earnings, are more reliant on Social Security benefits, have fewer financial assets, and are less likely to have health insurance. About 12 percent of early retirees are estimated to meet the strict disability criteria for receiving Social Security Disability Insurance (DI) or Supplemental Security Income (SSI). Many of them do not receive DI because they lack sufficient work histories to qualify. Another larger subgroup does not meet the test of low income and limited financial assets for means-tested SSI disability benefits. About as many 62–64 year olds classified as severely disabled receive early retirement benefits as receive disability benefits from DI or SSI. The evidence suggests that Social Security early retirement benefits serve as a substantial, albeit unofficial, disability program for some early retirees.


Health and Income Security
No. 7 December 2003
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NATIONAL ACADEMY OF SOCIAL INSURANCE
Increasing the Early Retirement Age Under Social Security: Health, Work, and Financial Resources
By Michael V. Leonesio, Denton R. Vaughan, and Bernard Wixon
Summary

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This *Brief* is sixth in a series on Health and Income Security for an Aging Workforce. The full text of Academy *Briefs* and information for ordering reports and briefs are available on our website, **www.nasi.org,** or by calling 202-452-8097.

The National Academy of Social Insurance is a nonprofit, nonpartisan organization made up of the nation's leading experts on social insurance. Its mission is to promote understanding and informed policymaking on social insurance and related programs through research, public education, training, and the open exchange of ideas.

Health and Income Security for an Aging Workforce is a project of the National Academy of Social Insurance. It examines challenges to the nation's system of health and income security as Baby Boomers pass through the second half of their work lives. The project takes a cross-cutting look at the people, the risks to health and income security they face between mid-career and retirement age, and the programs that protect them.

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