

## Is 65 the Best Cutoff for Defining “Older Americans?”

Marilyn Moon, Jing Guo, V. Eloesa McSorley

Is 65 the appropriate age to identify people as “older Americans” for policy purposes? That age is often used as the cutoff when talking about a range of policies aimed at our older citizens. However, that number no longer holds the accepted status it once did. For example, the normal retirement age for Social Security has already been increased from 65 to 66 and is scheduled to rise to 67 in the near future. In addition, proposals currently abound to raise the eligibility age for Medicare, based on observations that people typically enjoy longer life expectancies and better health status compared to when the program was first enacted.

Do the issues that define “old age” really begin at 65? Although Americans are living longer, other changes in health status and workforce behavior could be used to argue that age 65 is too late to begin to worry about the challenges of an aging population.

Two key areas of concern when considering age from a policy perspective are the health and economic status (including labor force behavior) of older individuals. These variables affect not only the well-being of older Americans but the pocketbooks of American taxpayers. If age for program eligibility can be increased without harming older Americans, billions of dollars in government spending could potentially be saved.

Furthermore, aging concerns are not limited only to health and workforce behavior; related factors such as family relationships also affect how we view aging

and can influence the overall well-being of seniors and their need for services.

What do trends in the key variables affecting health, economic status and other socioeconomic characteristics tell us about the aging process? Can research help us better understand the policy debates concerning how we treat older Americans in the United States? A closer look at these issues illustrates that the aging process is complicated and consequently, the answer about the appropriateness of using age 65 for policy purposes is likely to be, “It depends.”

### Age 65 as a Benchmark

The reason that age 65 is viewed as the traditional cutoff between older and younger Americans has a long history. Although its origins are often attributed to the German chancellor Bismarck in the 1880s, Germany did not adopt 65 as its retirement age until 1916.<sup>1</sup> Age 65 was used as the eligibility age for providing old-age benefits at that time because so few people survived beyond that age, making pension benefits affordable.

In the United States, Social Security legislation in the 1930s also established age 65 as the “normal retirement age” at which full benefits would be available to retirees. And when Medicare was passed in 1965, age 65 was the cutoff established to be eligible for that program as well. This age has become accepted as distinguishing between the “old” and the “young.”<sup>2</sup>

Since the time age 65 was written into Social Security legislation as the normal retirement age, average life expectancy in the United States has increased substantially. In 1940, life expectancy was 61.4 years at birth for men and 65.7 years for women. By 2012, the numbers had risen to 76.3 and 81.1, respectively.<sup>3</sup> This approximately 15-year increase in life expectancy at birth translates into an increase of about 6 to 7 years in life expectancy for those reaching age 65.

For many years, the expected longer period of life beyond age 65 was viewed as something that a wealthy society could afford for its citizens as they became “elderly.” But more recently, arguments have been made that shifting the eligibility age upward is one way to generate savings for society as a whole. This argument is even more compelling today because the share of the population accounted for by those over age 65 has increased with the aging of the large Baby Boom generation and the lower birth rates of cohorts following the Baby Boom. There are more older Americans these days, and they constitute a larger share of the total population, which makes it more difficult for the working-age population to support benefits for these older individuals. For those worried about the costs of an aging society, this becomes a compelling argument to limit eligibility for programs such as Social Security and Medicare.

Certainly statistics should be factored into debates about the future of public policy in the United States, but not everyone who looks at the data on our aging population sees rethinking the cutoff date as inevitable. Aging is considerably more complicated and nuanced. It is important to consider additional statistics to ensure a more informed discussion of policy in an aging society.

Although we could focus on many statistics, this paper examines four key areas:

1. Workforce participation and Social Security enrollment
2. Income and economic status
3. Health status and spending
4. Family responsibilities

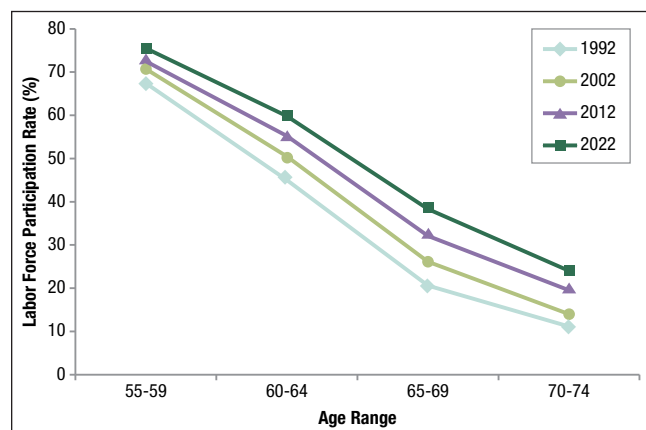
## Workforce Participation and Social Security Enrollment

As measured by the Bureau of Labor, labor force participation rates in the United States peak when individuals reach their mid-40s and then steadily decline. For example, for the 1944 birth cohort (which is currently age 70), the peak year for labor force participation was age 47 for the nondisabled population.<sup>4</sup> Withdrawal from the labor force is relatively gradual.

For many years, the trend in labor force participation at older ages was consistently downward, particularly for older men. Men of a specific age (say 55) were more likely to retire sooner than those reaching that age in earlier times. But in the mid-1990s that trend began to reverse, with older workers at most ages remaining in the labor force longer. As shown in Figure 1, for example, participation rates in 2012 were substantially higher in each of the five-year age groups shown as compared to 20 years earlier. In particular, the rates for those aged 55 to 59 and 60 to 64 increased by more than 10 percentage points from 1992 rates. According to Department of Labor projections, this trend is expected to continue over the next 10 years.

A recent study by Morrissey makes the point that it is more appropriate to look at labor force

**Figure 1. Change in Labor Force Participation Rate Over Time**



Source: U.S. Department of Labor, Bureau of Labor Statistics, Labor Force Statistics from the Current Population Survey — Civilian Labor Force Participation Rate, online at <http://www.bls.gov/data/home.htm>

participation rates after removing those who cannot work, such as the disabled, from the numerator.<sup>4</sup> This also increases the reported participation rate. She advocates focusing on the age at which participation rates fall below 50 percent and gives the example of the 1944 birth cohort in which that percentage is reached at age 62.2 when using the standard rate, but is 64.2 when the calculation is based on the nondisabled population.

These measures do not capture whether people are shifting out of their traditional occupations and into transitional jobs, or whether they are cutting back on hours. Phasing into retirement is an issue of increasing interest to policymakers, in part to reflect what may be workers' desire to find a better balance between working one day and retiring the next. Many studies have examined the return to the labor force of people who retire from their main occupations and take lower paying, less stressful jobs — either voluntarily or because that is all that is available to them. In 2014, 27 percent of those who call themselves “retirees” reported that they worked for pay, and a much higher percentage (65%) of current workers said they expect to work in retirement.<sup>5</sup> A more nuanced view of retirement may be needed to capture the desire or need for more gradual withdrawal from the labor force. This could be accelerated if employers become more amenable to more flexible work schedules.

Labor force participation rates are not the only indicator of retirement status that researchers and policymakers use. A second measure is the age at which people first begin to receive Social Security benefits. Because Social Security benefits can be received whether or not one is still working, this represents a different indicator that captures a separate phenomenon. Current workers may take benefits to supplement current earnings or because they fear they will die in the near future and wish to benefit from their contributions. On the other hand, some people who have left the labor force delay receiving benefits because their benefits will be greater the longer they delay. Many financial advisers recommend such a delay if people can draw on other resources, even if they have already left the labor

force. In 2009, the average age to begin receiving Social Security benefits was 63.8, little changed from 1970 (although it did fall considerably before that date).<sup>4</sup>

Thus, although much has been made of early retirement and people leaving the labor force well before age 65, even that statistic has been moving upward in recent years. Furthermore, early take-up of Social Security does not put enormous financial pressure on the program. Although individuals can choose to draw benefits at age 62, many wait to do so until later. (And, benefit levels are adjusted so the system is not adversely affected financially when people do take earlier retirement.) For purposes of moving out of the labor force, a range between age 60 and 65 would be a reasonable metric to use — and appropriately reflects the complexity of the transition.

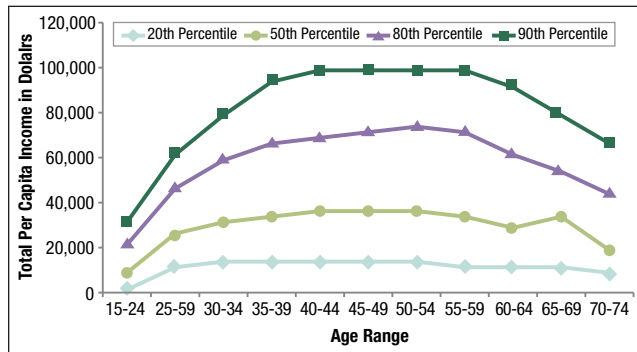
## **Income and Economic Status**

The major way we track economic well-being is via income — usually on the family level. Other indicators such as wealth or modifications of income are also potentially important, but they are not as consistently measured or reported over time or by age group. As traditionally defined, income includes annual flows of resources from earnings, interest, dividends, pensions, annuities and government benefits such as Social Security. These are the resources that most Americans depend on to meet their expenses; hence, they represent a reasonable measure of financial security. Income can be measured either as all resources that flow into a family or as the per capita share of a family's income (which implicitly controls for differences in family size across groups).

Largely because of earnings, family income peaks for people in their late 50s or early 60s. Above that age, people are less likely to work full time at their normal jobs and generally do not have sufficient additional resources to fully replace these lost wages. Thus, if one wants to consider when people need to begin supplementing wages with other sources such as pensions or annuities, an age earlier than 65 may be more appropriate for policy purposes.

Another important aspect of economic status is the distribution of resources within the population. Averages and medians often tell a misleading story about what is happening with resources. For example, for those with incomes in the top 10 percent of all families, incomes peak earlier and decline faster than for those at the bottom of the distribution (Figure 2).

**Figure 2. U.S. Total Money Income Distribution by Age, 2011**



Source: U.S. Census Bureau, Current Population Survey, 2012 Annual Social and Economic Supplement

Because some of the decline in income is “voluntary” — reflecting when people choose to retire and the extent to which they wish to draw down other resources — such declines might also reflect other changes in consumption or a need for resources to compensate for these changes. For example, if family size declines as children move away from home, or if individuals choose to downsize their housing and other discretionary consumption, they may choose to work less and hence have lower incomes. But sometimes this downturn reflects “involuntary changes” — for instance, job loss and subsequent difficulty returning to the labor force, or poor health that taxes resources and makes work less feasible. How we think about aging and economic well-being should be informed by a better understanding and analysis of these income changes and when they occur. Studying an aging society means focusing more on people in the decade before they turn 65.

Some observers of economic well-being have noted that other factors need to be taken into consideration, including the assets (such as accumulated stocks or housing) that older families control, which

can substitute for current income streams. Indeed, some measures of economic status seek to calculate the extent to which individuals can draw on assets — effectively converting them into flows of resources. This has potentially become even more important as employers have shifted from traditional defined-benefit pension programs, in which retirees receive a specific annual amount, into defined-contribution programs that leave retirees free to take their benefits either as annuities or lump sum distributions (or variations on this theme). This change complicates the study of how economic status has changed over time because today’s retirees show greater assets but lower incomes in many instances. They will need to convert assets into income streams, but they may do so in ways that do not show up as income — for example, by ad hoc withdrawals on an as-needed basis. That can make older Americans look less well off than they are. On the other hand, some people may assume that higher assets mean individuals are better off than in the past, whereas in actuality retirees must manage these assets to provide a stream of support over many years.

One interesting recent paper found that although these new forms of retirement benefits do result in an understatement of the level of income, they do not change the basic story about the distribution of those resources.<sup>6</sup> That is, those who have substantial amounts of other types of income are also the ones with defined-contribution savings. It is not the case, for example, that people who appear to have low income are actually very well off. People with low incomes typically also have little access to assets (Table 1). Thus, although there may be some distortions in measuring absolute well-being, the basic picture of the distribution of resources remains much the same.

### Health Status and Spending

Although it is well known that older Americans spend more on health care on average than those at younger ages, it is also interesting to consider when such distinctions begin to arise. At what ages

**Table 1. Per Capita Income, Savings, and Home Equity of Medicare Beneficiaries, 2013**

|                              |                  | 2013                               |          |                                |                                |
|------------------------------|------------------|------------------------------------|----------|--------------------------------|--------------------------------|
|                              |                  |                                    | Income   | Savings                        | Home Equity                    |
|                              |                  | Share of total Medicare population | Median   | Median among all beneficiaries | Median among all beneficiaries |
|                              | <b>Total</b>     | 100%                               | \$23,500 | \$61,400                       | \$66,700                       |
| <b>Federal Poverty Level</b> | <200% FPL        | 33%                                | \$12,250 | \$11,450                       | \$21,900                       |
|                              | 200-400% FPL     | 30%                                | \$23,050 | \$54,950                       | \$63,250                       |
|                              | 400% FPL or more | 38%                                | \$49,500 | \$220,150                      | \$111,650                      |

Source: Urban Institute/Kaiser Family Foundation analysis, 2013.

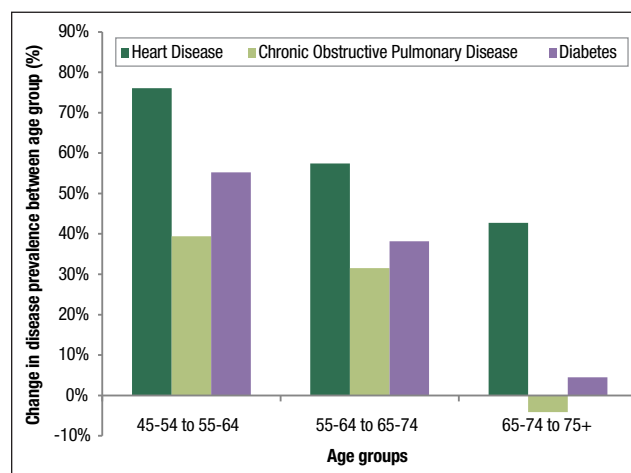
do health problems and treatments accelerate? The basic answer is that it is well before the age of 65: Spending on acute health care begins to rise rapidly after age 50, peaks around age 75, and then modestly declines. This is true for most types of health care spending, but it is particularly dramatic in the case of prescription drugs and hospitalizations. To the extent that aging implies greater health spending, age 50 would likely be a better age to begin tracking this important variable.

The onset of certain health problems also follows a pattern that is consistent with expenditures; specifically, the prevalence of major chronic conditions increases rapidly as individuals move into their 50s. The prevalence of diabetes, heart disease and chronic obstructive pulmonary disease increases more quickly in the 45-54 and 55-64 age groups than for any subsequent age group. The substantial increase in heart disease at earlier ages is particularly stark, with prevalence increasing 78 percent between the 45-54 and 55-64 age groups, and then increasing an additional 50 percent for the 65-74 age group (see Figure 3).

Not only are adverse health outcomes beginning to increase at a faster rate before populations reach Medicare eligibility, but so are the rates for underlying health conditions such as hypertension and obesity. These health conditions are often risk factors for the chronic diseases discussed above. Half of the male population has hypertension by age 65 and, although prevalence continues to increase,

the rate of growth declines after reaching the age of Medicare eligibility.<sup>7,8,9</sup>

When considering change in public policy — such as investing in prevention of disease — it may be more productive to focus on younger age groups (e.g., those in their 40s and 50s) if the goal is to reduce the costs of health care for older Americans.<sup>10</sup> Self-report of health status also supports earlier interventions, because the rate of adults reporting poor health increases most before the population reaches age 65 (36% from 45-55 year olds to 54-65 year olds), drops from 65-74 (13%) and then increases again.<sup>8</sup>

**Figure 3. Percentage of Change in Prevalence of Select Chronic Conditions Between Age Groups, 2011**

Sources: Data on COPD:

[http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6146a2.htm?s\\_cid=mm6146a2\\_w](http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6146a2.htm?s_cid=mm6146a2_w)

Data on Heart Disease: Health, 2013: <http://www.cdc.gov/nchs/data/hus/hus13.pdf>

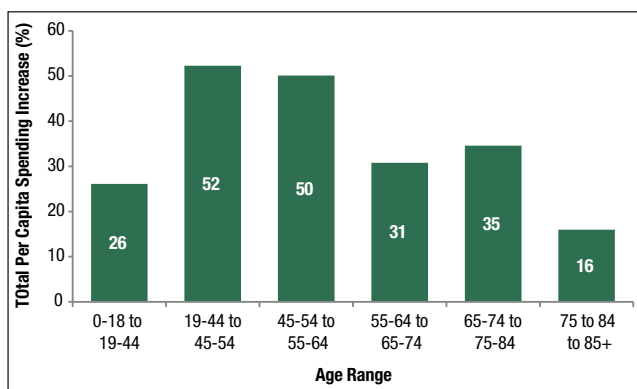
Data on Diabetes: NHANES Data, 2013

These adverse changes in health status are reflected in increases in health care spending across age groups. As seen in Figure 4, the largest increases in per-capita health care expenditures (net of home health care and nursing homes, as these tend to be concentrated among older age groups) are between the 19-44 and 45-54 age groups and between the 45-54 and 55-64 age groups, with a 52 percent and 50 percent increase, respectively.<sup>11</sup> These increases can be seen more clearly by type of service used. In particular, prescription medication (which actually decreases slightly between the 55-64 and 65-74 age groups), hospital care and physician care demonstrate important differences by age that underscore the increases in prevalence of disease before the age of 65 (see Figure 5).

### Family Responsibilities

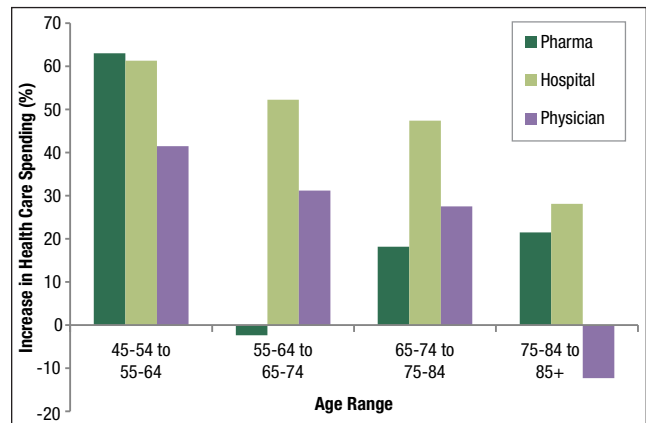
Families choose to live together in various combinations for a variety of reasons. That is, household composition may be associated with financial and/or health conditions. In the United States, household composition is mostly viewed as consumption — a conscious decision about how to organize family units. Parents usually help their children financially when they still live together, even when the child is old enough to live independently. When do parents have less financial responsibility for their children? In other words, at what ages do parents

**Figure 4: Percentage of Increase in Total Per Capita Spending (Less Home Health Care and Nursing Homes) Between Age Groups, 2004**



Source: National Center for Health Statistics. Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011.

**Figure 5. Percentage of Increase in Health Care Spending by Area of Spending Between Age Groups, 2004**

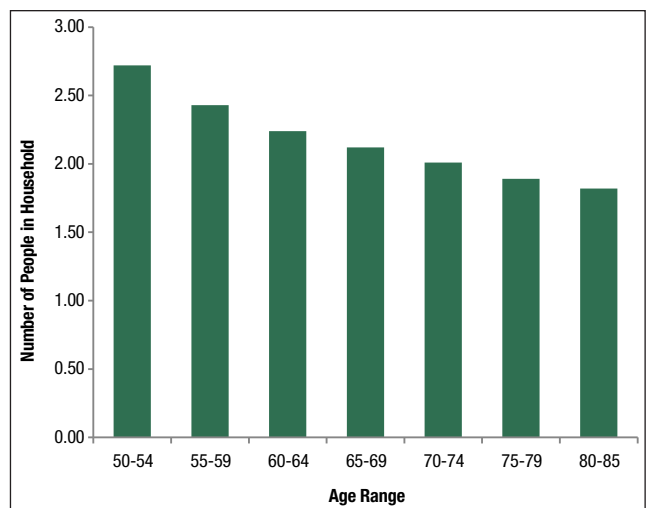


Source: National Center for Health Statistics. Health, United States, 2010: With Special Feature on Death and Dying. Hyattsville, MD. 2011.

no longer have to maintain a high income to support a large household?

As shown in Figure 6, household size decreases rapidly between ages 50 and 60.<sup>12</sup> When the head of the household is age 50, the average household size is 2.9, suggesting that many parents still have children at home. This average decreases to 2.3 when the householder reaches age 60, and eventually reaches 2 at age 72. This is confirmed by Figure 7, which indicates the presence of children in the household. Almost all households have children

**Figure 6. Number of People in Households**



Data Source: Health and Retirement Study 1996-2010, RAND HRS Data Version M, Cohorts HRS, CODA, War Baby, and Early Baby Boomer, born between 1924 and 1953.

living at home when the householder is age 50. A steady decline occurs until age 80. After that point, some children return to the household, likely providing support for their parents. The other reason for change in household size is the death of a spouse, which rises in frequency after age 70. Thus, Figure 7 also suggests that the decrease in household size before age 70 is not primarily caused by widowhood.

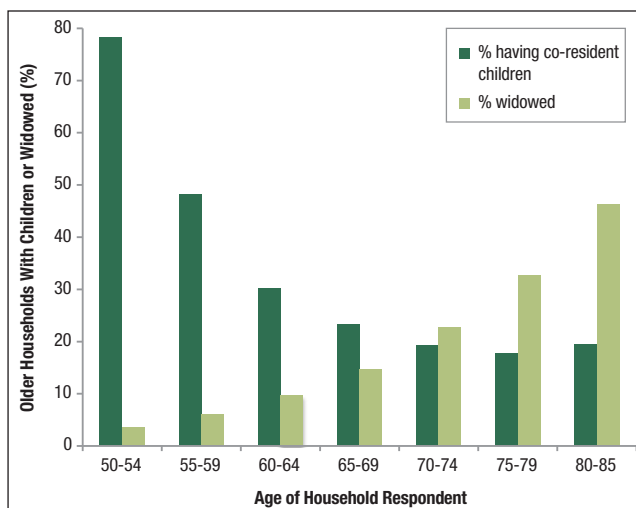
Many studies suggest that the elderly might prefer to live alone for privacy or independence (or their children prefer to live alone). Higher income increases the demand for living independently among the elderly, and living expenses affect the ability to live alone.<sup>13</sup> So when people do not have to help their children financially, they are less likely to live with them. Nonetheless, a substantial proportion of families share resources both when the families are living together and when they are independent. Children helping parents begins to increase after the head of household reaches age 70.

Family composition shows interesting patterns across ages with major changes occurring across the whole age range between 50 and 90. Age 65 certainly does not seem to be a meaningful cutoff point for variables that could be related to family status.

## Conclusions

Age 65 is often a convenient cutoff for discussing differences between “younger” and “older” Americans, but it is also the case that any concern for the aging of the U.S. population needs to look at younger families in the case of the emergence of health problems, and at older families when the concern is about cognitive issues. It is useful to use age 65 to consider differences in financial well-being and retirement, although even in this instance patterns are subject to change over time. Thus, although age 65 can certainly be questioned as the appropriate “cutoff” to use, it is also true that no other single age appears to be more useful for understanding who the “elderly” members of our society are.

**Figure 7. Percentage of Older Households Having Children or Widowed**



Data Source: Health and Retirement Study 1996-2010, RAND HRS Data Version M and RAND HRS Family Data Version B, Cohorts HRS, CODA, War Baby, and Early Baby Boomer, born between 1924 and 1953.

**NOTES**

1. Von Herbay, A. (2014). Otto von Bismarck is not the origin of old age at 65. *The Gerontologist*, 54(1), 5.
2. Age 62, when reduced Social Security benefits can begin, is sometimes used as a cutoff, and researchers are also fond of distinguishing between the “young old” (aged 65 to 74) and the “old old.” Nonetheless, 65 remains the most common date for distinguishing between the young and the old.
3. Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds. (2013). *The 2013 annual report of the Board of Trustees of the Federal Old-Age and Survivors Insurance and Federal Disability Insurance Trust Funds*. Washington, DC: U.S. Government Printing Office.
4. Morrissey, M. (2011). *The myth of early retirement*. Washington, DC: Economic Policy Institute.
5. Helman, R., Adams, N., Copeland, C., & VanDerhei, J. (2014). The 2014 Retirement Confidence Survey: Confidence rebounds—for those with retirement plans. *EBRI Issue Brief*, (397), 1–2, 5–34.
6. Iams, H. M., & Purcell, P. J. (2013). The impact of retirement account distributions on measures of family income. *Social Security Bulletin*, 73(2), 77–84.
7. National Center for Health Statistics. (2013). *National Health and Nutrition Examination Survey (NHANES), 2013*. Hyattsville, MD. Retrieved from [http://www.cdc.gov/nchs/nhanes/search/nhanes13\\_14.aspx](http://www.cdc.gov/nchs/nhanes/search/nhanes13_14.aspx)
8. National Center for Health Statistics. (2014). *Health, United States, 2013: With special feature on prescription drugs*. Hyattsville, MD. Retrieved from <http://www.cdc.gov/nchs/data/hus/hus13.pdf>
9. Chronic obstructive pulmonary disease among adults — United States, 2011. (2012). *Morbidity and Mortality Weekly Report*, 61(46), 938–943. Retrieved from <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6146a2.htm>
10. Work we conducted on diabetes, however, suggests that the payoff from such investments can take a long time. See Sherman, D., Pande, N., Moon, M., Lucado, J., McSorley, E., & Nguyen, Q. N. (2013). *Incentives to provide community-based diabetes prevention*. Washington, DC: Bipartisan Policy Institute.
11. National Center for Health Statistics. (2011). *Health, United States, 2010: With special feature on death and dying*. Hyattsville, MD. Retrieved from <http://www.cdc.gov/nchs/data/hus/hus10.pdf>
12. We used the Health and Retirement Survey (HRS) data for this analysis. These data come from the HRS cohorts born during 1924-1930, 1931-1941, 1942-1947, and 1948-1953, which show very similar age trends on changes of household composition.
13. Costa, D. L. (1999). A house of her own: Old age assistance and the living arrangements of older nonmarried women. *Journal of Public Economics*, 72(1), 39–59.

**FUNDING**

The Center on Aging is funded by American Institutes for Research.

**ABOUT AIR**

AIR is one of the world’s largest behavioral and social science research and evaluation organizations. Our overriding goal is to use the best science available to bring the most effective ideas and approaches to enhancing everyday life. For us, making the world a better place is not wishful thinking. It is the goal that drives us. Our mission is to conduct and apply the best behavioral and social science research and evaluation towards improving peoples’ lives, with a special emphasis on the disadvantaged.

**CONTACT AIR**

Kathleen Edmunds Cyr  
 Center on Aging  
 American Institutes for Research  
 1000 Thomas Jefferson Street, NW  
 Washington, DC 20007  
 301.592.2163  
 kcyr@air.org

