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Six steps to creating a health-aware retirement plan

Key points

- Retirees and those who care for them need a plan to prepare for the emotional and financial consequences of failing health, physical frailty, and cognitive decline associated with advancing age.
- Financial planners can play a role by providing not just financial strategies but also a context for helping clients confront difficult issues regarding how they want to live in retirement as they age and encounter health-related concerns.
- We propose a six-step framework for helping retirees confront these realities. Those steps are: Establish your health care priorities, decide on health insurance coverages, estimate your potential costs, incorporate health care costs into your retirement plan, take measures to deal with possible income gaps, and enact the plan.

Authors

Stephen M. Weber, CFP®, CLTC®

Julia Fuentes, CIMA®, WMS™, RSSA®

Ashley Greene, J.D., LL.M.

James M. Passman, CFA

The planning problems of getting older

One of the biggest worries we all have as we age is dealing with the natural decline that comes with getting older. We know there will be challenges, but we don't know what specific challenges we will face. This uncertainty creates a whole host of questions, both financial and nonfinancial, that need to be considered when creating a plan to support each retiree's best life. These questions include:

- What are the risks of my health failing in a way that affects my lifestyle?
- What costs might I encounter, and how will I pay for them?
- What happens if I start experiencing cognitive decline?
- Who will make decisions for me if I become incapable of doing so?
- How will I be able to maintain my lifestyle if I live a long time?
- How can I minimize the burden that my declining health may put on my loved ones?
- Will my spouse be able to cope if I die first?

While the answers to these questions may differ greatly based on your personal situation, the questions themselves are universal. It can be difficult to think about questions of sickness and mortality. However, it's impossible to say you've planned adequately for retirement if you haven't considered them.

The challenge of cost uncertainty

Academics and industry experts have placed a spotlight on health care costs that U.S. households can expect to incur during retirement. Most Americans realize that annual health care costs have been growing faster than inflation for some time; workers see this as they experience rising premiums and out-of-pocket costs in their employer benefits. They also know they will likely consume more services each year as they age. Pre-retirees and retirees are concerned about how these costs will affect their retirement and how they will pay for them. Thirty percent of workers surveyed were not confident they would have enough money for health care during retirement; this percentage was higher than the number who feared they would run out of money for any other reason.[1]

As presented by leading experts, the numbers are alarming. Since at least 2003, the Employee Benefit Research Institute (EBRI) has been quantifying the amount that individuals will need to have saved to cover their total health care premiums and out-of-pocket health care costs throughout retirement.[2] The EBRI analysis has evolved over the years and now focuses on the figure needed for a 65-year-old couple desiring a 90 percent chance of having enough savings: a daunting $351,000.[3] As we discuss later, this type of framing annual costs as a lifetime lump sum is generally unhelpful and scary, but that fear is real, and we need a good approach to manage these costs to overcome it.

The EBRI estimate does not factor in any long-term care expenses. Nearly half the population will need paid long-term care such as adult day care, homemaker services, home health aides, assisted living facilities, and nursing-home care.[4] The costs are justifiably a primary worry for many U.S. retirees: The national average for private-room nursing-home care exceeds $116,000 per year.[5]

1 Employee Benefit Research Institute (2020). Responses were based on the views of 1,018 workers in the U.S., with data weighted by age, gender, education, household income, and race.

2 Fronstin and Salisbury (2003).

3 Spiegel and Fronstin (2024).

4 Johnson and Dey (2022), Table 2.

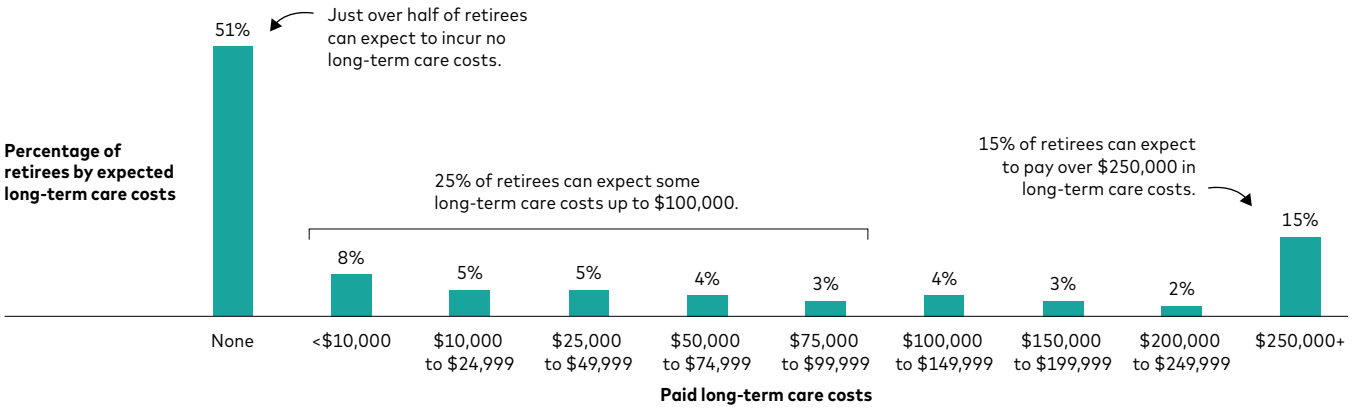
5 Genworth Financial, Inc. (2024).

People, of course, differ in important ways that can influence these costs. Retiree health care costs vary from person to person. Financial plans should factor in each investor's personal characteristics. Factors that can significantly affect retiree medical costs include how healthy you are, what insurance coverage you use, where you live, and whether you might be subject to tax surcharges or qualify for credits based on income.

Long-term care costs present a type of retirement planning challenge far different from annual health care. The costs are unpredictable—sometimes large, sometimes zero—and rarely covered by insurance other than long-term care policies, which are increasingly difficult to obtain or afford.

The total amount paid for long-term care represents a combination of whether a person will need care and, if so, what type and for how long. Just over half of retirees can expect no costs (**Figure 1**). Another 25% can expect total costs (public and private) below $100,000. But 15% can expect total costs exceeding a quarter of a million dollars. For those with expenditures, average total expected costs are about $245,000.[6] Retirees in the top income quintiles can expect to pay more out of pocket.

FIGURE 1
Costs for paid long-term care vary considerably



Note: Amounts are in 2021 dollars, for people turning 65 between 2021 and 2025.
Sources: Vanguard, based on data from Johnson and Dey (2022), Table 7.

A framework for retiree health care planning

Given all these uncertainties, it's important to construct a retirement income plan that is robust enough to handle a wide range of potential health care situations. How can a financial planner help clients navigate these choices, only some of which are directly related to a financial plan? Here's a basic six-step approach for thinking through these issues:

1. Establish your health care priorities.
2. Decide on health insurance coverages.
3. Estimate your potential costs.
4. Incorporate health care costs into your retirement plan.
5. Take measures to deal with possible income gaps.
6. Enact the plan.

Let's look at each of these steps in more detail.

6 Johnson and Dey (2022), Table 4.

Step 1: Establish your health care priorities

The problems of aging can be hard to think about and talk about. Financial planners can be an important catalyst in helping their clients face these questions. Everyone who is planning for retirement should understand the "who, what, where, and how" of their own desired care scenario. These are necessary prerequisites to knowing whether your retirement income plan is adequate to meet your needs. **Figure 2** is a sample checklist of questions that an investor and advisor should consider when putting together a plan. They are questions that everyone needs to face, regardless of financial condition, health, or marital status. In the same way that young savers need to think about their goals and objectives in order to put together an appropriate savings plan, retirees need to consider their health preferences in order to put together an appropriate retirement income plan.

FIGURE 2

A health care planning-needs assessment

Your support system	☐ Which loved ones will be affected if you have health issues?
	☐ Who will be your caretaker(s) if you become frail?
	☐ Who should have decision-making authority about your health care choices if you're unable to do so?
	☐ Who should have decision-making authority about your financial matters if you're unable to do so?
	☐ Who are the loved ones you might need to care for?
Your care preferences	☐ Where do your potential caretakers and decision-makers live?
	☐ Which hospital do you use? Is it the same one you would use if you experience severe medical issues?
	☐ If you need long-term care, would you prefer that it be administered in your home, or would you use a facility?
	☐ Which facilities might be used if needed?
	☐ Is your home suitable for aging in place?
	☐ Would you consider adult day care as a way to help your caregivers?
	☐ What are your preferences for end-of-life care? Would you want treatment to extend your life in any situation? If not, in what situations would you want to refuse care?
	☐ Have you communicated your health care preferences to your loved ones?
	☐ Which supports will those people need?
Your documents and authorizations	☐ Do you have a living will or other advanced directive?
	☐ Do you have a medical power of attorney document?
	☐ Do you have a financial power of attorney document?
	☐ Do the people to whom you want to give authority know you're counting on that from them? Do they know how and where to access the appropriate documents if needed?
Your decision-making processes	☐ How will you decide that it's time to stop driving?
	☐ How will you decide to hire help for household tasks such as cooking and cleaning?
	☐ How will you and your caretakers decide when paid long-term care support is needed?
	☐ If appropriate, how will you decide that it's time to move?
Your finances	☐ What financial resources will you have available to pay for the medical and custodial costs that you may incur?
	☐ Under what circumstances would you delegate financial decision-making authority?

Source: Vanguard.

Step 2: Decide on health insurance coverages

Choosing Medicare coverage

At age 65 and beyond, most investors will need to make choices about their Medicare coverage. Original Medicare can have substantial deductibles and coinsurance, and there is no limit to potential out-of-pocket costs. As a result, most people's primary choice is whether to use Original Medicare with supplemental Medigap insurance, or whether to use a Medicare Advantage plan. Some people will have employer-based subsidized coverage that dictates the choice, but otherwise investors need to make a decision. **Figure 3** outlines the major pros and cons of each type of coverage. In general, if cost is the primary concern, Medicare Advantage will usually lead to lower health care costs over time (though it may be more expensive in specific years in which you experience poor health outcomes). Original Medicare with a supplement will tend to provide a more flexible choice of health providers and more predictable costs, regardless of your health status in any particular year.[7]

FIGURE 3

Most retirees will choose between Medicare Advantage and Original Medicare with a supplement

	Medicare Advantage	Original Medicare + Medicare Part D + Medicare Supplement Plan G
Pros	• Generally has the lowest cost overall • Often includes prescription coverage • Often includes extras such as hearing and vision coverage and gym memberships • Offers the simplicity of "all-in-one" coverage • Coverage can be obtained without medical underwriting • Some plans have broad networks, low co-pays and deductibles, and/or low out-of-pocket maximums	• Premiums cover most expenses • No preapprovals or referrals are needed • You can see any doctor who takes Medicare, anywhere in the country • Coverage can be obtained without medical underwriting when you're first eligible to enroll • Can be the least expensive for those in very poor health • You can choose a separate Part D (prescription) policy that best fits your needs
Cons	• Often has geographic limitations • Not all doctors who accept Medicare are included in networks • Some plans require preapprovals and referrals for some situations • Coverage can be denied if a treatment or procedure isn't deemed medically necessary by the insurance company • Plans vary a lot; drug coverage, coinsurance, and co-pays can be confusing and inconvenient • Can be more expensive if you become very ill • You may face underwriting requirements if you want to switch to a supplemental policy	• Is usually more expensive over a lifetime • Typically has higher premiums than Medicare Advantage plans • Extras such as dental and vision care aren't covered • You need to shop for a separate Part D policy to cover prescription drugs • You can't use Health Savings Account (HSA) funds to pay for Medigap premiums • Coverage availability may be subject to medical underwriting for a new policy after your initial enrollment period • Entails multiple insurance cards

Sources: Vanguard, based on information found at www.medicare.gov.

7 For a more complete discussion of Medicare and how to think about choosing the Medicare plan that best fits your needs, see Weber (2022).

Step 3: Estimate your potential costs

Projecting conventional medical care costs

Now that you understand what your health care preferences, supports, and coverages may be like, you can start to estimate what those costs—or potential costs—might be. To better understand the financial planning implications of annual and long-term care health expenses, Vanguard has partnered with Mercer Health & Benefits to develop a proprietary model to forecast the range of costs for pre-retirees and retirees.[8] For a typical 65-year-old woman, the model predicts an annual health care expense of about $6,000 in 2025 if she purchased a Medicare Supplement Plan G and a standard Part D prescription drug plan.

Retiree health care costs, of course, vary from person to person. Financial plans should factor in each investor's personal characteristics. Factors that can significantly affect costs include health status and risk, geography, and Medicare premium surcharges.

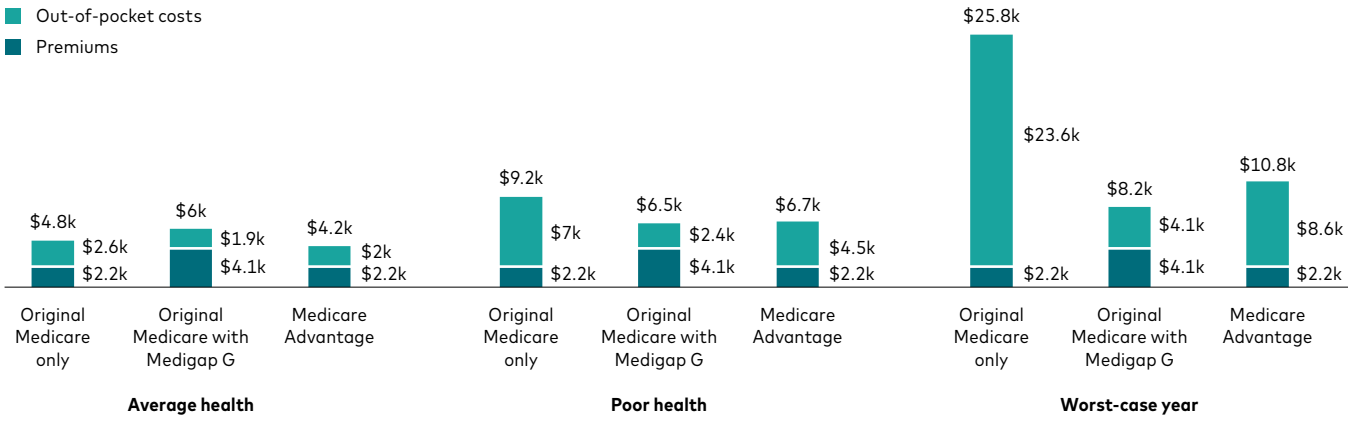
Health status and risk

One of the largest factors in estimating potential costs is the volume of health care services a given person will likely require. People with chronic medical conditions consume the most care.[9] Our model divides people into three health categories: excellent, average, and poor. People in poor health are assumed to incur health care costs associated with the top cost quartile. In our model, they typically are smokers, visit the doctor frequently, or have multiple chronic health conditions. People in the excellent health category are generally free of chronic conditions and incur costs associated with the bottom quartile. Average-risk retirees incur costs associated with the middle two quartiles. **Figure 4** shows how costs might be expected to vary based on coverage type and health status.

FIGURE 4

Higher-premium options may be costlier in average health years but less so when your health is poor

Estimated 2025 medical costs by Medicare coverage options for a 65-year-old woman



Notes: Projected costs are for a typical single 65-year-old female and include vision, dental, and prescription drug costs. All coverage options are assumed to include Part D prescription coverage. Average and poor health numbers are median projections for a person with those health statuses. The worst-case year represents a 95th percentile outcome for a person in poor health.

Source: Mercer-Vanguard health care cost model for 2025.

8 The Mercer-Vanguard health care cost model is also based on requirements arising under the Affordable Care Act as of this paper's publication date. These requirements could change or be clarified in a manner that may materially affect the analysis and resulting determinations.

9 Buttorff, Ruder, and Bauman (2017).

Geography

Where a retiree chooses to live also affects projected health care costs. Geography does not affect Medicare Part B premiums, but it may affect Part D premiums. It also affects the cost of private insurance, such as marketplace public exchange plans, Medicare Advantage premiums, and supplemental Medicare policy premiums. Some of these differences are due to variations in the cost of living or cost of medical services and the level of federal funding. Some are due to differences in the insurance providers that serve each state.

Medicare premium surcharges

Another factor affecting Medicare Part B and Part D premiums is income. Medicare premiums are subsidized by the government. As retirees reach higher income levels, those subsidies are reduced in the form of higher Part B and D premiums. This is known as the Income-Related Monthly Adjustment Amount (IRMAA). **Figure 5** shows these surcharges for 2025.

FIGURE 5

High income during retirement can mean significant Medicare surcharges

IRMAA income brackets and monthly surcharges for 2025

Single	Married filing jointly	Part B surcharge	Part D surcharge
Less than or equal to $106,000	Less than or equal to $212,000	$0.00	$0.00
Greater than $106,000 and less than or equal to $133,000	Greater than $212,000 and less than or equal to $266,000	$74.00	$13.70
Greater than $133,000 and less than or equal to $167,000	Greater than $266,000 and less than or equal to $334,000	$185.00	$35.30
Greater than $167,000 and less than or equal to $200,000	Greater than $334,000 and less than or equal to $400,000	$295.90	$57.00
Greater than $200,000 and less than $500,000	Greater than $400,000 and less than $750,000	$406.90	$78.60
Greater than or equal to $500,000	Greater than or equal to $750,000	$443.90	$85.80

Sources: Vanguard, based on data from the Social Security Administration.

Each year's surcharge amount is based on your modified adjusted gross income (MAGI) from two years earlier. MAGI is the adjusted gross income from your tax return plus certain deductions that you have to add back to it. You can appeal the surcharge if you experienced a life-changing event in the intervening two years that reduced your income substantially. Because life-changing events include retirement or a reduction in work, many people who retire and begin collecting Medicare may be able to appeal the surcharge. Other life-changing events include marriage, divorce, or loss of a pension or income-producing property. They do not, however, include IRA distributions or Roth conversions that might temporarily increase your income.

Bridging to Medicare

The absence or presence of subsidized coverage for retirees, and their nonworking spouses, under 65 can significantly affect planning. They need a strategy to bridge their health care coverage between retirement and Medicare.

Those without access to employer retiree health care benefits will probably use private insurance. Most people now get this type of coverage through public marketplace exchanges, typically purchasing either a Bronze plan (31% of enrollees) or a Silver plan (54% of enrollees).[10] The premium cost of a typical unsubsidized Bronze or Silver plan at age 64 can be more than four times the cost of most Medicare coverage at age 65.[11]

Many retirees, though, may be able to get this coverage at a subsidized rate. During open enrollment for 2024 coverage, 92% of enrollees had their premiums reduced by Affordable Care Act tax credits.[12] Such credits are available to individuals and families with incomes at or above the federal poverty level who buy coverage through their state's health insurance marketplace. **Figure 6** shows the health insurance premiums that people at different income levels were expected to pay in 2025.

Through the end of the 2025 coverage year, there is no maximum income limit for the premium tax credit. Anyone whose benchmark premium—the premium cost of the second-lowest-priced Silver plan available in your state—exceeds 8.5% of household income qualifies for such a credit. However, as of this paper's publication date, current law would cap any subsidies for those over 400% of the poverty line after 2025.

FIGURE 6

Many enrollees can get tax subsidies for marketplace health coverage

Expected premium contributions at different 2025 income levels

	Income		Expected premium contribution after credit	
	Percentage of poverty line	Annual dollar amount	Premium contribution as a percentage of income	Monthly premium
Family of four	<150%	<$46,800	0%	$0
	200	62,400	2	104
	250	78,000	4	260
	300	93,600	6	468
	>400	124,800	8.5	Varies
Individual	<150%	$22,590	0%	$0
	200	30,120	2	50
	250	37,650	4	126
	300	45,180	6	226
	>400	60,240	8.5	Varies

Notes: Income thresholds are determined using 2025 MAGI. The marketplace uses the federal poverty guidelines available during open enrollment to determine premium tax credit amounts for the following year (e.g., 2024 federal poverty guidelines are used for 2025 coverage).

Sources: Vanguard, based on data from the Center on Budget and Policy Priorities (2024).

10 Centers for Medicare & Medicaid Services (2024).

11 Mercer-Vanguard health care cost model for 2025.

12 Centers for Medicare & Medicaid Services (2024).

Beyond the public exchanges, people working for large employers may have access to employer-sponsored, and perhaps even employer-subsidized, retiree health benefits. According to Mercer's 2024 National Survey of Employer-Sponsored Health Plans, 17% of large employers offer such a plan for all employees, covering on average just over 40% of the cost of pre-Medicare retiree insurance. An additional 13% of large employers offer this coverage to a closed group of current or future retirees. This reflects the ongoing trend of fewer employers offering subsidized retiree health benefits. Our model projects that a 64-year-old retiree could pay premiums of about $8,600 a year ($717 a month) for employer-sponsored coverage. When these benefits exist, it's important to compare them with the potential costs of insurance on the exchanges. Just because an employer subsidy is available does not necessarily mean it will be the best choice in any given circumstance.

Long-term care costs

Long-term care does not generally require medical expertise, so it is not usually covered by medical insurance. Long-term care services help individuals with activities of daily living (ADLs): bathing, dressing, toileting, transferring (getting out of a bed or chair), continence, and eating. The Health Insurance Portability and Accountability Act (HIPAA) established that someone needing assistance with two or more of these activities for 90 days or more is consuming long-term care. HIPAA also established that the same is true for someone with severe cognitive impairment who requires substantial supervision for safety reasons.

Long-term care can be further categorized as either temporary or ongoing. Temporary care is episodic and shorter in duration, lasting only weeks or months. Examples include rehabilitation after a hospital stay or recovery from an injury or surgery, after which the person no longer requires services. Another example is hospice care provided in the case of a terminal medical condition; such care is temporary because the end of life is imminent. Some temporary costs may be covered by Medicare.

In contrast, ongoing long-term care lasts many months or even years. Examples include assistance with ADLs associated with cognitive decline, permanent disability, and other chronic conditions. Once begun, ongoing long-term care is generally needed for the rest of a person's life.

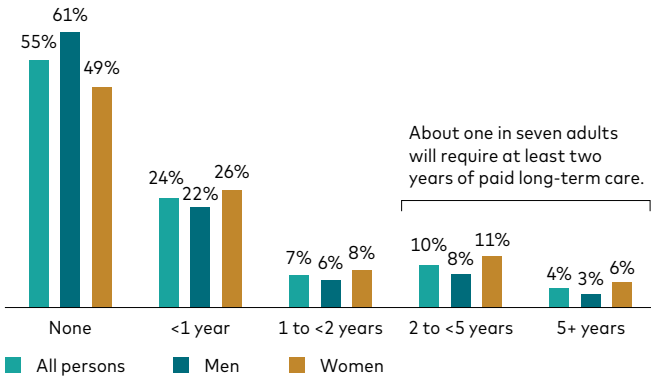
Not all long-term care is paid for. Family, friends, and neighbors frequently provide unpaid care. The National Care Planning Council estimates that informal caregivers represent approximately 20% of the U.S. population.[13] It describes the typical caregiver as a daughter, age 46, with a full-time job, who provides an average 18 hours per week of unpaid care. Of course, caregivers come in all types.

Nearly half the population will face the prospect of needing some sort of paid long-term care. Although most of these needs will be relatively short, about 14% of adults will require at least two years of such care, and 6% will need five years or more (**Figure 7**). This possibility is what fuels the worries of retirement savers.

FIGURE 7

Nearly half of individuals will need some paid long-term care

Projected use of long-term care for people turning age 65 between 2021 and 2025



Sources: Vanguard, based on data from Johnson and Dey (2022), Table 2.

13 Day (2021).

The incidence and duration of paid long-term care varies by gender. Sixty-one percent of men can expect not to need it at all, while 51% of women can expect to use it. Women also are more than twice as likely to require care for five or more years. It's not that men are healthier—rather, elderly men are more likely to be married than women, largely because women have longer life expectancies, and historically a woman tends to be the younger spouse in a heterosexual couple. As a result, 66% of informal caregivers are women.[14] Thus, men are more likely to receive a greater portion of unpaid care.

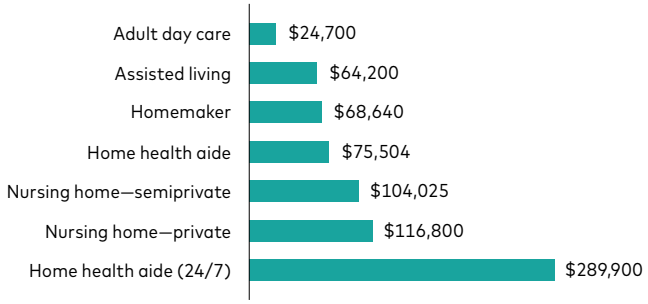
It's wrong, however, to think of years of paid care as being equivalent to years of nursing home care. Several types of formal long-term care services fall short of an extended nursing home stay. The cost varies by type of service. In 2023, the median annual cost ranged from about $24,700 for adult day care to more than $116,000 for a private nursing-home room (**Figure 8**). Homemaker services are considered "hands-off" care and entail assistance with cooking, cleaning, and running errands. Home health aides provide hands-on personal care but not medical care.

Adult day care centers are available in some communities; they provide social and support service in a protective setting and may also provide personal care, meals, and transportation. An assisted living facility is often an alternative to nursing home care; many such facilities provide personal care and may offer health services. Nursing home care is the most intensive type of long-term care, with services provided around the clock including personal care, room and board, supervision, medication, therapy, and rehabilitation. Note that the in-home care costs cited in Figure 8 assume 44 hours of care per week; around-the-clock home care is the most expensive caregiving option.

FIGURE 8

The cost of paid long-term care differs by the type of service

National median annual costs of long-term care by the type of service



Note: The costs shown assume 44 hours a week for homemaker and home health aide and five days a week for adult day care.

Sources: Vanguard, based on data from Genworth Financial, Inc. (2024).

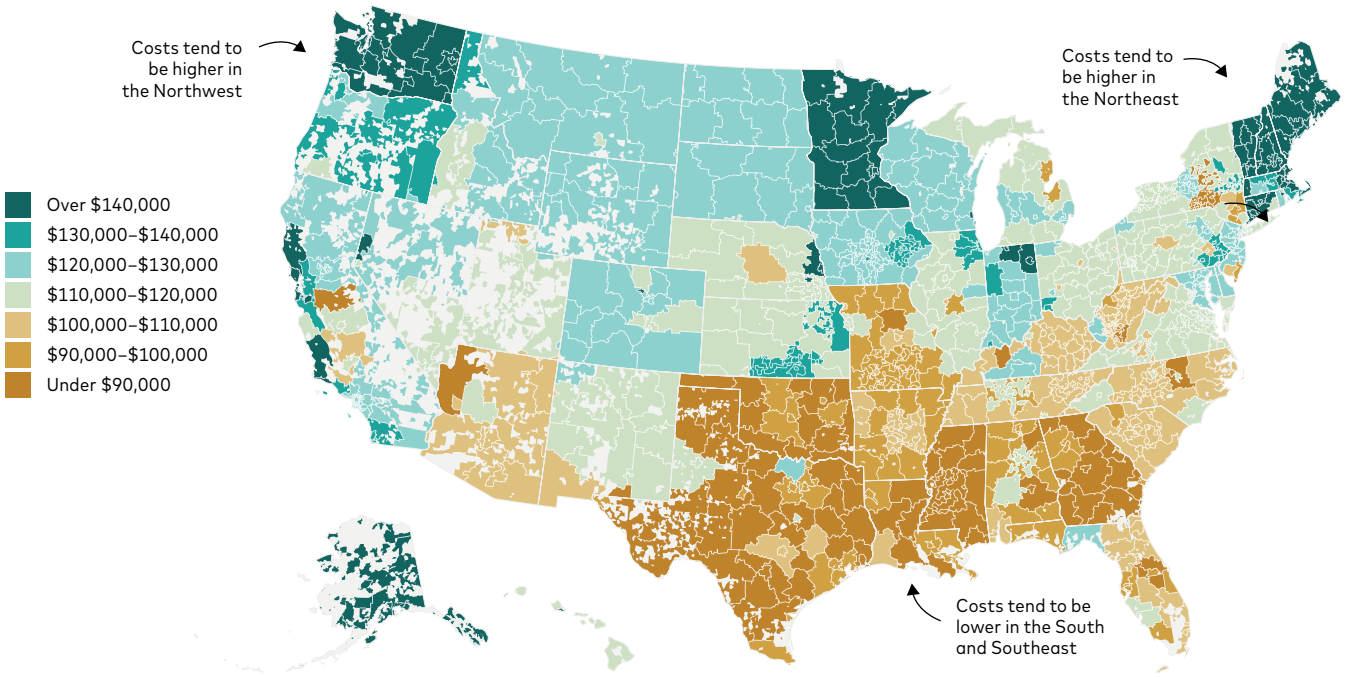
14 Johnson and Dey (2022).

Costs also vary by region (**Figure 9**). Even within a given region, they can vary greatly by provider. A private room in a high-end nursing home can cost 50% or more above the average for a particular location.

When estimating your potential costs, it's important to consider all these factors. How long will you need care? Which informal, unpaid caregivers will help? What kinds of paid care are you likely to use? What are the specific care costs in the area you live in? Knowing the answers to these questions can help give you a sense of your potential costs.

FIGURE 9

Annual costs for nursing home care vary by location



Source: Mercer-Vanguard health care cost model for 2025.

Step 4: Incorporate health care costs into your retirement plan

Now that you have an understanding of your health care priorities and the costs you may encounter, you can incorporate them into your retirement income planning process.

Health care costs are an income issue, not an asset balance issue

Earlier, we referenced the EBRI analysis that says a 65-year-old couple needs $351,000 in savings just to have a 90% chance of being able to cover health care costs during retirement. That's a scary number, but is it a useful framing for thinking about planning for those costs? Like most expenses, health care costs are bills we pay each month. How does turning them into a lump-sum cost help? When any annual recurring expense is framed as a lump sum rather than an annual flow, it can seem overwhelming.

Consider that, according to the U.S. Bureau of Labor Statistics (BLS), the average two-person household age 65 and older spends $34,603 per year on food, clothing, and shelter combined.[15] This seems reasonable. But what if we convert it into a lump-sum estimate? Assuming growth with inflation and a 27-year time horizon, that household would need more than $930,000 just to cover those basic costs.[16] The BLS reports that average total spending on all categories for couples 65 and older is $72,734 per year. This means our "average" couple would need nearly $2 million to cover future living expenses! Fortunately, these expenses don't always need to be fully funded by personal wealth. Retirees have various income sources, including Social Security, to help them pay their bills.

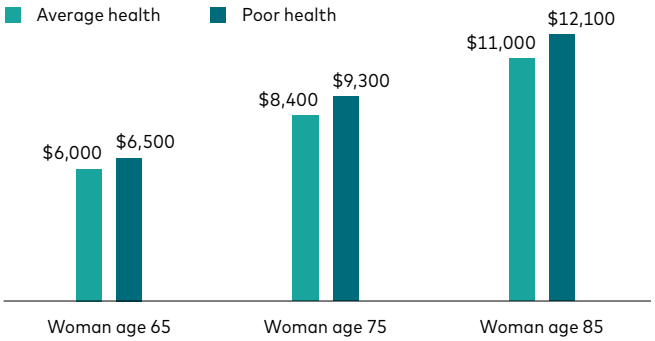
Planning for health care cost growth

Recall that our model projected that a typical 65-year-old woman living in a median-cost area could have expected to pay about $6,000 for premiums and out-of-pocket medical, dental, and vision costs in 2025 for Original Medicare with Part D and Supplemental Plan G. But how could those costs change over time? By age 85, our retiree could expect her annual health care consumption to nearly double in real dollars (**Figure 10**).

FIGURE 10

Retirees can expect to spend more on health care as they age

Projected annual costs for a typical woman who turns 65 in 2025



Notes: Projection is for a typical 65-year-old woman who enrolls in Original Medicare plus Part D and Supplemental Plan G. All amounts are in 2025 dollars.

Source: Mercer-Vanguard health care cost model for 2025.

15 U.S. Bureau of Labor Statistics (2024).

16 This is the median life expectancy for the second spouse to die in a nonsmoking 65-year-old couple in average health, according to the Society of Actuaries and American Academy of Actuaries' *Longevity Illustrator*.

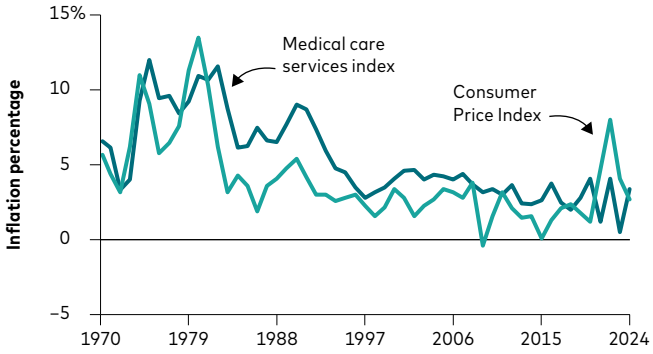
The growth of health care costs is so pronounced for two reasons. First, those costs have historically risen faster than inflation (**Figure 11**). Although this trend has recently moderated somewhat, it's projected to persist for the foreseeable future. Second, people generally spend more on health care as they age. All other factors being equal, an 85-year-old will consume more services than a 65-year-old.

Given these trends, it is not surprising that financial planners who want to incorporate health care costs focus on the risks associated with faster-than-inflation growth. It's important, however, to consider these costs relative to other basic living expenses. Although these costs increase, spending in other categories tends to decline with age.

BLS data support this conclusion (**Figure 12**). As we age, increases in health care spending are countered by declines in categories such as transportation, housing, and entertainment spending. This could be motivated by various factors, including a diminishing interest in consumption, an increase in precautionary savings for long-term care, or more restricted financial circumstances. Even health care growth rates that are materially higher than inflation are unlikely to outweigh these relative declines.[17]

FIGURE 11

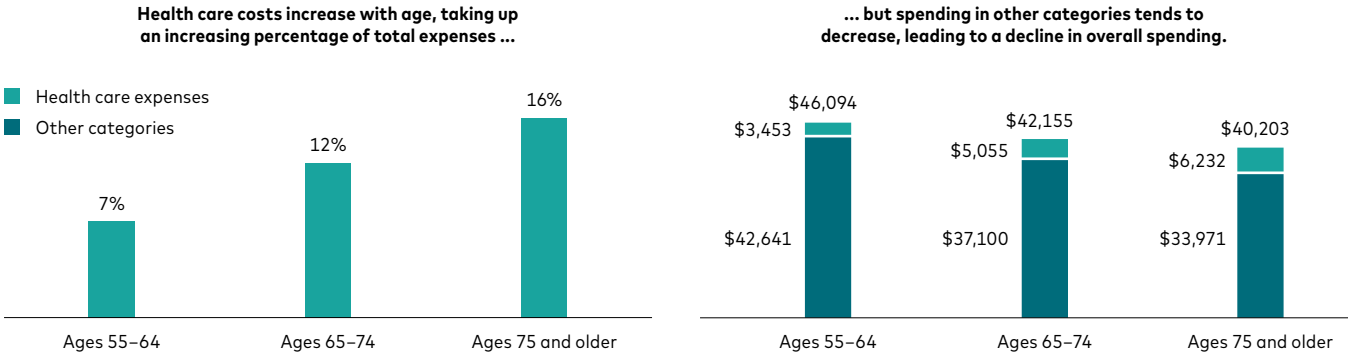
Health care costs have historically grown faster than inflation



Sources: Vanguard, based on data from the U.S. Department of Labor, Bureau of Labor Statistics, for 1970 through 2024.

FIGURE 12

Overall spending declines with age, even as health care spending increases



Note: Annual spending data shown are for one-person households.

Sources: Vanguard, based on data from the U.S. Bureau of Labor Statistics (2024).

17 Blanchett (2014). Others who have documented declines include Hurd and Rohwedder (2008) and Scholz, Seshadri, and Khitatrakun (2006).

The trend of higher-than-inflation health care cost growth is not new. Retirees have been facing this reality for decades. The evidence, however, does not show that it has distorted overall spending. Research by the Society of Actuaries indicates that "retirees are resilient, and they are willing to make substantial adjustments in spending to manage" their finances.[18] Retirement planning frameworks that assume that overall spending increases with inflation are already making a conservative assumption, providing an incremental hedge against the rising cost of health care. Planners who want to model faster-than-inflation growth for health care costs should be careful to also assume slower-than-inflation costs for other spending categories.

Stress test for worst-case long-term care outcomes

Few income plans will need substantial adjustment that's due to the costs of insured medical issues. The potential high costs of long-term care, which are not covered by medical insurance, are the bigger threat to financial well-being. Research shows that a big reason why investors are hesitant to spend their assets during retirement is that they're reserving them in case of a future health care spending need.[19]

Financial planners who incorporate possible long-term care costs into an income plan can help investors understand whether they are prepared to deal with those costs. By doing that, planners can help investors with their confidence in the plan and give them permission to spend with less concern about undermining their future needs.

One of the main roles of a financial planner is to help investors take prudent actions in the face of future uncertainties. Virtually all planners take one of these sources into account: namely, unpredictable market returns. They use Monte Carlo simulations or other techniques to demonstrate that an income plan will meet minimum asset requirements even in poor market outcomes.

Similarly, longevity is an unpredictable factor that must be planned for. Some planners do so by simply constructing a plan that goes to a low-probability life expectancy such as age 95 or 100. Others might incorporate variable life expectancy outcomes into their projections to capture the uncertainty of living longer—or shorter—than expected.

Health care costs and long-term care costs are a similar problem, because they are also uncertain and largely out of the individual investor's control. A wise planner will build a plan that accounts for these possible needs, just as they do for possible market and life expectancy outcomes. A "what-if" scenario that incorporates a low-probability, high-cost long-term care expense can be an important part of helping clients build an income plan that is resilient enough to prepare for that possibility.

Step 5: Take measures to deal with possible income gaps

Sometimes incorporating potential costs into the planning process can be reassuring, by letting investors know that they'll likely be able to handle any costs they may encounter. In other circumstances, however, such planning may reveal potential gaps in an investor's financial ability to manage adverse health outcomes.

A variety of planning strategies can make health care costs—especially long-term care costs—more manageable. Investors and financial planners should consider the strengths and weaknesses of each while constructing an income plan suitable for the needs and desires of each person's circumstances. The most appropriate strategies for each situation will depend on each investor's risks, caregiving resources, financial situation, and personal preferences and priorities. See the Appendix on pages 20–21 for a quick summary of the pros and cons of some potential solutions. But we'll first delve into each in a little more detail.

18 Rappaport (2017).

19 Ameriks et al. (2020).

Insurance strategies

One of the first answers that often come to mind when we think about planning for long-term care costs is long-term care insurance (LTC). As with other forms of insurance, you pay a premium in exchange for a benefit when certain conditions are met. For LTC insurance, the condition that pays is that you need assistance with at least two activities of daily living or that you experience cognitive decline that requires supervision.

LTC insurance has some tax benefits. The benefit payout amounts are not taxable, just as with medical insurance benefits. Also, some premiums are deductible as a medical expense, to the extent they contribute to medical expenses exceeding 7.5% of your adjusted gross income. As you get older, the deductible amount of the premiums increases. Some special tax provisions also apply to small-business owners.

There are two primary types of LTC coverage:

- **Traditional insurance** pays a daily or monthly benefit when the covered person meets the necessary conditions. These policies tend to be the least expensive, because the benefit is typically paid only if those conditions are met. Such policies also tend to offer the most customization choices. Premiums are designed to be level over time, but that is not guaranteed, and sharp price increases have historically been an issue.
- **Hybrid insurance** links an LTC benefit to a life insurance policy or annuity. The key feature is that a benefit is paid regardless of the health care outcome. If the LTC insurance coverage is not used, then the benefit is received in the form of a death benefit (or cash value if it is an annuity). This, of course, makes the product more expensive. Another benefit is that the premiums are guaranteed, so the cost—while higher—is more certain. There are many different forms of hybrid insurance, based on the specific product that the LTC insurance is bundled with. The deductibility of premiums may be limited, however, as any premium associated with the life insurance or annuity benefit is not deductible.

When buying an LTC policy, some key choices you need to make include:

- **The maximum policy benefit pool.** This is the maximum amount you can get over the life of the policy to reimburse qualified expenses. It's determined by multiplying the benefit period by the maximum benefit amount for each period. For example, if you have a three-year policy with a $200 daily benefit, the maximum policy benefit would be $219,000 ($200 per day multiplied by 365 days, multiplied by three years). It's important to note that the benefit period could be extended if the maximum amount is not being paid in each period. In the above example, if you needed only $100 per day, the benefits could extend to six years.
- **The elimination period.** This is the amount of time you have to receive long-term care before benefits will be paid. During the elimination period, you'll need to pay the cost out of pocket. Shorter elimination periods will result in higher premiums. Sometimes the period will be based on calendar days, but more often it will be based only on days on which paid services are received.
- **Inflation/growth adjustments.** Policies may adjust the benefit amount based on inflation or on a specified annual growth rate. Of course, higher growth rates will result in higher premiums, but failing to have an inflation adjustment may leave the benefit amount inadequate to cover the policyholder's need. Younger investors in particular will want to make sure to have sufficient inflation protection, while older ones may just prefer to go with a higher benefit amount instead, as there will be less time for inflation to have an impact.
- **Reimbursement features.** Most policies will simply reimburse for covered care received up to the maximum benefit. But a few may offer an indemnity benefit, which pays the full benefit regardless of how care is delivered or how much it costs. This can mean much less hassle in getting reimbursed. Of course, such a provision also costs more.

- **Types of care.** Most modern policies will pay for care delivered either at home or in a facility, but some may be limited to one or the other. Policies also may include different benefit amounts or elimination periods for different types of care.

So when does it make sense to consider insurance options as a key answer to health care cost concerns?

- You have the means to pay the premiums.
- You want to give yourself and your caretakers "permission to spend." In some cases, the "use it or lose it" aspect of benefits can make it psychologically easier to buy the support services that a beneficiary needs. Having a policy sets up the decision to spend in a way that's not oppositional to building or maintaining asset balances. The decision was already made when the choice to pay the premiums was made.
- Your support system has the wherewithal to handle the paperwork and claims process to get reimbursed.
- You want reassurance that the necessary supports are in place in order to feel comfortable with spending for other discretionary needs today.
- You are healthy enough to meet underwriting guidelines.
- You are a business owner who can take advantage of special tax-deductibility provisions.

Income annuities

Unexpected health care costs increase the need for income, so one possible option is to boost income using an income annuity. Unlike with LTC insurance, annuities provide income for life without conditions. There is no need to prove medical disability, and payments continue for life, sometimes as a joint life expectancy with a beneficiary.

The most common annuity in the U.S. is Social Security—and it's a particularly good one because it is adjusted for inflation every year. The payment amount depends on when you begin payments. For people who worry about the need to sustain a higher income due to medical costs later in life, deferring payments as long as possible can be a good strategy. For someone born in 1960 or later, Social Security's full retirement age is 67; the difference between claiming as early as possible (age 62) and waiting to the latest age (70) means a 77% increase in the monthly benefit amount. This, of course, requires an investor to make up for the lack of payments between ages 62 and 70. But if the concern is making sure that more income is available when needed, deferring Social Security can be a key piece of being prepared.

If that's not enough to meet the income need, investors may want to consider supplementing guaranteed income with a private income annuity. The following are five relevant types of income annuity, all similar but with a few differences:

- **Single premium income annuities (SPIAs)** are a simple way to augment guaranteed retirement income. Investors trade an upfront lump-sum payment for a lifetime series of payments. How much those payments cost depends on life expectancy (which can be based on a single person or the joint life expectancy of a couple), whether any inflation or growth is built into the payments, and whether there is any guaranteed minimum payment amount.
- **Deferred income annuities (DIAs)** are just like SPIAs, except that the benefits begin at a future time instead of right away. These are often called "longevity insurance" because the income will be skewed to a point later in life. They generally allow for a much larger payment amount for a given purchase price, due to the later payment start date. They can be a great choice for long-term care planning, because you won't be paying for income support in the near term when you probably won't need it.
- **Qualified longevity annuity contracts (QLACs)** are DIAs purchased with money from a qualified retirement plan such as an IRA or 401(k). One advantage of using those qualified assets for this purpose is that they are no longer part of your balance for required minimum distribution (RMD) purposes, so you

can defer taxes in the period between your RMD age and the age that you specify your payments to start. Also, while the payments themselves will be taxable, if you're using them to pay long-term care expenses, you will likely have deductible medical expenses that may mitigate those taxes.

- **Medically underwritten annuities** are sometimes referred to as "point of need" long-term care plans. They are generally single premium income annuities or LTC insurance policies written explicitly for someone who is already needing care. Because the applicant is already in poor health, their life expectancy is short, and the payment will be higher the worse their health is. Although there is a risk that an early death may prevent you from collecting as much as you paid for the annuity, you reduce the risk associated with an extended LTC need, because your payments will continue for life.
- **Long-term care annuities** combine an income annuity with a long-term care benefit so that the monthly income amount increases when an LTC need is demonstrated.

So when does it make sense to consider an annuity as a key answer to health care cost concerns?

- You have enough assets to buy the annuity.
- You want to receive income without having to worry about proving the need for long-term care.
- You are unable to qualify for a long-term care policy.
- You want assurance that a minimum amount will be paid out (with a cash refund or a term certain provision).
- You are worried about outliving your assets.
- You are not worried about the reduction in cash liquidity and a possibly smaller inheritance for your heirs.

Home equity strategies

Home equity may serve as part of a contingency reserve for nursing home stays. If you won't live in your home anymore, the sale proceeds from it can provide the means to fund an LTC need. However, this option may be less useful for those who'll prefer to get home care, or for married retirees who need to consider a surviving spouse's continued use of the home.

Those who need to access the equity in their home while still living in it might consider a reverse mortgage. A reverse mortgage can be structured as either a lump sum, a regular payment, or a line of credit that can be used as needed. You don't repay the loan monthly, but interest and fees accrue over time and are due for payback after you no longer live in the home, and they can be paid by selling the home if needed.

The most common type of reverse mortgage is a Home Equity Conversion Mortgage (HECM), which is insured by the Federal Housing Administration. The loan amount will depend on the age of the youngest borrower (at least one borrower must be at least 62), the value of your home, your equity in it, the federal maximum HECM amount ($1,149,825 in 2024), and interest rates. An HECM can also have very high fees.

Continuing Care Retirement Communities (CCRCs)

A continuing care retirement community allows you to start in independent living and to move into assisted living or nursing home care, within the same community, when needed. Some CCRCs include other important facilities, such as memory care. They can be an attractive option for healthy seniors who are well-off financially. They offer the opportunity to live in a community with other seniors, with such conveniences as meals and exercise classes and the security of knowing that your accommodations can change, along with your needs, as you age.

In general, to enter a CCRC you must be healthy when you enter the community. Usually there are monthly fees as well as a large up-front fee to enter it—a fee that may be partly refundable if you leave the community. When you join the community, you sign a contract that lays out its entry fee, services, and care provisions. You're

likely to have a choice of contract structures with different levels of amenities and costs. These can be complex and should be reviewed carefully with an attorney and a financial planner before you sign.

When does it make sense to consider a CCRC?

- You want to live in a community of seniors where "everything is provided."
- You have the financial resources to pay the potentially high up-front fees and monthly costs.
- You have a less-robust, informal care support system or want to provide peace of mind and lessen responsibilities for potential caregivers.
- You are currently healthy and able to live on your own.
- You don't want to deal with moves later in life.
- You want more predictability about your expenses and care as you age.
- You are confident in the financial soundness of the community you're looking to join.

Investment strategies

Many people will simply depend on being able to use their invested assets to cover health care and long-term care costs when they need to. If this is their choice, there are several techniques they might want to think about.

First, investors with access to a health savings account should consider maximizing contributions into that HSA and investing those in the mutual fund options provided in the plan. HSAs are triple tax-free, meaning they're deductible when you make the contribution, they grow with tax-free earnings, and they're tax-free at withdrawal when used to pay for qualified medical expenses, including many long-term care expenses. It's unlikely you'll be able to save more in an HSA than you'll be able to find qualified expenses to spend it on.

Beyond an HSA, investors may want to think about carving out a dedicated bucket of assets to use for long-term care expenses, when necessary. Doing so can help give you confidence that the need is covered, which can help you feel more confident in spending from your remaining investments without worrying that you may be jeopardizing your future health care needs.

Consider filling this bucket with tax-deferred assets such as IRAs or 401(k) plans. When you have extensive medical costs, there's a good chance you'll be able to deduct them on your tax returns, and that deduction can be used to offset the income tax liability that the withdrawal from a tax-deferred asset will create.

Medicaid

A last-resort payer for long-term care costs is Medicaid. To qualify for it, the patient must, with some exceptions, deplete all other assets. It's therefore not surprising that the vast majority of people who are projected to get Medicaid funding for long-term care are in the lowest income quintiles. Only about 6% of those in the top income quintile are expected to ever receive Medicaid assistance with long-term care expenses, and those people are typically ones who will survive extended-care needs into their mid- to late 90s.

Step 6: Enact the plan

For a plan to be effective, it must be executed properly. Now that you've thought through the issues, it's important that you take the steps to ensure that your plan is carried out properly. Here are some of the actions you should take to make sure you're prepared to manage your retirement health care experience:

- Prepare or update your key documents:
  - Create or revise a living will.
  - Name a health care proxy.
  - Assign a power of attorney.
  - Review your wills, any trusts, etc.
- Make your wishes known:
  - Talk to loved ones about your wishes and directives.
  - Make sure that agents have pertinent documents and know where to find your key information such as your preferred doctors, insurance policies, and prescriptions.
  - Talk to doctors, lawyers, insurance agents, and financial institutions about your wishes, and set up arrangements to allow them to work with your potential caregivers.
- Prepare your care environment:
  - Make your home aging-friendly.
  - If you are interested in a CCRC, research choices and get on waiting lists. Remember that you need to be healthy when joining such a community.
- Get your financial situation in order:
  - Buy insurance products, if applicable.
  - Set up reverse mortgage lines of credit, if applicable.
  - Organize your investment portfolio.
  - Devise a thoughtful retirement income strategy to manage taxable income and minimize Medicare surcharges.

Revisit these steps regularly to make sure that everything remains appropriate to your life circumstances.

Conclusion

An important part of planning for retirement is planning for the decline in health that is an inevitable part of aging. Financial planners can help clients think about how they want this aspect of their lives to unfold and to ensure that they'll be able to have care that conforms to their wishes.

A key part of this task is understanding the financial implications of each client's health care preferences. A financial planner should develop a retirement income plan that is robust to possible adverse health care cost outcomes. For many people, the plan's most important outcome might be the simple reassurance that they're prepared. In other instances, planners may need to help clients consider strategies to mitigate possible health expense-related financial shortfalls.

Preparing for health care eventualities in retirement is much more than just a financial issue. It is something that everyone, regardless of financial circumstances, should be doing. Helping clients to confront their preferences and needs and putting them in a financial position to execute on those preferences can be a key value driver for financial planners who serve retired clients.

Appendix

FIGURE 13

A toolbox of health care cost options

	Description	Pros	Cons
Traditional long-term care insurance	Provides specific coverage for a long-term care need	• Comprehensive and custom coverage • Premiums may be deductible • Most affordable form of LTC insurance	• Use it or lose it • High costs and complexities • Premiums can increase
Hybrid long-term care insurance	Combines life insurance or an annuity with LTC benefits	• Fixed guaranteed premiums • Cash value if the LTC benefit isn't needed • Death benefit	• Lower LTC benefits • Premiums may be higher initially than for traditional LTC insurance • Premiums may not be tax-deductible
Single-premium income annuity (SPIA)	A contract with an insurance company that converts a lump sum into a stream of payments for life	• Payments last for a lifetime, even if assets are otherwise depleted • Payments can be spent on anything, not just on health care costs • No claims filing is necessary	• Often requires a large initial investment to generate the desired income
Medically underwritten annuity	A SPIA with a relatively high payment, based on known poor health status	• Is available even after you're sick • Has higher payouts than traditional SPIAs	• Often requires a large initial investment to generate desired income • An earlier death could mean getting back much less than the premiums you paid; provisions that mediate this risk can be quite costly
Deferred income annuity	A SPIA that begins at a future date; also known as "longevity insurance"	• Offers higher payouts than traditional SPIAs with a smaller upfront cost • Can reduce required minimum distributions if purchased with tax-deferred assets	• An earlier death could mean getting back much less than the premiums you paid; provisions that mediate this risk can be quite costly • Payments may not keep up with inflation
Long-term care annuity	An income annuity that provides an increased payout if LTC is needed	• Guaranteed income • No premium increase • Usually has lower underwriting standards than traditional LTC insurance	• High initial investment • No premium deductibility
Continuing Care Retirement Community (CCRC)	A community that allows residents to move from independent living to assisted living to nursing care in the same place	• Access to different levels of care • Social network • All-inclusive, maintenance-free living • Flexibility for spouses with different medical needs • Less dependence on informal/unpaid caregivers	• High entrance fees and monthly maintenance fees • Community could be a bad fit or have financial problems • Must join the community before you are sick

(Continued on next page)

	Description	Pros	Cons
Dedicated investment bucket	"Partitioning off" a slice of investment assets and investing it specifically to use for health care costs	• Separates other assets from needing to be reserved for medical expenses, leading to a less stressful drawdown • Money can be moved in or out as projected needs change • Unspent assets can be left to heirs	• Doesn't change how much money is available for the needs • Market events can change the amount available for costs
Health Savings Account (HSA)	Specialized account that allows tax-free withdrawals for health care costs	• Can be used either for expenses directly or to pay for qualified LTC insurance premiums • Is extremely tax-efficient ("triple tax-free") • Unspent assets can be left to heirs	• Balances need to be accumulated before Medicare begins • Contribution eligibility is limited to employees in a high-deductible health plan (HDHP) • Tax advantages are lost when passed on to a nonspouse beneficiary
Home sale proceeds	If residential care is needed for a single person, proceeds from the sale of the home can provide a funding source for LTC costs	• Home equity is often one of the biggest sources of net worth • Is a good solution if the home isn't needed anymore when moving to a care facility	• Is not a good solution if a surviving spouse or child still needs to live in the home • Home sales can be complex
Reverse mortgage	A loan against a home's equity that doesn't need to be repaid until you sell the home, move out permanently, or pass away	• Home equity is often one of the biggest sources of net worth • A reverse mortgage can be taken as a lump sum or as needed (reverse mortgage line of credit) • The recipient and/or spouse can continue to live at home while using home equity for costs	• Can often have high costs and fees • Interest is not tax-deductible • Can affect Medicaid eligibility • The loan balance increases over time, while taxes, homeowners insurance, and maintenance costs continue and must be paid to avoid possible early repayment/loss of the home
Deferral of Social Security	Waiting until age 70 to begin taking Social Security payments	• Means higher payouts that last for life, adjusted for inflation, even if other assets are depleted • If married, deferral by the higher-benefit spouse means higher payouts for a surviving spouse, even if assets are depleted	• Possibility of needing to spend more from assets while waiting for payments to start • Possibility of getting less in total lifetime benefits if you die at a younger age
Medicaid	State-run program offering low-cost or free custodial and medical services to those with low incomes who qualify	• Provides last-resort coverage for those who need it	• Must deplete assets and have low income to qualify • Coverage is sometimes limited to nursing home care • Many facilities don't accept Medicaid payment, so quality of care may be inferior

Source: Vanguard.

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