DO RETIREMENT INVESTORS ACCURATELY PERCEIVE HEALTHCARE RISKS, AND DO ADVISORS HELP?

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Introduction

Households approaching retirement must account for a wide variety of risks to their financial security. They may live longer than planned and deplete their resources; they may experience unexpectedly high inflation; or they may receive unusually poor returns on their investments. Equally consequential is the risk that major expenses to ensure their physical well-being will drain their resources.

In this paper, we use "healthcare" to refer to any health-related costs, whether they involve periodic medical care or long-term care (LTC). Medical and LTC risks can be substantial in retirement. Each, however, has different implications for retirement planning. Both risks have two components – individual risk and general price risk. The individual risk is the likelihood that a retiree will actually face a medical shock or need LTC. The general price risk is the likelihood that prices for healthcare services will grow considerably, eroding a person's retirement income over time. The difference between these two components is that individual risk can, theoretically, be insured by risk pooling, while general risk affects everyone and thus cannot be handled by pooling. Since the uninsured components of these risks can be substantial, households' perceptions of the risks have important implications for how they plan their spending in retirement.

Using two new surveys of older households and financial advisors, this paper examines how households' perceptions of their healthcare risks in retirement might differ from the actual risks they might face. The household survey captures the extent to which older households are worried about healthcare risks in retirement, their assessment of how much healthcare shocks could cost, and how they plan to manage these risks. The advisor survey assesses how concerned advisors are about the healthcare risks their clients may face, along with the associated costs. The survey also asks what advisors recommend their clients do to manage these risks and their views on various contingency strategies should their clients run out of money.

The results show that older households tend to underestimate their healthcare risks in retirement and have very little sense of how much medical shocks or LTC support services may cost. Many also believe cutting back on non-essential spending, such as travel, will be enough to cover the costs or that Medicaid will step in for them. Advisors, on the other hand, are more worried than their clients about healthcare risks because they have a better sense of the

prevalence and the costs of medical shocks and LTC support services. Interestingly, older households who work with advisors do not have a much better sense of their healthcare risks or costs. Questions for future research include why advisors have little impact on their clients' perceptions and how inaccurate perceptions affect their clients' retirement security.

The paper is organized as follows. The first section provides some background on the uninsured components of healthcare risks that households face. The second section describes the data used in the analysis, including the two new surveys. The third section compares the survey responses of older households regarding likely healthcare shocks and their out-of-pocket (OOP) costs with the actual experiences of retirees from the *Health and Retirement Study* (HRS). The fourth section reports advisors' knowledge of risks and costs and their role in affecting their clients' behavior. The final section examines whether older households' fallback plans are reasonable and how they compare with the behavior of actual retirees.

Uninsured Healthcare Risks in Retirement

Households entering retirement face an uncertain trajectory of medical and LTC spending over their remaining lives. Both have important implications for retirement security even though the uninsured components of each risk are different.

Uninsured Medical Risks

Medical risks are fundamentally high and uncertain. Fortunately, much of this risk is insured by Medicare (in combination with Medicaid for those eligible for both programs) and some form of supplementary insurance. Overall, the vast majority of retirees are insured by plans featuring annual OOP maximums, which limit the risk they face in any given year.[1] While not negligible, these maximums ensure that households can plan for medical shocks in the near future by setting aside a sufficient buffer.

Importantly, the risk that cannot be insured is that of rising premiums. Medicare Part B premiums have increased faster than inflation over the past few decades. Even since 2021, a period over which national health expenditure (NHE) growth has been relatively modest, these

[1] Nevertheless, for middle-income households, medical costs eat up a large share of income, with average OOP spending of $4,274 per year in 2014, of which two-thirds were insurance premiums (McInerny, Rutledge, and King 2017). This spending represented about one-third of Social Security income and 18 percent of total income. Medicare Part D and subsequent reforms have likely improved the situation somewhat since then.

premiums have seen increases of over 14 percent and 20 percent, respectively, in some years. Retirees may be moderately well-insured against a large medical expenditure in a given year, but compounding increases of unpredictable size in premiums can erode their disposable income over time in ways that strategies besides health insurance are necessary to address. Identifying such strategies is one of the objectives of the surveys that will accompany this review of current knowledge.

Uninsured LTC Risks

Of course, medical costs are just one component of late-life spending. Most older adults will have some LTC needs. In fact, only about 20 percent will get by scot-free (see Table 1). However, among the 80 percent who will need some LTC, needs vary dramatically in intensity and duration. About 20 percent will have high-intensity needs for more than three years.[2]

Many of those who fall into the high-intensity, long-duration care needs group have Alzheimer's Disease or related dementias (ADRD). Providing care for those with ADRD is expensive because these individuals often need around-the-clock supervision and can live for many years with the disease. Estimates for total ADRD costs vary significantly and are mostly more than a decade old.[3] One recent study estimates that OOP costs for those with ADRD average costs are around $23,000 over the first eight years (Oney, White, and Coe 2022).[4] These costs seem modest for such a serious disease; the most likely explanation is that many households deplete their resources and end up on Medicaid.

Individual risk also does not represent the full scope of exposure to LTC. For coupled households, LTC risk in retirement is not only about the care needs each individual might have, but the LTC risks of both spouses. If one spouse has moderate or high-care needs, households may spend down a substantial portion of assets to supplement informal family care.

Despite the high likelihood and cost of LTC, most households do not have private insurance. Currently, only about 7.5 million people have LTC insurance in the United States, representing around 3 percent of all U.S. adults or 15 percent of those ages 65 and older (Gruber

[2] This estimate is consistent with Favreault and Dey (2016), Belbase, Chen, and Munnell (2021), and Johnson and Dey (2022).
[3] An older study by Kelley et al. (2015) estimated substantially larger OOP costs, totaling $61,500 over the last five years of life, or around $12,000 per year. See review by Fishman et al. (2019).
[4] The Penn Wharton Budget Model expects Medicaid LTC spending to grow 3 percent faster than inflation.

and McGarry 2023 and American Association of Long-term Care Insurance 2020).[5] Additionally, even with insurance, the LTC insurance market, unlike healthcare, offers limited protection against LTC risks, so the individual risk remains high.

Medicaid, the public program targeted at low-income individuals, has become a default insurer for catastrophic costs. However, planning how to become eligible with the least disruption to household finances is a complex problem. In 2024, the income limit for Medicaid eligibility for those over ages 65+ is typically around $2,800 a year ($5,600 for couples) and the asset limit is typically $2,000 ($3,000 for couples), but varies by state. Qualifying for Medicaid generally requires spending down the household's personal resources.[6]

In addition to individual risk, households also face general price risk for LTC. The cost of LTC has grown substantially over the past decades (de Meijer et al. 2013; Hagen 2013; and Redfoot and Favreault 2018). Several factors contribute to the general cost risk of LTC going forward, including the rising cost of paid (formal) care and the dwindling supply of family (informal) care. On the other hand, the shift from institutional care to home-based care may slow cost growth.

Family members often cover the majority of care hours for people with low and moderate care needs and supplement the efforts with paid caregivers as care needs increase.[7] Historically, women, particularly spouses and daughters, have provided the bulk of family care. Going forward, changes in the labor force participation of women may impact the supply of family caregivers, which could impact the general price risks that households face. Additionally, children and other relatives will be limited in how much care they can provide if they live far away. The share of retirees with children who lived within 10 miles fell from 68 percent to 55 percent between 1994 and 2004 (U.S. Congress Joint Economic Committee 2019). However, some studies suggest the growth in remote work, even before the pandemic, may help children remain closer to their parents even as they pursue job opportunities (Chokshi 2017; Radu 2018;

[5] The market for private stand-alone LTC insurance reached a peak in the early-2000s. Over time, many insurance providers have dropped out of the market or consolidated. By the early 2010s, many of the large insurers in the market stopped selling LTC policies. Recently, there has been some increase in LTC policies that are combined with life insurance or annuities (Spillman et al. 2020).

[6] For households where one spouse is still living in the community, their house can be exempt from the Medicaid asset limits. In some states, the community living spouse's 401(k) or IRA assets can also be exempt. Additionally, a certain amount of the couple's income is protected to prevent spousal impoverishment, although the rules vary by state.

[7] See also Spillman (2009); Johnson and Wiener (2006); Spillman and Pezzin (2000); Wolff and Kasper (2006); and Freedman and Spillman (2014).

and Gohringer 2017). Finally, declining fertility suggests that fewer kids will be available to care for older adults in the coming decades (Wettstein and Zulkarnain 2019).

Rising formal care costs are driven largely by the shortage of qualified workers and increasing need for specialized care (Spillman et al. 2020). Fortunately, some studies suggest that the shift from nursing home care to home-and-community-based services (HCBS) in recent decades may help slow the price trends for formal care. Although not always the case, HCBS can be more cost-effective than nursing home care (Spillman, Allen, and Favreault 2021).

Uninsured medical and LTC risks are often the largest financial risks older households face in retirement. However, prior studies showed that older households tend to rank these risks low (Hou 2020). Our survey confirms these findings (see Figure 1). Fortunately, while older households tend to be less worried about healthcare risks relative to other risks, among healthcare risks they tend to be the most worried about the large uninsured risks (see Figure 2).

In short, households face the prospect of large outlays for healthcare costs in retirement. The questions are the extent to which households and their advisors perceive these risks and what plans they have to address them.

Data

To answer these questions, we developed two surveys, in collaboration with Jackson National and Greenwald Research. The surveys were fielded online in July and August 2024 and the results were compared with the actual experiences of older adults in the HRS to determine whether households have a good sense of their uninsured risks.

Survey Data

Household Survey. Greenwald Research interviewed 508 individuals ages 48-78 with at least $100,000 in investable assets about their perceived likelihood of experiencing a medical shock or needing extensive LTC, as well as the potential cost of these events. Participants were also asked what decisions they would make about their healthcare needs should their resources prove inadequate. In the case of married/partnered individuals, the survey participant must at least share financial decision-making responsibilities. The responses were then compared to the actual experiences of older adults in the HRS to determine whether households have a good sense of the likelihood and costs of a medical or LTC shock.

Advisor Survey. The advisor survey interviewed 401 financial professionals and asked them to assess their clients' healthcare and LTC risks in retirement. Advisors in our survey are required to: 1) currently work as a financial professional; 2) work with a national full-service broker-dealer, regional broker-dealer, independent broker-dealer, RIA, bank broker-dealer, or an insurance broker-dealer; 3) been a financial professional for at least three years; 4) derive at least 50 percent of their income from individual sales; 5) have at least $30 million in assets under management; 6) make recommendations directly to clients; 7) have at least 40 percent of their clients be ages 50 or older; and 8) serve at least 75 clients. The advisor responses were also compared with the actual experiences of older adults in the HRS to determine the accuracy of their perceptions regarding their clients' potential healthcare shocks and the cost of these uninsured risks.

The Health and Retirement Study

Actual experiences come from the HRS. The HRS is a biennial survey representative of the U.S. population over age 50 and their spouses. The data, which come from the 1998-2020 waves, include information on the number of activities of daily living (ADLs) for which the individual needs assistance and whether they were diagnosed with ADRD, which is used to predict future LTC needs for current retirees. The HRS also includes questions on general health conditions and hospitalizations, which are used to determine households' risks of facing serious medical shocks. In addition, the HRS has information on income and wealth, living arrangements, and health insurance – such as whether a household is on Medicaid. The HRS data on LTC and serious medical shocks serve as a basis for comparison with respondents' perceptions regarding risks, costs, and required resources.

The next section explores how older households perceive healthcare risks and costs in retirement.

Perceptions of Healthcare Risks

To effectively ensure or plan for these two risks, households need a good assessment of how likely they are to experience medical shocks or need extensive LTC in retirement, as well as how much uninsured or OOP costs they will face should these events arise.

Incidence of Medical Shock or LTC Need

First, our survey asked older households how worried they were about experiencing various medical shocks or LTC needs in retirement. Specifically, we asked whether they were concerned about having a major illness, developing LTC needs, or having cognitive impairment. Interestingly, only about a third of older households surveyed were concerned about facing each of these risks in retirement (see Figure 3). In reality, households are much more likely to experience a major illness than develop LTC needs and less than a third will end up with Alzheimer's or dementia.

The definition of major illness is subjective; we examine three measures that many would consider a serious medical condition: 1) a hospitalization that lasts five or more nights; 2) a cancer diagnosis, a stroke, or lung disease; and 3) an injury due to a fall or a broken hip. Sixty-eight percent of households will have a hospitalization that will require five or more nights in the hospital. Similarly, 67 percent of households will have a serious medical shock such as cancer, a stroke, or lung disease, and 55 percent of households will have an injury due to a fall or a broken hip. All of these measures are much higher than the 35 percent predicted by the household survey (see Figure 4).[8]

The financial implications for households in underestimating their risk of a medical shock may not be that severe because most of these costs are insured. LTC costs, on the other hand, are not well insured so it may be more important for households to have a good sense of their LTC needs. Only 32 percent of households are worried about developing LTC needs. In reality, over half of households ages 65+ will need help with at least two activities of daily living (ADLs) – such as dressing, bathing, feeding, toileting, getting out of bed – and/or receive an ADRD diagnosis (see Figure 5).[9]

Interestingly, the share of older households worried about just cognitive impairment is similar to the share of households who will need care for just ADRD. This similarity may just be a coincidence since households reported similar levels of worries across all risks.

Fortunately, households who face a higher risk of adverse medical events or LTC needs are more worried. Households who self-rate that they are in fair or poor health and those who

[8] Another recent study (Chen, Munnell, and Gok 2025 forthcoming) found that people in more vulnerable groups – Black individuals and women – may underestimate their long-term care needs.

[9] These numbers are slightly higher than the share of individuals who will have high-intensity needs in Table 1 because these numbers represent household level risks while Table 1 represents individual level risks.

spend over $100 a month on prescription drugs are much more likely to be worried about having a major illness, perhaps because they have personally experienced adverse medical shocks (see Table 2). The share who are worried align better with the actual risks in retirement. Similarly, households who are caregivers themselves are also much more aware of healthcare risks in retirement. However, these households, while more worried than the average household, still tend to underestimate the risk of needing LTC (although they tend to overestimate the risk of having cognitive impairment as they get older).

Cost of Healthcare Risks

Having a good estimate of the likelihood of facing a medical shock or needing LTC is only part of the retirement planning equation. The other important component is having a good sense of how much these risks might cost should they occur.

Medical Costs. As discussed above, OOP costs are generally well insured. For example, the median OOP cost for those with hospitalizations was $0, and even at the 90th percentile the average was around $3,500 (see Figure 6). Although $3,500 is not a trivial amount of money, households with more than $100,000 in investable assets are likely able to cover these OOP costs.

The bigger financial risks for medical care are the general risks of premium increases. Medicare Part B (doctor visits) premiums have grown 20 percent faster than the Consumer Price Index in the last 10 years, 70 percent faster in the last 20 years, and more than twice as fast in the last 30 years (see Table 3). Fortunately, Part D premiums have remained relatively steady since the program's inception in 2006. If premium growth going forward is similar to historical trends, Medicare premiums could substantially erode older households' purchasing power in retirement.

Older households seem equally worried about drug price inflation as they are about Medicare inflation even though, historically, Medicare Part B premiums have grown much faster. Not surprisingly, younger households and those with less wealth are more worried about the prices of medical care and drugs going forward (see Table 4).

LTC Costs. Unlike medical costs, LTC costs are not well insured. And given that more than half of older households will need some period of high-intensity care at some point in retirement, having a good sense of the financial costs is important for retirement planning. One

complicating factor is that LTC costs vary substantially across geographic area (see Table 5). For example, the median price for a private room at a nursing home ranges from $78,500 in the lowest-cost state to $415,000 in the highest-cost state a year. A home health aide ranges from $50,300 to $96,100 dollars a year and an assisted living facility ranges from $45,600 to $114,750 a year.

Even so, we tried to assess whether older households had a broad sense of how much LTC services might cost. Respondents who estimate nursing home costs at $75,000+ a year, home care costs at $20-$50 per hour ($45,760-$114,400 a year), and assisted living costs at $50,000-$150,000 a year are categorized as being correct. Figure 7 shows that a large portion of older households could not guess about the cost of nursing homes, home care services, or assisted living facilities in their area. Even among those who provided an estimate, many underestimated these costs. Only 39 percent could correctly estimate the cost of a nursing home, 34 percent for home care services, and only 15 percent for assisted living facilities. Perhaps more concerning is that households who are at higher risk (such as those in poor health and those with high drug expenditures) and those who have caregiving experience are also not much better at estimating costs (see Table 6).

One reason why households have such big misperceptions about both the risk and the costs of potential LTC costs may be that they think these risks are well insured. Indeed, several surveys have found that many households mistakenly believe that Medicare covers the cost of LTC. The most recent comprehensive survey was conducted by KFF in 2023. The results, presented in Table 7, show that close to half of respondents ages 65+ think that Medicare will pay for their LTC. Another 9 percent think their private health insurance would pay. Another recent assessment comes from the Associated Press/NORC Center for Public Affairs.[10] Again, Medicare tops the list of sources (see Table 8). Interestingly, Medicaid, which will actually cover LTC costs if income and assets are low enough, is considerably down the list.

In short, misperceptions about the likelihood and who bears the cost for LTC could well play an important role in how households plan for LTC risks in retirement. A large share

[10] Beginning in 2013, the Associated Press/NORC Center for Public Affairs has interviewed a nationally representative sample of individuals ages 40+ regarding their understanding of LTC, their perceptions of needing care, the likely cost of such care, and what sources they intend to rely on to pay for LTC needs.

mistakenly believes that Medicare will cover their future LTC needs, which may explain why so many households have a poor sense of both their own risks and the costs of future LTC needs.[11]

The Role of Financial Advisors

About two-thirds of the older households surveyed work with a financial advisor. An important question is whether advisors have a good sense of healthcare risks and costs in retirement. And if so, do households with an advisor have a better sense of their risks and make better plans? To answer these questions, we once again compare actual experiences of older households from the HRS survey to the responses of financial advisors.

Advisor Perceptions of Risks

Unlike older households, financial advisors surveyed think that LTC affordability or covering medical costs are the biggest risks that their clients face for ensuring a financially secure retirement (see Figure 8). Almost three-fifths of advisors believe that LTC affordability is a major risk to their client's financial security compared to just 33 percent of older households. Similarly, almost half of advisors are worried about their clients covering medical expenses compared to just 24 percent of older households surveyed. Advisors also rank these two risks the highest among all the risks older households face while older households themselves rank them among the lowest.

Advisor Perceptions of Likelihoods and Costs

Advisors might be much more worried about their client's ability to cover medical and LTC costs in retirement than their clients seem to be because they have a much better understanding of the likelihood and costs of needing such care. The analysis will focus on LTC risks and costs since medical costs are well-insured. Close to 60 percent of advisors think that at least a quarter of their clients will need three or more years of LTC in retirement (see Figure 9). This estimate is very close to that in Table 1, which showed that about 20 percent of individuals ages 65+ will need at least three years of high-intensity care.

[11] The confusion may be because Medicare does cover post-acute nursing home stays for up to 100 days. Medicare, however, does not cover LTC when non-medical services are the only care people require; many analysts exclude Medicare entirely when describing LTC payers (Hado and Komisar 2019).

Similarly, financial advisors have a pretty good sense of the cost of LTC support services, with over 80 percent estimating the correct range for nursing home and assisted living costs (see Figure 10). Advisors were slightly less knowledgeable about home care costs but, even then, almost three-quarters of advisors provided a good estimate. Advisors are also fairly confident about their cost estimates, suggesting that they are very versed in potential healthcare costs (see Figure 11).

Do Advisors Influence Their Client's Risk Perceptions?

Despite the fact that financial advisors have a pretty good sense of costs, older households surveyed do not seem to have a better sense of their risks. In fact, those with advisors are even less worried about their risks and their ability to cover the cost of major healthcare shocks (see Table 9). One reason may be that households with a financial advisor are more prepared to handle the risks. For example, they could have bought LTC insurance, be wealthier, and/or be married and have children who may be able to take care of them, so they are less concerned about these risks. However, even after controlling for LTC insurance, wealth, marital status, and other demographic characteristics, those with an advisor are still less concerned about their healthcare risks that those without (see Table 10).

A second reason why older people with advisors are not well informed may be that advisors are not discussing these risks with their clients. However, survey results show that the vast majority of advisors at least discuss LTC risks with their clients and over 60 percent either recommend a policy or direct their clients to a professional who is more knowledgeable about LTC insurance products (see Figure 12).

If advisors do indeed discuss LTC risks with clients, a third reason for low client knowledge could be that they rely on the advisors to understand these issues for them and do not focus on absorbing the information.

The fact that advisors, despite their own knowledge and awareness, have very little impact on what older households know is somewhat puzzling. Studies on the impact of financial advisors on retirement security have largely focused on advisors' roles in helping clients make investment decisions.[12] A few limited studies have shown that financial advisors can be helpful

[12] A number of papers have examined the role of financial advisors on household finances, with mixed results (Shapira and Venezia 2001; von Gaudecker 2015; Hackethal, Haliassos, and Jappelli 2012; Kramer 2012; and

in guiding households to set savings goals.[13] However, virtually no research has focused on how advisors can help their clients manage the large spending risks from medical and, particularly, LTC needs in retirement. This is an area for future research.

Implications of Underestimating Healthcare Risks

The implications of older households underestimating their healthcare risks is that they may not make the appropriate plans to protect themselves against these risks. The main reasons advisors cite for their clients not buying LTC insurance is that they "underestimate the cost of LTC" or they "would rather not think about needing LTC."

Without the appropriate insurance or plan in place, older households may have to make substantial adjustments or consider options that they do not prefer. When households were asked what contingency plans they would consider if they could not afford their medical or LTC expenses, over 60 percent stated that they would consider spending down to Medicaid, while only 30 percent said they would consider using their home equity or moving in with their children (see Figure 13). However, many of these preferences may not be realistic.

Spend Down to Medicaid

While many older households believe they can always fall back on Medicaid should they need long periods of high-intensity LTC, they may not realize that the income and asset limits for Medicaid require impoverishment. Even if households were willing to spend down all their savings to qualify for Medicaid, almost none of those who started with at least $100,000 in investable assets would qualify because their combined Social Security and defined benefit income would be too high (see Table 11). Several states have special income rules for LTC that have slightly higher income limits. Even then, 70 percent of households in our sample would not qualify because their incomes are too high. Going forward, most older households will not have defined benefit income. If we just consider Social Security income, close to 90 percent of households in our sample still would have too much retirement income for Medicaid. In states with a special income rule, close to a third still would not qualify (see Table 12).

Chalmers and Reuter 2020). Advisors could help clients manage risks by diversify their portfolios (Goetzmann and Kumar 2008; French and Poterba 1991; Grinblatt and Keloharju 2001) or reducing risks during financial downturns (Liu, Finke, and Blanchett 2024).

[13] See Kim et al. (2018) and Marsden et al. (2011)

In reality, only 15 percent of households with more than $100,000 in initial assets will actually end up on Medicaid, compared to the 60 percent of households who think that spending down to Medicaid is an option for them (see Figure 14).

Tapping Home Equity

One of the least popular contingency options for financing healthcare costs is tapping home equity. Less than a third of households said they would consider tapping their home equity. However, in reality, over 40 percent of households will tap home equity in retirement – either by getting a second mortgage, applying for a home equity line of credit or other loans against the house, or downsizing and moving to a less valuable house (see Figure 15). While our data do not show us the reasons older households tap their home equity, many households will eventually tap this resource.

Living with Children

Finally, another unpopular option for managing healthcare needs among respondents we surveyed is moving in with children. Again, less than a third of respondents say they would consider moving in with children. Interestingly, in the real-world, only about a quarter of older households in our wealth group end up living with their children (see Figure 16). So, moving in does seem like the least preferred back-up option should plans fall through.

Conclusion

Households entering retirement face an uncertain trajectory of healthcare spending over their remaining lives. Both have important implications for retirement security even though the uninsured components of each risk are different.

Using two new survey results of older households and financial advisors, this paper examines how households' perceptions of their healthcare risks in retirement compare to the actual risks they might face. The results show that older households tend to underestimate the medical and LTC risks in retirement and have very little sense of how much medical shocks or LTC support services may cost. Advisors, on the other hand, have a better sense of the prevalence and the costs of medical shocks and LTC support services. Interestingly, older

households who work with advisors do not appear to be better informed about their medical and LTC risks or costs. It is not clear why advisors have little impact on their clients' perceptions.

The implications of older households underestimating their healthcare risks is that households may not make the appropriate plans to protect themselves again these risks and many may have to make substantial adjustments or consider options that they do not prefer. The majority of older households say they would spend down to Medicaid and prefer to preserve their home equity. In reality, many end up tapping home equity and only a minority end up on Medicaid.

References

American Association for Long-term Care Insurance. 2020. "Long-Term Care Insurance Facts - Data - Statistics - 2020 Reports." Westlake Village, CA.

Belbase, Anek, Anqi Chen, and Alicia H. Munnell. 2021. "What Level of Long-Term Services and Supports Do Retirees Need?" *Issue in Brief* 21-10. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Centers for Medicare & Medicaid Services. 2024. *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* Washington, DC: U.S. Department of Health and Human Services.

Chalmers, John and Jonathan Reuter. 2020. "Is Conflicted Investment Advice Better Than No Advice?" *Journal of Financial Economics* 138(2): 366-387.

Chen, Anqi, Alicia H. Munnell, and Gal Wettstein. 2025. "Healthcare and Long-term Care Risks in Retirement: A Review of Existing Literature." Special Report. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Chen, Anqi, Alicia H. Munnell, and Nilufer Gok. 2025 (forthcoming). "Do Households Have a Good Sense of Their Long-Term Care Risks?" Working Paper. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Chokshi, Niraj. 2017. "Out of the Office: More People Are Working Remotely, Survey Finds." (February 15). New York, NY: *The New York Times*.

de Meijer, Claudine, Bram Wouterse, Johan Polder, and Marc Koopmanschap. 2013. "The Effect of Population Aging on Health Expenditure Growth: A Critical Review." *European Journal of Ageing* 10(4): 353-361.

Favreault, Melissa and Judith Dey. 2016. "Long-Term Services and Supports for Older Americans: Risks and Financing." Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Freedman, Vicki A. and Brenda C. Spillman. 2014. "Disability and Care Needs of Older Americans." *Milbank Quarterly* 92(3): 509-541

French, Kenneth R. and James M. Poterba. 1991. "Investor Diversification and International Equity Markets." *The American Economic Review* 81(2): 222-226.

Fishman, Paul, Norma B. Coe, Lindsay White, Paul K. Crane, Sungchul Park, Bailey Ingraham, and Eric B. Larson. 2019. "Cost of Dementia in Medicare Managed Care: A Systematic Literature Review." *The American Journal of Managed Care* 25(8): e247.

Genworth Financial. 2023. "Cost of Care Survey." Richmond, VA.

Goetzmann, William N. and Alok Kumar. 2008. "Equity Portfolio Diversification." *Review of Finance* 12(3): 433-463.

Gohringer, K. 2017. "Telecommuting and Dependent Care: Work Solutions for Caregivers. Virtual Vocations." Available at: https://web.archive.org/web/20220313101553/https://www.virtualvocations.com/blog/telecommuting-survival/telecommuting-dependent-care-solutions/

Grinblatt, Mark and Matti Keloharju. 2001. "How Distance, Language, and Culture Influence Stockholdings and Trades." *The Journal of Finance* 56(3): 1053-1073.

Gruber, Jonathan and Kathleen M. McGarry. 2023. "Long-Term Care in the United States." Working Paper w31881. Cambridge, MA: National Bureau of Economic Research.

Hackethal, Andreas, Michael Haliassos, and Tullio Jappelli. 2012. "Financial Advisors: A Case of Babysitters?" *Journal of Banking & Finance* 36(2): 509-524.

Hado, E. and H. Komisar. 2019. "Long-Term Services and Supports." Fact Sheet. Washington, DC: AARP Public Policy Institute.

Hagen, S. 2013. "Rising Demand for Long-Term Services and Supports for Elderly People." Washington, DC: Congressional Budget Office.

Hamel, Liz and Alex Montero. 2023. "The Affordability of Long-Term Care and Support Services: Findings from a KFF Survey." San Francisco, CA: KFF.

Hou, Wenliang. 2020. "How Accurate Are Retirees' Assessments of Their Retirement Risk?" Working Paper 2020-14. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Johnson, Richard W. and Judith Dey. 2022. "Long-Term Services and Supports for Older Americans: Risks and Financing, 2022." ASPE Research Brief. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation.

Johnson, Richard W. and Joshua M. Wiener. 2006. "A Profile of Frail Older Americans and Their Caregivers." Occasional Paper Number 8. Washington, DC: Urban Institute.

Kelley, Amy S., Kathleen McGarry, Rebecca Gorges, and Jonathan S. Skinner. 2015. "The Burden of Health Care Costs for Patients with Dementia in the Last 5 Years of Life." *Annals of Internal Medicine* 163(10): 729-739.

Kim, Kyoung T., Tae-Young Pak, Su H. Shin, and Sherman D. Hanna. 2018. "The Relationship Between Financial Planner Use and Holding a Retirement Saving Goal: A Propensity Score Matching Analysis." *Financial Planning Review* 1(1-2): e1008.

Kramer, Marc M. 2012. "Financial Advice and Individual Investor Portfolio Performance." *Financial Management* 41(2): 395-428.

Liu, Zhikun, Michael Finke, and David Blanchett. 2024. "Professional Financial Advice and Investor Behavior during the COVID-19 Pandemic." *Financial Planning Review* 7(1): e1172.

Marsden, Mitchell, Cathleen D. Zick, and Robert N. Mayer. 2011. "The Value of Seeking Financial Advice." *Journal of Family and Economic Issues* 32: 625-643.

McInerney, Melissa, Matthew S. Rutledge, and Sara Ellen King. 2017. "How Much Does Out-of-Pocket Medical Spending Eat Away at Retirement Income?" Working Paper 2017-13. Chestnut Hill, MA: Center for Retirement Research at Boston College

Oney, Melissa, Lindsay White, and Norma B. Coe. 2022. "Out-of-Pocket Costs Attributable to Dementia: A Longitudinal Analysis." *Journal of the American Geriatrics Society* 70(5): 1538-1545.

Radu, Sintia. 2018. "How Soon Will You Be Working from Home? Telecommuting Might Not Just Be a Company Perk in the Next Decade." (February 16). Washington, DC: *U.S. News & World Report.*

RAND, *Health and Retirement Study Longitudinal File*, 1992-2020v2. Santa Monica, CA.

Redfoot, Donald and Melissa Favreault. 2018. "Population Aging: A Poor Predictor of Medicaid Expenditures." *Public Policy & Aging Report* 28(2): 48-55.

Shapira, Zur and Itzhak Venezia. 2001. "Patterns of Behavior of Professionally Managed and Independent Investors." *Journal of Banking & Finance* 25(8): 1573-1587.

Spillman, Brenda C. and Liliana E. Pezzin. 2000. "Potential and Active Family Caregivers: Changing Networks and the 'Sandwich Generation.'" *The Milbank Quarterly* 78(3): 347-374.

Spillman, Brenda C., Eva H. Allen, and Melissa Favreault. 2021. "Informal Caregiver Supply and Demographic Changes: Review of the Literature." Report. Washington, DC: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation and the Urban Institute.

Spillman, Brenda C., Vicki A. Freedman, Judith D. Kasper, and Jennifer L. Wolff. 2020. "Change Over Time in Caregiving Networks for Older Adults With and Without Dementia." *Journal of Gerontology Series B* 75(7): 156-1572.

The Associated Press-NORC Center for Public Affairs Research. 2021."Long-Term Care in America: Americans Want to Age at Home." Chicago, IL.

University of Michigan. *Health and Retirement Study*, 1992-2020. Ann Arbor, MI

U.S. Centers for Medicare & Medicaid Services. 2024. *Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds.* Baltimore, MD: U.S. Department of Health and Human Services.

U.S. Congress Joint Economic Committee. 2019. "An Invisible Tsunami: 'Aging Alone' and Its Effect on Older Americans, Families, and Taxpayers." Washington, DC.

von Gaudecker, Hans-Martin. 2015. "How Does Household Portfolio Diversification Vary with Financial Literacy and Financial Advice?" *The Journal of Finance* 70(2): 489-507.

Wettstein, Gal and Alice Zulkarnain. 2019. "Will Fewer Children Boost Demand for Formal Caregiving?" Working Paper 2019-6. Chestnut Hill, MA: Center for Retirement Research at Boston College.

Wolff, Jennifer L. and Judith D. Kasper. 2006. "Caregivers of Frail Elders: Updating a National Profile." *The Gerontologist* 46(3): 344-356.

Table 1. *Lifetime Probability of a 65-Year-Old Needing LTC, by Duration and Intensity*

Duration	None	Intensity		
		Low	Middle	High
0-1 years		10%	5%	14%
1-3 years	18%	5	3	20
3+ years		5	2	18

Source: Chen, Munnell and Wettstein (2025).

Table 2. *Percentage of Respondents Who Are Worried or Very Worried About the Incidence of Various Healthcare Risks, by Select Characteristics*

	Major illness	Cognitive impairment	LTC need
Parents have dementia/need LTC	41%	39%	37%
Caregivers	63	58	41
Spends a lot on prescription drugs	61	59	44
Self-rated fair/poor health	55	34	37
Average older households	35%	35%	32%

Source: Authors' calculations from 2024 Greenwald household survey.

Table 3. *Historical Medicare Part B Premium Inflation Over Various Periods, 2023*

Time period	Nominal premium inflation	Real premium inflation
Last 10 years	57%	20%
Last 20 years	181	70
Last 30 years	351	114

Note: Medicare premium inflation is based on Medicare Part B standard premium.
Source: Centers for Medicare & Medicaid Services (2024).

Table 4. *Percentage of Respondents Who Are Worried or Very Worried about Inflation, by Wealth and Age Group*

	Drug price inflation	Medicare inflation
Wealth group		
$100k - $200k	39%	43%
$200k - $500k	35	44
$500k+	27	29
Age group		
Younger than 65	41	44
65 or older	21	26
All	31	36

Source: Authors' calculations from 2024 Greenwald household survey.

Table 5. *Annual Median Costs of Care in the United States, 2023*

	Median	Lowest cost state	Highest cost state
Nursing home (private room)	$116,800	$78,475	$415,005
Home health aide	75,504	50,336	96,096
Assisted living facility	64,200	45,600	114,750

Source: Genworth (2023).

Table 6. *Percentage of Respondents Who Correctly Estimate Major Care Costs, by Select Characteristics*

	Nursing home	Home care	Assisted living
Parents have dementia/need LTC	45%	35%	59%
Caregivers	50	26	57
Spends a lot on prescription drugs	66	34	55
Self-rated fair/poor health	35	28	33
Overall	39%	34%	52%

Source: Authors' calculations from 2024 Greenwald household survey .

Table 7. *Percentage Believing Source Would Cover Long-Term Nursing Home Care If Needed, Ages 65+, 2022*

Source	65+
Medicare	45%
Private health insurance	9
Personal income or savings	18
Medicaid	6
LTC insurance	3
Financial help from family	1
Not sure	15

Source: Hamel and Montero (2023).

Table 8. *For Those 40+, Percentage Who Expect to Rely "Completely" or "Quite A Bit" on Each Source, 2021*

Source	Percentage who expect to rely "completely" or "quite a bit"
Medicare	49%
Savings	48
Social Security	47
Future income	27
A pension	26
Medicaid	25
Unpaid care from family	18
LTC insurance	17

Source: Associated Press/NORC Center for Public Affairs (2021).

Table 9. *Percentage of Respondents Who Are Worried or Very Worried About Various Healthcare Risks in Retirement*, *by Whether They Have a Financial Advisor*

	Has a financial advisor	
	Yes	No
Incidence		
Cognitive impairment (incl. spouse)	34%	38%
Having a major illness	30	44
Developing LTC need	25	44
Cost		
LTC affordability	31	49
Medicare or Medicare Advantage cost inflation	30	46
Drug cost inflation	25	43
Spending cut to meet healthcare needs	22	33
Access specialist care	19	30
Cost of major illness	19	45
Cost of dental care	19	31
Affording crucial prescription drugs	18	34
Sample size	319	189

Source: Authors' calculations from 2024 Greenwald household survey.

Table 10. *Regression of Whether Households Are Worried or Very Worried About Various Healthcare Risks in Retirement*

	(1)	(2)	(3)	(4)	(5)	(6)
	Major illness	Cognitive impairment (incl. spouse)	Need LTC	Afford LTC	Cost of major illness	Medicare cost inflation
Have a financial advisor	-0.115**	-0.021	-0.157***	-0.148***	-0.208***	-0.114**
	(0.046)	(0.046)	(0.045)	(0.046)	(0.042)	(0.045)
Household investable assets						
$200,000 to $499,999	0.106	0.072	0.024	0.042	-0.057	0.062
	(0.068)	(0.069)	(0.067)	(0.068)	(0.063)	(0.067)
$500,000+	0.014	0.091	-0.002	0.018	-0.111*	-0.029
	(0.066)	(0.067)	(0.065)	(0.066)	(0.061)	(0.065)
Age	-0.011***	-0.009***	-0.006**	-0.012***	-0.008***	-0.013***
	(0.003)	(0.003)	(0.003)	(0.003)	(0.002)	(0.003)
Education group						
Some college	-0.040	-0.031	-0.000	-0.039	-0.058	-0.086
	(0.067)	(0.068)	(0.066)	(0.068)	(0.062)	(0.067)
College or more	-0.038	-0.137**	-0.049	-0.150**	-0.050	-0.171***
	(0.066)	(0.067)	(0.065)	(0.066)	(0.061)	(0.065)
Has child	0.008	0.099**	0.047	0.021	0.028	0.022
	(0.048)	(0.049)	(0.047)	(0.048)	(0.044)	(0.047)
Married/partnered	-0.064	-0.063	-0.084*	-0.064	-0.107**	-0.085*
	(0.050)	(0.050)	(0.049)	(0.050)	(0.046)	(0.049)
Constant	1.175***	0.921***	0.854***	1.334***	1.105***	1.384***
	(0.185)	(0.188)	(0.182)	(0.185)	(0.170)	(0.182)
Observations	508	508	508	508	508	508
R-squared	0.068	0.043	0.054	0.087	0.113	0.097

Notes: Standard errors are in parentheses. * $p < 0.1$, ** $p < 0.05$, *** $p < 0.01$.
Source: Authors' calculations from 2024 Greenwald household survey.

Table 11. *Percentage of Households whose Social Security Retirement and Defined Benefit Pension Income is Higher than Medicaid Income Limits*

Higher than eligibility rule	95%
Higher than special income rule for LTSS	70

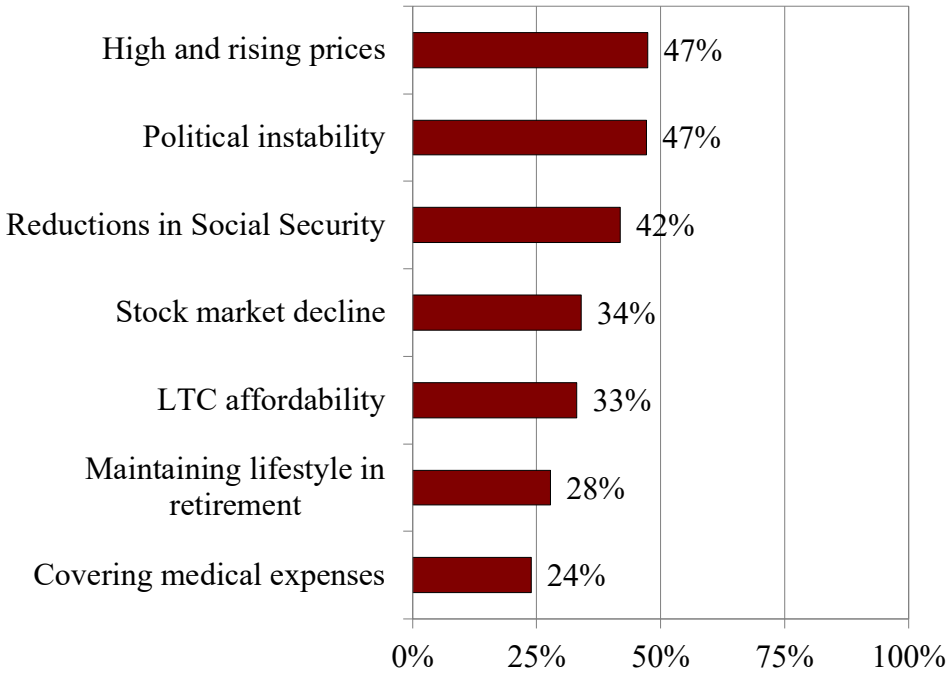
Notes: Sample is only among households with more than $100,000 in investible assets at their first interview. Income thresholds are based on Hamel and Montero (2023). Most states offer coverage for seniors with incomes around the Supplementary Security Income (SSI) limit (74 percent - 100 percent of the federal poverty limit (FPL)). Our calculation is based on the U.S. median of 77 percent. Some states have special income rules for LTSS that covers seniors with incomes up to 300 percent of the SSI benefit rate. In 2023, special income thresholds were $11,249 for Medicaid coverage, and $32,434 for the special income rule for a one-person household.
Source: Authors' calculations from 2024 Greenwald household survey.

Table 12. *Percentage of Households whose Social Security Retirement is Higher than Medicaid Income Limits*

Higher than eligibility rule	87%
Higher than special income rule for LTSS	32

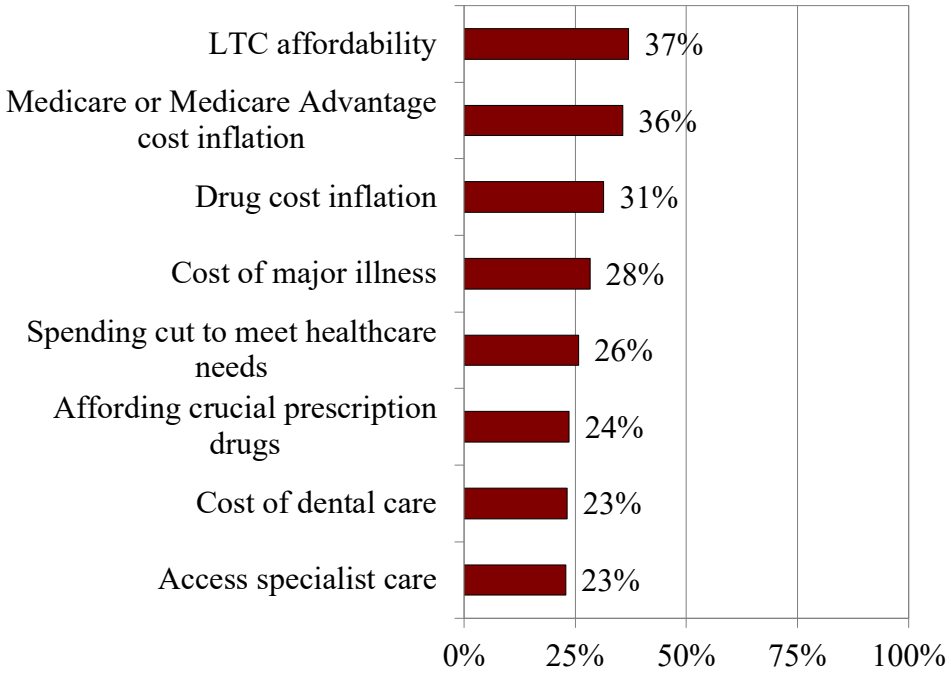
Notes: Sample is only among households with more than $100,000 in investible assets at their first interview. Income thresholds are based on Hamel and Montero (2023). Most states offer coverage for seniors with incomes around SSI limit (74 percent - 100 percent of the FPL). Our calculation is based on the U.S. median of 77 percent. The special income rule covers seniors with incomes up to 300 percent of SSI benefit rate. In 2023, special income thresholds were $11,249 for Medicaid coverage, and $32,434 for the special income rule for a one-person household.
Source: Authors' calculations from 2024 Greenwald household survey.

Figure 1. *Percentage of Respondents Who Are Worried or Very Worried About Various General Retirement Risks*



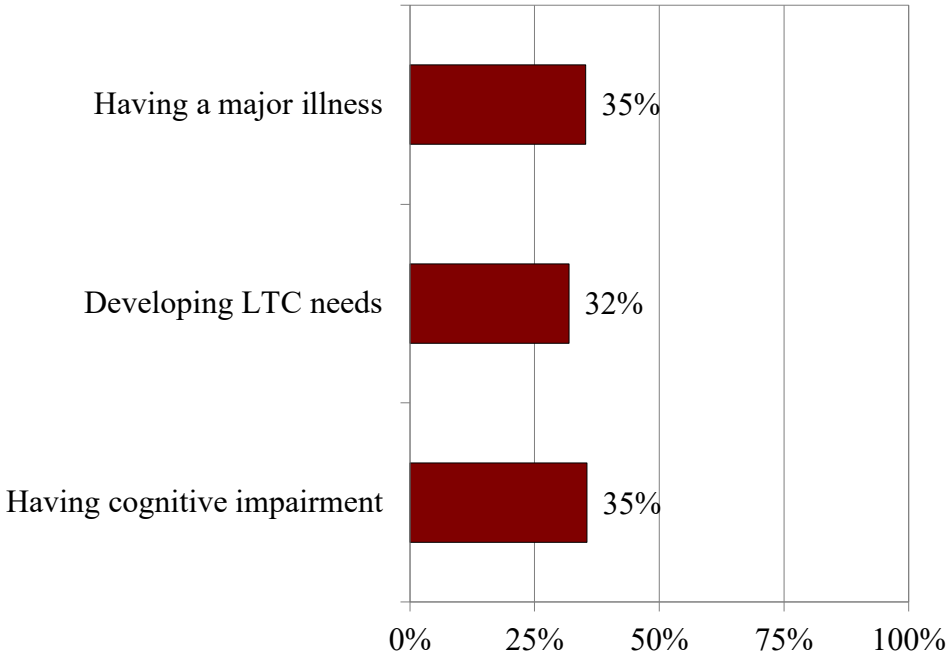
Source: Authors' calculations from 2024 Greenwald household survey.

Figure 2. *Percentage of Respondents Who Are Worried or Very Worried About Various Healthcare Cost Risks in Retirement*



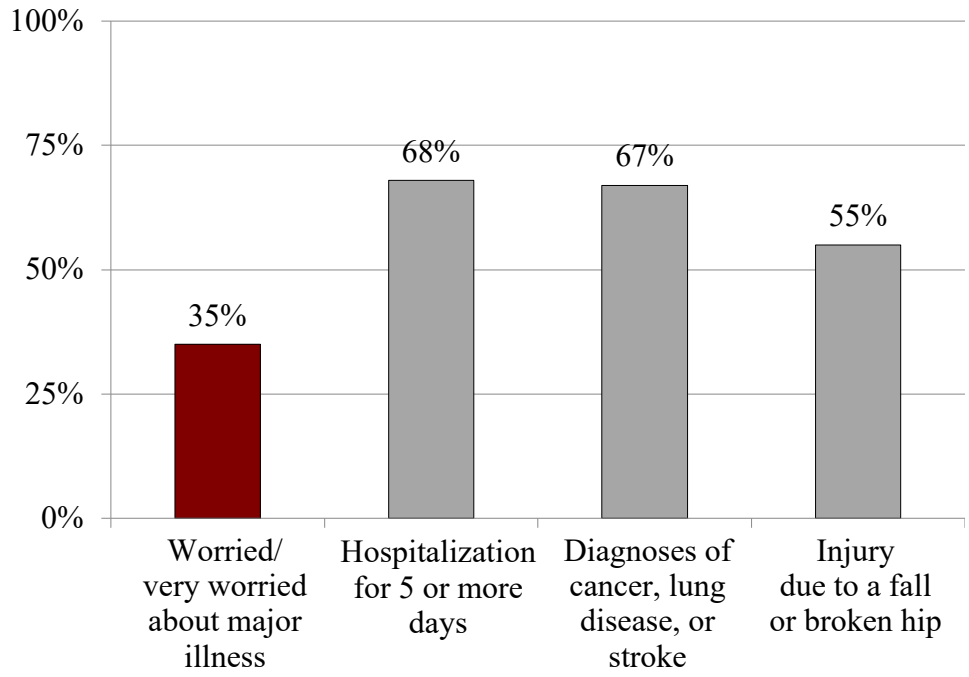
Source: Authors' calculations from 2024 Greenwald household survey.

Figure 3. *Percentage of Respondents Who Are Worried or Very Worried About Various Healthcare Risks in Retirement*



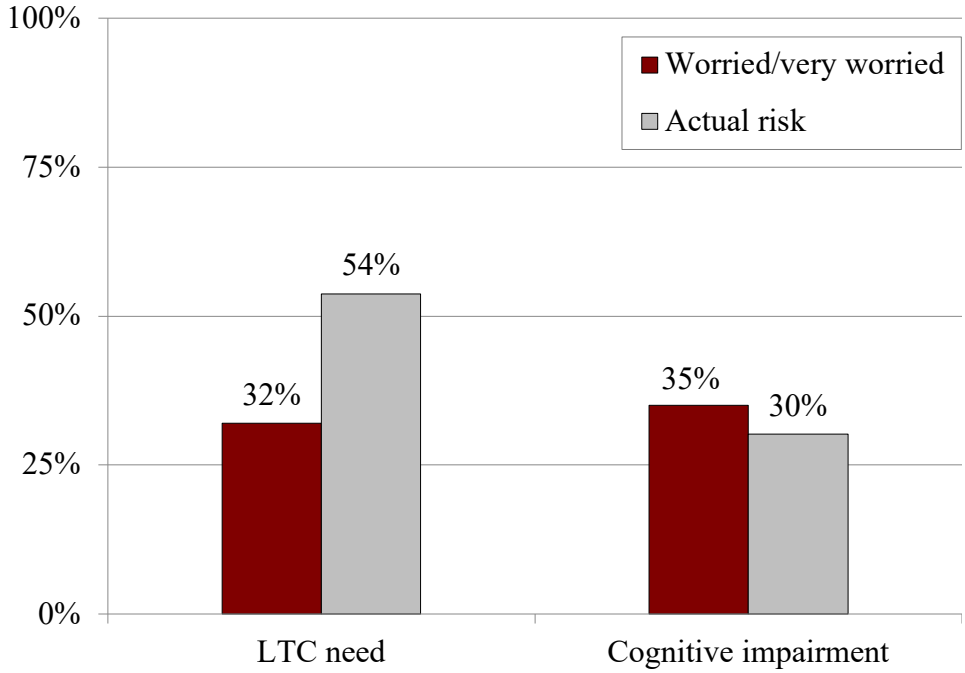
Source: Authors' calculations from 2024 Greenwald household survey.

Figure 4. *Comparison of Worries about Major Illness with the Actual Risk of Major Medical Events*



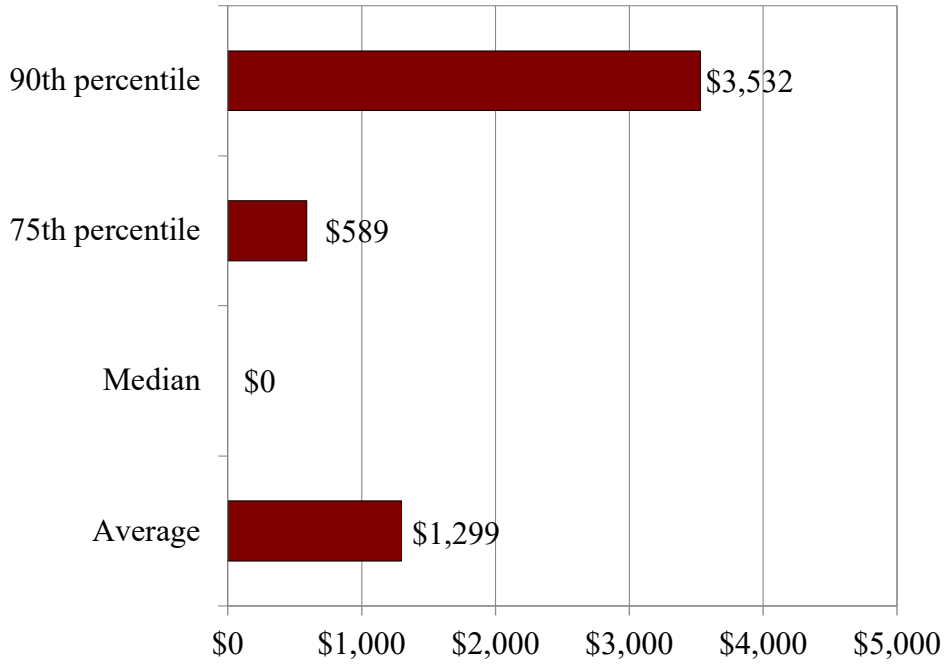
Notes: Actual risk is calculated for a sample of household heads born in 1931-1941 who had $100k in investible assets (in 2023 dollars), who were not in a nursing home or Medicaid during their first interview, who have died since, or have been interviewed at least once after age 80. The risks are for the household (incidence for either spouse) and excludes hospitalizations right before death.
Sources: Authors' calculations from 2024 Greenwald household survey; RAND *Health and Retirement Study* (HRS) *Longitudinal File* (1992-2020v2); and HRS (1992-2020).

Figure 5. *Comparison of Worries with the Actual Risk of Cognitive Impairment and LTC Need*



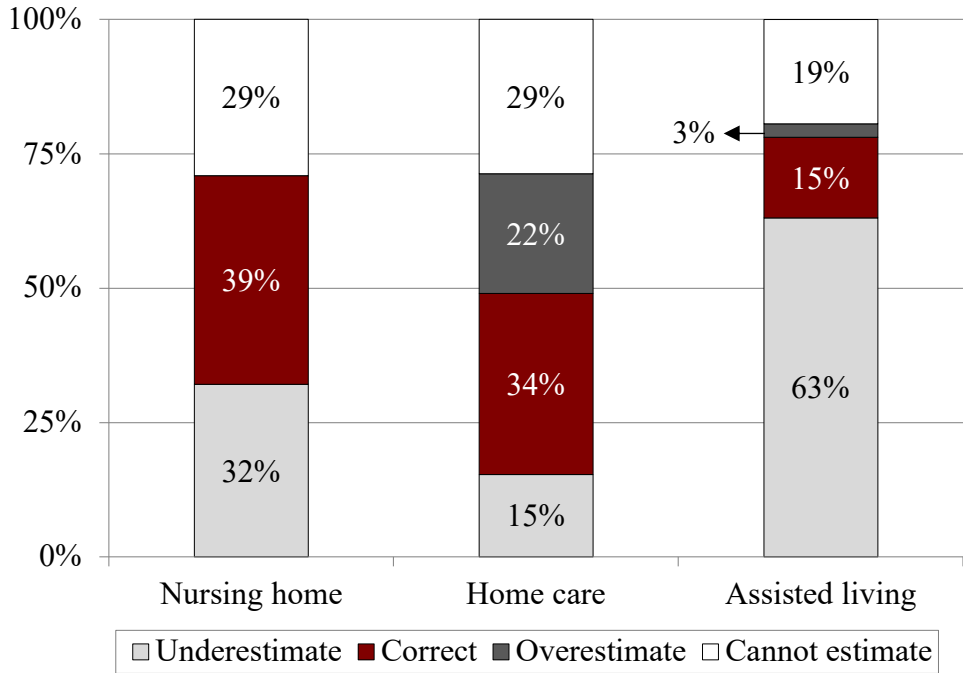
Notes: Actual risk is calculated for a sample of household heads born in 1931-1941 who had $100k in investible assets (in 2023 dollars), who were not in a nursing home or Medicaid during their first interview, who have died since, or have been interviewed at least once after age 80. The risks are for the household.
Sources: Authors' calculations from 2024 Greenwald household survey and Chen, Munnell, and Gok (2025 forthcoming).

Figure 6. *OOP Cost Hospitalization Among Those Who Utilized Such Services in 2020, by Type of Insurance, Households Ages 65+*



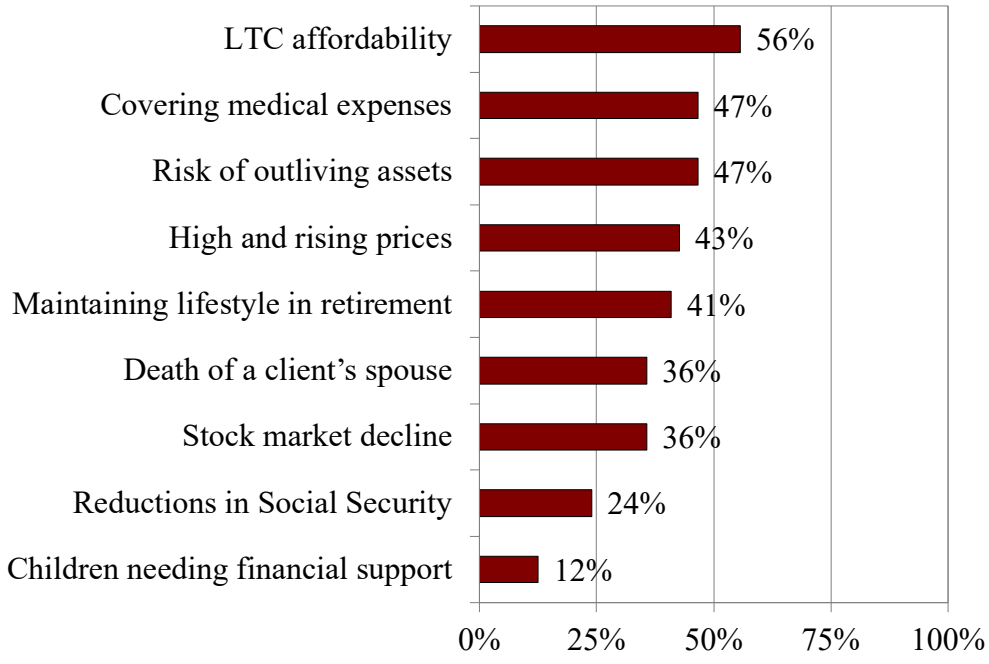
Note: Values are in 2023 dollars and show the expenditure in the previous two years.
Sources: Authors' calculations from RAND HRS *Longitudinal File* (1992-2020v2) and RAND HRS *Longitudinal Imputations File* (1992-2020v2).

Figure 7. *Percentage of Respondents Who Correctly Estimate Average Annual LTC Costs*



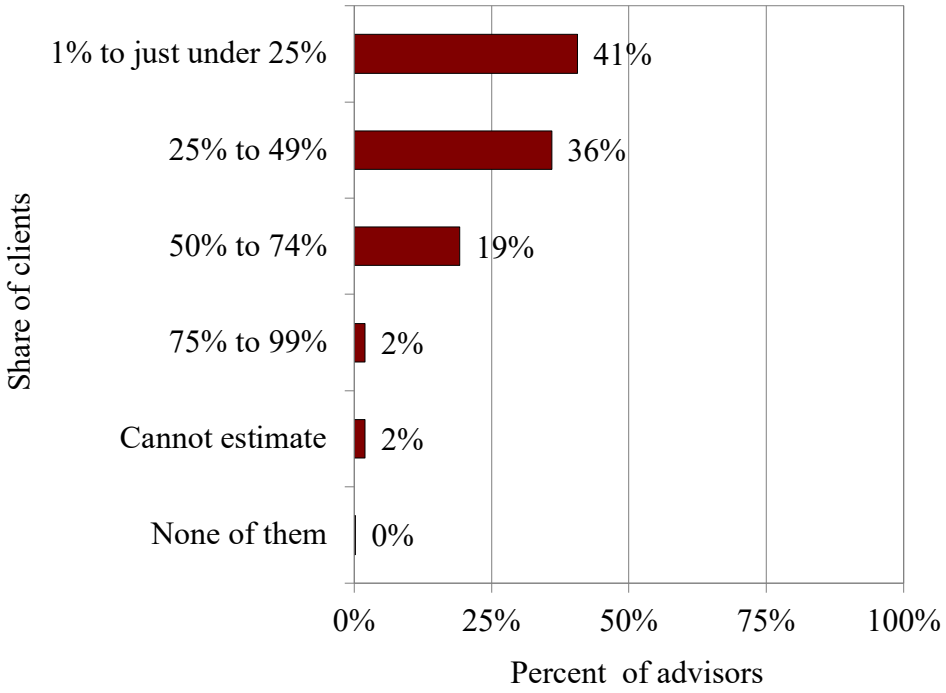
Source: Authors' calculations from 2024 Greenwald household survey.

Figure 8. *Percentage of Advisors Who Think Various Things Are a Major Risk to Their Clients' Financial Security*



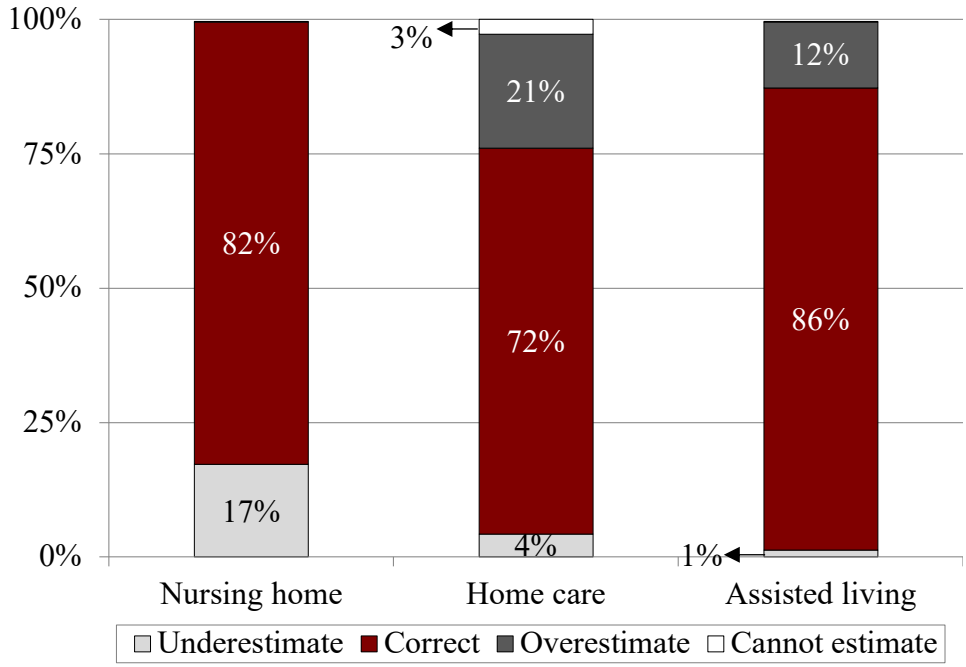
Source: Authors' calculations from 2024 Greenwald advisor survey.

Figure 9. *Percentage of Advisors, by the Proportion of Their Clients That They Believe Will Need Three or More Years of LTC*



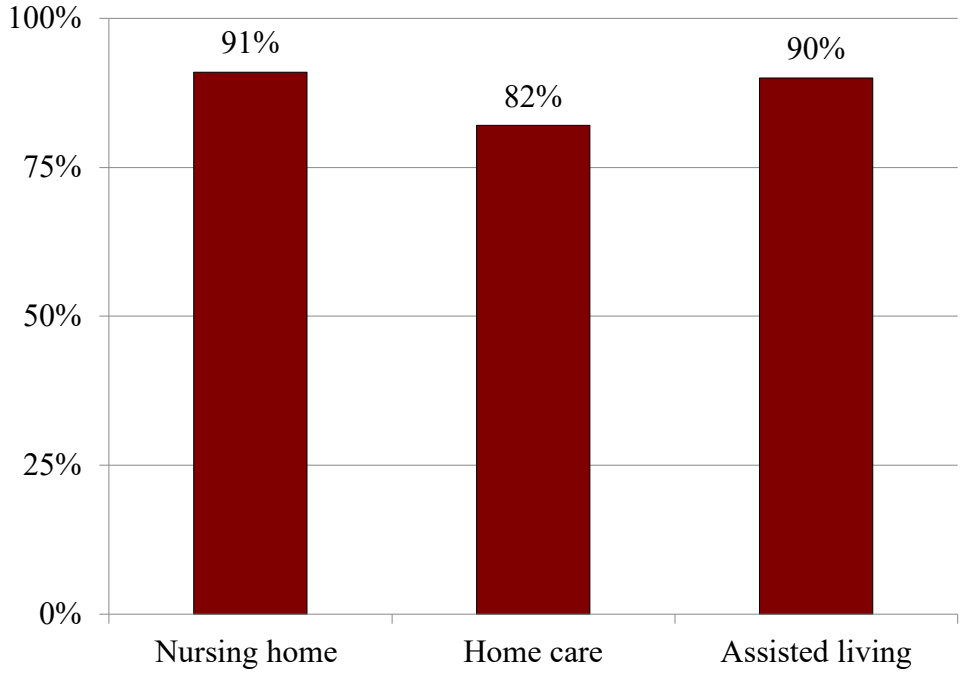
Source: Authors' calculations from 2024 Greenwald advisor survey.

Figure 10. *Percentage of Advisors Who Correctly Estimate LTC Costs*



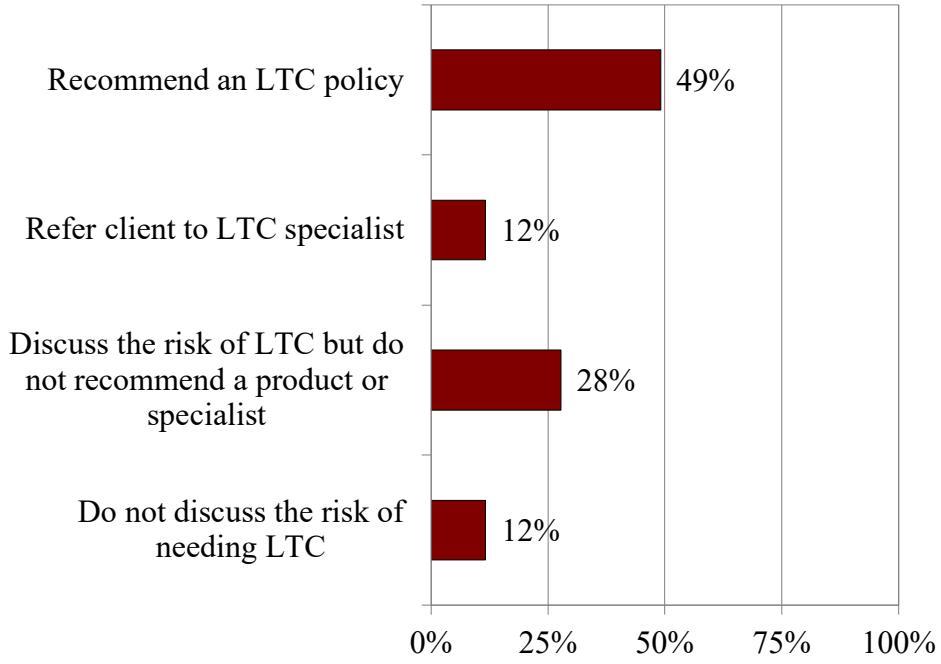
Notes: Correct estimates for nursing home cost is $75k or more annually; for home care, $20-$50 per hour; and assisted living, $50k - $150k.
Source: Authors' calculations from 2024 Greenwald advisor survey.

Figure 11. *Percentage of Advisors Who Are Confident or Somewhat Confident about LTC Costs*



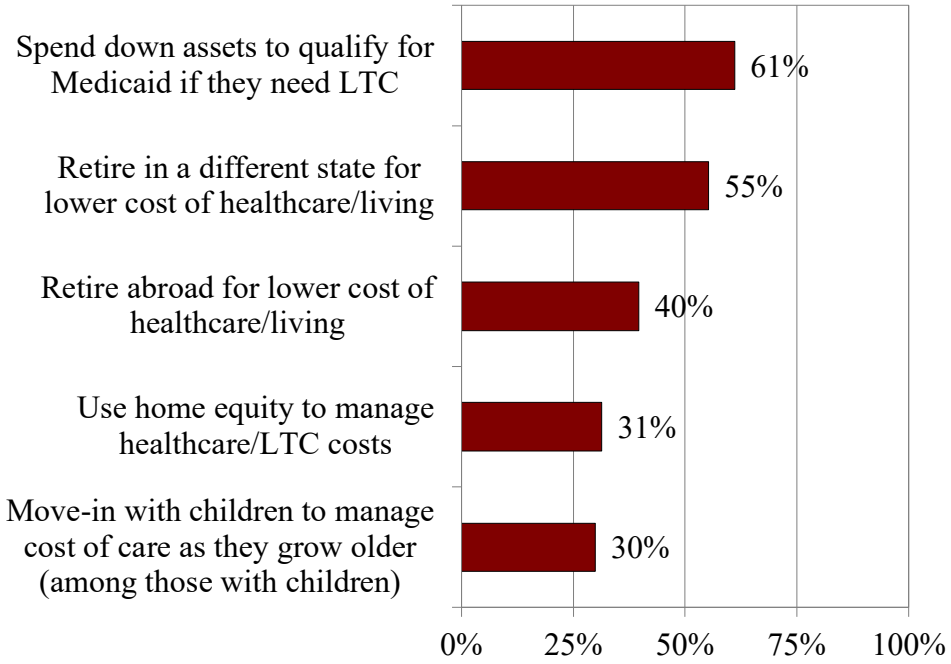
Source: Authors' calculations from 2024 Greenwald advisor survey.

Figure 12. *Different LTC Strategies Advisors Discuss with Their Clients*



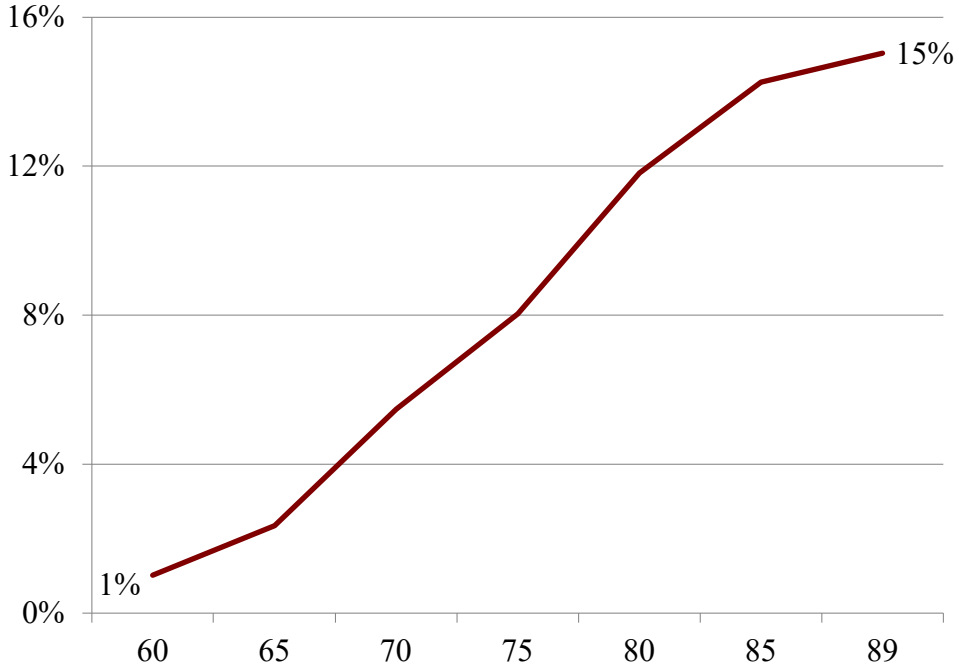
Source: Authors' calculations from 2024 Greenwald advisor survey.

Figure 13. *Percentage of Respondents Who Have Already Made/ Have Considered Making/ May Consider Making Various Changes*



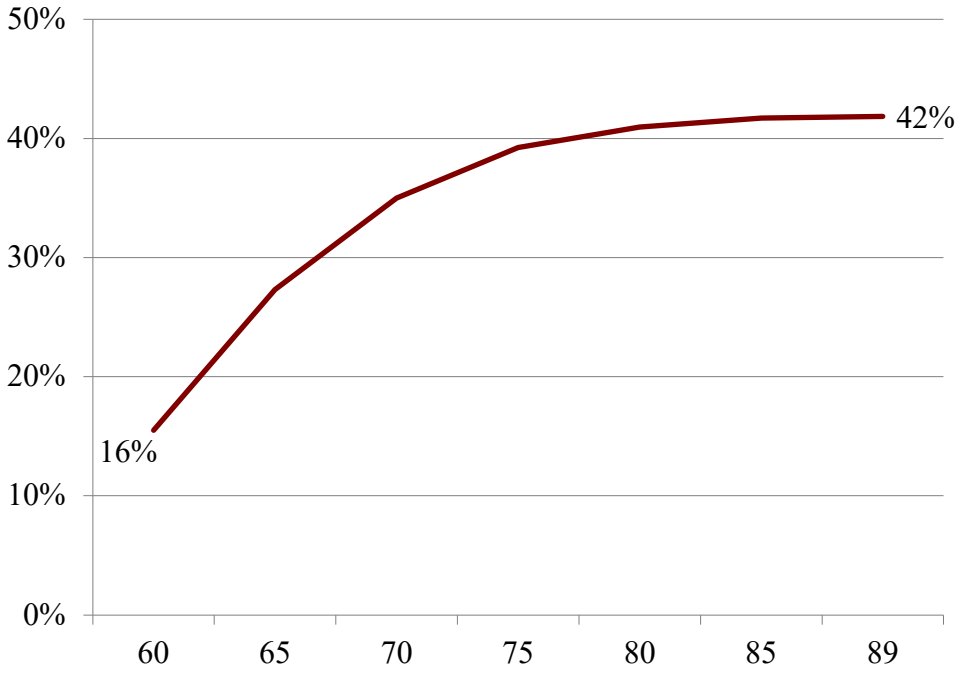
Sources: Authors' calculations from 2024 Greenwald household survey.

Figure 14. *Cumulative Likelihood of Having Medicaid, by Age*



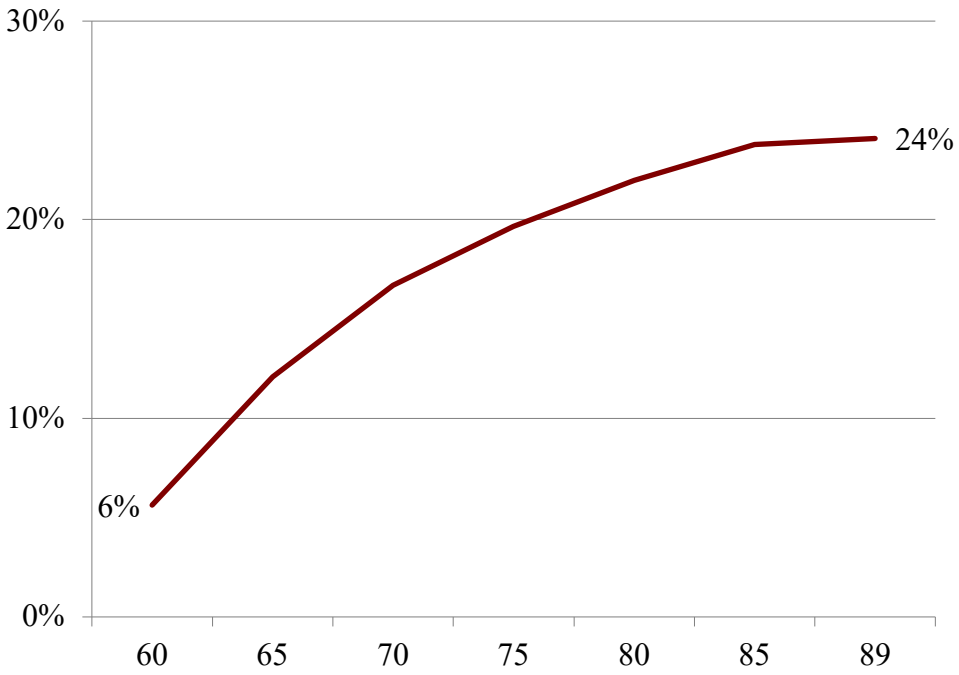
Note: Sample is only among households with more than $100k in investible assets at their first interview.
Sources: Authors' calculations from RAND HRS *Longitudinal File* (1992-2020v2) and HRS (1992-2020).

Figure 15. *Cumulative Likelihood of Tapping into Home Equity, by Age*



Notes: Sample is only among households with more than $100k in investible assets at their first interview. Tapping home equity includes any instances of second mortgage, home equity line of credit or similar loans against house, as well as downsizing (selling home and buying a cheaper home within a three-year range).
Sources: Authors' calculations from RAND HRS *Longitudinal File* (1992-2020v2) and HRS (1992-2020).

Figure 16. *Cumulative Likelihood of Moving in with Child or a Child Moving in with Them if Household Has Kids, by Age*



Note: Sample is only among households with more than $100k in investible assets at their first interview.
Sources: Authors calculations from RAND HRS *Longitudinal File* (1992-2020v2) and HRS (1992-2020).

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