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This chapter explains the finances of *older adults* including: income, net worth, poverty, debt, emergency funds, labor force participation, consumption, housing, health care, long-term care, and financial scams. Americans are living longer and better than ever before thanks to major medical and public health advances and greater access to health care (White House Conference on Aging, 2015). Life expectancy at birth for Americans of both sexes and all races was 78.7 years in 2010. As age increases, life expectancy increases. Therefore, a 65-year-old man can expect to live another 17.7 years and a 65-year-old woman can expect to live another 20.3 years. A 75-year-old man can expect to live another 11.0 years and a 75-year-old woman can expect to live another 12.9 years (Health, United States, 2013, p. 82).

Increased life expectancy leads to the question: Will older adults enjoy economic well-being in their later years? Xiao, Chen, and Sun (2015) studied age differences in financial capability using data from the 2012 National Financial Capability Study commissioned by the Financial Industry Regulatory Authority (FINRA) Investor

Education Foundation. The study included 25,509 American adults and 1000 military members; data were collected through online surveys. The study focused on objective financial literacy, subjective financial literacy, desirable financial behaviors, and perceived financial capability. Perceived financial capability was measured using this question: "I am good at dealing with day-to-day financial matters, such as checking accounts, credit and debit cards, and tracking expenses." The youngest group (aged 18–24) had the lowest score for perceived financial capability and the oldest group (aged 65+) had the highest score for perceived financial capability. Each of the six age groups had higher scores than the age group that was younger than their group. Also, all six age groups had scores for perceived financial capability that were statistically different from each other (Xiao et al., 2015).

For many years, the Publication Manual of the American Psychological Association (2010) has stated that authors should refrain from using "elderly" or "aged" as a noun. Also, the use of these terms as adjectives should be avoided. Although using these terms in this way was a common practice through the mid-1980s, the American Psychological Association has helped scholars think of alternative terms to respect and represent the diversity of the population (K. Ferraro, personal communication, June 1, 2015). The term *older adult* is preferred (American Psychological Association, 2010, p. 76).

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Demographics

The US Census Bureau issued a Special Study report titled “65+ in the United States: 2010” in June 2014 (West, Cole, Goodkind, & He, 2014). The report was a rich source of information on older adults in the USA. In 2010, there were 40.3 million people aged 65 and older in the USA; this was 12 times the number in 1900. The percentage of the population aged 65 and over among the total population increased from 4.1 % in 1990 to 13.0 % in 2010; the percentage aged 65 and over is projected to reach 20.9 % by 2050 (West et al., 2014).

The old age dependency ratio (number of working age persons, measured as the number between age 20 and 64, divided by the number of persons aged 65 and older) is expected to rise sharply when the Baby Boomers enter their later years. In 2030, the dependency ratio is expected to be about three workers supporting every older person (West et al., 2014). Dependency ratios are thought to impact national savings rates and the rate of economic growth. They have implications for financing programs for dependent populations such as children and older adults (Clark, Burkhauser, Moon, Quinn, & Smeeding, 2004). The predicted low dependency ratios will make it challenging to fund the social programs that support and serve those who are not in the labor force such as children and older adults.

The older population has become more racially and ethnically diverse. Those who identify their race as White alone were 84.8 % of the population in 2010. This is down from 86.9 % in 2000. The older White alone population was less likely than the older Black alone population and the Asian alone population to live in poverty in 2010. Older Hispanics were more likely to live in poverty than were older non-Hispanic White alone residents (West et al., 2014).

States with the highest proportions of older adults in their population in 2010 included Florida, West Virginia, Maine, and Pennsylvania. In each of these states, the proportion of older adults was greater than 15 % of the total population. The USA is not the only country experiencing population aging. In 2010, 50 countries had a

higher proportion of people aged 65 and over than the USA. By 2050, this number is expected to reach 98 which means that almost half the countries in the world will have a higher proportion of people aged 65 and over than the USA (West et al., 2014).

Theoretical Framework

Although several theories from psychology and sociology are used to interpret changes that occur as people age, there are at least three theories from economics that should be included in the study of older adults and financial issues. The economic theories are: the life-cycle hypothesis of savings, the permanent income hypothesis, and precautionary savings.

The life-cycle hypothesis of savings suggests that people try to maintain a relatively stable level of consumption over their lifetime (Ando & Modigliani, 1963). This behavior is observed when those who are younger borrow to meet consumption needs, those who are middle-aged save a relatively large proportion of their earnings, and those who are older spend down their assets when income is reduced in retirement. A strict interpretation of the life-cycle hypothesis suggests that people will spend all of their assets before the end of their life. However, it has been observed that people reduce consumption as they age; the purpose is to retain assets to provide for unexpected increases in both longevity and health care expenses.

The permanent income hypothesis suggests that people adjust their spending level to their perceived level of future income. Permanent income is believed to be what people can confidently expect to receive. Transitory income is believed to be income that is received accidentally or by chance. Transitory income is not expected to affect long-term consumption (Friedman, 1957).

Precautionary saving is intended to safeguard against declines in future income. The precautionary savings model suggests that older adults will be cautious about spending down their assets. The reluctance to spend down assets is

explained by uncertainty about longevity, the cost of health care in the future, and the possibility of becoming impoverished (Carroll, 1997; Deaton, 1992).

Concerns of Pre-Retirees and Retirees

The Society of Actuaries (2014) has studied post-retirement risks and how they are managed for more than 15 years. In August 2013, the Society conducted The Risks and Process of Retirement Survey using online interviews to collect data from 1000 pre-retirees and 1000 retirees. The age range of interviewees was 45–80. Results from the survey revealed that inflation, health care, and long-term care were the top three risks for both retirees and pre-retirees. Pre-retirees were often more concerned about inflation, health care, and long-term care than retirees.

The survey showed that 77 % of pre-retirees and 58 % of retirees were very or somewhat concerned about “keeping the value of savings and investments up with inflation.” The second largest concern expressed by 73 % of pre-retirees and 46 % of retirees was having enough money to pay for adequate health care. The third biggest concern expressed by 68 % of pre-retirees and 52 % of retirees was having enough money to pay for long-term care. The possibility of depleting savings was in fourth place; it was expressed by 66 % of pre-retirees and 41 % of retirees. Maintaining a reasonable standard living for the rest of their life was in fifth place; it was expressed by 65 % of pre-retirees and 41 % of retirees (Society of Actuaries, 2014).

Retirees may feel more confident than pre-retirees in regard to these issues because many retirees receive Social Security retirement benefits and those aged 65 and over should have Medicare coverage. In contrast, pre-retirees might have limited retirement savings due to slow wage growth. Perhaps pre-retirees expect inflation to rise because inflation rates have been at historic lows for some time. Another concern for pre-retirees could be that the expected low worker to dependent ratio suggests that Social Security benefits and Medicare will be reduced in the future.

Income

Median household income in 2013 for households of all ages was \$51,939 while median income for households maintained by a person aged 65 and older in 2013 was \$35,611. Notably, the median income of households maintained by a person aged 65 and older increased by 3.7 % from \$34,340 in 2012 to \$35,611 in 2013. This was the first increase in median income for this age group since 2009 (DeNavas-Walt & Proctor, 2014).

Total money income for those 65 and over comes primarily from four sources: Social Security, earnings, pensions, and asset income. The importance of Social Security varies by income level. For those 65 and older in the lowest income quintile, Social Security represented 84.3 % of total income, followed by 7.0 %, public assistance; 2.9 %, pensions; 2.4 %, earnings; 1.8 %, asset income; and 1.6 %, other. For those 65 and older in the highest income quintile, earnings represented 44.9 % of total income; pensions, 19.1 %; Social Security, 17.3 %; asset income, 16.1 %; other, 2.4 %; and public assistance, 0.1 % (West et al., 2014).

Net Worth

Net worth (wealth) is the sum of the market value of assets owned by every member of the household minus liabilities owned by household members. Components of net worth include interest-earning assets, rental property, home ownership, Individual Retirement Accounts and Keogh accounts, 401(k) retirement plans, vehicles, and checking accounts. Assets not included in net worth include equities in defined benefit pension plans, the cash value of life insurance policies, and the value of home furnishings and jewelry. Liabilities include mortgages on the home, mortgages on rental property, vehicle loans, credit card debt, educational loans, and medical debt not covered by insurance (Vornovitsky, Gottschalck, & Smith, 2014a).

As shown in the September 2014 Federal Reserve Bulletin, different age groups experienced very different trends in net worth between

Table 13.1 Family median and mean net worth from the 2010 and 2013 surveys of consumer finances, in thousands of 2013 dollars

Age of head	Median net worth		
	2010	2013	% Change
65–74	221.5	232.1	+5
75 or more	232.3	194.8	–16

Age of head	Mean net worth		
	2010	2013	% Change
65–74	909.2	1057.0	+16
75 or more	726.5	645.2	–11

2010 and 2013 (Bricker et al., 2014). Both mean and median net worth increased for those under age 45, decreased for those between age 45 and 64, increased for those between age 65 and 74, and decreased for the oldest group aged 75 and older. Increases were generally larger for mean net worth than for median net worth, while declines were similar in magnitude for the two measures. Gains in median net worth for families of all ages ranged between 3 % and 5 %, while declines in median net worth for all families ranged between 14 % and 17 % (Table 13.1).

Poverty

In 1959, 35.2 % of people aged 65 and over lived in poverty (West et al., 2014). The proportion of older adults living in poverty declined during the 1960s and 1970s due to the expansion of Social Security and introduction of Medicare. In contrast to the 1959 poverty rate of 35.2 %, the poverty rate for those aged 65 and over in 2013 was 9.5 % (DeNavas-Walt & Proctor 2014). The poverty rate in 2013 for women aged 65 and older was 11.6 %, while the poverty rate for men aged 65 and older was 6.8 %.

The term “near poverty” means that income is at or above the poverty threshold but it is below 125 % of the poverty threshold. Poverty and near-poverty rates differ by age group for older adults. Poverty and near-poverty rates are higher for those aged 75 and over compared to those aged 65–74. Also, higher percentages of older women lived in or near poverty in 2010 than did older men. Older White single individuals

were less likely than older Black singles and older Asian singles to be in poverty in 2010 (West et al., 2014).

Debt

Secured debt includes debt against a household’s primary residence and vehicles while unsecured debt includes amount owed for credit cards, loans from a bank or credit union, and other debt such as student loans, medical debt, money owed to individuals, and any other unsecured debt. In 2000, the median amount of secured debt for households aged 65 and older was \$25,400 while in 2011, it was \$50,000. In 2000, the median amount of unsecured debt for households aged 65 and older was \$2300 and, in 2011, it was \$3500. However, the total of household debt at \$12,100 in 2000 and \$26,000 in 2011 was lower than median secured debt because not every household holds secured debt (Vornovitsky, Gottschalck, & Smith, 2014b).

Emergency Funds

In September 2013, the Federal Reserve Board conducted The Survey of Household Economics and Decision-making (SHED). The results were based on a nationally representative online survey panel. All ages were included in the survey. However, responses to the question “Have you set aside emergency or rainy day funds that would cover your expenses?” were categorized by age (Board of Governors of the Federal Reserve System, 2014).

Individuals aged 60 and older were more likely to say “Yes, they set aside emergency or rainy day funds to cover expenses.” Over half (56.3 %) aged 60 and older said “Yes” compared to 39.4 % which was the average for all respondents. Similarly, 66.6 % of those aged 60 and older said “Yes” in response to the question “Could you cover expenses for 3 months by borrowing money, using savings, selling assets, or borrowing from friends/family?” compared to 55.6 % of all respondents (Board of Governors of the Federal Reserve System, 2014).

Labor Force Participation

The labor force participation rate (LFPR) of men aged 65 and older decreased from 45.8 % in 1950 to 15.6 % in 1993. In contrast, older women's LFPRs were stable; their rate was less than 10 % in 1950 and almost the same at 10 % in 2000. The trend toward earlier retirement in the 1960s, 1970s, and 1980s began to change in the 1990s for men and in the 2000s for women (Leonesio, Bridges, Gesumaria, & Del Bene, 2012).

In 2010, the LFPR for older men was 22.1 % and 13.8 % for older women. As the age of workers rose, the share of those who were working part time increased. For workers aged 70 and older, almost half of all employed men and the majority of employed women were working part time instead of full time. Self-employment was more common for older employees than younger employees. For employed workers aged 65 and over, the self-employed shares rose to 2.9 % for agriculture and 13.5 % for non-agricultural industries. Men had higher self-employment rates than women regardless of age (West et al., 2014).

Berkman, Boersch-Supan, and Avendano (2015) believe that working at older ages can lead to a better quality of life for older people and a more resilient society overall. They state that there is growing evidence that employment yields both physical and mental health benefits. They analyzed several studies and concluded that employment may improve health and well-being by increasing social engagement, and developing and maintaining intellectual and interpersonal skills. Also, continued employment by older adults is likely to delay the use of savings, pensions, and other benefits.

Consumption

Lee, Sohn, Rhee, Lee, and Zan (2014) analyzed the consumption patterns of households whose heads or spouses were aged 65 and over using data from the 2010–2011 Consumer Expenditure Survey. The criteria for inclusion in their study consisted of three factors. First, household heads

or spouses were aged 65 and over and had participated in four consecutive quarters of the Consumer Expenditure surveys. Second, the study excluded households within the highest and lowest 1 % of disposable income. Third, the survey includes only the civilian non-institutional population. The researchers developed a weight variable to account for the fact that those who completed all four quarters of the survey were more likely to be older, married, and homeowners compared to those who did not complete all four quarterly interviews (Lee et al., 2014).

The final sample included 1943 older American households. The mean household income was \$43,431 and the mean household expenditure was \$38,199. The mean age was 74.44 years, 87.53 % were White, 8.30 % were Black, and 4.17 % were described as other races. Slightly less than half (48.58 %) were a married couple, 47.18 % had more than a high school education, and 27.68 % had an employed household member (Lee et al., 2014).

The Consumer Expenditure categories were regrouped into 17 mutually exclusive categories. Then factor analysis was used to identify factors that reflected the consumption patterns of older households. The factor analysis produced six factors: essentials and contributions, postponables, health care and reading, shelter and transportation, expendables, and treats. Essentials and contributions included: necessities such as food and utilities and cash contributions. Postponables included: clothing, personal care, and housing equipment and furnishings. Expendables included: travel and entertainment, and some household operations such as gardening, moving, storage, and repair of household appliances. Treats included: tobacco and alcoholic beverages (Lee et al., 2014)

Spending Patterns

Then the researchers used cluster analysis to group older households with similar spending patterns. For this analysis, “contributions” and “shelter” were separated and treated as independent factors so eight factors were used in the

cluster analysis. The researchers found six clusters (Lee et al., 2014). Labeled by the authors, the clusters and their percentage of the sample were basic needs, 26.87 %; housing burdened, 25.89 %; healthcare burdened, 21.10 %; transportation burdened, 12.09 %; happy retirees, 6.33 %; and balanced budgeters, 5.40 %.

The “health-care burdened” and the “basic-needs” were the poorest groups. The “health-care burdened” spent 27.5 % of their total expenditures on health care compared with 10–12 % spent on health care by the other clusters. The “basic-needs” group spent 43.4 % of their total expenditures on food and utilities. However, this group spent more on “treats” (tobacco and alcoholic beverages) than did the average older household (Lee et al., 2014).

The “transportation burdened” and the “housing burdened” were the middle groups in terms of total expenditure levels. The “transportation burdened” spent almost 33 % of their total expenditures on transportation expenses compared to other clusters who spent between 8 % and 12 % on transportation. The “housing burdened” spent 42.2 % of their total expenditures on rent and mortgages while those in other clusters spent between 5 % and 17 % on rent and mortgages (Lee et al., 2014).

The “happy retirees” were the most well-off group and the “balanced-budgeters” were the second most well-off group. The “happy retirees” could afford to spend as much as 30.7 % of their expenditures on “expendables” which included entertainment, travel, and household operations compared to spending of 7–11 % on expendables by the other clusters. The “balanced budgeters” had a spending share of 15.8 % on postponables (personal care, clothing, and housing equipment). In other clusters, the spending on expendables ranged from 3 % to 5 % (Lee et al., 2014).

Differences in Socio-Demographic Characteristics

Next the researchers conducted F-tests to find significant mean differences in socio-demographic characteristics among the six consumption clusters.

The F-tests showed the following characteristics for the clusters. The “transportation burdened” were the youngest with an average age of 71.1 years; they had a higher percentage of married couples (58.6 %) and a higher percentage (37.4 %) of employed household members (Lee et al., 2014).

The “balanced budgeters” were relatively younger (average age of 72.4 years), and this group included more married people and more members with higher education degrees. They were the most ethnically diverse (17.7 % were nonwhite). The “happy retirees” had the second-highest percentage of white members (93.5 %), the highest percentage of married couples, (58.8 %), and the highest percentage of members (82 %) with more than a high school diploma. In other clusters, the proportion with more education than a high school diploma ranged from 31.4 % to 57.1 % (Lee et al., 2014).

The “housing burdened” had an average age of 74; they had the highest share of single households (53.0 %) and the highest share of mortgage payers. Nearly 78 % of the “housing burdened” were still paying on mortgages. This is compared to 23.4–33.6 % of the other clusters who were still paying on mortgages. The “basic-needs” had the highest share of Blacks (13.4 %) and the least educated members among all clusters. This group had the lowest percentage of married couples (40.3 %) and the highest percentage of people with living arrangements other than couples or singles (17.2 %) (Lee et al., 2014).

The “health care burdened” were the oldest with an average age of 77.1 years. They had the highest share of white members (94.5 %). They were less educated with 57.5 % having a high school diploma or less education. They had the highest percentage of homeowners (76.7 %) and the lowest percentage of households with employed members (20.2 %) (Lee et al., 2014).

In summary, the two relatively well-off groups were the “balanced budgeters” and the “happy retirees.” Together they represented only 11.7 % of all older households. Three groups: the “basic needs,” “housing burdened,” and “healthcare burdened” represented nearly 74 % of older households. These households could be experiencing

financial stress because of spending on food, utilities, healthcare, and housing. Finally, nearly 12 % of older households had heavy transportation expenses (Lee et al., 2014). See Chap. 3 for information about saving for retirement.

Housing and Reverse Mortgages

The population aged 65 and over in the USA has a high homeownership rate. In 2009, homeownership rates for householders aged 65 and over were as follows: white, 82.2 %; American Indian and Alaska Native, 82.7 %; Native Hawaiian and other Pacific Islander, 67.4 %; Black, 65.0 %; Asian, 63.5 %; and people who report two or more races, 73.0 %. Older households were less vulnerable to home foreclosures during and after the Great Recession of 2008 and 2009 (West et al., 2014).

A reverse mortgage is an interest-bearing loan secured by the equity in the home. Homeowners who want to use the equity in their homes can (1) sell their home and downsize, (2) take out a home equity loan, or (3) consider a reverse mortgage. To be eligible for a reverse mortgage, the individual must own the home and be 62 or older. During the life of the loan, homeowners make no interest or principal payments. The interest is added to the principal. The loan becomes due when the homeowner dies or sells the home or leaves the home for more than 12 months (for example, entering a nursing home) (Walsh, 2014a).

The federal government requires borrowers to meet with Housing and Urban Development (HUD) approved counselors before obtaining a federally guaranteed loan for a reverse mortgage. The homeowner should get advice from a trusted financial advisor who has no interest in either the mortgage or any investment that the homeowner might make after receiving any of the proceeds. Also, at the time of the sale, the homeowner could owe more than the amount that was borrowed because interest on the loan has been accruing and if home values have fallen, the homeowner might owe more than the home is worth. In addition, a reverse mortgage means that the homeowner is still responsible for property taxes, insurance, and home maintenance costs

(Walsh, 2014a, 2014b). For more information about financial protection available to consumers, see Chap. 25 on consumer financial protection.

Medicare

Many retirees will no longer be covered by their employer's health insurance. Although older adults aged 65 and over are likely to be eligible for Medicare, they need to make choices about Medicare options and to pay part of the cost of care. The various aspects of Medicare are explained in the following sections.

Medicare Parts A and B

Medicare is health insurance for people aged 65 or older, people under 65 with certain disabilities, and people of any age with permanent kidney failure requiring dialysis or a kidney transplant. Medicare has four parts: Part A (Hospital Insurance), Part B (Medical Insurance), Part C (Medicare Advantage), and Part D (Medicare Prescription Drug Coverage). The official US government handbook titled “Medicare & You 2015” explains the four parts of Medicare. To obtain a copy, a person should call 1-800-633-4227. The handbook can be downloaded from Medicare.gov/publications (Centers for Medicare & Medicaid Services, 2014).

The Medicare Initial Enrollment Period for Part A and/or Part B begins 3 months before a person's 65th birthday and concludes at the end of the third month after the 65th birthday (Votava, 2014). In most cases, coverage starts the first day of the person's birthday month. There is no premium for Medicare Part A. The Medicare Part B premium is \$104.90 a month. Beneficiaries with 2013 adjusted gross income (plus tax-exempt interest income) over \$85,000 — or \$170,000 if married filing jointly — will pay higher means-tested premiums. Means-tested rates range from \$146.90 to \$335.70 per person per month, depending on income. The Part B annual deductible for 2015 is \$147 (Centers for Medicare & Medicaid Services, 2014).

The Medicare Part A deductible—which people pay when admitted to a hospital—is \$1,260 in 2015. That deductible covers up to 60 days of Medicare-covered inpatient hospital care. For days 61 through 90 of hospital inpatient care in 2015, beneficiaries will pay \$315 a day in coinsurance. For hospital stays beyond 90 days, beneficiaries will pay \$608 a day in coinsurance (Centers for Medicare & Medicaid Services, 2014).

Medicare Part C

Medicare C is also known as the Medicare Advantage Plans. A Medicare Advantage Plan is another way to obtain Medicare coverage. If a person joins a Medicare Advantage Plan, he or she will still have Medicare. The person will get Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance) coverage from the Medicare Advantage Plan, not from Original Medicare. Medicare Advantage Plans are offered by private companies approved by Medicare (Centers for Medicare & Medicaid Services, 2014).

Medicare Advantage Plans must cover all of the services that Original Medicare covers except hospice care and some care in qualifying clinical research studies. Medicare Advantage Plans may offer extra coverage, like vision, hearing, dental, and health and wellness programs. In addition to a Part B premium, a person must pay a monthly premium for the Medicare Advantage Plan. Each Medicare Advantage Plan can charge different out-of-pocket costs and have different rules for how a person gets services (such as whether a person needs a referral to see a specialist) (Centers for Medicare & Medicaid Services, 2014).

There are different types of Medicare Advantage Plans. They include Health Maintenance Organization (HMO) plans, Preferred Provider Organization (PPO) plans, Private Fee-for-Service (PFS) plans, Special Needs Plans (SNPs), HMO Point-of-Service (HMOPOS) plans, and Medical Savings Account (MSA) plans. A person should contact his or her State Health Insurance Assistance Program (SHIP) for help comparing plans. Also, a person can visit

Medicare.gov or call 1-800-MEDICARE (1-800-633-4227). A person can only join or leave a plan at certain times during the year (Centers for Medicare & Medicaid Services, 2014).

Medicare Part D

Medicare D is also known as Prescription Drug Coverage. There are two ways to get Medicare Part D (prescription drug coverage). The first way is through a Medicare Prescription Drug Plan (sometimes called PDPs). These plans add drug coverage to Original Medicare, some Medicare Cost Plans, some Medicare Private Fee-for-Service plans, and Medical Savings Account plans. The second way to get Medicare Part D is through Medicare Advantage Plans (like an HMO or PPO) or other Medicare health plans that offer Medicare prescription drug coverage. A person must live in the service area of the Medicare drug plan that he or she wants to join (Centers for Medicare & Medicaid Services, 2014).

Between October 15 and December 7 of each year, anyone can join, switch, or drop a Medicare drug plan. The change will take effect on January 1 as long as the plan gets the person's request by December 7. Many drug plans have a yearly deductible. Also, the drug plan will probably have a copayment or coinsurance which the person will need to pay. Each prescription drug plan will have its own list of covered drugs (this is called a formulary). To obtain a current formulary, a person should contact the plan or visit the Medicare Plan Finder at Medicare.gov/find-a-plan or call 1-800-MEDICARE (1-800-633-4227) (Centers for Medicare & Medicaid Services, 2014).

Medicare Spending

Neuman, Cubanski, Huang, and Damico (2015) examined patterns of Medicare spending by age and type of service. As shown in Table 13.2, people aged 80 and over accounted for 24 % of the Medicare population and 33 % of Medicare spending. In 2011, Medicare per capita spending (not shown) peaked at age 83 for physician and

Table 13.2 Distribution of traditional medicare beneficiaries and medicare spending, 2011

Age	Share of beneficiaries (%)	Share of spending (%)
Under age 65	18	22
Age 65–69	26	15
Age 70–79	32	30
Age 80+	24	33

Source: Kaiser Family Foundation analysis of a 5 % sample of Medicare claims from the Chronic Conditions Warehouse, 2011. *Note:* Analysis excludes Beneficiaries with Medicare Advantage

outpatient services, at age 89 for inpatient care, at age 96 for home health care, at age 98 for skilled nursing facility, and at age 104 for hospice.

Medicaid

Medicaid is the nation’s main public health insurance program for people with low income and resources. It is a joint federal/state program in which states have some latitude in establishing eligibility and coverage. Medicaid provides health coverage to more than 4.6 million low-income seniors, nearly all of whom are also enrolled in Medicare. Medicaid also provides coverage to 3.7 million people with disabilities who are enrolled in Medicare. In total, 8.3 million people are “dually eligible” and enrolled in both Medicaid and Medicare, composing more than 17 % of all Medicaid enrollees. Individuals, who are enrolled in both Medicaid and Medicare, by federal statute, can be covered for both optional and mandatory categories (Medicaid.gov, n.d.).

Medicare enrollees who have limited income and resources may get help paying for their premiums and out-of-pocket medical expenses from Medicaid. Medicaid also covers additional services beyond those provided under Medicare, including nursing facility care beyond the 100-day limit or skilled nursing facility care that Medicare covers, prescription drugs, eyeglasses, and hearing aids. Services covered by both programs are first paid by Medicare with Medicaid filling in the difference up to the state’s payment limit (Medicaid.gov, n.d.).

Table 13.3 Medicaid enrollees and expenditures, FY 2011

Enrollees	Share of enrollees (68 Million) (%)	Share of expenditures (Total=\$397.6 Billion) (%)
Children	48	21
Adults	27	15
Disabled	15	42
Elderly	9	21

Source: KCNU/Urban Institute estimates based on data from FY 2011 MSIS and CMS-64. MSIS FY 2010 data were used for FL, KS, ME, MD, NM, NJ, TX, UT, OK but adjusted to 2011 spending levels

The Affordable Care Act (ACA) enacted on March 23, 2010, expanded the Medicaid program significantly as part of a broader plan to cover millions of uninsured Americans (Paradise, 2015). The ACA expanded Medicaid eligibility to nearly all non-elderly adults with income at or below 138 % of the federal poverty level (FPL). That amount is about \$16,245 for an individual in 2015. The law also provided for 100 % federal funding of the expansion through 2016, declining gradually to 90 % in 2020 and future years. However, the Supreme Court ruling in June 2012 made the Medicaid expansion optional for states.

States generally must provide Medicaid automatically to seniors and people with disabilities who receive Supplemental Security Income (SSI) benefits; the federal rate for SSI is 74 % FPL. Table 13.3 shows the share of enrollees in Medicaid and the share of expenditures used by each category of enrollees. For example, in 2011, the elderly were 9 % of the total enrollees in Medicaid and they accounted for 21 % of total expenditures for Medicaid (Paradise, 2015).

Long-Term Care

Only about 13 % of single individuals buy long-term care insurance; comparable data is not available for couples (Friedberg, Hou, Sun, & Webb, 2015). Research using data from the Health and Retirement Study (HRS) shows that only 44 % of men and 58 % of women will ever use long-term care. Conditional on using care, men and women will spend averages of 0.85 and 1.37 years, respectively, in long-term care. A survey showed

that when Medicare covers the first three months of care, only 19 % of men and 31 % of women have a positive willingness-to-pay for long-term care insurance compared with 22 % of men and 34 % of women when it is assumed that Medicare does not cover any costs. For more information about long-term care and long-term care insurance, see Chap. 22 on consumer financial issues in healthcare.

Internet Usage

Internet usage for the older population increased dramatically between 2000 and 2010. The percentage of the older population using the Internet rose from 14.3 % to 44.8 % between 2000 and 2010. Among the population that uses the Internet, the following usage by older adults in 2010 was sending or reading email, 89 %; online news, 62 %; online travel arrangements, 58 %; and online banking, 40 %. In comparison, among adults age 50–64 that used the Internet in 2010, their usage was email, 92 %; online news, 76 %; online travel arrangements, 70 %; and online banking, 58 % (Lee et al., 2014).

Financial Scams

Older adults are especially vulnerable to financial scams because they tend to be trusting and polite, they could be lonely and socially isolated, they might be vulnerable due to grief or loss, and they usually have regular income and some assets. Examples of financial scams are identity theft, lottery and sweepstakes scams, computer and Internet scams, and scams by telemarketers, mail offers, or door-to-door salespeople. Many older adults will not report financial scams because they are ashamed or embarrassed, they don't know where and how to report a financial problem or they fear retaliation from someone (DeVaney, 2014).

To minimize the risk of being scammed, a person: (1) should be aware of anyone who offers to handle their finances, (2) should secure their financial documents including checks,

financial statements, and credit cards, and (3) should not let others use their credit or debit cards. A popular practice by scammers is to use a designation to imply that they are an expert. An older adult could plan to meet regularly with a trusted advisor to discuss their financial matters (DeVaney, 2014).

To check on an investment, an individual can call the Security and Exchange Commission at 1-800-732-0330. To check on an investment advisor, an individual should call the FINRA at FINRA Broker Check: at 1-800-289-9999. To call a state regulator, use 1-202-737-0900. Also, an individual could contact the [Consumer Financial Protection Bureau](#) to obtain a copy of Money Smart for Older Adults at www.consumerfinance.gov Resources include [OnGuardOnline](#) (www.OnGuardOnline.gov, n. d.) to help guard against Internet fraud, and Senior Medicare Patrol. SMP will help Medicare and Medicaid beneficiaries to avoid, detect, and prevent health care fraud ([Senior Medicare Patrol](#), n.d.). For more information about how to obtain protection against scams, see Chap. 25 on consumer financial protection.

Conclusions

In some respects, older adults in the USA may be better off financially than people who are younger because adults aged 65 and over should have access to Medicare or Medicaid. Also, the majority of older adults should have access to Social Security retirement benefits which they have acquired through their employment history or through a spouse's employment history. However, older adults are more likely than younger adults to have chronic diseases or declining health. It is anticipated that the need for health care and health care services will increase as people age. Some economists suggest there will be a decline in the price of homes because aging adults may be likely to sell their homes in an attempt to downsize. After they sell their homes, it is anticipated that older adults will move to apartments and congregate housing instead of buying homes.

Suggestions for Future Research

A national survey in 2013 identified the top concerns of both pre-retirees and retirees (Society of Actuaries, 2014). The three top concerns were keeping up with inflation, paying for adequate health care, and paying for long-term care. Pre-retirees were more concerned than retirees about post-retirement risks. It could be helpful to follow up with a survey 3–5 years after pre-retirees have left the work force. By this time, pre-retirees will have enrolled in Medicare and probably many will be receiving Social Security retirement benefits. Questions about inflation could be included. For example, how has the individual been affected by inflation and what has he or she done to cope with inflation?

The analysis of the Consumer Expenditure Survey (Lee et al., 2014) revealed that 74 % of households aged 65 and over were in one of three ‘vulnerable’ clusters: health care-burdened, housing-burdened, or basic needs. It could be beneficial for policy makers if researchers studied how these households are coping with their financial constraints. A qualitative study using interviews or focus groups could reveal how older adults cope with the stress of health care and/or housing burdens or managing with only enough resources to meet basic needs.

Some policy makers would like to make changes in Social Security eligibility and benefits. One change is increasing the age for full retirement benefits. Currently it is 67. A second change that is mentioned would be to increase the age for early retirement. Currently it is 62. It would be interesting to survey Americans of different ages to learn how they feel about these potential changes. It is hypothesized that younger consumers would prefer to extend the age at which benefits are available and that older consumers would prefer to maintain the status quo.

Currently there is a lot of advertising for reverse mortgages. It would be helpful to survey pre-retirees to determine if they understand the risks associated with reverse mortgages. Also, it would be helpful if organizations such as AARP provided even more information about the propensity of scammers to prey on older adults.

Use of the Internet to obtain health care information is another topic for research. It would be interesting to interview medical practitioners to learn whether those who use the Internet to obtain health care information are more likely to make changes in their health-related behavior.

About the Author

Sharon A. DeVaney, Ph. D., is a Professor Emeritus, Purdue University, and Editor of the *Family and Consumer Sciences Research Journal*. Her research interests include financial preparation for retirement, consumer credit, and self-employment. She has received awards from the American Council on Consumer Interests (Mid-Career, Mentor, and Distinguished Fellow Awards), the Certified Financial Planner Board of Standards (3 Best Paper Awards), the Association of Financial Counseling and Planning Education (Educator of the Year and Best Paper Awards), and the American Association of Family and Consumer Sciences (Research Award). Her research was funded by AARP, USDA, National Endowment for Financial Education, and National Institute of Aging. She received the B.S. and M.S. from the South Dakota State University and the Ph.D. from The Ohio State University. She is a Fellow of the Association of Gerontology in Higher Education and a Distinguished Alumnus of the South Dakota State University, and was a New Leader at The Ohio State University.

References

- American Psychological Association. (2010). *Publication manual of the American Psychological Association* (6th ed.). Washington, DC: Author.
- Ando, A., & Modigliani, F. (1963). The life cycle hypothesis of saving: Aggregate implications and tests. *The American Economic Review*, 53(1), 55–84.
- Berkman, L. F., Boersch-Supan, A., & Avendano, M. (2015). Labor-force participation, policies & practices in an aging America: Adaptation essential for a healthy & resilient population. *Daedalus Journal of the American Academy of Arts & Sciences*, 144(2), 41–54. doi:10.1162/DAED_a_00329.
- Board of Governors of the Federal Reserve System. (2014). Report on the economic well-being of U.S. households in 2013. September, 1–100.

- Bricker, J., Dettling, L. J., Henriques, A., Hsu, J. W., Moore, K. B., Sabelhaus, J., et al. (2014). Changes in U.S. family finances from 2010 to 2013: Evidence from the Survey of Consumer Finances. *Federal Reserve Bulletin*, 100(4), 1–41. Retrieved from <http://www.federalreserve.gov/pubs/bulletin/2014/pdf/scf14.pdf>
- Carroll, C. D. (1997). Buffer stock saving and the life cycle/permanent income hypothesis. *Quarterly Journal of Economics*, 112(1), 1–55.
- Centers for Medicare and Medicaid Services. (2014). *Medicare & You 2015*. Baltimore, MD: U.S. Department of Health and Human Services.
- Clark, R. L., Burkhauser, R. V., Moon, M., Quinn, J. F., & Smeeding, T. M. (2004). *The economics of an aging society*. Malden, MA: Blackwell Publishing.
- Consumer Financial Protection Bureau. (2014). Money Smart for Older Adults. http://files.consumerfinance.gov/f/201306_cfpb_msoa-participant-guide.pdf
- Deaton, A. (1992). *Understanding consumption*. Oxford: Oxford University Press.
- DeNavas-Walt, C., & Proctor, B. D. (2014). *Income and Poverty in the United States; 2013, Current Population Reports*, Issued September 2013, P60-249. U.S. Census Bureau. Retrieved from <http://www.census.gov/content/dam/Census/library/publications/2014/demo/p60-249.pdf>
- DeVaney, S. A., (2014). Financial scams. *The Affiliate*. Military Officers' Association of America. Online. Retrieved from www.moaa.org
- Friedberg, L., Hou, W., Sun, W., & Webb, A. (2015). *Long-term care: How big a risk?* Center for Retirement Research at Boston College, November, Number 14–18
- Friedman, M. (1957). *A theory of the consumption function*. Princeton, NJ: Princeton University Press.
- Health, United States, 2013. (2014). Retrieved from <http://www.cdc.gov/nchs/data/abus/abus13.pdf#016>
- Lee, S., Sohn, S.-H., Rhee, E., Lee, Y. G., & Zan, H. (2014). Consumption patterns and economic status of older households in the United States. *Monthly Labor Review*, 100(5), 1–13.
- Leonesio, M. L., Bridges, B., Gesumaria, R., & Del Bene, L. (2012). The increasing labor force participation of older workers and its effect on the income of the aged. *Social Security Bulletin*, 72(1), 59–77.
- Medicaid.gov. (n.d.). Retrieved from <http://www.medicaid.gov>
- Medicare Plan Finder. Retrieved from <http://Medicare.gov/find-a-plan>
- Medicare. (n.d.). Retrieved from <http://medicare.gov/publications>
- Neuman, T., Cubanski, J., Huang, J., & Damico, A. (2015). *The rising cost of living longer: Analysis of Medicare spending by age for beneficiaries in traditional Medicare*. Menlo Park, CA: The Henry J. Kaiser Family Foundation. January 14
- OnGuardOnline. Retrieved <http://www.OnGuardOnline.gov>
- Paradise, J. (2015). *Medicaid moving forward* (Issue Brief). Menlo Park, CA: The Henry J. Kaiser Family Foundation. March 9
- Senior Medicare Patrol. Retrieved <http://www.smp-source.org>
- Society of Actuaries. (2014). *2013 Risks and Process of Retirement Survey Report*. Retrieved from <http://www.soa.org> <http://sss.soa.org>
- Vornovitsky, M., Gottschalck, A., & Smith, A. (2014a). Distribution of household wealth in the U.S.: 2000 to 2011. *U.S. Census Bureau*. Retrieved from <http://www.census.gov/people/wealth/files/Wealth%20Distribution%202000to%2020.pdf>
- Vornovitsky, M., Gottschalck, A., & Smith, A. (2014b). Household debt in the U.S.: 2000 to 2011. *U.S. Census Bureau*. Retrieved from <http://www.census.gov/people/wealth/files/Debt%20Highlights%202011.pdf>
- Votava, K. (2014). Understanding Medicare enrollment periods. *Journal of Financial Planning*, 27(8), 20–22.
- Walsh, G. (2014a). Don't rush into a reverse mortgage. *Better Investing*, September, 13–14.
- Walsh, G. (2014b). Reverse mortgages: Questions to ask. *Better Investing*, October, 11–12.
- West, L. A., Cole, S., Goodkind, D., & He, W. (2014). 65+ in the United States: 2010. *U.S. Census Bureau*. Retrieved from <http://www.census.gov>
- White House Conference on Aging. (2015). Retrieved from <http://whitehouseconferenceonaging.gov/blog/policy/file.axd?files/HealthyAging>
- Xiao, J. J., Chen, C., & Sun, L. (2015). Age differences in consumer financial capability. *International Journal of Consumer Studies*, 39(4), 387–395.