Beyond the Nest Egg

A Retirement Guide to Everything the Money Talk Leaves Out

2026 Edition

Helping America's Seniors
RESOURCES FOR YOUR NEXT CHAPTER

WHY WE WROTE THIS

At Helping America's Seniors, our mission is to be your dependable, neighborly guide to health, wealth, safety, and vibrant living after 55. When most people think about retirement, they think about money — how much is in the 401(k), when to claim Social Security, whether the savings will last. Those questions matter, and there is no shortage of books, websites, and advisors ready to answer them. Far fewer guides talk about everything else that shapes these years: where you'll live and whether your home still fits you, how your insurance needs change, how to protect your vision, hearing, and mental health, and which legal and medical decisions are worth making before you have to. That gap is the reason for this guide, and it is where the title comes from — the most important parts of this chapter of life lie beyond the nest egg. The concept of this guidebook is to compile all of that essential information into one convenient location while keeping it simple and easy to read. The simplicity of all this information will in turn allow you to start thinking about the steps needed to achieve a comfortable, well-rounded retirement — not just a financially secure one.

Based on all the information that we uncovered, the idea naturally unfolded to make a guide that was easy to follow and that simplified everything for anyone who was interested. The Helping America's Seniors editorial team reviewed all of the details and organized them into a helpful resource for retirement planning.

Our number one goal at Helping America's Seniors is to provide insight.

This insight bridges the gap between what you want to do and how you are going to get there. All we did was organize this information into a single resource to provide insight and assistance so you can accomplish your goals. This information is to be used as a helpful guide, which encompasses both the idea of "did you start thinking about planning for your retirement?" with "here are some additional concepts you didn't include in your retirement plan." The added bonus is that Helping America's Seniors offers this guide free for you, the same way we share our trusted guides with more than 50,000 seniors nationwide.

About this edition. This is a revised edition from Helping America's Seniors. Every dollar figure, statistic, program rule, and clinical guideline in the original 2021 guide was re-checked against the most recent published source available as of July 2026 and updated where it had changed. Where a rule or recommendation has changed substantially since the first edition — Medicare's prescription drug cap, the colorectal cancer screening age, Alzheimer's treatments, over-the-counter hearing aids — the change is noted in the text so you can see what is new. A complete list of what was updated appears in the Appendix at the end of the book.

A note on numbers. Costs, premiums, tax rules, and screening guidelines change every year, and many vary considerably by state. Treat the figures here as a starting point for your own planning rather than a quote. Verify anything you intend to act on with the relevant agency, a licensed professional, or a local provider.

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FORWARD

As baby boomers move through retirement age, they face many more decisions about their "golden years" than previous generations did. While most people think about the financial aspects of retirement and others address the where-to-retire question, few tick all the planning boxes. Even if they don't plan on retiring, boomers need to think about changes in their insurance needs, health care management, and housing. Addressing it all can be overwhelming, especially if you are also responsible for aging parents or other family members. While a lot of information is available on various websites, this book brings it all together in one convenient format.

The timing matters more now than it did five years ago. The United States is in the middle of what demographers have nicknamed "Peak 65" — the largest wave of Americans ever to reach age 65 in a single stretch, running through the second half of this decade. Every member of the baby boom generation will be 65 or older by 2030.

INTRODUCTION

Anyone born between 1946 and 1964 is part of the baby boomer generation. Most older boomers have already retired, and even the youngest members are past 60. No matter where they are in the process and whether they plan on retiring or not, they need to make decisions and plans to ensure their 60s, 70s, 80s, and beyond are easier and happier. Planning well also puts less stress on the next generation.

That next generation is closer to this material than it may realize. The oldest members of Generation X turn 61 in 2026 and the oldest Millennials turn 45 — which is why this guide is written for anyone thinking about retirement, at any age. Several of the screening recommendations in Section 3 now begin at 40 or 45, not 50.

Most people understand they need to plan financially for the years after they stop working. Social Security, retirement funds, IRAs, whole life insurance, and other investments are important, but there's more to consider. Where to live, what changes to make in the home, how insurance policies should change, and how to best manage health and health support are all parts of transitioning smoothly into retirement.

People presently in their 50s, 60s, or 70s may currently be involved in caring for members of the previous generation. Having parents, aunts, uncles, or possibly grandparents in assisted living or nursing homes is stressful, especially if there are financial pressures. When a loved one dies, dealing with the aftermath of losing someone can be especially challenging if that someone's affairs weren't well managed. Many boomers come to realize during the process that their own plans could use some attention so that their children, nieces, or nephews have it a bit easier than they did.

If that describes you, you are far from alone. A joint study by AARP and the National Alliance for Caregiving released in 2025 found that **63 million Americans — nearly one in four adults — provided ongoing care for an adult or a child with a complex medical condition or disability in the past year.** That is an increase of 20 million people over ten years. Nearly one in four of those caregivers provides 40 or more hours of care a week, and nearly one in three is simultaneously raising children under 18.

SECTION 1. WHERE WILL I LIVE?

One of the big decisions everyone must make when they get older is where to live after retirement. Some people have dreamed of moving to the beach or the desert or know they want to live in a 55-plus senior community. Others assume they will live where they have always lived. There are a lot of factors to consider when deciding whether to stay or move. Where to live can depend mainly on finances for some, but retirees also consider climate, hobbies, family and friends, work opportunities, healthcare availability, physical limitations, and community services.

Retirement studies consistently find that a substantial minority of retirees relocate, and Census Bureau data show that **nearly one million Americans aged 60 and over crossed state lines in a single recent year** — among the highest totals on record. The most commonly cited reasons for choosing a destination are closeness to family and friends, cost of living, healthcare access, comfortable climate, and low crime rates.

What has changed since the first edition of this guide is *where* people are going and *why*. Warm-weather destinations still lead, but affordability has become the dominant factor. Analyses of 2025 relocation data found that **South Carolina, Texas, and North Carolina posted the largest net gains of retirement-age movers**, while Florida — still the single largest destination by raw numbers — now sees nearly as many people 65 and older leave each year as arrive, largely because of home prices, property insurance costs, and congestion. **Las Vegas was the single most popular city destination for retirement-age movers in 2025**, followed by other Southwestern cities such as Tucson, Phoenix, and Mesa. California and New York continue to see the largest outflows.

Common reasons seniors relocate: cost of living · proximity to family and friends · weather and climate · healthcare and hospital access · crime rates · taxes

CHAPTER ONE: WHAT FACTORS TO CONSIDER WHEN RELOCATING

Many people think a lot about where they want to retire. People who hate the cold can't wait to move to a warmer climate, and someone tired of city life might look for a small town or country living. If a retiree's children live in another state, moving there might be the plan. Whether they've decided on a target location or not, there are some things they should consider before moving.

It's important to include your interests and hobbies in the thought process. That includes spending time with family and friends. Making sure the finances work by looking at the cost of living in the new state is vital. Consider the climate. Will someone who loves four seasons be miserable in Florida? Traditionally, retirees buy smaller houses because they need less space, but a meaningful share of boomers upsize rather than downsize — surveys of pre-retirees over the past several years have consistently found roughly one in five planning a *larger* home rather than a smaller one, a shift that began during the pandemic when spare rooms became offices, gyms, and guest quarters. Beyond all that, there are retirement communities to consider.

One more caution worth naming: relocation is not always permanent. Studies of higher-income movers have found that **roughly half relocate again within five years.** Renting in a new area for a season before buying is one of the cheapest forms of insurance available.

PERSONAL INTEREST

What do you like to do, and what resources do you need?

How someone will spend their time in retirement can make a difference when deciding where to live. Seniors often go back to school to study whatever interests them — languages, art history, photography — so having a college nearby is important. Colleges also offer concerts and sports teams to watch and follow. Skiers shouldn't be far from the slopes, and yoga enthusiasts need access to studios. Artists might like an artist's community and want there to be galleries or museums. Boaters need water, and so do those who fish. Foodies need restaurants and gourmet grocery stores. If you're going to work, are there jobs you would like? Volunteer opportunities? Do you want to be close to, or within easy traveling distance of, family? Some like to travel and only want a small home base somewhere. There's a lot to think about before deciding.

CLIMATE

Do you want year-round warm weather or all four seasons?

Living where it's warm year-round appeals to many older Americans, and the Sun Belt still dominates senior migration. Florida, Texas, Arizona, South Carolina, Georgia, Nevada, and North Carolina consistently rank among the top destinations for movers 60 and older.

Two things have changed since the last edition and deserve weight in the decision:

Climate risk is now a cost-of-living issue. Property insurance in hurricane- and wildfire-exposed states has risen faster than almost any other household expense. Florida is now the most expensive state in the country for homeowners insurance, with average annual premiums in the thousands of dollars, and more than twenty insurers have stopped writing new policies there or exited the market entirely. Louisiana and California face similar pressures. If you are considering a coastal or wildfire-prone area, get an actual homeowners insurance quote for the specific address *before* you make an offer, not after.

Temperate states are gaining. Retirees who want four seasons without harsh winters continue to look at Delaware, North Carolina, Tennessee, and South Carolina. Idaho and other Mountain West states attract retirees more for cost-of-living reasons than for weather.

If moderate weather year-round is the priority, the traditional short list of American cities with the fewest days above 90°F and below 32°F still holds up: Santa Maria and San Diego, California; Hilo, Hawaii; Miami and Vero Beach, Florida; Cape Hatteras, North Carolina; and Wallops Island, Virginia.

ECONOMICS & SERVICES

What's the cost of living, and what services are provided?

People planning to retire know their income when they stop working, but the other half of the equation is how much it will cost to live. Some expenditures will go down because you're not working, but consider the local cost of living when deciding on a retirement location. It differs from state to state and community to community. A cost-of-living statistic encompasses utilities, taxes, rent, food, transportation, government services, and health care. Because you might eventually need them, it's important to also look at assisted living facility and nursing home costs in the area (see Chapter 4 for current national figures).

The Missouri Economic Research and Information Center publishes a free quarterly Cost of Living Data Series that indexes all fifty states against a national average of 100 and breaks the number down by grocery, housing, utilities, transportation, health, and miscellaneous costs. It remains the simplest apples-to-apples state comparison available, and it is updated four times a year — worth checking directly rather than relying on any figure printed in a book.

TAXES

Understanding the impact of state and local taxes takes some study. Some states have no sales tax, for example. The same jurisdictions could have high property taxes. The total tax picture can be complicated. It's a balancing act, and cost-of-living statistical comparisons by state can be helpful.

This is one of the areas that has changed the most since the first edition of this guide. In 2021, thirteen states taxed Social Security benefits. **As of the 2026 tax year, only eight do: Colorado, Connecticut, Minnesota, Montana, New Mexico, Rhode Island, Utah, and Vermont.** West Virginia completed its phase-out effective January 1, 2026, and Nebraska and Missouri eliminated theirs shortly before that. Even in the eight remaining states, income

thresholds and exemptions shelter most lower- and middle-income retirees — the practical question is usually not "does my state tax benefits?" but "is my income low enough to be exempt?"

Nine states levy no broad personal income tax at all: Alaska, Florida, Nevada, New Hampshire, South Dakota, Tennessee, Texas, Washington, and Wyoming.

A new federal deduction for people 65 and older. The One Big Beautiful Bill Act, signed in July 2025, created a temporary "senior bonus" deduction of **up to $6,000 per person age 65 or older ($12,000 for a qualifying married couple), available for tax years 2025 through 2028.** It can be claimed whether you itemize or take the standard deduction, and it stacks on top of the existing additional standard deduction for older filers. The deduction begins phasing out at $75,000 of modified adjusted gross income for single filers and $150,000 for joint filers, and disappears entirely above $175,000 and $250,000 respectively. Married couples must file jointly to qualify. Because it expires after 2028, it creates a four-year window in which managing your taxable income — the timing of IRA withdrawals, Roth conversions, or capital gains — can be worth real money. This is a good conversation to have with a tax professional rather than to improvise.

SERVICES

Once you narrow your search to a state, you might want to zero in on local communities and their services. When you can no longer drive, is there free or inexpensive senior transportation available? Are there active senior centers and affordable adult day programs? A senior center with workout rooms, free classes, low-cost trips, and free or inexpensive meals can make a huge difference. Search senior services for the area you are considering to see what's available. The federal Eldercare Locator (eldercare.acl.gov, 1-800-677-1116) will connect you to the Area Agency on Aging for any ZIP code in the country, which is the fastest way to find out what a given community actually offers.

It's a bit overwhelming, but fortunately you won't have to do the statistics work yourself. Many studies have been done and the results published.

DOWNSIZING VS. UPSIZING

Traditionally, retired, empty-nested older Americans downsize. They need less room and want less house to maintain. When you sell a larger home with substantial equity, perhaps in a more affluent area, the sale may allow you to purchase a smaller home outright. If not, you likely will have a lower mortgage payment. Property taxes will be less unless you move to a city with higher property taxes. Utility bills and maintenance costs should also be lower. If you plan to travel, a smaller home base has advantages. You probably have more money to spend on travel, and closing up a smaller place for extended periods is certainly easier.

One caution the last few years have added: downsizing does not always reduce your housing payment as much as the math suggests. Retirees who sold a home carrying a 3% mortgage and bought a smaller one at 6–7% have sometimes found their monthly cost went *up* despite buying less house. Run the actual numbers at current rates before assuming smaller means cheaper.

Some boomers upsize instead, especially if they retire early. With more free time, they want to entertain and enjoy the extras a larger home allows. Houses with guest accommodations mean you can have lots of out-of-town visitors, too — and a spare suite is also what you will need if you ever require live-in help.

Whether you upsize or downsize, make your home retirement-ready. Read the next chapter for the steps that make a home more energy-efficient, easier to maintain, and safer.

RETIREMENT COMMUNITIES

Housing specifically designed for older Americans falls into four categories: active communities (or independent living), assisted living, nursing homes, and memory care facilities. Housing communities for the 55-plus or 62-plus demographic often stand alone and are usually traditional housing styles with community facilities for recreation. When living alone becomes difficult, people often move to assisted living communities to maintain as much independence as possible without compromising safety. Nursing homes are for people who need daily nursing care due to medical conditions, and memory care facilities provide safe housing for those with Alzheimer's and other dementias. Many companies offer all these levels of supported housing so you can move within the community as you need to.

COSTS

Living in a retirement community often costs more than living in an average house or condominium. For the extra money, you usually get lots of perks and services. There's usually a community center with classes and activities, a gym, a pool, maybe golf, tennis courts, and walking trails. You also live among people your age, which makes socializing easy and fun. You may get extra security and outside property maintenance, too. If you anticipate using many of these amenities, a 55-plus or 62-plus community might be a good choice.

Independent living communities are sometimes different from other retirement places. There may be more services, like meals in a dining room and a clinic or health room. Sometimes these are part of a continuing care community that offers assisted living and nursing care options when you need them. Continuing care retirement communities frequently require a substantial entrance fee in addition to monthly charges; ask specifically what portion is refundable and under what conditions.

As you progress from an independent living arrangement to assisted living and then a nursing home, costs increase sharply. **As of the 2025 CareScout (Genworth) Cost of Care Survey, the national median cost of an assisted living community is $6,200 per month, or $74,400 a year. A semi-private nursing home room runs $315 per day — $114,975 a year — and a private room $355 per day, or $129,575 a year.** Costs vary substantially from state to state and region to region. If you have long-term care insurance that will cover a lot of it, the expense is less problematic.

For more information on what assisted living and nursing home care will cost, see Chapter 4, Long-Term Care Insurance.

ADVANTAGES

The advantages of living in a continuing care community with all support stages include less worry and reduced work for you and your loved ones. While you're still independent, you can enjoy life and not be burdened with home maintenance. Your space is usually small and easier to keep. You typically have the option for community dining, and you probably can use community transportation for shopping and getting to the doctor. There are others around to socialize with and support you. If you should develop mobility problems or cognitive limitations, moving to assisted living is easy within the community. If illness or injury causes a need for daily nursing, you can temporarily move to that level of care and move back to assisted living if and when you are ready. Communities usually also have a nursing facility specifically for those with memory loss. Once you're in a continuing care facility, you'll never have to worry about maintaining or selling a home, moving, or being isolated.

CHAPTER 2: STAYING IN YOUR HOME

If you're happy in your home, love your community, and want to remain close to family and friends, staying in your home may be your choice. If so, getting your home ready for stress-free, easy maintenance and safe living should be in your plans. You and your spouse may currently be able to climb into the attic, clean gutters, and do all the landscape maintenance, but it won't always be so. Getting into and out of a bathtub could eventually become more difficult. To reduce financial stress, improving your home's energy efficiency can help lower utility bills. Your home as a financial asset can also provide income through its equity.

The desire to stay put is nearly universal — surveys consistently find that around three-quarters of adults over 50 want to remain in their current home as long as possible. The gap is between wanting it and being ready for it. A national poll of adults aged 50 to 80 found that while 80% believed their home had the features needed to support aging in place, **fewer than one in five had a wheelchair-accessible home and fewer than half had other common safety and accessibility features** such as grab bars, a main-floor bathroom, or non-slip flooring. Most of the fixes are inexpensive and most people simply haven't gotten to them.

HOME IMPROVEMENTS

If there are any major repairs like a new roof needed on your home, do them now. Beyond that, you can make changes and improvements to make life simpler, less expensive, and safer.

SIMPLIFY

Start with simplifying and decluttering your home. You've collected a lot over the years that you no longer need. Making decisions about what to keep and what to let go of can be difficult, but setting parameters helps. For clothing, experts say discard anything not worn in a year. After retirement, pare your wardrobe down to what you will actually wear. Reduce the number of knick-knacks on shelves so dusting isn't a chore. Keep what you love and sell, donate, or gift the rest. To make some extra cash, try selling online — an eBay account for books and collectibles, or Poshmark for designer clothes, is simple to set up, and local marketplace apps handle furniture better than either. If you intend to hand down your third set of china or an antique picture frame to your daughter, do it now. Keep books you want to reread and let the rest go. You might be surprised to find you have some valuable volumes. The fewer things you have to care for and clean around, the more time you will have to enjoy retirement.

EASY-MAINTENANCE LANDSCAPE & HARDSCAPE

Suppose you love to garden — great. But don't saddle yourself with more landscaping than you want to manage, and anticipate a time when you will only want to maintain your flower beds or vegetable patch. Add large garden beds and hardscaping to reduce the amount of grass you need to cut. Even if you are not ready to plant right away, adding large garden beds and covering them with mulch will reduce the lawn size. The mulch will turn into good soil you can later use for plants. Add low-maintenance plants and consider a rock garden. Choose hardy,

low-maintenance plants appropriate to your region and add garden sheeting, mulch, or stones to keep from having to weed.

Adding hardscaping like patios and walkways also cuts down on lawn you need to cut. Consider expanding your paved driveway. If you plan to entertain more, the extra driveway and patio space could be great. Grass lawns need regular watering, cutting, and chemical treatments, but some grass alternatives need less work. Clover, for example, helps keep weeds and insects out and needs mowing less often. Fescue is still grass but is drought resistant and needs cutting less frequently. Consider installing in-ground irrigation, too. When you redo walkways, make them wide, level, and well lit — the most expensive thing that happens in a poorly designed yard is a fall.

SIDING

Experts recommend painting a house's siding every five to ten years, depending on the paint's durability and your climate. For wood siding, staining should be done every three to seven years. Doing the painting or staining yourself will be more difficult and dangerous as you age, and paying someone will be expensive. By replacing your present siding with low-maintenance alternatives, you will save money and labor over the long run. Materials range from vinyl at the low end through aluminum, engineered wood, fiber cement, and stone veneer at the high end. Vinyl is the least expensive and usually needs only an annual rinse; fiber cement and high-end woods cost the most but last longest.

Installed siding prices have risen substantially in recent years and vary widely by region, material, house size, and how much prep work the job requires, so any per-square-foot figure printed in a book will be wrong by the time you read it. Get three written quotes for your specific house. Many low-maintenance sidings also improve energy efficiency, which may partially offset the cost. If you love your home's look and don't want to make a change, budget to hire someone to paint or stain the siding when it's needed.

GUTTER COVERS

You've seen the commercials about the dangers of standing on ladders to clean gutters. The older you get, the more difficult and dangerous climbing ladders will be. Adding covers to your rain gutters is relatively inexpensive, saves you from ladders, and prevents siding and foundation damage caused by clogged gutters.

INSULATION

When was the last time you inspected the insulation in your home? You might consider bringing in an expert to evaluate your home's energy efficiency. They measure airflow to see where your home is vulnerable to heat loss. Not only will you learn about insulation needs, but you'll know how well windows and doors prevent heat loss. Cellulose and fiberglass insulation breaks down over time and becomes less efficient. Perhaps you don't have insulation everywhere you should. Caulking around windows and doors could need replacing, too.

Besides reducing energy costs, good insulation improves indoor air quality. Some foam insulation types can prevent water and pests from getting in and even strengthen the structure itself. You may eventually want to sell your house, and buyers look for well-insulated homes. No one wants to inherit high utility bills.

On tax credits: federal energy-efficiency incentives for homeowners have changed repeatedly in recent years, and several of the credits available when the first edition of this guide was published have since been modified or allowed to expire. Before budgeting a project around a tax credit, confirm what is currently available at energystar.gov and irs.gov, and check your state and utility programs — utility rebates for insulation, heat pumps, and windows are often more generous and more reliable than federal credits.

The ENERGY STAR insulation climate zone map, which shows recommended attic and wall R-values for each region of the country, is available free at energystar.gov and is the right starting point for figuring out what your house should have.

WINDOWS

Old drafty wooden windows need to be painted regularly, as often as the house is painted. You also need a ladder to wash the outside glass. If you struggle now to open stubborn sashes, it won't get easier over time. To improve energy efficiency and ease of use and cleaning, consider replacing your windows. Replacing old windows with modern double-hung styles means you can easily clean windows inside and out while standing inside your home — these windows unlatch and tilt inward so you can wash the outside pane. Even if you don't want double-hung windows, windows made from vinyl, aluminum, or fiberglass don't require painting and save money on your energy bills.

DOORS

New, energy-efficient, high-security doors could lower your utility bills and make you more secure in your home. A common type of exterior door has a steel skin and a core made of polyurethane foam. A magnetic strip at its bottom prevents air leaks, so you won't need weather stripping. These are much better at insulating than wooden doors. Old, leaky glass patio doors should be replaced with models with thermal breaks, which are plastic insulators between an inner and outer glass layer. The more layers of glass in the door, the better. Weatherstripping should be replaced regularly, too. While you're at it: lever handles are far easier than round knobs for arthritic hands, and they cost the same.

GUEST ACCOMMODATIONS AND ENTERTAINMENT SPACE

Adding more hardscape for outdoor entertaining cuts lawn maintenance and encourages you to bring in friends and family. Once you've decluttered, you may have a room or two you can set up for guests. If you have children or other family members who visit from out of town, you might consider finishing off a garage for guests or adding a room and bath to your home. In addition to providing guest space, if you ever need someone to move in with you full time, you'll be all set. Many states and municipalities have relaxed rules on accessory dwelling units in

recent years, which may make a garage conversion or backyard cottage more feasible than it was a few years ago — check your local zoning before you plan.

THE CREDIT FOR CARING ACT — STILL A BILL, NOT A LAW

If you decide to stay in your home and a family member cares for you when you need it, they may eventually be eligible for a federal tax credit — but not yet.

The Credit for Caring Act, which the first edition of this guide described in its 2021 form, has been reintroduced in Congress repeatedly since. **The current version is the Credit for Caring Act of 2025 (H.R. 2036 and a Senate companion), introduced in March 2025 by a bipartisan group of legislators.** It would create a **nonrefundable federal tax credit equal to 30% of qualified caregiving expenses above $2,000, capped at $5,000 per year and indexed for inflation.** It has broad bipartisan support and backing from AARP and more than a hundred other organizations, but as of mid-2026 it has not been enacted. Do not plan around it.

What is real today: AARP and the National Alliance for Caregiving estimate that **63 million Americans are family caregivers**, and that the average family caregiver spends **more than $7,200 a year out of pocket** — roughly 26% of their income — on caregiving costs. Sixty-one percent of family caregivers also work full or part time. Several states have enacted their own caregiver tax credits or paid family leave programs; check what your state offers.

MAKE A HOME COMFORTABLE AND SAFE

Falls are the single largest preventable threat to independence in later life, and most of the fixes below cost less than a nice dinner out.

BEDROOM

If you presently have your bedroom upstairs, consider moving to the main floor or adding a main-floor primary bedroom suite. If this isn't possible, you may have to add a stairlift later. Make sure there is a light switch reachable from the bed and a clear, unobstructed path from the bed to the bathroom; a motion-activated night light in that path is one of the cheapest safety improvements available.

BATHROOM

You may be perfectly comfortable getting in and out of your bathtub right now, but adding grab bars to prevent falls should be done sooner rather than later. If you don't need them yet, your spouse or a house guest may. Install them into studs or with proper anchors — a towel bar is not a grab bar. Add a no-slip surface to your tub if you haven't already. Walk-in tubs and curbless showers will allow you to stay in your home longer. Many walk-in tub styles include whirlpool jets, which will ease your muscles after a hike, fun run, or day of gardening. A handheld shower head and a shower seat are inexpensive and useful long before they are necessary.

If you regularly need a step stool to reach things in the linen closet or medicine cabinet, you may want to lower the cabinet and clean out the linen closet so you only use the lower shelves. Use the upper shelves for things you rarely need, so you can ask someone to spot you on the step ladder or ask someone less vulnerable to get them down.

KITCHEN

Just as in the bathroom, be aware of how often you need a step stool to get something you need. Lower cabinets or clean out and arrange your kitchen so you can get what you need more easily. Use upper cabinets for things you only use for holidays, when someone else is there to climb up and get them. If nonperishable foods are stored high, add a freestanding pantry so everything is accessible. Bending to get pots and pans out of low cabinets can be avoided if you hang your pots above your head within easy reach. Consider lazy-susan shelf inserts and pull-out drawers so you don't need to reach as often. Under-cabinet lighting makes a bigger difference to safe food prep than most people expect.

STORAGE

Do you climb a ladder or pull-down stairs to get into your attic? Climbing ladders and hoisting yourself into the attic will become a problem, and severe temperatures in your summer or winter attic may also be dangerous as you get a bit older.

Sort through your attic, discard or give away what you don't need, and relocate stored items you regularly use. Repurpose a spare room, finish a basement space, or use the garage for seasonal clothing, summer fans, and holiday decorations so you don't need to climb into the attic. Self-storage units don't cost much and might be an alternative, too. If your basement is difficult to access or damp and unhealthy, bring in an expert to improve conditions or store your things elsewhere.

ORGANIZATION

In addition to decluttering and simplifying your home, give some thought to how your belongings are organized. If you have clothes stored all over the house and craft supplies spread across kitchen drawers and work-shed shelves, get organized. If you don't have time before retirement, make organization a priority once you do. Hopefully your memory will stay sharp and you'll remember where you left your leather jacket, pinking shears, or Phillips-head screwdriver — but don't count on it. Establish a place for everything and put everything in its place. Your older, more forgetful self will thank you.

Working to make your home safer, more energy-efficient, and easier to maintain will allow you to stay in your home longer. Your life will be easier and less stressful, and you'll save some money on utility bills. Your home will also be worth more upon resale.

SECTION 2. HOW WILL MY INSURANCE NEEDS CHANGE?

Everyone knows that at age 65 you are eligible for Medicare, but Medicare decisions are more complex than people realize. Are you required to enroll? What if you're still working? What about all the commercials promising extra benefits? In addition to changes in your healthcare insurance, other insurance types — auto, life, homeowners, and mortgage insurance — often change as you age.

This section has changed more than any other since the first edition of this guide, because Medicare itself changed. The Inflation Reduction Act of 2022 rewrote the prescription drug benefit, eliminating the coverage gap and adding a hard annual cap on what beneficiaries pay out of pocket for drugs. Those provisions took full effect in 2025 and continue in 2026. If your understanding of Part D is more than a couple of years old, read Chapter 3 carefully.

CHAPTER 3: MEDICARE & SUPPLEMENTAL INSURANCE

HISTORY

While discussions about a national health insurance program started in Teddy Roosevelt's day, Harry S. Truman was the first to try to create one. His plan to offer basic insurance to all Americans failed, and the idea wasn't seriously considered again until John F. Kennedy's presidency. Kennedy proposed insurance for Americans 65 and older who were not otherwise covered. Legislation to establish Medicare was finally approved under Lyndon B. Johnson in 1965.

Medicare now covers roughly 69 million Americans, of whom about 64 million are enrolled in both Part A and Part B. The program has more than doubled in size since 1990 and grew by roughly eight million people in the five years after the first edition of this guide was written.

The other headline number: **more than half of eligible Medicare beneficiaries — about 35 million people, or 55% — are now enrolled in a Medicare Advantage plan rather than Original Medicare.** That share was 19% in 2007 and 42% in 2021. The Congressional Budget Office projects it will reach about 63% by the mid-2030s. Medicare Advantage is no longer the alternative; for most new enrollees it is the default choice they are comparing against.

BASIC MEDICARE

Medicare is health insurance provided by the United States federal government for citizens who are 65 or older, and for certain younger people with disabilities or end-stage renal disease. The basics, which include Part A and Part B, pay part of the cost for most medical services and supplies. Part A covers hospital stays; Part B pays for doctor visits, tests, and supplies. You pay a deductible every year, and then Medicare pays 80% of covered hospital and medical expenses. Some services, like an annual wellness visit, are paid for in full. Like any insurance plan, Medicare sets maximum fees for services, so you pay 20% of what Medicare allows a doctor to charge. You can choose any doctor who accepts Medicare (most do), and typically you don't need a referral to see a specialist.

Two things Original Medicare does *not* do, and that surprise people every year:

- **It does not cap your out-of-pocket costs.** There is no annual maximum on the 20% coinsurance under Parts A and B. This is the single biggest argument for either a Medigap policy or a Medicare Advantage plan, all of which do cap in-network out-of-pocket spending.
- **It does not cover prescriptions.** Parts A and B don't cover most outpatient drugs. You add Part D for prescription coverage, and Medigap or Medicare Supplement plans to cover expenses not paid by Medicare.

COSTS FOR MEDICARE PARTS A & B — 2026 FIGURES

Most people get hospital coverage, Part A, at no premium; about 99% of beneficiaries qualify because they or a spouse paid Medicare taxes for at least 40 quarters. If you don't qualify, the 2026 Part A premium is **$311 per month** with 30–39 quarters of work history and **$565 per month** with fewer than 30.

Item	2021	2026
Standard Part B premium	$148.50/month	**$202.90/month**
Part B annual deductible	$203	**$283**
Part A hospital deductible (per benefit period)	$1,484	**$1,736**

Before you start taking Social Security payments, you pay the Part B premium yourself. You can connect an automatic payment to your bank account or a credit card, or pay each month. Once your Social Security benefits begin, the premium is deducted from your check.

While Part B is seldom free, there are programs that help lower-income beneficiaries pay the premium. These Medicare Savings Programs are administered by the states and are widely underused — millions of people who qualify have never applied:

- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Qualifying Individual (QI)
- Qualified Disabled and Working Individuals (QDWI)

There is also **Extra Help** (the Part D Low-Income Subsidy), which was expanded under the Inflation Reduction Act so that everyone who qualifies now receives the *full* subsidy rather than a partial one. Your State Health Insurance Assistance Program (SHIP) will screen you for all of these for free — find yours at shiphelp.org or by calling 1-877-839-2675.

HIGHER-INCOME SURCHARGES (IRMAA)

Higher-income individuals pay an Income-Related Monthly Adjustment Amount, or IRMAA, in addition to the standard premium. **In 2026, IRMAA begins at $109,000 of modified adjusted gross income for an individual and $218,000 for a couple filing jointly** — up from $88,000 and $176,000 in 2021.

The surcharges have grown a great deal. In 2021 the Part B add-on ranged from $59.40 to $356.40 per month. **In 2026 the Part B add-on ranges from $81.10 to $486.50 per month, producing a total Part B premium between $284.10 and $689.90.** There is a separate, smaller Part D surcharge on top of your drug plan premium.

Two things to know about IRMAA:

1. **It is based on your tax return from two years earlier.** Your 2026 premium is set from your 2024 return.
2. **You can appeal it after a life-changing event.** Retirement, the death of a spouse, divorce, or the loss of income-producing property all qualify. File Form SSA-44 with Social Security. Many people who retire mid-year pay a surcharge for a year that they could have avoided simply by filing this form.

PART C: MEDICARE ADVANTAGE PLANS

Medicare Part C, also called Medicare Advantage, plans are offered by private insurance companies and approved by Medicare. They combine Parts A and B, usually include Part D drug coverage, and provide additional services and benefits not covered by Original Medicare. They commonly include vision, dental, and hearing coverage, and often extras such as gym memberships, over-the-counter allowances, and transportation to medical appointments. Every Medicare Advantage plan is required to cap your annual in-network out-of-pocket spending, which Original Medicare does not do.

The trade-offs are real: plans generally require you to stay within a network of doctors, have their own rules for referrals and prior authorization, and can change their networks and formularies from year to year.

You continue to pay your Part B premium, plus the plan's premium if it has one. **The average Medicare Advantage premium for 2026 is projected at about $14 per month, and many plans charge $0 beyond the Part B premium.** That is lower than the roughly $25 average of five years ago — but a $0 premium is not the same as $0 cost, and the copays, network, and drug formulary matter more than the premium.

Availability has improved dramatically. Where rural areas once had few or no Medicare Advantage options, **over 99% of Medicare beneficiaries now have access to a Medicare Advantage plan, and the average beneficiary can choose among roughly 32 plans.** That said, 2026 saw a 9% decrease in the number of individual plans offered nationwide, and a larger-than-usual number of enrollees had their plans terminated — a reminder to read your Annual Notice of Change every September rather than auto-renewing.

Open enrollment for changing your Medicare Advantage policy runs January 1 through March 31 each year. You can also switch during the fall Annual Enrollment Period (October 15 – December 7).

PART D: PRESCRIPTION COVERAGE — MAJOR CHANGES

To cover prescription drugs, you can choose from Part D plans managed by major insurance companies. You can compare plans at medicare.gov using the Plan Finder, which will price your specific prescription list at your specific pharmacies — this is the single most useful thing you can do during open enrollment and it takes about twenty minutes.

2026 Part D figures:

- **Annual out-of-pocket cap: $2,100.** Once your out-of-pocket spending on covered drugs (deductible, copays, and coinsurance, but not premiums) reaches $2,100, your plan pays 100% of covered drug costs for the rest of the year.
- **Maximum deductible: $615.** Plans may set a lower deductible or none at all.
- **Average standalone plan premium: about $34.50 per month**, down slightly from 2025. The national base beneficiary premium, used to calculate penalties and surcharges, is $38.99.
- **Insulin is capped at $35 per month** per covered product, with no deductible.
- **Recommended adult vaccines covered under Part D cost $0.**

The "donut hole" no longer exists. The coverage gap that confused Medicare beneficiaries for nearly twenty years was eliminated as of January 1, 2025. Part D now has just two stages: a deductible phase (if your plan has one) and an initial coverage phase, after which the out-of-pocket cap takes over.

The Medicare Prescription Payment Plan is a voluntary program, new since 2025, that lets you spread your out-of-pocket drug costs across the calendar year in interest-free monthly installments instead of paying a large amount at the pharmacy counter in January. It does not reduce what you owe; it smooths it. It is most useful for people taking expensive specialty drugs who would otherwise hit their cap in the first month or two of the year. Enrollment renews automatically.

Medicare drug price negotiation began producing results in 2026, with negotiated Maximum Fair Prices taking effect January 1, 2026 for the first ten selected drugs — including several widely used cardiovascular and diabetes medications — at discounts reported between roughly 38% and 79% off list price. Additional rounds of negotiated drugs are scheduled for later years.

Plans still classify drugs into tiers to determine coverage, and formularies differ. Because plans cover different drugs at different prices, the plan that costs the least for one person may be among the most expensive for another. Re-run the comparison every fall; plans change.

MEDIGAP OR SUPPLEMENTAL PLANS

If you choose Original Medicare (Parts A and B) instead of a Medicare Advantage plan, you can arrange supplemental coverage through insurance companies to help with uncovered medical costs like copayments, coinsurance, and deductibles. Premiums vary widely depending on your age, health, location, gender, tobacco use, and the amount of coverage you want.

In 2026, Medigap premiums generally run from about $100 to $300 or more per month. Plan G, the most comprehensive plan available to people newly eligible for Medicare, averages roughly $180 to $220 per month at age 65 and rises with age — average Medigap premiums are around $189 per month at 65 and around $238 at 75. A high-deductible version of Plan G costs far less per month (around $61) but requires you to pay roughly $2,950 out of pocket before coverage begins.

You pay your monthly premium directly to your insurance company. **You cannot enroll in a Medicare Advantage plan and a Medigap policy at the same time.**

The most important Medigap rule is one the first edition did not emphasize enough. Your Medigap Open Enrollment Period is a **one-time, six-month window that begins the month you are 65 *and* enrolled in Part B.** During that window, insurers must sell you any Medigap policy they offer at their best available rate regardless of your health. After it closes, in most states insurers may medically underwrite you — meaning they can charge you more or decline you outright. A handful of states (including New York, Connecticut, Massachusetts, and Maine) provide broader guaranteed-issue rights year-round, and several others have "birthday rules" allowing an annual switch. If you choose Medicare Advantage at 65 and later want to move to Original Medicare with a Medigap policy, in most states you may not be able to get one. This is the least reversible decision in Medicare, and it is worth understanding before you make it.

WHEN AND HOW TO APPLY FOR MEDICARE

Your Initial Enrollment Period is seven months long: the three months before the month you turn 65, your birthday month, and the three months after. Apply at least three months before turning 65 so coverage begins the month you turn 65. (The first edition of this guide described a 30-day window; that was incorrect, and the seven-month rule is what governs.)

If you already receive Social Security or Railroad Retirement benefits, you will be enrolled in Parts A and B automatically and your card will arrive in the mail. Everyone else has to sign up.

Set up your Social Security account first — the correct address is **ssa.gov/myaccount**. Having a personal Social Security account makes applying for Medicare and, later, for your retirement benefits much easier, because your identity and date of birth are already verified. You can also make an appointment at a Social Security office and have someone help you sign up, or call 1-800-772-1213. You'll need your Social Security number and identification.

Apply for Medicare online at **ssa.gov/medicare**, by phone, or in person at a Social Security office. Once you have Part A and Part B, you can enroll in a Medicare Advantage plan or a Medigap policy plus a Part D drug plan through an insurance company. You can explore options online at medicare.gov or have literature sent to you before signing up. You can also meet with a local insurance agent who specializes in Medicare, or — for free, unbiased help with no sales involved — with a counselor from your State Health Insurance Assistance Program.

THE ENROLLMENT PERIODS, IN ONE PLACE

Period	Dates	What you can do
Initial Enrollment Period (IEP)	7 months around your 65th birthday	Enroll in Parts A, B, C, D; buy Medigap
Medigap Open Enrollment	6 months from Part B start at 65+	Buy any Medigap policy, no underwriting

Period	Dates	What you can do
Annual Enrollment Period (AEP)	Oct 15 – Dec 7	Change Part D or Medicare Advantage plans
Medicare Advantage Open Enrollment	Jan 1 – Mar 31	Switch MA plans or return to Original Medicare
General Enrollment Period (GEP)	Jan 1 – Mar 31	Enroll in Part B if you missed your IEP
Special Enrollment Period (SEP)	8 months after employer coverage ends	Enroll penalty-free

LATE ENROLLMENT PENALTIES

These are permanent, and they are the most expensive avoidable mistake in Medicare.

- **Part B:** your premium increases **10% for each full 12-month period** you could have had Part B and didn't, and you pay it for as long as you have Part B. Two years late in 2026 means a $40.58 monthly surcharge — roughly $487 a year, every year, for life.
- **Part D:** if you go 63 days or more without creditable drug coverage, you pay **1% of the national base beneficiary premium ($38.99 in 2026) for every month you went without**, added to your premium permanently.
- **Part A** (only if you have to buy it): 10% surcharge, paid for twice the number of years you delayed.

You can avoid the Part B and Part D penalties entirely if you have qualifying coverage through your own or a spouse's *current* employment. **COBRA, retiree insurance, and VA benefits do not count** for the Part B special enrollment period — this trips up a great many people. If you believe a penalty was applied in error, or you were given incorrect information by a federal employee, you can request reconsideration in writing.

ARE YOU STILL WORKING?

If you are still working at 65, the rules depend on the size of your employer.

- **Employer with 20 or more employees:** you may generally delay Part B without penalty while covered by that group plan, and you get an 8-month Special Enrollment Period after the coverage or the employment ends.
- **Employer with fewer than 20 employees:** Medicare usually becomes the primary payer, and you generally need to enroll in Part B at 65 or risk large gaps in coverage. Confirm this with your benefits administrator in writing.

One trap worth naming: **if you contribute to a Health Savings Account, you must stop HSA contributions before Medicare begins**, and enrollment in Part A is retroactive up to six months when you sign up after 65. Plan the timing with your benefits administrator or tax advisor.

Some companies that pay for your regular health insurance will pay you to switch to a Medicare Advantage plan, or to Parts A, B, D plus a Medigap plan, because it saves them money. You can also choose to keep your employer insurance in addition to Medicare.

CHAPTER 4: LONG-TERM CARE INSURANCE

WHAT IS IT?

Long-term care insurance helps pay for the care you may need if you develop a chronic medical condition, illness, or disability. If there comes a time when you can no longer accomplish everyday tasks like dressing, bathing, or preparing meals, you will depend on help from somewhere. Unless that help is a friend or family member, it will cost something. The service can be delivered in several settings:

- Your home
- An assisted living facility
- A nursing home
- Adult day health care

By buying a long-term care insurance policy, you know there will be money to pay for in-home care by aides or nurses. If a family member can help you part of the time, you have money to pay for transportation and care at an adult day facility. **Medicare pays for a short skilled nursing stay after a qualifying hospitalization, but not for long-term custodial care.** Long-term care insurance will provide funds for nursing homes, assisted living, and memory care homes.

WHEN SHOULD YOU BUY IT?

The sooner you purchase a plan, the lower the premium will be. People typically wait until they are in their 50s or early 60s, but if they have certain health conditions, they may not qualify. Companies consider diabetes, long-term chronic pain, heart conditions, cancer, and other illnesses and conditions. Obesity could also prevent you from qualifying — most insurers set a weight limit for your height. Conditions like dementia, muscular dystrophy, and cystic fibrosis generally make you ineligible outright, and **once a carrier declines your application there is no appeals process that restores eligibility.** Older people can still get a policy if they are in good health, but options narrow considerably after 70.

Most planners point to **ages 55 to 65 as the practical window**, with 55–60 as the sweet spot: premiums are still manageable, you are likely healthy enough to qualify at preferred rates, and you have fifteen to twenty-five years for an inflation-protected benefit pool to grow before you draw on it.

DO YOU NEED IT?

Whether or not to buy long-term care insurance depends on your financial and family situation. If you are wealthy and know there's enough money to pay for care, you may not need it. If you think family members will care for you, you may need less insurance coverage. Unless you have a medical professional willing to care for you, at some point you will likely have care costs.

Americans live longer today than they did 50 or 100 years ago. **According to the CDC's final 2024 mortality data, U.S. life expectancy at birth reached 79.0 years — an all-time high, up from 78.4 in 2023.** Life expectancy is 81.4 years for women and 76.5 years for men. (These figures are meaningfully higher than the 78.6 years cited in the first edition of this guide, which reflected 2017 data; life expectancy fell sharply during the pandemic and has since recovered past its previous peak.) Women live longer than men, and average lifespan in some states is considerably longer than in others.

Total life expectancy at birth takes all deaths into account. Taking people who die young out of the equation changes the number substantially. **In 2024, life expectancy at age 65 was 19.7 more years — meaning the average 65-year-old can expect to live to about 85.** For men who reach 65, it is 18.4 more years; for women, roughly 20.8 more years. The conclusion is the same as it was in the first edition and if anything stronger: **although average life expectancy at birth is 79, if you make it to your mid-60s without major health problems you are likely to live well into your 80s.**

The chance you will need some assistance during part of those years is high. **Roughly 70% of people turning 65 today will need some form of long-term care services during their lifetime**, according to the U.S. Department of Health and Human Services. The need rises steeply with age: a minority of people in their late 60s and early 70s require services, but well over a third of those 85 and older do.

WHAT DOES LONG-TERM CARE COST?

In-home care, nursing homes, and assisted living costs vary substantially from state to state and region to region. The figures below are the national medians from the **2025 CareScout Cost of Care Survey** (the successor to the Genworth Cost of Care Survey), based on more than 25,000 provider rates collected between July and November 2025.

Care setting	National median (2025)	Annualized	vs. this guide's 2020 figures
Non-medical caregiver (in home)	$35/hour	**$80,080/yr** (44 hrs/wk)	up from ~$53,000
Skilled nursing in the home (private duty nurse)	$90/hour ($160/visit)	varies	*new category in 2025*
Adult day health care	$95/day	**$24,700/yr** (5 days/wk)	up from ~$19,000
Assisted living community	$6,200/month	**$74,400/yr**	up from $51,600
Nursing home, semi-private room	$315/day	**$114,975/yr**	up from $93,075
Nursing home, private room	$355/day	**$129,575/yr**	up from ~$105,850

Two things stand out. First, **the assisted living figure is 44% higher than it was five years ago** — it jumped 10% in a single year in 2024 alone, driven by occupancy rates rebounding from 77% to 84%. Second, cost growth is finally moderating: most settings rose between 1% and 5% in 2025, and adult day health care actually fell 5%. That is a slowdown, not a reversal. The first edition of this guide projected a semi-private nursing home room would reach $125,000 a year by 2030; at $114,975 in 2025, that projection now looks conservative.

Note also that CareScout has merged the old "homemaker services" and "home health aide" categories into a single **non-medical caregiver** rate, because two-thirds of agencies now charge the same price for both. Extra services like physical therapy add to all of the above.

Memory care is not tracked separately in the survey but typically runs 20–30% above assisted living, which puts it in the neighborhood of $7,400 to $8,100 a month nationally.

WHAT MEDICARE AND MEDICAID DO AND DON'T PAY

Medicare pays for the first 20 days in a skilled nursing facility at 100% and days 21–100 with a substantial daily coinsurance, and only after a qualifying inpatient hospital stay. It does not pay for custodial long-term care.

Medicaid pays for nursing home care if your income and assets are very low, but your choice of facilities may be limited and there are lookback rules on asset transfers. Medicaid is the largest payer of long-term care in the country, which tells you how many families exhaust their savings first.

The National Investment Center has reported an average stay in an assisted living facility of roughly 29 months, and industry data indicate that a majority of assisted living residents eventually move to a nursing home for some period. Average nursing home stays are shorter than most people expect, in part because the statistic includes short-term rehabilitation stays.

THREE SCENARIOS, AT 2026 PRICES

These scenarios are simplified, are based on today's costs (which will be higher when you need care), assume semi-private nursing home accommodations, and don't include other medical expenses. They give you an idea of how much money you would need to pay for long-term care yourself.

Scenario 1 — a moderate progression

- Adult day health care, 6 months: $12,350
- In-home caregiver, 12 months: $80,080
- Nursing home, 9 months: $86,231
- **Total: approximately $178,700**

Scenario 2 — home care then extended nursing care

- In-home caregiver, 2 years: $160,160
- Nursing home, 3 years: $344,925

- **Total: approximately $505,100**

Scenario 3 — assisted living then nursing care

- Assisted living, 3 years: $223,200
- Nursing home, 2 years: $229,950
- **Total: approximately $453,150**

For comparison, the equivalent scenarios in the first edition of this guide totaled $126,000, $336,000, and $339,000. **Costs have risen roughly 35–50% in five years.** That is the argument for inflation protection on any policy you buy.

COST OF LONG-TERM CARE INSURANCE

Premiums depend on your present age and health, on whether you add inflation protection, and on what the payouts will be when you need them. Talking to an insurance broker who represents multiple carriers will get you specific quotes — and ask any agent directly how many companies they are appointed to sell, because a captive agent has exactly one answer for you.

The figures below come from the **American Association for Long-Term Care Insurance 2025 Price Index**, for a policy with an initial benefit pool of $165,000, select health, and a 90-day elimination period. The inflation-protected column reflects 3% compound growth, which would grow that $165,000 pool to roughly $400,500 by age 85 if purchased at 55.

Age at purchase	Level benefits	With 3% compound inflation
55, single male	$950/yr	$2,200/yr
55, single female	$1,500/yr	$3,750/yr
55, couple (combined)	$2,080/yr	$5,050/yr
60, single male	$1,200/yr	$2,610/yr
60, single female	$1,900/yr	$4,550/yr
60, couple (combined)	$2,600/yr	$5,800/yr
65, single male	$1,750/yr	$3,280/yr
65, single female	$2,700/yr	$5,290/yr
65, couple (combined)	$3,750/yr	$7,150/yr

Waiting from 55 to 65 raises a man's level premium by roughly 84%, and the higher premium continues for the life of the policy. Couples who take out a policy together pay less than if they each bought separately. People in excellent health pay less than people with health conditions. Women pay substantially more than men because they live longer and are likelier to need extended care.

Two cautions the first edition did not include. First, **traditional long-term care premiums are not guaranteed to stay level.** Many carriers filed for significant rate increases — in some cases 20% to 90% — during the 2010s and 2020s as claims exceeded projections. Ask any carrier about its rate increase history before you buy. Second, **hybrid or "linked benefit" policies** — life insurance or annuities with a long-term care rider — have become the dominant product sold in this market. They cost more up front but pay a death benefit if you never need care, which addresses the "use it or lose it" objection that stops many people from buying traditional coverage. They are worth comparing.

A WORKED EXAMPLE

A 60-year-old woman in average health buying a policy with a $165,000 initial benefit pool and 3% compound inflation protection pays roughly $4,550 a year. If she begins needing care at 82, she will have paid about $100,100 in premiums — and her benefit pool will have grown to roughly $317,000. At 2025 prices, that is enough to cover about two and a half years in a semi-private nursing home room, or about four years of assisted living, or roughly four years of in-home care. Without the policy, that money comes from savings, from the sale of a home, or from her children.

PEACE OF MIND

No matter how the finances total, the biggest benefit of long-term care insurance is the peace of mind you get. Worrying that if you get sick you will become a financial burden — or worse, not be able to pay for care at all — can weigh heavily on you. It also weighs on the people who would otherwise have to make those decisions on your behalf.

CHAPTER 5: FINAL EXPENSE INSURANCE

If you don't have life insurance and are worried about how your loved ones will pay for your funeral and manage any bills you leave, you might consider getting final expense insurance. While getting traditional life insurance might be difficult and expensive because of your age or health, just about everyone can get final expense insurance. No matter what final arrangements you want, once you die there will be expenses. Even if you pay your bills regularly and don't have debt, there will be medical bills not covered by insurance and other unexpected costs your family will need to pay once you're gone.

WHAT IS FINAL EXPENSE INSURANCE?

Final expense insurance is a whole life insurance policy. A whole life policy pays a set amount when the insured dies. Unlike term insurance, it never expires as long as premiums are paid. Whole life insurance can be difficult to get for older people or people with health conditions. Final expense insurance is more affordable because the death benefit amount is smaller. The face value typically runs between **$5,000 and $25,000**, though some carriers write policies up to $50,000. The smaller benefit means the premiums are more affordable, even for higher-risk buyers. Because it is whole life, **the premium is locked in — if you buy at 65, you pay the same monthly amount at 95.**

There are two main varieties. **Simplified issue** policies ask health questions but require no medical exam, and coverage generally begins immediately; this is what most people should aim for. **Guaranteed issue** policies ask no health questions at all but almost always carry a two-year graded benefit, meaning that if you die of natural causes in the first two years, your beneficiary receives only your premiums back plus interest rather than the full death benefit. Verify which kind you are being sold, in writing.

WHAT DOES FINAL EXPENSE INSURANCE COST?

Rates depend on your age, gender, tobacco use, and the payout amount. For a **$10,000 policy** in 2026:

Age	Non-smoking woman	Non-smoking man
50	about $30/month	about $38/month
65	about $40–$55/month	about $50–$70/month
70	about $60–$75/month	about $75–$90/month
75	about $87/month	about $113/month
80	about $125/month	about $164/month

Smokers pay roughly 25–50% more at every age. The steepest single jump in the rate tables occurs **between 75 and 80**, when average premiums rise about 45% — so if you are approaching 75, buying sooner rather than later has a measurable payoff.

When comparing quotes, compare **cost per $1,000 of coverage**, not just the monthly premium, and confirm that the policy is true whole life that never expires. Some heavily advertised plans priced by age bracket increase every five years and terminate entirely at 80 — which is precisely when you are most likely to need them.

WHAT DOES THE BENEFIT PAY FOR?

Like any life insurance policy, the death benefit your family receives can be used for anything they choose. Typically the money pays for a funeral or memorial service, embalming or cremation services, a casket or urn, a burial plot, and a marker or headstone. In addition, the money can help pay household and medical bills left after your final illness. Your family may need funds for travel or to prepare your house for sale as well. In a nutshell, the money will pay whatever expenses your family needs to pay on your behalf.

HOW MUCH WILL I NEED?

FUNERAL ARRANGEMENTS

Thinking about what happens to your remains after you die is uncomfortable, but it's important. To decide how much final expense insurance you need, you must give thought to your final arrangements.

According to the National Funeral Directors Association's most recent General Price List Study, the national median cost of a funeral with viewing and burial is $8,300 — or $9,995 once a burial vault is included. A funeral with viewing and cremation runs a median of $6,280. These medians do not include cemetery costs such as the plot, the opening and closing of the grave, or a monument or marker, which can add several thousand dollars more.

Regional variation is significant: Northeast funeral costs average roughly 8% above the national figure and can run more than 30% above the least expensive Southern states.

Cremation is now the majority choice in the United States. The cremation rate reached an estimated **63.4% in 2025** against a burial rate of 31.6%, and NFDA projects cremation will reach **82.3% by 2045**. This is a substantial shift from a generation ago, when cremation accounted for barely a third of funerals, and it is driven largely by cost.

The breakdown below gives a general idea of what individual components cost. Prices depend heavily on your city and state.

- **Funeral home basic service fee:** typically $2,500–$3,000. This non-declinable fee covers obtaining the death certificate, necessary permits, sheltering the body, and coordinating arrangements.
- **Embalming:** roughly $800–$1,000. It is *not* required by law in most circumstances; funeral homes may require it for a public viewing.

- **Casket:** a basic steel casket runs around $2,000; premium hardwood, bronze, or copper caskets exceed $10,000. **You may legally buy a casket from any retailer** and the funeral home cannot charge you a handling fee for it.
- **Burial plot:** the national average is around $2,750, but plots vary enormously — a few hundred dollars in some rural public cemeteries to well over $5,000 in private ones, and far more in metropolitan areas like New York and Los Angeles.
- **Opening and closing the grave (interment fee):** roughly $1,000–$1,500.
- **Grave liner or burial vault:** roughly $900–$7,000, depending on material. Many cemeteries require one.
- **Added funeral home fees** for transportation, flowers, and other extras: $500–$1,000.
- **Cremation:** direct cremation, with no service, is the least expensive option at roughly $1,000–$3,000. Cremation with a viewing and memorial service runs closer to the $6,280 median above.
- **Urns:** $50 to several hundred dollars. If you choose to bury the ashes you will need an urn vault, generally $100–$300.
- **Markers:** a flat grave marker runs roughly $1,000–$2,000; an upright headstone $2,000–$5,000 or more.

Veterans are entitled to burial in a national cemetery at no cost, including the grave, opening and closing, a government headstone or marker, a burial flag, and perpetual care. A spouse and dependent children are generally eligible as well. Certain veterans also qualify for burial and plot allowances toward a private cemetery. Contact the VA National Cemetery Scheduling Office at 1-800-535-1117 or visit va.gov/burials-memorials — this benefit is frequently overlooked and is worth thousands of dollars.

Know the FTC Funeral Rule. Federal law requires every funeral home to give you an itemized General Price List, free, to anyone who asks — in person, and over the phone for pricing questions. You may buy only the goods and services you want. Get lists from at least three funeral homes before deciding; price differences within the same city are routinely in the thousands of dollars.

OTHER EXPENSES

Beyond funeral expenses, think about your personal debt and spending habits. Think about taxes that might come due. Suppose you don't have much credit card debt and anticipate having enough savings to cover taxes and final medical bills. In that case, you might only need enough for the funeral home and burial. If you worry that your family will be burdened and aren't sure how much final personal and medical bills might be, adding a few thousand to your policy might be wise.

It is worth knowing what the total picture typically looks like. Analyses of end-of-life costs put the average combined burden at roughly **$88,000** — about $80,000 in final-year medical expenses plus the funeral itself — with Medicare beneficiaries generally facing $8,000 to $12,000 of that out of pocket in the final year. Final expense insurance is sized for the funeral, not for that whole number; it is not a substitute for savings or for long-term care planning.

To decide how much final expense insurance to purchase, it's best to talk to a few local funeral homes to determine what services cost in your area. Decide what services you want and anticipate price increases. If you choose not to speak to local funeral homes, check the median funeral cost for your region and use that figure. Keep in mind that family and friends will likely be able to contribute something.

PREPAYING FUNERAL COSTS

As an alternative to final expense insurance, people sometimes work with an individual funeral home to arrange and prepay for funeral costs. You can choose your casket and preplan some of the arrangements. It takes the burden off family and friends. Funeral homes sell these "preneed" plans, which you can purchase with a lump sum or monthly payments. The home usually puts the money in a trust fund for you or buys an insurance policy naming itself as beneficiary. There are some questions you should ask:

- Does your money earn interest, and who keeps the interest?
- If you change your mind, can you get your money back — and how much of it?
- Is the plan transferable if you move to another state?
- Is there a waiting period if the funeral home uses the money to purchase a final expense policy?
- Does the plan guarantee prices, or only credit your payments against future prices?
- What happens if the funeral home goes out of business or is sold? Does the plan transfer?

State protections for preneed funds vary widely, and consumer advocates have documented cases of funds being mishandled. If you don't feel comfortable with the answers you get to these questions, buying your own final expense life insurance policy — which your family controls — might be better. Keep in mind that prepaying for funeral arrangements won't provide funds for your family's other expenses.

Whatever you choose, write down your wishes and tell someone where the paperwork is. A prepaid plan or an insurance policy that no one can find helps no one.

CHAPTER 6: LIFE INSURANCE

Most baby boomers either won't qualify or won't get affordable rates on large-benefit life insurance. For younger boomers and Gen Xers who might still be able to buy it, and for those who already have insurance but don't completely understand it, here are the basics.

Life insurance comes in two broad types: term and permanent. The basic differences are the duration of the policy and whether it accumulates cash value. While there are variations within these categories and completely understanding life insurance is challenging, understanding the basics will certainly help.

TERM LIFE INSURANCE

Term insurance is purely and only insurance. You pay premiums, and if you die during the term specified in the policy, a death benefit goes to the beneficiary. Because the policy does nothing else, has a limited duration, and has no cash value, it's much less expensive than whole life insurance. The term typically runs between 10 and 30 years. When the term is over, the policy no longer exists. It expires, and there is no insurance.

There are two categories of term life insurance: level term and decreasing term. Most policies are level term, which means the payout benefit is the same throughout the term. With the decreasing term type, the benefit goes down as time passes.

You may wonder why you would choose a policy that eventually expires. It's less expensive and easier to get, but there are other reasons. People buy term life insurance to ensure there's money available while their children are growing up and going to college. They may choose term insurance that expires when they pay off a mortgage, knowing that the home's value will replace the need for insurance. If you know that in 20 years your children will be on their own and you will have built a substantial nest egg, a 20-year term policy may be sufficient. If you anticipate an inheritance, you may want a term policy in the meantime.

One feature worth asking about: convertibility. Many term policies allow you to convert some or all of the death benefit to permanent coverage without a new medical exam, up to a certain age. If your health changes during the term, that option can be worth a great deal. Ask about it before you buy, not after.

The older you are, the more expensive insurance will be. That fact is inescapable. **Current average monthly rates for a 20-year, $500,000 level term policy for a healthy non-smoker:**

Age at purchase	Women	Men
30	about $30	about $38
40	$47	$59
45	$69	$88
50	$102	$137
60	$286	$395

Age at purchase	Women	Men

Two inflection points stand out in this data. **Rates roughly double between 40 and 50**, and then **nearly triple again between 50 and 60.** Applying at 50 instead of 60 saves in the range of $44,000 to $62,000 over a 20-year term. And most carriers will not issue a *new* 20-year term policy to an applicant older than 65; a 10- or 15-year term may be the only option at that point.

A shorter term or a smaller benefit lowers the premium considerably. A 10-year, $250,000 policy for a 50-year-old woman runs roughly $41 a month. If you are specifically concerned about family finances for a defined period — until a mortgage is paid or a spouse reaches full retirement age — a shorter, smaller policy may be exactly right and costs a fraction of the figures above.

Variables like health and gender influence the rates. If you have serious health conditions, you may not qualify at all or may have to pay much more. Smokers generally pay two to three times the non-smoker rate.

WHOLE LIFE INSURANCE

Whole life insurance, sometimes also called "straight" or "ordinary" life insurance, provides a death benefit whenever you die — even if you live to 100 — as long as you keep up the premium payments. The policy also usually builds cash value you can borrow against or cash out. It costs substantially more than term insurance for the same death benefit: **commonly five to fifteen times more**, and a $500,000 whole life policy that a healthy 35-year-old could buy for $300–$500 a month would cost several times that at 55 or 60. There are three main types — traditional, universal, and variable universal — and each has many variations.

TRADITIONAL WHOLE LIFE INSURANCE

Your premium and the death benefit remain the same throughout. Example: your monthly premium payment is always $225, and your beneficiary will receive $50,000 no matter when you die. The coverage continues until you die. The cash value on a traditional policy increases at a set rate and isn't tied to the financial market.

UNIVERSAL LIFE INSURANCE

Universal life insurance is permanent insurance like traditional whole life but with an investment savings element added. It sometimes requires a lump-sum payment and then monthly payments. Some policies have a flexible premium. Because the credited interest is tied to market rates, your premium may change over time — and this is the most common source of unpleasant surprises in life insurance. Policies sold decades ago on the assumption of high interest rates have required much larger premiums than illustrated to stay in force. You can borrow from your cash value account. **If you own a universal life policy, request an in-force illustration from the carrier every few years to confirm the policy will actually last as long as you need it to.**

VARIABLE LIFE INSURANCE

Variable life insurance also has a cash value element, and the money you submit is split between the death benefit and a cash value account invested in subaccounts you select. This type of insurance is regulated as a securities product because the cash account carries investment risk — the cash value can go down. There are tax advantages, including tax-deferred growth. You can borrow from the policy, but unpaid loans are deducted from the death benefit.

HOW TO CHOOSE

Life insurance is complicated and speaking to a professional is the best idea. The main questions most people over 55 have are:

- Can I qualify?
- How much will it cost?
- Should I get it?
- Term or permanent?
- If I have it, should I continue it or cash out?

Because it's also an investment product and lasts until you die, whole life insurance costs many times what term insurance does. Before buying permanent insurance primarily as an investment, check with a fee-only investment advisor about alternatives — the analysis is different for estate planning, business succession, or leaving a legacy to a special-needs child than it is for general savings.

If you want some insurance to help your family pay for funeral costs and outstanding bills when you pass away, investigate final expense insurance (Chapter 5). Most people qualify, and it's affordable. The benefit is much smaller, but you can usually get enough to help your family.

DO I STILL NEED IT?

If you already have insurance, consider your present financial situation. If premiums are a burden or you need money to live on, talk to a professional about your options before you let a policy lapse. You can often stop paying premiums or pay less by agreeing to a smaller payout (a "reduced paid-up" option). With a whole life policy, premiums can sometimes be paid from the cash value. If you are no longer concerned about your family having what they need after you're gone, you might want to reduce the benefit amount or convert the insurance to another vehicle.

Do not simply stop paying on a policy you no longer want. Options that are often better than lapsing include surrendering for the cash value, a reduced paid-up policy, a 1035 exchange into a different product, or — for larger policies held by people over about 65 with a health change — a life settlement, in which a third party buys the policy for more than its surrender value. Life settlements are regulated in most states and are worth investigating before surrendering a large policy. Talk to investment, insurance, or tax professionals about your options and the tax ramifications.

CHAPTER 7: AUTO INSURANCE

Auto insurance rates and coverage needs change as you get older. If you have the same auto insurance policy you've had for years and pay the same or more than you did five or ten years ago, you might want to evaluate your coverage and do some shopping around. To compare rates from different companies, first determine what kind of coverage you need and what discounts you might be entitled to so you can make fair, apples-to-apples comparisons.

Shopping around matters more now than it used to. Auto insurance premiums rose sharply nationwide between 2022 and 2024 as vehicle repair and replacement costs climbed, and while rates eased somewhat in 2025, tariffs on imported vehicles and parts have put renewed upward pressure on premiums in 2026. **Nearly two-thirds of drivers saw an increase at their most recent renewal.** Comparing at least two competing quotes before auto-renewing is one of the highest-return hours available to a retired household.

WHAT'S IN AN AUTO INSURANCE POLICY?

Coverage is divided into categories from liability to towing service. Each has a coverage maximum and a cost.

Liability is divided into bodily injury and property damage. It pays for the other driver's property, medical injuries, and lost pay for anyone in the other vehicle if you are at fault. The bodily injury coverage is usually listed as two amounts — the first per person in the other vehicle, the second for the entire incident.

No-fault insurance, sometimes called personal injury protection or PIP, helps cover you and anyone in your car after an accident, regardless of who is at fault. Many states added this to reduce the number of lawsuits filed over auto accidents. The coverage amount is usually minimal.

Comprehensive insurance covers damage to your car from causes other than a collision — a falling tree or ladder, theft, hail, or flooding.

Collision covers your car repairs after an accident you caused. Be aware of the deductible as well as the total coverage amount; increasing the deductible will lower the premium.

Emergency roadside assistance covers roadside mechanical service or towing, including a jump start, tire change, or unlock service. If you have AAA or coverage through your vehicle manufacturer, you may not need this.

Car rental and travel provides a rental car while yours is being repaired, and partial coverage if you must take a taxi, bus, or train home after an accident or stay overnight in a hotel. If you never drive more than 20 miles from home and have friends and family who can get you home, you may not need this.

Uninsured and underinsured motorist coverage pays for damages caused by a driver without insurance or without enough of it, including hit-and-run incidents. Some states require

it. This is one of the last coverages you should ever consider dropping — roughly one in seven drivers nationally is uninsured, and in some states it is closer to one in four.

WAYS OLDER DRIVERS CAN REDUCE PREMIUMS

As an experienced driver, you are probably eligible for discounts. Many insurers offer reduced rates to older drivers with clean records, and driving fewer miles can also earn a discount. If you start struggling with your driving, have accidents, or get tickets, your premiums will go up. Let the insurance company know if you stop driving and your spouse or another family member has taken over the car.

AVERAGE FULL-COVERAGE RATES BY AGE (2026)

Age	Approximate annual full-coverage premium
50	about $2,290
60	about $1,930–$2,310
65	about $2,270
70	about $2,090–$2,410
75	about $2,740

Rates are typically lowest in the mid-50s through the mid-60s and begin climbing around age 70. **Across the industry, premiums rise roughly 30% between age 60 and age 80**, with the steepest increases between 70 and 75. The reason is straightforward: per mile traveled, fatal crash rates begin rising noticeably for drivers 70 to 74 and are highest among drivers 85 and older.

State variation dwarfs age variation. The same 65-year-old driver with the same record can pay under $1,000 a year in one state and well over $3,000 in another.

DISCOUNTS

Make sure you receive every discount to which you're entitled:

- **Safe driver.** Accident-free, defensive driving course completion, good driving habits, senior discounts (often from age 55), and low mileage (usually under 7,500 miles per year). **In many states, completing an approved defensive driving or mature driver course entitles you to a mandatory discount for three years** — AARP, AAA, and the National Safety Council all offer them online for a modest fee. This is often the single largest discount available to an older driver.
- **Telematics and usage-based programs.** Apps and plug-in devices that track speed, braking, time of day, and mileage. These have become mainstream since the first edition of this guide and can produce meaningful savings for low-mileage, careful drivers. They can also *raise* your rate with some carriers if the data looks bad — ask specifically whether the program is discount-only.

- **Pay-per-mile policies.** A newer option worth investigating if you drive under roughly 7,000 miles a year, which describes many retirees.
- **Multiple policies or bundling.** Homeowners, boat, and car insurance with the same company usually reduces each.
- **Multiple vehicles** on the same policy.
- **Vehicle safety and security features.** Antilock brakes, airbags, alarms, GPS tracking, and increasingly automatic emergency braking and blind-spot monitoring.
- **Payment and billing.** Early pay, pay in full, paperless, and electronic payment discounts.
- **Military or federal employee.**
- **Good student or student away**, if you have children or grandchildren living with you.
- **Loyalty.** Most companies reward you for staying — though loyalty discounts rarely outweigh what you can save by shopping.

ADJUST DEDUCTIBLES

Most older Americans are in a better financial situation than they were when they first bought car insurance. If you are accident-free and have a substantial rainy-day fund, consider raising deductibles. If you presently have a $250 deductible on your collision insurance, raising it to $500 or $1,000 means you will pay that much of repair costs if you have an accident — but it lowers your premium every month. Only do this if you can comfortably absorb the higher deductible.

REDUCE COVERAGE — CAREFULLY

If you rarely drive far and have people who can help you out if you have an accident and need a ride, consider dropping rental car and travel coverage. If you have other towing coverage, like AAA, you could drop roadside assistance. If you have a second family car that's old and not worth much, you could cancel collision and perhaps comprehensive on that vehicle alone — the chances are the car's value won't be worth the repairs, and you will only receive its book value.

Insurance experts are close to unanimous that it is not wise to cut liability coverage. State minimum liability limits are far below the cost of a serious accident, and the difference in premium between minimum limits and substantially higher ones is usually small. If you have assets to protect, consider an umbrella policy on top of your auto and homeowners limits; they typically cost a few hundred dollars a year for a million dollars of additional coverage.

CANCEL COVERAGE

As obvious as this seems, cancel your insurance if you no longer drive and no longer own a vehicle. It's not uncommon for family members to discover that an older, non-driving relative continued to pay car insurance for months or years, because the insurance was bundled with other policies or because payments were automated. If you still occasionally drive someone

else's car, ask about a non-owner policy instead — it is far cheaper and keeps your liability coverage continuous.

CHAPTER 8: MORTGAGE INSURANCE AND HOMEOWNER'S INSURANCE

WHAT IS HOMEOWNER'S INSURANCE?

Homeowners insurance pays when your home or personal property sustains damage from an accident, a fire, or certain natural disasters. It also includes personal liability coverage to protect you in case someone is hurt on your property or files a property damage lawsuit against you. The insurance is vital and shouldn't be canceled even if your house is paid off. However, there are ways to pay less for it.

This has become a much harder market than it was five years ago. Homeowners insurance premiums have risen steeply nationwide, driven by higher rebuilding costs and by weather-related losses. In the most exposed states the increases have been severe: Florida now has the most expensive homeowners insurance in the country, with average annual premiums in the thousands, and more than twenty insurers have stopped writing new policies there or left the market entirely. California and Louisiana face parallel problems. If you are planning a retirement move to a coastal, wildfire-exposed, or hail-prone area, **get an actual insurance quote for the specific address before you commit to the purchase.** In some markets, availability — not price — is the binding constraint.

HOW TO SAVE

SHOP

Just as with auto insurance, comparing prices and coverage from different companies could result in significant savings. Make sure the company is reputable and financially sound. Your state Department of Insurance and the National Association of Insurance Commissioners publish complaint data and licensing information for companies operating in your state.

RAISE YOUR DEDUCTIBLE

If you are financially stable and can afford to pay a higher amount when you make a claim, consider raising your deductible from $500 to $1,000 or more. Consider each deductible separately: when you look at your policy, you may find that certain perils have a different deductible. **If you live in a hurricane-, wind-, or hail-prone state, you may have a separate percentage deductible for those claims** — often 1% to 5% of the dwelling coverage rather than a flat dollar amount, which on a $400,000 home means $4,000 to $20,000 out of pocket. Know which one applies to you before a storm, not after.

HOME IMPROVEMENTS

Making your home more secure or disaster-resistant will save you on insurance. Adding an alarm system, smoke detectors, and deadbolt locks can produce meaningful discounts. Reinforcing your roof, adding storm shutters, or upgrading to stronger roofing material can save more, particularly in wind-exposed states — several states now mandate discounts for verified wind mitigation features. Improvements to plumbing and electrical systems, especially in an old house, could reduce your premiums. Water sensors and automatic shutoff valves earn

discounts with a growing number of carriers, and non-weather water damage is one of the most common claims there is.

LOOK FOR DISCOUNTS

Insurance companies offer discounts for loyalty and policy bundling. Many also reduce premiums when you reach age 55 and again when you retire, on the theory that a home occupied during the day is at less risk. If you work from home or are simply home most of the time, tell your insurance company.

EVALUATE YOUR BELONGINGS

You may need less coverage if you've passed some things down to your children. You might have a rider — a scheduled personal property endorsement — for an item you no longer own. Evaluate your belongings regularly to be sure your coverage amount is appropriate. If you have jewelry, art, or collectibles, consult experts about their present worth; values move in both directions, and standard policies impose low sub-limits on jewelry, silverware, and firearms regardless of your overall coverage.

While you're at it, **make a home inventory.** Photograph or video every room, including the insides of closets and drawers, and store it somewhere outside the house — a cloud account or a relative's computer. It takes an afternoon and it is the difference between a smooth claim and an argument.

CLOTHING

Most people simplify their wardrobe when they retire. If you no longer need to replace work clothes, you might reduce your personal property coverage. Ask yourself how much it would actually cost to replace your current wardrobe.

DON'T INSURE YOUR LAND

If your home burns to the ground, you still have the property. Carry enough coverage to rebuild the house, but don't include the value of the land it's built on. If the insurance pays you for the home and you decide to move rather than rebuild, you still have the property to sell.

Do, however, make sure you carry **enough** dwelling coverage to rebuild at today's construction costs, which have risen substantially. Ask your agent about **extended or guaranteed replacement cost** coverage, which pays a percentage above your dwelling limit if rebuilding costs exceed it. Being underinsured is a far more expensive mistake than being slightly overinsured.

CREDIT RATING

In most states, a solid credit history lowers your premium. A few states restrict or prohibit the use of credit-based insurance scores; if yours is one of them, this factor won't apply.

BUY THE RIGHT HOUSE

If you move when you retire, buy the right house. Homes close to a fire hydrant or served by a professional fire department cost less to insure. Newer homes, or older homes with updated plumbing, electrical, and roofing, cost less too. Consider construction type appropriate to local hazards. Look at security features. Ask for the **CLUE report** (Comprehensive Loss Underwriting Exchange) on the house you are considering — it shows the property's claims history for the past several years and will tell you whether the home has a water or roof problem the seller hasn't mentioned. Buying with insurance in mind can save 5% to 20% on homeowners premiums, and in some markets it determines whether you can get a policy at all.

WHAT IS PMI?

If you purchase a home with less than a 20% down payment on a conventional loan, you will generally be required to carry **private mortgage insurance (PMI)**. This insurance protects the mortgage company in case you default on your home loan — it provides no protection to you.

PMI typically costs between 0.3% and 1.5% of the original loan amount per year, most commonly quoted in the 0.46% to 1.5% range, paid monthly as part of your mortgage payment. A useful rule of thumb is roughly **$30 to $70 per month for every $100,000 borrowed.** On a $300,000 loan at a 1% rate, that's $3,000 a year, or $250 a month. Your credit score is the biggest single factor: borrowers with scores of 760 and above may pay as little as 0.46% annually, while those in the 620–639 range may pay the full 1.5%. Some buyers avoid PMI by borrowing enough from an independent source (a "piggyback" second loan) to reach the 20% threshold. VA loans require no monthly mortgage insurance at all; FHA loans use a different system called MIP that, for most borrowers, lasts the life of the loan.

Getting rid of PMI. Many homeowners don't realize or track that PMI should end. Under the federal Homeowners Protection Act:

- You may **request cancellation** in writing once your loan balance reaches **80%** of the original property value, provided you are current on payments.
- The servicer must **automatically terminate** PMI once the balance reaches **78%** of the original value.

Keep track of this yourself — servicers do not always act promptly, and the automatic termination is based on the original amortization schedule, not on how much you've actually paid down. If your home has appreciated substantially, you may be able to reach 80% equity years early by paying for a new appraisal; ask your servicer what it requires.

One tax change worth knowing: the deduction for mortgage insurance premiums, which expired after 2021, was **permanently reinstated by the One Big Beautiful Bill Act beginning with tax year 2026.** Premiums are now treated as mortgage interest for deduction purposes, subject to income limits. Confirm your eligibility with a tax professional.

SECTION 3. HOW SHOULD MY HEALTH MANAGEMENT CHANGE?

Some younger people who don't have any serious health problems might get a yearly checkup; others only visit a medical professional when they have a problem. They have tests when their doctor orders them and may not know much about their own health statistics. In your 40s, 50s, 60s, and beyond, it's best to take a proactive approach to health. You should know what screenings you need and how often, and track and understand your personal numbers.

Medical information is private, and you may feel awkward sharing information with family members, but at some point you may need help with healthcare decisions. Putting medical proxies in place and permitting doctors to share information with someone you designate — *before* that becomes necessary — will help smooth the way. Most medical facilities now have patient portals where you can pay bills, see test results, message your care team, and set appointments. Set yours up and make a note of the website and credentials for someone close to you in case they need it.

One structural change since the first edition of this guide is worth knowing: **federal information-blocking rules now require that most test results be released to your patient portal as soon as they are finalized**, often before your doctor has reviewed them with you. This is generally a good thing, but it means you may see an abnormal result on your phone on a Saturday. Ask your care team in advance how they prefer to handle results so you know what to expect.

CHAPTER 9: VISION

If you've never had vision problems or an eye infection, you may not have much experience with eye doctors. There are eye conditions and diseases that affect mostly older adults, and regular screening should become part of your routine. There are also prevention measures you can take.

MEDICAL PROFESSIONALS

Ophthalmologists. Training includes medical school, internship, and residency like any medical doctor. They provide comprehensive eye care, including vision tests, diagnosis and treatment for eye diseases and conditions, and eye surgery. There are subspecialties in retina, cornea, glaucoma, refractive surgery, pediatrics, uveitis, pathology, and neuro-ophthalmology.

Optometrists. Training entails four years of undergraduate study and four years of optometry school, often followed by a residency. A Doctor of Optometry (OD) can diagnose and treat many eye diseases and disorders and specializes in vision correction with glasses or contacts.

Opticians fill prescriptions written by the two above; they do not examine eyes or diagnose conditions.

COMMON EYE PROBLEMS FOR OLDER PEOPLE

PRESBYOPIA

The most common age-related eye change begins in your 40s. **Presbyopia is the gradual loss of the eye's ability to focus on nearby objects.** It is not nearsightedness — it is essentially the opposite, and it happens because the lens inside the eye stiffens with age and can no longer change shape as easily. (The first edition of this guide described presbyopia as nearsightedness; that was incorrect.)

Even if you have never worn glasses, you may now need them for reading and other close work. If you start holding a magazine or menu away from your face to focus, or get headaches after doing needlework, you may need reading glasses. If you already wear glasses for distance, you might now need bifocals or progressive lenses. Presbyopia is universal — it affects essentially everyone eventually — and it is not a disease. Prescription eye drops that temporarily improve near vision have become available in recent years as an alternative to reading glasses for some people; ask your eye doctor whether you're a candidate.

DRY EYE

Dry eye, or keratoconjunctivitis sicca, happens because the eyes can't make enough tears, or the tears are of poor quality. It's uncomfortable — your eyes itch and burn, and your vision can fluctuate. It has become considerably more common with the rise of screen time, because people blink less when looking at screens. Treatment options range from over-the-counter artificial tears and a bedroom humidifier through prescription drops, punctal plugs, and in-

office procedures. Several new prescription treatments have been approved since 2021. If drops aren't working, ask for a referral rather than continuing to buy drops.

EXCESSIVE TEARING

If you tear up more easily due to bright light, wind, or temperature changes, wearing sunglasses can help — but there may be a more serious problem such as an eye infection or a blocked tear duct. Paradoxically, excessive tearing is often a symptom of dry eye. If the problem persists, see a doctor.

FLOATERS AND FLASHES

Most people experience floaters or flashes during their lifetimes, but they become more common with age. Floaters are small specks that drift across your field of vision, especially in bright light. **A sudden increase in floaters, a shower of new floaters, flashes of light, or a shadow or curtain across part of your vision is a medical emergency** — it can indicate a retinal tear or detachment, which is treatable if caught within hours or days and can cause permanent vision loss if it isn't. Do not wait for a routine appointment.

EYE DISEASES IN SENIORS

Some eye diseases and conditions occur almost exclusively in later years. Knowing the symptoms and having regular exams can make a huge difference in preventing them or minimizing the damage.

CATARACTS

A cataract is a cloudy area in the eye's lens. **Cataracts affect more than 20 million Americans age 40 and older, and by age 80 roughly half of Americans have a cataract or have had cataract surgery.** You may not notice any vision problems in the early stages, but eventually your vision gets hazy or blurry and less colorful, and glare from headlights at night becomes difficult. When it becomes a problem, surgery corrects it. Cataract surgery is among the most common and most successful operations performed in the United States, typically takes under half an hour per eye, and is covered by Medicare.

Most cataracts are age-related. Before about age 40, your lens is clear. As you age, proteins break down and clump together to create the cloud. Your doctor will diagnose the problem by dilating your eyes with drops and looking at the lens. You can help prevent or delay progression by wearing UV-blocking sunglasses and a brimmed hat. Lifestyle factors that increase risk include smoking, diabetes, and prolonged steroid use.

GLAUCOMA

Glaucoma is a group of eye diseases that damage the optic nerve at the back of your eye. It causes vision loss and blindness. Symptoms are subtle and start slowly, so regular eye exams including dilation are important. **Roughly half of people with glaucoma don't know they have it** — an estimated two million Americans have been diagnosed and roughly the same

number have not. As the disease progresses, you lose peripheral or side vision, and by the time you notice, permanent damage has occurred.

Risk factors include elevated intraocular pressure, family history, age, and race — African Americans and Hispanic Americans have substantially higher risk than other groups, and African Americans tend to develop it earlier. There is no cure, but it is possible to prevent further damage and protect vision with early detection and treatment. Lowering eye pressure through prescription eye drops, laser treatment, or surgery can slow or halt further damage. **Medicare covers an annual glaucoma screening for people at high risk**, including those with diabetes, a family history of glaucoma, African Americans 50 and older, and Hispanic Americans 65 and older.

MACULAR DEGENERATION

Age-related macular degeneration (AMD) is the leading cause of vision loss among older Americans. The macula — the part of the retina responsible for sharp central vision — deteriorates. **An estimated 19.8 million Americans aged 40 and older were living with some form of AMD as of the most recent national estimate, including about 1.5 million with the vision-threatening late stage.** Prevalence rises steeply with age, from about 2% of people in their early 40s to roughly 46% of people 85 and older.

Most people experience no symptoms in the early stages, so regular eye checkups matter. An optometrist or ophthalmologist can detect early-stage AMD by finding yellow deposits called drusen beneath the retina. In intermediate stages, patients may or may not begin to notice some central vision loss. As the disease progresses, the retina captures and interprets less and less.

There is no cure for the dry form, though the AREDS2 formulation of vitamins and minerals has been shown to slow progression in people with intermediate disease, and a treatment for advanced dry AMD (geographic atrophy) was approved in recent years. **The wet form is now highly treatable** with injected anti-VEGF medications, and newer longer-acting versions have reduced how often injections are needed. Early detection is what makes treatment possible.

Risk factors include family history, age, race — Caucasians are more likely to develop AMD than other groups — and above all **smoking**, which roughly doubles the risk. To prevent the disease and possibly slow progression: don't smoke, exercise, eat a diet rich in leafy greens and fish, control blood pressure, and protect your eyes from ultraviolet light. If you have been diagnosed, ask your doctor about an Amsler grid, a simple home test that helps detect the conversion from dry to wet AMD early enough to treat.

DIABETIC RETINOPATHY

If you have diabetes, get an annual dilated eye exam to check for retinopathy — this is one of the most consistently skipped appointments in medicine and one of the most consequential. Diabetes damages blood vessels throughout the body. In the eye, the tiny vessels that nourish the retina are damaged, reducing blood supply and prompting the eye to grow new vessels. The new vessels are weak, and they break and leak, causing impaired vision.

Preventing the disease and reducing damage is accomplished by keeping blood sugar, blood pressure, and cholesterol controlled. In later stages, treatment may include injections, laser treatment, or surgery. **Medicare covers an annual diabetic retinopathy exam for beneficiaries with diabetes.** Retinal imaging systems that can screen for retinopathy in a primary care office without dilation have become widely available since the first edition of this guide; ask whether your practice offers one.

CHECKUPS

Eye diseases and vision difficulties can usually be treated, and damage reduced, when caught early. How often should older adults get their eyes checked? **The American Optometric Association recommends an annual comprehensive eye exam for adults 65 and older**, and at least every two years for adults 40 to 64 without risk factors. Anyone with diabetes, a family history of glaucoma or AMD, or any new symptom should be seen sooner.

A gap worth planning for: Original Medicare does not cover routine eye exams or eyeglasses. It covers medically necessary eye care, the high-risk glaucoma screening, the diabetic retinopathy exam, cataract surgery, and one pair of corrective lenses after cataract surgery — but not the annual refraction or the glasses. Most Medicare Advantage plans include a routine vision benefit, which is one of the main reasons people choose them. Once you're on Medicare, you will be given a simple vision check during your annual wellness visit, but that does not screen your eyes for disease.

VISION AIDS

For those who lose vision and are not helped enough by regular eyeglasses, low-vision aids may help. There are magnifying glasses and devices, lenses that filter light, telescopic glasses, and electronic magnifiers. The category has expanded substantially: smartphone accessibility features, screen readers, text-to-speech, wearable cameras that read text aloud, and AI-powered apps that describe surroundings are now free or inexpensive and are often more useful than dedicated devices. A low-vision specialist or your state's vocational rehabilitation agency can help you find what fits.

CHAPTER 10: HEARING

HOW WE HEAR

To understand why our hearing can decline as we age, it helps to understand the basics of how humans hear. The process takes sound vibrations and converts them to nerve signals for the brain, but there are many steps and mechanisms involved.

- Sound waves are captured by the outer ear, enter the ear canal, and the eardrum moves in response.
- The eardrum, or tympanic membrane, at the beginning of the middle ear sends vibrations to three small bones called the ossicles.
- The chain of three bones connects the middle ear to the inner ear. As the eardrum moves, the ossicles transmit the movement to the cochlea in the inner ear.
- The cochlea looks a bit like a snail, and as the fluid inside it moves, tiny hair cells move with it. Different hair cells respond to different frequencies and convert the movement into electrical signals.
- The signals travel through the auditory nerve to the brain for interpretation.

While it's not important to understand the process completely, it helps to know about all the moving parts. Damage to any of them can interfere with hearing.

WHY DO WE LOSE HEARING AS WE GET OLDER?

Approximately one in three people between 65 and 74 has hearing loss, and nearly half of those over 75 have difficulty hearing. About 30 million American adults could benefit from hearing aids. It's called presbycusis and has several causes.

A development worth taking seriously. Since the first edition of this guide, evidence linking untreated hearing loss to cognitive decline has strengthened considerably. The Lancet Commission on dementia prevention identifies **hearing loss as the single largest modifiable risk factor for dementia in midlife**, and a major randomized trial found that hearing intervention slowed cognitive decline by roughly half over three years among older adults at elevated risk. Hearing aids also reduce fall risk. Treating hearing loss is no longer just about conversation; it is about protecting your brain and your balance.

NOISE-INDUCED LOSS

Older Americans experience hearing loss from several causes. Boomers who grew up with rock and roll experience hearing trouble due to noise exposure. The National Institutes of Health defines noise-induced hearing loss as loss caused by long-term exposure to sound that's too loud or lasts too long. The longer we live, the more likely we are to be exposed to loud or prolonged noise. The noise damages the sensory hair cells that convert sound waves to nerve impulses. Once damaged and lost, these cells don't regrow, and which hair cells are damaged determines which pitches are lost. Usually, older people lose the highest pitches first — which is why consonants like *s*, *f*, and *th* become hard to distinguish before vowels do.

MEDICATIONS AND DISEASE

Some medications are toxic to the hair cells. Certain chemotherapy drugs, some antibiotics, and high doses of some common pain relievers are examples; ask your pharmacist whether anything you take is ototoxic. Diseases such as high blood pressure and diabetes can cause hearing loss through damage to blood vessels.

OTHER CAUSES

There are less common causes, including abnormalities of the middle or outer ear that reduce the function of the hearing system. Hearing impairment can result from reduced function of the three tiny bones within the ear or of the eardrum. Bones become more brittle in our 70s and 80s, and repeated ear infections increase the chance of eardrum damage. And sometimes the cause is simply earwax, which is easily treated.

WHEN TO GET TESTED

Before age 50, most people don't get their hearing tested, but experts recommend a baseline test and then a test every decade before 50, and roughly every three years after. Chances are you won't get tested until you notice a problem — and the average person waits several years after noticing changes before doing anything about it.

Family and friends may notice changes in your hearing before you do. They notice you play the television louder than before and that you ask them to repeat things. If you have trouble hearing higher pitches or certain consonants like *s*, *f*, and *t*, or if you struggle to follow conversation in a noisy restaurant, you may have lost some hearing. Online and app-based hearing screeners are a reasonable first step, but seeing a professional is how you know for sure. You may find you simply have wax buildup or an infection.

HEARING TESTS

You will be screened for hearing loss at regular office visits, and the Medicare Annual Wellness Visit includes a hearing screening. If you suspect hearing loss, you should see an otolaryngologist, an audiologist, or a hearing aid specialist.

- **Otolaryngologist** — also called an ENT, a medical doctor specializing in diagnosing diseases of the ear, nose, throat, head, and neck. Once a diagnosis is made, the ENT may refer you to another specialist.
- **Audiologist** — specializes in identifying the type and measuring the degree of hearing loss, and is licensed to fit hearing aids.
- **Hearing aid specialist** — licensed by your state to evaluate your hearing and to recommend and fit hearing aids.

OVER-THE-COUNTER HEARING AIDS — THE BIGGEST CHANGE IN THIS CHAPTER

This did not exist when the first edition of this guide was written. **On October 17, 2022, a new FDA rule took effect creating a category of over-the-counter hearing aids that can be**

sold directly to consumers in stores and online, without a medical exam, a prescription, or a fitting by an audiologist. They are intended for adults 18 and older with *perceived mild to moderate* hearing loss. Devices for more severe loss, and any device for someone under 18, remain prescription products.

Why this matters: prescription hearing aids purchased through an audiologist have long cost roughly $2,000 to $7,000 a pair, are rarely covered by insurance, and are not covered by Original Medicare. Only about one in five people who could benefit from hearing aids uses them, and cost has consistently been the leading barrier. OTC devices are typically a fraction of that price, and several are sold by well-known consumer electronics companies. Some mainstream wireless earbuds now include an FDA-authorized hearing aid feature.

How to use this option sensibly:

- **Get evaluated first if you can.** OTC devices are appropriate for mild to moderate, roughly symmetrical, age-related loss. They are not appropriate if you have sudden hearing loss, hearing loss in only one ear, pain or drainage, dizziness, ringing in only one ear, or a history of ear surgery. Those are reasons to see a doctor, not to buy a device.
- **Know the return policy before you buy.** Adjustment takes time, and not every device suits every ear.
- **Prescription devices are still better for some people** — more powerful, professionally fitted and programmed, and supported over time. OTC lowered the price of entry; it did not make audiologists obsolete.

Medicare coverage note. Original Medicare still does not cover hearing exams for fitting hearing aids or the aids themselves. Most Medicare Advantage plans include some hearing benefit. Medicaid coverage varies by state, and the VA provides hearing aids to eligible veterans at no cost — a benefit many veterans do not realize they have.

OTHER HEARING ASSISTING DEVICES

- **Bone-anchored hearing systems.** Rather than using the ear canal and middle ear, these bypass those structures and send vibrations directly to the inner ear through the skull. Both surgically implanted and non-surgical versions exist.
- **Cochlear implants.** Surgically implanted electronic devices that help people with severe to profound hearing loss perceive sound. Candidacy criteria have broadened considerably in recent years, and many older adults who were told years ago that they were not candidates now would be. Medicare covers them for qualifying patients.
- **Assistive listening devices.** Sound-amplifying devices for everything from a landline telephone to a tablet. Hearing loops and closed-circuit systems with headsets are available at many museums, places of worship, and theaters — and both major smartphone platforms now support live captioning of phone calls and in-person conversation for free.

HOW CAN OTHERS HELP?

Hearing loss can be embarrassing for some, but letting others know and telling them how to help makes life easier. Ask people to face you and speak clearly. Reduce background noise during conversations — turn off the television, move away from the restaurant kitchen. If you need someone to be louder, say so, and work together until they talk loudly enough without shouting. Rephrasing helps more than repeating. If you get hearing aids, ask for patience while you adjust; the brain takes weeks to recalibrate.

PREVENTING HEARING LOSS

While not everything is known about why older people lose hearing, much of it can be prevented or reduced. Use hearing protection around loud noise — machinery, lawnmowers, power tools, firearms. A leaf blower may not seem dangerously loud, but because the noise lasts an hour or more, it can do damage. Keep music at a reasonable volume; roughly half of people aged 12 to 35 use headphones at volumes that put their hearing at risk. If you go to a concert, use earplugs — musicians' earplugs preserve sound quality far better than foam.

Staying healthy helps too. If you have diabetes or hypertension, keeping blood sugar and blood pressure controlled helps protect your hearing along with everything else.

TINNITUS

Another common hearing problem for people over 50 is tinnitus, or ringing in the ears. The noise you hear isn't caused by external sound, and other people can't hear it. **Roughly 10% of U.S. adults — about 25 million people — have experienced tinnitus lasting at least five minutes in the past year, and prevalence peaks between ages 60 and 69.** It is the leading service-connected disability among U.S. military veterans.

Like hearing loss, tinnitus is usually caused by damage within the ear, often from noise exposure, and it frequently accompanies hearing loss. Usually described as ringing, the phantom sound can also present as buzzing, hissing, humming, clicking, or roaring.

There is no cure, but there are treatments that meaningfully reduce its impact: hearing aids (which often help substantially when tinnitus accompanies hearing loss), sound therapy and masking, and **cognitive behavioral therapy, which has the strongest evidence of any treatment for reducing tinnitus-related distress.** If you notice symptoms — particularly in one ear only, or pulsing in time with your heartbeat, both of which warrant prompt evaluation — see an ENT. Tinnitus can be isolating and frustrating, and it is more treatable than most people have been told.

CHAPTER 11: MENTAL HEALTH

Mental health risks can occur at any age, but stressors common in the lives of older Americans can lead to mental illness. **The World Health Organization estimates that approximately 14% of adults aged 60 and over live with a mental disorder**, and that these conditions account for roughly 10.6% of the total years lived with disability in this age group. (The first edition of this guide cited a figure of 20%; WHO has since revised its estimate and its methodology.)

Depression and anxiety are the most common disorders. If someone has become less mobile and isolated, or suffers from chronic pain, psychological stress can lead to depression. Older adults without enough financial resources face everyday economic worries. Any combination of these and other risk factors can lead to depression and anxiety.

Loneliness and social isolation are now recognized as central risk factors, not incidental ones. The U.S. Surgeon General issued an advisory identifying loneliness as a public health epidemic, citing evidence that social isolation carries mortality risk comparable to smoking. Roughly a quarter of older adults are socially isolated. This is the single most actionable item in this chapter.

As you reach your 50s, 60s, and beyond, you will lose family members and friends. It's not uncommon for a 65-year-old to lose several people within a year. The living parents, aunts, and uncles of a 65-year-old are in their 80s or 90s. Dealing with loss is always difficult but can be worse when other risk factors are present.

Elder abuse can cause long-term psychological damage. **The World Health Organization estimates that around one in six people aged 60 and older experienced some form of abuse — emotional, verbal, physical, sexual, financial, or neglect — in community settings in the past year**, and rates in institutional settings are higher. Financial exploitation is the most commonly reported form in the United States. If you suspect abuse of an older adult, the national Eldercare Locator (1-800-677-1116) will connect you to your state's Adult Protective Services.

SYMPTOMS OF DEPRESSION AND ANXIETY

While any of the following symptoms can happen to anyone for short periods, someone experiencing several of them for more than two weeks may be having a major depressive episode. Getting evaluated by a professional and treated with medication, talk therapy, or both can help.

- Unusual anger, irritability, and frustration over small things
- Sadness or hopelessness, feeling empty
- Loss of interest in usual activities
- Sleep problems — sleeping too much or being unable to sleep well
- Unexplained fatigue
- Changes in appetite or eating habits

- Difficulty thinking clearly, forgetfulness
- Anxiety or restlessness without cause
- Dwelling on failures, feeling worthless
- Thoughts of death or suicide
- Physical problems without a known cause

Depression in older adults often looks different than it does in younger people. It is more likely to show up as physical complaints, irritability, memory problems, or loss of interest than as expressed sadness — which is one reason it is so frequently missed, and why it is sometimes mistaken for dementia. Depression in later life is not a normal part of aging and it responds well to treatment.

If you or someone you know is in crisis, the 988 Suicide and Crisis Lifeline is available 24 hours a day by calling or texting **988** in the United States. This service did not exist when the first edition of this guide was published; it replaced the older ten-digit hotline number in July 2022. Adults 75 and older have among the highest suicide rates of any age group in the country, and men over 75 have the highest of all — which makes this number worth writing down.

PREVENTING DEPRESSION

As things change, making healthy life adjustments can prevent depression. If someone stops being able to bowl, for example, replacing it with another social activity is beneficial. When a person retires, establishing a new routine is vital. Joining clubs, volunteering, taking classes, or working at hobbies can all be part of the new schedule. If you have a vague idea of home improvement projects and catching up on reading, make lists and schedules and follow them.

Take care of your physical health, eat well, and exercise. The more active you are, the less likely you are to become depressed or anxious. If you move to an assisted living or nursing home, staying as active as possible can prevent feelings of isolation and abandonment. Participate in any activities offered.

If you lose a friend or family member, share the loss with others. Talk about it with a grief counselor if you need to. If your circle is dwindling, add new people any way you can. Take or teach a class at the local senior center. Volunteer at a hospital, mentor, or tutor kids in your area if you are able. If you can do very little physically, connect regularly by phone or video with as many people as you can — and ask others to call you.

Two practical notes that are new since the first edition. Medicare now covers a much broader range of mental health care than it once did: **Medicare Part B began covering services from licensed marriage and family therapists and mental health counselors in 2024**, substantially expanding the number of providers who can bill Medicare. And telehealth for mental health is now well established and covered, which removes transportation as a barrier — a significant change for anyone who has stopped driving or lives far from a provider.

If you do start to have symptoms of depression, tell someone. The sooner the illness is addressed, the easier it will be to handle.

ALZHEIMER'S AND DEMENTIA

DEMENTIA

Dementia is a syndrome, usually chronic or progressive in nature, in which memory deteriorates and thinking clearly becomes difficult. Dementia patients find everyday tasks like dressing harder. It mainly affects older people but **is not a normal part of aging.**

Globally, an estimated 57 million people were living with dementia as of the most recent WHO figures, with nearly 10 million new cases every year. Over 60% live in low- and middle-income countries. The number is projected to reach roughly 78 million by 2030 and about 139 million by 2050. Dementia is currently the seventh leading cause of death worldwide. **Alzheimer's disease accounts for an estimated 60–70% of dementia cases.**

The good news is that some dementias have other causes and can be treated. Determining the cause and getting evaluated as soon as symptoms appear is therefore very important.

REVERSIBLE DEMENTIAS

Dementia is caused by damage or disruption to brain cells, especially in the cerebral cortex, where memory, perception, consciousness, and language are controlled. Some causes are treatable and reversible:

Delirium — disorientation caused by fever and infection, drug withdrawal, stroke, dehydration, or reactions to medication. Common and frequently missed in hospitalized older adults. The sooner the cause is treated, the better the outcome.

Normal pressure hydrocephalus — caused by a buildup of fluid in the brain's ventricles. Symptoms are the classic triad of walking difficulty, urinary problems, and cognitive impairment. It can be treated by surgical implantation of a shunt.

Wernicke-Korsakoff syndrome — caused by long-term alcohol use and vitamin B1 (thiamine) deficiency. Symptoms include memory and cognitive impairment. Only partially reversible.

Vitamin B12 deficiency — B12 assists in the production of red blood cells, which transport oxygen to the brain, and is directly involved in nerve function. Deficiency causes fatigue, shortness of breath, neuropathy, and cognitive changes. It can be caused by diet, by absorption problems, and notably by **long-term use of metformin and acid-reducing medications** — worth knowing if you take either. Supplements or injections can reverse it.

Thyroid disease — affects women considerably more often than men, and thyroid hormone replacement can restore normal function and reverse the associated cognitive symptoms.

Drug or chemical reactions — a broad category including heavy alcohol use, environmental toxins, and reactions to medications or interactions among multiple medications. **Polypharmacy is one of the most common and most reversible causes of confusion in older adults.** Ask your pharmacist for a comprehensive medication review — Medicare Part D

plans are required to offer Medication Therapy Management to qualifying beneficiaries at no cost. Anticholinergic medications, including many over-the-counter sleep aids and antihistamines, are a frequent culprit.

Cancer and tumors — can cause dementia and are usually accompanied by headaches or other neurological signs. Personality changes can result. Removal of a tumor may reverse the problem entirely.

Subdural hematoma — a head injury and resulting blood clot in the brain can produce Alzheimer's-like symptoms. Even a minor fall weeks earlier could be to blame, particularly in someone on a blood thinner. Removing the clot reverses the signs.

Sleep apnea, depression, and hearing loss all produce cognitive symptoms that improve with treatment, and all three are commonly mistaken for early dementia.

IRREVERSIBLE DEMENTIAS

ALZHEIMER'S DISEASE

All aging brains accumulate some abnormal proteins. In Alzheimer's, beta-amyloid forms plaques between neurons and tau protein forms tangles within them. For some people the changes are limited and don't cause severe dysfunction; for others there is extensive damage to brain cells. Heredity is a factor, as is age. Anyone with a close relative who has or had Alzheimer's is at meaningfully elevated risk.

Current U.S. figures, from the Alzheimer's Association 2026 Facts and Figures report:

- **An estimated 7.4 million Americans age 65 and older are living with Alzheimer's dementia.** That number could reach 13.8 million by 2060 absent medical breakthroughs.
- **About 1 in 9 people age 65 and older — roughly 11% — has Alzheimer's.** Prevalence rises sharply with age: **5.2% of people 65–74, 13.8% of those 75–84, and 35.8% of those 85 and older.**
- Nearly two-thirds of Americans with Alzheimer's are women. Older Black Americans are about twice as likely, and older Hispanic Americans about one and a half times as likely, to have Alzheimer's or another dementia as older White Americans.
- Roughly 200,000 Americans have younger-onset dementia, beginning before age 65.
- Alzheimer's was the sixth-leading cause of death in the United States in 2024, and the fifth-leading cause among people 65 and older. Reported deaths rose 134% between 2000 and 2024.
- **Total payments for health care, long-term care, and hospice for people with dementia will reach an estimated $409 billion in 2026**, not counting the value of unpaid care. Nearly 13 million family members and friends provided more than 19 billion hours of unpaid care last year.

SYMPTOMS

The Alzheimer's Association lists the following ten warning signs. Any one of them occasionally may mean nothing; a pattern of several is a reason to be evaluated.

1. **Memory loss that disrupts daily life** — repeating yourself, forgetting recently learned information, increasingly relying on notes and reminders for things you used to handle.
2. **Challenges in planning or solving problems** — trouble following a familiar recipe, paying bills, or keeping track of monthly expenses.
3. **Difficulty completing familiar tasks** — trouble driving to a familiar place, using a phone, or managing a task at work.
4. **Confusion with time or place** — losing track of dates or seasons, or forgetting how you got somewhere.
5. **Trouble understanding visual images and spatial relationships** — difficulty with balance, judging distance, reading, or determining color and contrast.
6. **New problems with words** — trouble following or joining a conversation, stopping mid-sentence, calling things by the wrong name.
7. **Misplacing things and losing the ability to retrace steps** — putting things in unusual places and being unable to reconstruct where they went, sometimes accompanied by accusing others of stealing.
8. **Decreased or poor judgment** — vulnerability to scams, less attention to grooming, neglecting a pet.
9. **Withdrawal from work or social activities.**
10. **Changes in mood and personality** — becoming confused, suspicious, fearful, anxious, or easily upset.

Memory is the first symptom experienced in a slight majority of cases, but not all: language, executive function, behavior, and visuospatial difficulties are each the presenting symptom in a meaningful minority of people.

SCREENING AND TESTING

Your Medicare Annual Wellness Visit includes a **cognitive assessment** — the practitioner is required to detect cognitive impairment as part of the visit, using direct observation and a brief structured test. Several validated brief tests are in use; which one your practice uses varies. Medicare also covers a separate, more detailed **cognitive assessment and care planning visit** for patients where impairment is detected, which did not exist in most practices when the first edition of this guide was written and which is worth asking about specifically.

If a problem is detected, you will be referred to a neurologist or geriatrician for further testing. The specialist will review symptoms and test for the other possible causes listed above, including brain imaging and bloodwork.

The biggest change in diagnosis since the first edition: blood tests. Blood-based biomarker tests that detect Alzheimer's-related proteins have moved from research settings into clinical practice, with the first receiving FDA clearance in 2025. They are far less invasive and less expensive than the PET scans and spinal taps that previously confirmed a diagnosis, and they are beginning to make earlier, more accessible diagnosis realistic. They are diagnostic aids, not screening tests for people without symptoms, and results should be interpreted by a specialist.

ALZHEIMER'S TREATMENT — THIS SECTION HAS CHANGED COMPLETELY

Cholinesterase inhibitors — donepezil, rivastigmine, and galantamine — remain in use to help manage symptoms in early and moderate stages. They prevent the breakdown of acetylcholine, a brain chemical important to memory and thinking, whose production declines as Alzheimer's progresses. **Memantine** is used in moderate to severe disease, sometimes in combination. None of these change the underlying disease.

Aducanumab (Aduhelm) is no longer available. The drug described as "the only disease-modifying medication currently approved" in the first edition of this guide was **discontinued by its manufacturer, Biogen, in 2024** and withdrawn from the market. If you are reading an older reference that recommends it, that reference is out of date.

Two anti-amyloid antibody treatments are now FDA-approved for early symptomatic Alzheimer's:

- **Lecanemab (Leqembi)** — received full FDA approval in July 2023. Given by IV infusion every two weeks initially, with a subcutaneous maintenance injection available after 18 months. List price around $26,500 per year.
- **Donanemab (Kisunla)** — received full FDA approval in July 2024. Given by monthly IV infusion, with the option to *stop* treatment once brain scans show amyloid has been cleared, which can reduce total cost and infusion burden.

What these drugs do and don't do. In trials, both slowed the rate of cognitive decline by a modest amount — in the range of 25–35% over 18 months — in people with mild cognitive impairment or mild Alzheimer's dementia with confirmed amyloid in the brain. They do not stop, reverse, or cure the disease. They are not appropriate for people with moderate or advanced dementia. Both carry a risk of **ARIA** (amyloid-related imaging abnormalities — brain swelling or small bleeds), which requires periodic MRI monitoring and is more common in people who carry two copies of the ApoE4 gene, so genetic testing is part of the workup. **Medicare covers both under a registry requirement.**

There is genuine and ongoing scientific debate about how meaningful the benefit is. A large systematic review published in 2026 concluded that the class effect on cognition is small; major Alzheimer's organizations and regulators have pushed back on that analysis, noting it pooled failed earlier drugs with the two current ones. Access is also a real barrier — many people live hours from a center that can diagnose and infuse. This is a conversation to have with a specialist about your specific situation, not one to settle from a book.

PREVENTION — THE MOST HOPEFUL CHANGE IN THIS CHAPTER

The first edition of this guide said that "nothing has been proven to avoid or delay" Alzheimer's. **That statement is no longer accurate, and the change is substantial.**

In July 2026, the World Health Organization issued new guidelines concluding that up to 45% of dementia risk is attributable to modifiable risk factors and could potentially be prevented or delayed. This mirrors the findings of the Lancet Commission on dementia prevention, which identifies fourteen modifiable risk factors across the life course:

In midlife and later life: hearing loss (the largest single modifiable factor), high LDL cholesterol, depression, traumatic brain injury, physical inactivity, diabetes, smoking, high blood pressure, obesity, excessive alcohol, social isolation, air pollution, and untreated vision loss. **In early life:** less education.

None of this guarantees anything, and having risk factors does not mean you will develop dementia any more than avoiding them means you won't. But the practical implication is clear and it is not complicated: **treat your hearing loss, get your cataracts fixed, control your blood pressure and cholesterol and blood sugar, move your body, don't smoke, drink moderately, wear a helmet, treat depression, and stay connected to other people.** Nearly every one of those things is already recommended for other reasons.

Mental health is connected to physical health, and a healthy lifestyle can help prevent depression, anxiety, and some types of dementia. Social interaction and staying active help too.

If someone in your family is diagnosed, the Alzheimer's Association 24/7 Helpline (1-800-272-3900) is staffed by clinicians, free, and genuinely useful — for care planning, for behavior questions at two in the morning, and for finding local resources.

CHAPTER 12: CHECKUPS AND RECOMMENDED SCREENINGS

Several of the recommendations in this chapter changed after the first edition of this guide was published, and two of them changed by a full five years. Colorectal cancer screening now begins at 45 rather than 50, breast cancer screening now begins at 40 rather than 50, lung cancer screening now begins at 50 rather than 55, and the pneumococcal vaccine is now recommended at 50 rather than 65. If you are between 40 and 50 and assumed you had time, you may not.

WELCOME TO MEDICARE PREVENTIVE VISIT

During your first twelve months on Medicare Part B, you can have a Welcome to Medicare visit with your primary care physician's office. The goals include recording your personal and family medical history, doing basic health screenings, and creating a personalized disease prevention plan. Whether you have Original Medicare or an Advantage plan, this visit costs the patient nothing. If your provider discovers medical conditions that require additional diagnosis or treatment, those services may be billed separately — this is the most common source of surprise bills from an otherwise free visit, so ask before agreeing to add-on services.

MEDICARE ANNUAL WELLNESS VISIT

Once you have had Medicare Part B for 12 months, you qualify for an Annual Wellness Visit with your primary care provider, and every 12 months thereafter. During the visit you work with your provider to update your medical history and personalized prevention plan. There is no cost to you.

Covered elements include:

- Height, weight, and body mass index
- Blood pressure
- Vision check using an eye chart
- Screening for depression
- Social and medical history updates
- A full review of your medications, including over-the-counter drugs and supplements
- Safety screening, including fall risk and home safety
- **Cognitive assessment for dementia**
- Advance care planning discussion, if you wish
- Referrals to educational and counseling services when indicated

These appointments are not complete physicals, and they are often conducted by a nurse or advanced practice provider rather than a physician. Medicare does not cover a traditional annual physical exam. The wellness visit does provide important baseline screenings, and it is the natural place to raise advance directives and cognitive concerns.

MEDICAL SCREENINGS

AGES 40 TO 64

The following screenings are recommended by major medical organizations for adults between 40 and 64. Frequency changes after 64, and some additional preventive screenings begin at 65.

Colorectal cancer screening — begins at age 45. Both the U.S. Preventive Services Task Force and the American Cancer Society now recommend that average-risk adults begin at **45, not 50**, in response to rising colorectal cancer rates among younger adults. Screening continues through 75, and from 76 to 85 the decision is individualized based on health and screening history. Several test options exist, and **the best test is the one you will actually do:**

- Colonoscopy every 10 years
- Fecal immunochemical test (FIT) every year
- Stool DNA test (FIT-DNA) every 1 to 3 years
- Flexible sigmoidoscopy every 5 years, or every 10 years combined with annual FIT
- CT colonography (virtual colonoscopy) every 5 years
- Blood-based screening tests have recently become available and are an option for people who decline other testing; discuss their performance characteristics with your doctor

Any abnormal result on a non-colonoscopy test must be followed by a colonoscopy. Note that **double-contrast barium enema, listed in the first edition of this guide, is no longer a recommended screening method** and has been superseded by the tests above.

Lung cancer screening — begins at age 50. Annual low-dose CT is now recommended for adults **aged 50 to 80 with a 20 pack-year smoking history** who currently smoke or who quit within the past 15 years. The previous guideline started at 55 with a 30 pack-year history; the criteria were broadened in 2021, roughly doubling the number of eligible people. Fewer than one in five eligible Americans is actually screened, which makes this one of the largest missed opportunities in preventive medicine.

Cholesterol. A lipid panel measures cholesterol and triglycerides in your blood. High cholesterol builds plaque in arteries, leading to narrowed or blocked arteries (atherosclerosis), which raises the risk of coronary artery disease, heart attack, and stroke. Cholesterol is a waxy fat-like substance produced by the liver and present in foods like meat and dairy. Your results give you several numbers. **Generally accepted desirable ranges for adults:**

- Total cholesterol: under 200 mg/dL
- LDL ("bad") cholesterol: under 100 mg/dL — lower if you have cardiovascular disease or diabetes
- HDL ("good") cholesterol: 40 or higher for men, 50 or higher for women
- Non-HDL cholesterol (total minus HDL): under 130 mg/dL
- **Triglycerides: under 150 mg/dL.** (The first edition listed 150–199 as healthy; that range is actually classified as *borderline high*. Normal is below 150.)

Your target LDL depends on your overall cardiovascular risk, not on the number alone. Ask your doctor to calculate your 10-year risk estimate rather than reacting to a single value.

Diabetes screening. The USPSTF recommends screening for prediabetes and type 2 diabetes in **adults aged 35 to 70 who are overweight or obese**, repeated every three years if normal — more often with a family history or other risk factors. Many primary care physicians screen during the annual physical regardless.

- Fasting blood glucose: normal is 70–99 mg/dL. 100–125 indicates prediabetes; 126 or above on two occasions indicates diabetes.
- **A1C** measures average blood sugar over roughly three months. **Below 5.7% is normal; 5.7% to 6.4% is prediabetes; 6.5% or above indicates diabetes.** (The first edition of this guide gave 6.7% as the diabetes threshold; the correct figure is 6.5%.)

Prediabetes is common, reversible, and largely silent. The CDC-recognized National Diabetes Prevention Program is covered by Medicare and by most insurance and has strong evidence behind it.

Depression screening — annually. You will be asked a short series of questions about your mood and daily activities.

Hepatitis C — the CDC and USPSTF recommend that **all adults aged 18 to 79 be screened at least once**, regardless of risk factors. Many boomers were never tested. Hepatitis C is now curable in the large majority of cases with a short course of oral medication, and it is a leading cause of liver cancer and cirrhosis in people who don't know they have it. If you have never been tested, ask.

Dental exam — everyone should continue to visit a dentist for exams and cleanings every six to twelve months. Checkups detect oral cancer and signs of bone loss in addition to cavities. Note that **Original Medicare does not cover routine dental care**; plan for this expense or look for a Medicare Advantage plan with a dental benefit.

FOR WOMEN

Mammography — begins at age 40. The USPSTF updated its guidance in 2024 to recommend **screening mammography every two years for all women aged 40 to 74**, down from a previous starting age of 50. The American Cancer Society recommends women have the option to begin annual mammograms at 40, with annual screening recommended from 45 to 54 and the option of every two years from 55 onward. Women with a family history or other elevated risk may need to start earlier or add MRI screening — ask about a formal risk assessment.

Two newer points: many women have **dense breast tissue**, which reduces mammogram sensitivity, and FDA rules now require that mammogram reports notify you of your breast density. And as of 2026, federal rules require most health plans to cover follow-up diagnostic imaging after an abnormal screening mammogram at no cost — a change that removes a significant financial barrier.

Cervical cancer screening. Before 65, women should continue getting a Pap test every three years, or a Pap plus HPV test every five years, or **primary HPV testing alone every five years**, which is now an accepted option. Women who have had consistently normal results and no history of cervical precancer can generally stop screening at 65. Self-collection for HPV testing has been FDA-approved in health care settings, which may make screening easier for women who have avoided it.

FOR MEN

Prostate cancer screening. This recommendation is more nuanced than the first edition of this guide suggested. Rather than a routine PSA test starting at 50, current guidance emphasizes **shared decision-making**: the USPSTF recommends that men **aged 55 to 69** discuss the potential benefits and harms of PSA screening with their clinician and decide individually, and recommends **against** routine PSA screening for men 70 and older. The American Cancer Society suggests the conversation begin at **45 for men at higher risk — African American men and men with a first-degree relative diagnosed before 65 — and at 40 for men with multiple affected relatives.**

If you and your doctor decide to screen, a baseline PSA is drawn and future tests look for the trend as much as the absolute value. An elevated or rising PSA no longer leads directly to biopsy in most practices; MRI-guided evaluation has substantially reduced unnecessary biopsies, and active surveillance rather than immediate treatment is now standard for many low-risk cancers. The harms of over-treatment are the reason for the caution — this is a genuinely individual decision.

IMMUNIZATIONS

Adult vaccine recommendations changed meaningfully after the first edition of this guide. The current picture:

- **Influenza** — annually, for everyone. **Adults 65 and older should preferentially receive a high-dose, adjuvanted, or recombinant flu vaccine**, which produce a stronger immune response than the standard version. Ask for one by name.
- **Pneumococcal — now recommended at 50, not 65.** The CDC lowered the age in late 2024. A single dose of PCV20 or PCV21 completes the series for most adults who have never been vaccinated. Adults under 50 with certain conditions are also recommended.
- **Shingles (Shingrix)** — two doses, two to six months apart, for **all adults 50 and older**, regardless of whether you recall having had chickenpox and regardless of whether you previously received the older Zostavax vaccine. Also recommended for immunocompromised adults 19 and older.
- **RSV — new since the first edition.** RSV vaccines were first approved in 2023. A **single dose is recommended for all adults 75 and older, and for adults 50 to 74 who are at increased risk of severe RSV disease.** At present it is a one-time dose; additional doses are not recommended. Best given in late summer or early fall.
- **Tdap/Td** — one dose of Tdap if you have never had it, then a Td or Tdap booster every 10 years.

- **COVID-19** — recommendations have been revised repeatedly and continue to evolve, with age and risk-based criteria. Check current CDC guidance or ask your pharmacist or physician what applies to you this season.
- **Hepatitis B** — now recommended universally for adults 19 through 59, and for adults 60 and older with risk factors.

Under Medicare, **Part D covers all vaccines recommended by ACIP at no cost to you** — a change from the Inflation Reduction Act that eliminated what used to be significant out-of-pocket costs for shingles vaccination in particular. Flu, pneumococcal, COVID, and hepatitis B vaccines are covered under Part B.

AFTER AGE 65

Many tests that were optional become recommended after 65 and are typically covered. Cognitive and home-safety screenings are part of your Medicare Wellness Visit. Vision and hearing are discussed in Chapters 9 and 10. Additional screenings include:

Osteoporosis — bone density testing. Recommended for **all women 65 and older**, and for younger postmenopausal women with risk factors. For men, the USPSTF has found insufficient evidence to make a blanket recommendation, but many clinicians screen men at 70, or earlier with risk factors such as smoking, long-term steroid use, low body weight, or a prior fragility fracture. Frequency of repeat testing depends on the initial result. Medicare covers a bone density scan every 24 months for qualifying beneficiaries.

Abdominal aortic aneurysm — a one-time ultrasound screening is recommended for **men aged 65 to 75 who have ever smoked.** Medicare covers it as part of the Welcome to Medicare visit. This is a simple, painless test for a condition that is usually silent until it is catastrophic, and it is frequently overlooked.

Fall risk assessment. Falls are the leading cause of injury death among adults 65 and older. Your wellness visit should include a fall risk screen; if it doesn't, ask. Exercise programs that include balance training, medication review, vision correction, and home modification all have evidence behind them.

ADVOCATING FOR YOURSELF

While speaking up for yourself at medical appointments is always important, it becomes more important as you get older. Older people sometimes feel awkward or embarrassed about asking questions and requesting help from doctors, especially if their cognitive function begins to diminish. If you start to feel intimidated or have questions about test results or symptoms, bring someone with you who can help. Two sets of ears are better than one, and a family member may think of things to ask that you don't.

Write your questions down before the appointment and hand the list to the doctor at the start. Ask "what are we doing about the thing I came in for?" before the visit ends. And if a new medication is prescribed, ask what it is for, what it replaces, how long you should take it, and what would make you stop.

PERSONAL RECORDS

Many medical offices and hospitals have patient portals where you can see test results. Whether you use the portal or get results verbally or on paper, keep track on your own. Note when you have had each screening and what the results were. Put together a list of your doctors, your prescriptions, and other medical information you might need. Most medical facilities are good about appointment reminders, but the more involved you are, the easier understanding your health care needs and goals will be. If there comes a time when you cannot handle your healthcare needs, having records will make bringing in a family member much easier.

A practical suggestion: keep a one-page summary — current medications and doses, allergies, major diagnoses, past surgeries, your doctors' names and numbers, your emergency contacts, and whether you have an advance directive and where it is. Put a copy in your wallet and give one to whoever would be called if you were hospitalized. Emergency departments make better decisions with that page than without it.

UPDATE RECORDS

Hopefully your primary care provider and local hospital update their records regularly, but take responsibility yourself — especially if you don't go to the doctor or hospital often. Let them know about changes of address, phone, and email, and update who has access to your records when you need to. The older you get, the more likely you will need help with decisions, so be sure your family or friends listed on your records can still help, and make sure their contact information is updated too.

This is also the moment to complete a **HIPAA authorization** naming the people your providers may speak with. It is a separate document from a health care proxy, it is short, and every practice has one. A proxy generally takes effect only when you cannot make decisions for yourself; a HIPAA authorization lets a family member call the office and get an answer today.

CHAPTER 13: LEGAL PAPERWORK

If, at any point, because of illness or accident, someone loses the ability to communicate or make decisions about their finances or medical care, it's important to have legal documents in place. These documents vary from state to state, but all states allow the creation of documents making medical treatment wishes known so they can be followed if someone can no longer communicate. All states also permit you to designate someone to handle financial decisions for you.

State laws vary concerning the type of documents that cover these situations. All U.S. states permit you to express your wishes about medical treatment during a terminal illness or injury and to appoint someone to communicate for you in the event you cannot speak for yourself. Depending on the state, these documents might be known as "living wills," "medical directives," "health care proxies," or "advance health care directives."

How common is this? Less than you'd hope. A national survey conducted in September 2025 found that **only about 31% of U.S. adults have a living will or advance health care directive**, and only 32% have a will at all. The numbers rise sharply with age — **44% of adults in their 60s, 64% of adults in their 70s, and roughly 80% of those 80 and older** have an advance directive — but the pattern is that most people wait until their seventies. Fewer than half of adults have discussed their preferences for living arrangements if they could no longer live independently.

The documents cost little or nothing to prepare and they take an afternoon. They are the single highest-return item in this entire book.

MEDICAL PROXY

A medical or healthcare proxy names someone you trust as your agent to express your wishes and make medical decisions for you. Depending on your state, the document might be called a durable medical power of attorney, healthcare surrogate designation, or healthcare agent appointment. Your proxy makes decisions whenever you are incapable of communicating. You don't have to be terminally ill for them to step in, but a doctor may have to certify that you are incapacitated. Depending on how the paperwork is worded, your proxy may or may not be allowed to see your medical records; you can place any restrictions you see fit on medical information when you create the document.

Be sure you trust the person you choose. Choose someone you know will be assertive enough to ensure your wishes are followed, and who can be reached and can function in a crisis — geography and temperament matter more than birth order. Make sure the person knows:

- Your attitude toward illness and dying
- Your medical treatment preferences concerning palliative care, life-sustaining care, and other needs while you are unconscious
- Any religious beliefs which might affect your healthcare decisions
- Any attitudes or feelings you have about specific providers or healthcare institutions

Then have the conversation out loud. A document tells your agent what to do; a conversation tells them why, which is what they will need when a situation arises that the document didn't anticipate. Free conversation guides from The Conversation Project (theconversationproject.org) and PREPARE for Your Care (prepareforyourcare.org) make this easier than starting cold.

You can name a second person as a backup if your primary agent can't serve. Let family members know who you have designated — the time to find out is not in a hospital corridor. If you have not selected anyone, your state's laws will determine who makes decisions for you, and the default order may not be who you would have chosen. **You don't need an attorney to name a proxy.**

A healthcare proxy may be included within a living will; some states combine the proxy and the living will into a single advance directive document.

LIVING WILLS OR ADVANCE HEALTHCARE DIRECTIVES

These two are essentially the same document by different names. Depending on your state, they can also be called a personal directive, advance directive, or medical directive. These legal documents specify the actions you wish taken for your health when you can no longer make decisions and express them yourself. You may include a medical proxy within your living will or make it a separate document.

Depending on your state law, a living will may let you decide in advance whether you want doctors to provide life-sustaining treatments. When your life cannot be saved, you may not want treatments like ventilators, feeding tubes, dialysis, and CPR.

An advance directive guides your caregivers and doctors if you become terminally ill, are in the last stages of dementia, have been seriously injured, are in a coma, or are near the end of your life. The document helps ensure you get the care you want and avoid unnecessary suffering. Deciding in advance about these issues also lifts a burden from loved ones and avoids confusion or disagreement among family members.

POLST AND MOLST FORMS

These did not appear in the first edition of this guide and they are worth knowing about. A **POLST** (Physician Orders for Life-Sustaining Treatment) — called MOLST, POST, or MOST in some states — is different from an advance directive in an important way. **An advance directive is a legal document expressing your wishes; a POLST is a medical order signed by a clinician that emergency personnel must follow.**

POLST forms are appropriate for people who are seriously ill or frail, generally those whose clinicians would not be surprised if they died within a year — not for healthy adults. They travel with the patient between home, hospital, and nursing facility, and they address specific interventions: CPR, intubation, hospitalization, artificial nutrition. If you or a family member has a serious progressive illness, ask the treating physician whether a POLST is appropriate. Most states now have a program; the National POLST office maintains a directory.

POWER OF ATTORNEY

A power of attorney names a person you trust to make financial, property, and other legal decisions on your behalf should you become incapacitated. What powers you can assign varies widely from state to state, and you can put any limits you think wise on the decisions your agent can make. Things you might authorize them to do include:

- Collect your Social Security benefits
- Pay your bills, conduct banking, and file taxes for you
- Run your business
- Manage investments and retirement accounts
- Buy and sell property and other assets
- Hire an attorney for you
- Donate money to charities on your behalf
- Choose or change your healthcare insurance plan
- Communicate with your insurance company and appeal coverage decisions

Make sure it is durable. A general power of attorney terminates when you become incapacitated, which is exactly when you need it. A **durable** power of attorney survives incapacity. This distinction is the most common and most expensive error people make with this document.

Two practical cautions: many financial institutions are difficult about accepting a power of attorney they did not draft, so ask your bank and your brokerage whether they require their own form and complete it while you still can. And **Social Security does not recognize powers of attorney at all** — to manage someone's Social Security benefits you must be appointed a Representative Payee through the Social Security Administration, which is a separate process.

DON'T FORGET THE DIGITAL ACCOUNTS

Nearly every state has now adopted a version of the Revised Uniform Fiduciary Access to Digital Assets Act, which governs whether your agent or executor can access your email, photos, and online accounts. In practice, the most effective steps are simpler than the law: use a password manager and make sure a trusted person can get into it, and use the built-in legacy tools the major platforms now offer — Google's Inactive Account Manager, Apple's Legacy Contact, and the equivalents on social platforms. Without this, families routinely lose access to photographs, accounts, and subscriptions they cannot cancel.

WHERE TO GET THE FORMS

For information about creating documents and complying with your state's laws, check:

- **Your state's Attorney General's office or Department of Health** — most publish free, state-specific advance directive forms

- **Your local hospital** — hospitals are required to provide information about advance directives and most will give you the forms and often notarize them
- **CaringInfo** (caringinfo.org), a program of the National Hospice and Palliative Care Organization, which offers free state-specific advance directive forms and instructions for all fifty states and the District of Columbia
- **The American Bar Association Commission on Law and Aging**, which publishes a free consumer toolkit for health care advance planning
- **Your state or local bar association**, for a lawyer referral
- **Your Area Agency on Aging**, findable through the Eldercare Locator at 1-800-677-1116

Online form services can generate these documents, but they vary in quality and in how well they track state-specific requirements. For a straightforward advance directive and health care proxy, the free state forms above are usually sufficient. For a durable financial power of attorney — and certainly for anything involving a trust, a business, blended families, or a special-needs beneficiary — an elder law attorney is worth the fee.

AFTER YOU SIGN

The documents only work if they can be found.

- Give copies to your health care agent, your backup agent, your primary care physician, and any specialist you see regularly. Ask that they be scanned into your medical record.
- **Do not put the only copy in a safe deposit box**, which your family may not be able to open when they need it.
- Keep a copy somewhere obvious at home and tell someone where. Some people keep one on the refrigerator, which is where emergency responders are trained to look.
- Consider a digital copy in a shared cloud folder or one of the advance directive registries several states now operate.
- **Review them every few years** and after any major life change — a death, divorce, diagnosis, or a move to a new state. Documents remain valid across state lines in most circumstances, but forms drafted to your new state's requirements are less likely to be questioned.

GLOSSARY

A1C Test — measures average blood sugar over roughly three months. Below 5.7% is normal; 5.7% to 6.4% is prediabetes; **6.5% or above indicates diabetes.**

Acetylcholine — a brain chemical important to memory and thinking. The amount produced declines as Alzheimer's progresses.

Active community — a housing community designed for people over 55 or sometimes 62. Usually offers activities and services for older adults.

Adult day health care — centers providing supervised care, meals, light exercise, and social activity for older adults during the day. Designed to give caregivers respite. National median cost: $95 per day.

Advance healthcare directive — a legal document specifying the actions you wish taken for your health when you can no longer make decisions and express them yourself. May include a medical proxy or be separate. Also called a living will, personal directive, or medical directive depending on the state.

Age-related macular degeneration (AMD) — loss of central sight due to deterioration of the macula, part of the retina. The leading cause of vision loss among older Americans. Affects an estimated 19.8 million Americans 40 and older.

Alzheimer's disease — an irreversible dementia associated with a buildup of beta-amyloid plaques and tau tangles in the brain. Accounts for an estimated 60–70% of dementia cases. An estimated 7.4 million Americans age 65 and older have it.

Amyloid-related imaging abnormalities (ARIA) — brain swelling or small bleeds that can occur as a side effect of anti-amyloid Alzheimer's treatments, requiring periodic MRI monitoring.

Anti-amyloid antibody — a class of Alzheimer's drug that clears beta-amyloid from the brain and modestly slows cognitive decline in early disease. Currently **lecanemab (Leqembi)** and **donanemab (Kisunla)**.

Assisted living facility — a residential facility for older adults and people with disabilities who cannot or choose not to live independently. Staff provide security and assistance with daily tasks. National median cost: $6,200 per month.

Audiologist — specializes in identifying the type and measuring the degree of hearing loss, and is licensed to fit hearing aids.

Auditory nerve — the nerve that carries sound signals from the cochlea to the brain as electrical impulses.

Baby Boomer — someone born between 1946 and 1964, so named because they were part of a boom of babies born after World War II.

Bone-anchored hearing system — a hearing device that bypasses the ear canal and middle ear, sending vibrations directly to the inner ear through the skull.

Cataract — a cloudy area in the eye's lens producing hazy, blurry, or less colorful images. Caused by proteins breaking down and clumping with age. Corrected with surgery. Roughly half of Americans have a cataract or have had cataract surgery by age 80.

Cholesterol — a waxy fat-like substance produced by the liver and present in foods like meat and dairy. Elevated levels raise the risk of heart disease. A lipid panel reports total cholesterol, LDL ("bad"), HDL ("good"), non-HDL, and triglycerides.

Cholinesterase inhibitors — drugs such as donepezil, rivastigmine, and galantamine used to manage symptoms of Alzheimer's disease. They prevent the breakdown of acetylcholine but do not modify the underlying disease.

CLUE report — Comprehensive Loss Underwriting Exchange report, showing a property's insurance claims history. Worth requesting before buying a home.

Cochlea — a snail-shaped structure in the inner ear; fluid within it moves in response to sound, moving tiny hair cells that convert the motion to electrical signals.

Cochlear implant — a surgically implanted electronic device that helps people with severe to profound hearing loss perceive sound.

Collision insurance — covers repairs to your car after an accident you caused.

Colonoscopy — a procedure performed under sedation using a flexible scope with a camera to examine the entire colon for polyps and cancer. Recommended every 10 years for average-risk adults beginning at 45.

Comprehensive insurance — auto coverage for damage from causes other than a collision, such as a falling tree, theft, hail, or flood.

Credit for Caring Act — proposed federal legislation, most recently reintroduced as the Credit for Caring Act of 2025, that would create a nonrefundable tax credit of up to $5,000 for working family caregivers, equal to 30% of qualified expenses above $2,000. **Not yet law.**

Decreasing term life insurance — term coverage where the premium stays constant but the death benefit declines over time.

Delirium — acute disorientation caused by fever, infection, dehydration, medication reactions, or drug withdrawal. Common in hospitalized older adults, often mistaken for dementia, and usually reversible when the cause is treated.

Dementia — a syndrome, usually chronic or progressive, in which memory deteriorates and thinking clearly becomes difficult. **Not a normal part of aging.** Alzheimer's accounts for an estimated 60–70% of cases; the remainder have other causes, some of them treatable.

Diabetic retinopathy — damage to the tiny blood vessels that nourish the retina, caused by diabetes. The eye responds by growing new, fragile vessels that break and leak, impairing vision. Annual dilated eye exams are essential for anyone with diabetes.

Donut hole (Part D coverage gap) — a former stage of Medicare Part D in which beneficiaries paid a larger share of drug costs. **Eliminated as of January 1, 2025.**

Double-hung windows — windows whose sashes tilt inward for cleaning from inside the house.

Downsizing — moving to a smaller home to reduce financial and upkeep burdens.

Dry eye (keratoconjunctivitis sicca) — occurs when the eyes can't produce enough tears or the tears are of poor quality, causing itching, burning, and fluctuating vision.

Durable power of attorney — a power of attorney that remains in effect after you become incapacitated. A non-durable power of attorney terminates at incapacity, which is why durability matters.

Extra Help (Low-Income Subsidy) — a federal program that helps Medicare beneficiaries with limited income and resources pay Part D costs. Eligibility for the full subsidy was expanded under the Inflation Reduction Act.

Fecal immunochemical test (FIT) — an annual at-home stool test that detects hidden blood, used to screen for colorectal cancer.

Fiber cement — a composite building material used for low-maintenance home siding.

Final expense insurance — whole life insurance with a small death benefit ($5,000–$25,000 typically) designed to cover funeral costs and remaining bills. Permanent rather than term coverage, with premiums locked at issue.

FIT-DNA (stool DNA test) — a stool test that detects both blood and DNA changes associated with colorectal cancer, used every one to three years.

Floaters and flashes — specks that drift across the field of vision and perceived flashes of light. Common with age, but a sudden increase, a shower of new floaters, or a curtain across the vision is a medical emergency indicating possible retinal detachment.

FTC Funeral Rule — federal regulation requiring funeral homes to provide an itemized price list to anyone who asks and to allow consumers to buy only the goods and services they want.

Generation Alpha — people born between 2013 and 2024.

Generation X — people born between 1965 and 1980, also called Thirteeners.

Generation Z — people born between 1997 and 2012. Also called Zoomers.

Glaucoma — a group of eye diseases that damage the optic nerve, causing peripheral vision loss and eventually blindness. Symptoms start subtly, so regular dilated exams matter. Roughly half of people with glaucoma don't know they have it.

Greatest Generation — also known as the G.I. Generation, born 1901–1927; fought World War II and came of age during the Great Depression.

Guaranteed issue — insurance issued without health questions or a medical exam. In final expense insurance, guaranteed issue policies almost always carry a two-year graded death benefit.

Gutter covers — guards secured over gutters to prevent leaves and debris from clogging them, eliminating the need to climb ladders.

Hardscape — non-living landscape elements including paved areas, retaining walls, patios, and walkways.

Healthcare proxy — see medical proxy.

Hearing aid specialist — licensed by your state to evaluate hearing and to recommend and fit hearing aids.

HIPAA authorization — a document naming the people your health care providers may share information with. Separate from a health care proxy, which generally takes effect only when you cannot decide for yourself.

Hybrid (linked benefit) long-term care policy — life insurance or an annuity with a long-term care rider, paying a death benefit if long-term care is never needed. Now the dominant product in the long-term care market.

Independent living — a residential community within a continuum of care, the step before assisted living; a protected environment allowing residents to live without daily assistance.

IRMAA (Income-Related Monthly Adjustment Amount) — a surcharge added to Medicare Part B and Part D premiums for higher-income beneficiaries, based on modified adjusted gross income from two years earlier. Begins at $109,000 (individual) and $218,000 (joint) in 2026. Appealable after a life-changing event using Form SSA-44.

Level term life insurance — term coverage that pays the same benefit and charges the same premium throughout the term.

Liability insurance — auto coverage divided into bodily injury and property damage, paying for the other party's losses when you are at fault.

Lipid panel — bloodwork measuring cholesterol and triglycerides.

Living will — see advance healthcare directive.

Long-term care insurance — a policy that pays or helps pay for care once an individual needs help with daily activities. Benefits apply to in-home care, adult day care, assisted living, and nursing home care.

Lost Generation — people born between 1883 and 1900, who came of age during World War I.

Mammography — X-ray imaging used to screen for and diagnose breast cancer. Recommended every two years for women aged 40 to 74.

Medical proxy — a legal document naming someone you trust to express your wishes and make medical decisions for you if you become incapacitated.

Medicare — national health insurance for people 65 and older and certain younger people with disabilities. Part A covers hospital stays; Part B covers doctor visits, tests, and outpatient treatment. After the annual deductible, Medicare generally pays 80% of covered costs, with no annual out-of-pocket maximum.

Medicare Advantage (Part C) — plans offered by private insurers and approved by Medicare that combine Parts A and B, usually include Part D, and often add vision, dental, hearing, and other benefits. All cap annual in-network out-of-pocket spending. Now covers about 55% of eligible beneficiaries.

Medicare Part A — hospital insurance.

Medicare Part B — medical insurance covering doctor visits, tests, and outpatient treatment. Standard premium $202.90 per month in 2026.

Medicare Part C — see Medicare Advantage.

Medicare Part D — prescription drug coverage, sponsored by Medicare and delivered by private insurers. In 2026, out-of-pocket spending on covered drugs is capped at $2,100 per year.

Medicare Prescription Payment Plan — a voluntary program, effective since 2025, that lets Part D enrollees spread out-of-pocket drug costs across the calendar year in interest-free monthly installments.

Medicare Savings Programs — state-administered programs (QMB, SLMB, QI, QDWI) that help lower-income beneficiaries pay Medicare premiums and cost-sharing. Widely underused.

Medigap (Medicare Supplement) — private insurance that helps cover costs Original Medicare doesn't, such as coinsurance and deductibles. Cannot be combined with a Medicare Advantage plan. **Guaranteed issue only during a one-time six-month window beginning when you are 65 and enrolled in Part B**, after which most states permit medical underwriting.

Memory care facility — an assisted living residence for people with memory loss due to dementia, providing daily care and personal security. Typically costs 20–30% more than standard assisted living.

Millennials (Generation Y) — people born between 1981 and 1996.

Non-medical caregiver — the current industry term for in-home help with daily tasks, combining what were previously separate "homemaker" and "home health aide" categories. National median rate: $35 per hour.

No-fault insurance (PIP) — personal injury protection; auto coverage for you and your passengers regardless of fault.

Normal pressure hydrocephalus — a buildup of fluid in the brain's ventricles causing walking difficulty, urinary problems, and cognitive impairment. Treatable by surgical implantation of a shunt.

Nursing home — a residential facility for anyone needing daily skilled nursing care. National median cost: $315 per day semi-private, $355 private.

Ophthalmologist — a medical doctor providing comprehensive eye care including diagnosis, treatment, and surgery.

Optometrist — a Doctor of Optometry (OD) who can diagnose and treat many eye diseases and specializes in vision correction with glasses or contacts.

Ossicles — the chain of three small bones connecting the eardrum to the cochlea.

Otolaryngologist — an ENT; a medical doctor specializing in diseases of the ear, nose, throat, head, and neck.

OTC hearing aids — hearing aids sold directly to consumers without a prescription, medical exam, or professional fitting, for adults 18 and older with perceived mild to moderate hearing loss. **A new FDA category effective October 17, 2022.**

Part D out-of-pocket cap — the annual limit on what a Medicare beneficiary pays for covered prescription drugs. **$2,000 in 2025, $2,100 in 2026**, indexed annually. Created by the Inflation Reduction Act of 2022.

PMI (private mortgage insurance) — insurance protecting the mortgage lender if you default, generally required on conventional loans with less than 20% down. Typically costs 0.3%–1.5% of the loan amount per year. Cancelable at 80% loan-to-value on request; automatically terminated at 78%.

POLST / MOLST — Physician (or Medical) Orders for Life-Sustaining Treatment. A **medical order**, signed by a clinician, that emergency personnel must follow — distinct from an advance directive, which is a legal expression of wishes. Appropriate for people who are seriously ill or frail.

Power of attorney — a document naming someone to make financial, property, and legal decisions on your behalf. Should be **durable** to survive incapacity.

Presbycusis — age-related hearing loss.

Presbyopia — **age-related loss of the eye's ability to focus on near objects**, caused by stiffening of the lens. Universal, begins in the 40s, and is corrected with reading glasses, bifocals, or progressive lenses. It is not nearsightedness.

Prostate-specific antigen (PSA) — a protein produced by prostate cells. A PSA blood test can be used to screen for prostate cancer, but current guidance emphasizes shared decision-making between ages 55 and 69 rather than routine screening.

Representative Payee — the person appointed by the Social Security Administration to manage someone's Social Security benefits. **Social Security does not recognize a power of attorney for this purpose.**

RSV vaccine — respiratory syncytial virus vaccine, first approved in 2023. A single dose is recommended for all adults 75 and older and for adults 50–74 at increased risk of severe disease.

Senior bonus deduction — a temporary federal tax deduction of up to $6,000 per person age 65 or older ($12,000 per qualifying couple), available for tax years 2025 through 2028, phasing out above $75,000 (single) and $150,000 (joint) of modified adjusted gross income.

SHIP (State Health Insurance Assistance Program) — free, unbiased Medicare counseling available in every state. Find yours at shiphelp.org or 1-877-839-2675.

Shingrix — the recombinant shingles vaccine, given in two doses two to six months apart, recommended for all adults 50 and older.

Silent Generation — people born between 1928 and 1945, who were children during the Depression and World War II.

Simplified issue — insurance issued based on health questions but without a medical exam. In final expense insurance, coverage generally begins immediately.

Subdural hematoma — a blood clot on the surface of the brain, often from a fall. Can produce Alzheimer's-like symptoms; removing the clot reverses them.

Telematics / usage-based insurance (UBI) — insurer-provided apps or devices that track driving behavior such as speed, braking, mileage, and time of day, used to set premiums.

Term life insurance — life insurance covering a specific number of years, with no cash value.

Thermal break — an insulating barrier within a door or window that reduces heat conduction.

988 Suicide and Crisis Lifeline — the national three-digit number for mental health, substance use, and suicide crises, available 24 hours a day by call or text. Launched July 2022.

Tinnitus — the perception of sound with no external source, usually described as ringing, buzzing, hissing, or roaring. Affects roughly 10% of U.S. adults; most common between ages 60 and 69.

Traditional whole life insurance — permanent insurance where the premium and death benefit remain constant and cash value grows at a set rate not tied to markets.

Triglycerides — a type of fat carried in the blood. **Desirable level is under 150 mg/dL**; 150–199 is borderline high.

Tympanic membrane — the eardrum.

Uninsured/underinsured motorist insurance — auto coverage paying for damages caused by a driver with no insurance or insufficient insurance, including hit-and-run incidents.

Universal life insurance — permanent insurance with an investment savings element. Because credited interest is tied to market rates, premiums may change; request an in-force illustration periodically.

Upsizing — moving to a larger home to allow for entertaining, guests, or future live-in help.

Variable life insurance — permanent insurance whose cash value is invested in subaccounts you select, carrying investment risk. Regulated as a securities product.

Vitamin B12 deficiency — a reversible cause of fatigue, neuropathy, and cognitive symptoms. Can result from diet, absorption problems, or long-term use of metformin or acid-reducing medications.

Walk-in tub — a bathtub with a door allowing the bather to step in at floor level and sit rather than climbing over a tub wall.

Wernicke-Korsakoff syndrome — caused by long-term alcohol use and vitamin B1 deficiency; produces memory and cognitive impairment and is only partially reversible.

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APPENDIX: WHAT CHANGED IN THIS EDITION

This appendix lists every substantive data update made to the original edition, so readers of the first edition can see exactly what moved. Items are grouped by chapter.

Structural and framing updates

Original	Updated
Generation year ranges (Silent 1925–45, Gen X 1965–79, Millennials 1980–2000, Gen Z "mid-late 90s to early 2010s")	Standardized to Pew definitions: Silent 1928–45, Gen X 1965–80, Millennials 1981–96, Gen Z 1997–2012; Generation Alpha (2013–2024) added
Boomers "getting close" to retirement	Boomers are 62–80 in 2026; all will be 65+ by 2030; "Peak 65" wave noted
Framed for boomers only	Reframed to include Gen X and older Millennials, since several screenings now begin at 40–45

Section 1 — Where will I live?

Original	Updated
"40% of retirees move after retirement" (Transamerica)	Replaced with Census data: nearly 1 million adults 60+ crossed state lines in a recent year
Top senior destination states, 2018 Census data	2025 data: South Carolina, Texas, North Carolina lead net gains; Florida now near net-neutral for 65+; Las Vegas top city destination
Del Webb survey, 22% upsizing (2021)	Generalized to "roughly one in five," since the specific 2021 survey is no longer current
13 states tax Social Security	**8 states in 2026: CO, CT, MN, MT, NM, RI, UT, VT.** West Virginia completed phase-out effective 2026; Nebraska and Missouri also eliminated theirs
—	**Added:** new federal senior bonus deduction, up to $6,000 per person 65+, tax years 2025–2028, with phase-out thresholds
Retirement community costs referenced generally	Added current CareScout figures for assisted living and nursing home care
—	**Added:** climate-driven property insurance costs as a relocation factor; Florida now most expensive state for homeowners insurance
—	**Added:** roughly half of higher-income relocators move again within five years

Chapter 2 — Staying in your home

Original	Updated
Credit for Caring Act of 2021, introduced May 2021	**Credit for Caring Act of 2025** (H.R. 2036), reintroduced March 2025; 30% of expenses over $2,000, max $5,000, inflation-indexed. **Still not law**
AARP: ~48 million family caregivers	**63 million (AARP / National Alliance for Caregiving, "Caregiving in the U.S. 2025")** — up 20 million in ten years
—	**Added:** average family caregiver spends over $7,200/year out of pocket, ~26% of income
Vinyl siding "as little as $2 per square foot"	Removed the stale per-square-foot figure; replaced with guidance to obtain three local quotes, since installed prices have risen sharply and vary widely
Tax credit references for home improvements	Rewritten — federal energy credits have changed repeatedly; readers directed to energystar.gov, irs.gov, and utility rebate programs
—	**Added:** National Poll on Healthy Aging finding that under 20% of homes of adults 50–80 are wheelchair accessible despite 80% believing they are ready to age in place
—	**Added:** accessory dwelling unit rule changes in many jurisdictions

Chapter 3 — Medicare

Original	Updated
61.3 million Americans covered (2021)	**~69 million; ~64 million with both Part A and B**
Medicare Advantage described as often unavailable in rural areas	**35 million enrollees, 55% of eligible beneficiaries; over 99% of beneficiaries have access; average 32 plans available**
Part B premium $148.50/month	**$202.90/month (2026)**
Part B deductible (implied 2021: $203)	**$283 (2026)**; Part A deductible **$1,736**
IRMAA thresholds $88,000 / $176,000	**$109,000 / $218,000 (2026)**
IRMAA surcharges $12.30–$77.10	**Part B surcharge $81.10–$486.50; total Part B premium $284.10–$689.90**
Part C average premium "about $25"	**~$14/month projected for 2026**
Part D premiums "average about $40, as little	**Average standalone plan ~$34.50;**

Original	Updated
as $12"	**national base beneficiary premium $38.99; maximum deductible $615**
—	**MAJOR ADDITION: $2,100 annual Part D out-of-pocket cap (2026); donut hole eliminated as of 2025; $35/month insulin cap; $0 recommended vaccines; Medicare Prescription Payment Plan; drug price negotiation effective January 2026**
Medigap "$50 to over $300"	**~$100–$300+; Plan G ~$180–$220/month at 65, ~$238 average at 75**
—	**Added:** the six-month one-time Medigap open enrollment window and medical underwriting after it closes — arguably the most consequential omission in the original
"If you don't sign up for Medicare Part A within 30 days of your 65th birthday, you will pay a fine"	**Corrected: the Initial Enrollment Period is seven months (three months before through three months after your birthday month).** Penalty structure detailed: Part B 10% per 12 months, permanent; Part D 1% per month
"You can set up Social Security online at mysocialsecurity.com"	**Corrected to ssa.gov/myaccount**
Three Medicare Savings Programs listed	Four listed (QMB, SLMB, QI, QDWI), plus expanded Extra Help and SHIP counseling referral
—	**Added:** enrollment period reference table; employer size rules for working past 65; HSA contribution warning

Chapter 4 — Long-term care insurance

Original	Updated
Life expectancy 78.6 years (2017 data)	**79.0 years (CDC final 2024 data) — an all-time high.** Women 81.4, men 76.5
Life expectancy at 65 quoted from 2019 data	**19.7 additional years at 65 (2024); men 18.4, women ~20.8**
Nursing home, semi-private: $93,075/yr	**$114,975/yr ($315/day)**
Nursing home, private (implied)	**$129,575/yr ($355/day)**
Assisted living: $51,600/yr	**$74,400/yr ($6,200/month)** — a 44% increase

Original	Updated
In-home services: $53,000–$54,000/yr	**$80,080/yr at 44 hrs/week ($35/hour median)**; category renamed "non-medical caregiver"
Adult day care: ~$19,000/yr	**$24,700/yr ($95/day)**
—	**Added:** private duty nursing at home, $90/hour — new survey category in 2025
Projection: semi-private room $125,000/yr by 2030	Noted as now conservative given 2025 actuals
Three cost scenarios totaling $126,000 / $336,000 / $339,000	**Recalculated at 2026 prices: ~$178,700 / ~$505,100 / ~$453,150**
LTC insurance premiums (thebalance.com, four figures)	**Replaced with the AALTCI 2025 Price Index — full table by age, gender, couple status, level vs. 3% inflation protection**
—	**Added:** carrier rate-increase history warning; hybrid/linked-benefit policies; "no appeals process after a decline"
Morningstar/Genworth need statistics	**~70% of people turning 65 today will need some long-term care (HHS)**

Chapter 5 — Final expense insurance

Original	Updated
Funeral cost: Maine $8,675 highest, Florida $5,875 lowest	**NFDA national medians: $8,300 (viewing + burial), $9,995 with vault, $6,280 (cremation with viewing)**; Northeast ~8% above national average
—	**Added:** cremation rate reached 63.4% in 2025 and is projected at 82.3% by 2045
Basic service fee $2,000–$2,500	~$2,500–$3,000
Embalming $500–$1,000	~$800–$1,000, and noted that it is not legally required in most circumstances
Burial plot $350–$5,000; opening/closing ~$1,200	Plot national average ~$2,750; interment ~$1,000–$1,500; grave liner/vault $900–$7,000
Casket ~$2,000, high-end $10,000	Basic steel ~$2,000, premium exceeding $10,000; **added the legal right to buy a casket elsewhere with no handling fee**
Cremation "Texas $350, Pennsylvania $850"	Direct cremation ~$1,000–$3,000 nationally
Face value "$2,000 to $50,000"	Typical range $5,000–$25,000
CNN: 65-year-old woman, $10,000 for	**2026 table by age and gender: ~$30**

Original	Updated
~$55/month	**(woman, 50) to ~$164 (man, 80)**
—	**Added:** simplified issue vs. guaranteed issue and the two-year graded benefit; warning about bracket-priced plans that terminate at 80
Veterans' burial mentioned in passing	Expanded with VA contact information and scope of benefits
—	**Added:** the FTC Funeral Rule and the right to an itemized price list
—	**Added:** ~$88,000 average total end-of-life cost, of which the funeral is a fraction

Chapter 6 — Life insurance

Original	Updated
ValuePenguin term rates: $118 at 50, $190 at 55, $318 at 60, $593 at 65 (20-yr, $250K)	**Replaced with 2026 rates for a 20-year $500K policy by age and gender, plus a 10-year $250K comparison**
Policygenius whole life: $213/$189 at 30, $322/$264 at 40, $865/$705 at 60	Replaced with current general guidance; whole life at $500K runs $300–$500/month at 35 and far more at older ages
—	**Added:** term policy convertibility; in-force illustrations for universal life; alternatives to lapsing a policy, including reduced paid-up, 1035 exchange, and life settlements

Chapter 7 — Auto insurance

Original	Updated
Rate chart topping out around $1,800/year	**2026 averages: ~$1,930–$2,310 at 60, ~$2,090–$2,410 at 70, ~$2,740 at 75; roughly 30% increase from 60 to 80**
"Most insurance companies charge seniors 10% less"	Generalized; discount structures vary by carrier and state
"Reduce deductibles" heading with text describing *raising* them	Heading corrected to "Adjust deductibles"
Telematics/UBI described as emerging	Now mainstream; added pay-per-mile policies and a caution that some programs can raise rates
—	**Added:** state-mandated defensive driving course discounts; umbrella policies; non-

Original	Updated
	owner policies; 2025–26 premium pressure from tariffs on vehicles and parts

Chapter 8 — Homeowners insurance and PMI

Original	Updated
PMI "typically between .5% and 1%"	**0.3%–1.5%, most commonly 0.46%–1.5%; roughly $30–$70/month per $100,000 borrowed**
—	**Added:** mortgage insurance premium deduction permanently reinstated for tax year 2026 under the One Big Beautiful Bill Act
PMI cancellation at 78%	Clarified: request at 80% LTV, automatic termination at 78%
"Reducing your deductible from $500 to $1000"	Corrected to *raising*; added separate percentage-based wind and hurricane deductibles
—	**Added:** the current availability and affordability crisis in FL, CA, and LA; extended/guaranteed replacement cost coverage; home inventory; water sensor discounts

Chapter 9 — Vision

Original	Updated
"The most common is nearsightedness. The medical term is presbyopia."	**Corrected. Presbyopia is age-related loss of near focus, not nearsightedness**
"Over 50% of Americans over 80 have or have had cataracts"	Retained and sourced: 20+ million Americans 40+; roughly half by age 80
AMD described qualitatively	**19.8 million Americans 40+ with some AMD; ~1.5 million vision-threatening; 46% prevalence at 85+**
Glaucoma: 50% undiagnosed	Retained, with ~2 million diagnosed and ~2 million undiagnosed
"There isn't a cure" for wet AMD	Updated: wet AMD is now highly treatable with anti-VEGF injections; a treatment for advanced dry AMD has been approved
—	**Added:** sudden floaters/flashes as a medical emergency; Medicare's coverage gap for routine eye exams and glasses; Medicare-

Original	Updated
	covered glaucoma and diabetic retinopathy screening; modern low-vision technology

Chapter 10 — Hearing

Original	Updated
—	**MAJOR ADDITION: over-the-counter hearing aids, an entirely new FDA category effective October 17, 2022** — with guidance on who they are and aren't appropriate for
—	**Added:** hearing loss identified by the Lancet Commission as the largest modifiable dementia risk factor; randomized trial evidence that treating it slows cognitive decline
CDC hearing loss statistics	Retained and re-sourced: 1 in 3 aged 65–74, nearly half over 75; ~30 million adults could benefit; only ~1 in 5 who could benefit use hearing aids
Tinnitus "affects between 15 and 20% of Americans"	**~10% of U.S. adults (~25 million), peaking between ages 60 and 69**
Tinnitus: "there isn't a cure, but there are treatments"	Specified: hearing aids, sound therapy, and **cognitive behavioral therapy**, which has the strongest evidence
—	**Added:** ototoxic medications; Medicare/VA/Medicaid coverage differences; free smartphone live-captioning; broadened cochlear implant candidacy

Chapter 11 — Mental health, Alzheimer's, and dementia

Original	Updated
WHO: "20% of seniors have a mental illness"	**~14% of adults 60+ live with a mental disorder (WHO current estimate)**
—	**Added:** the 988 Suicide and Crisis Lifeline, which did not exist in 2021; note that men 75+ have the highest suicide rate of any group
—	**Added:** Surgeon General's advisory on loneliness and social isolation
WHO: 50 million with dementia	**57 million worldwide; ~10 million new**

Original	Updated
worldwide; 82 million by 2030; 152 million by 2050	**cases/year; ~78 million by 2030; ~139 million by 2050**
"About 60% of dementia cases are Alzheimer's"	**60–70%**
"About 10% of Americans over 65 have the disease, and 30% over 85"	**7.4 million Americans 65+; 1 in 9 (11%) of those 65+; 5.2% of 65–74, 13.8% of 75–84, 35.8% of 85+**
—	**Added:** $409 billion in 2026 dementia care costs; Alzheimer's now the 6th leading cause of death overall and 5th among those 65+; deaths up 134% since 2000
"Aducanumab … is the only disease-modifying medication currently approved"	**Aducanumab (Aduhelm) was discontinued by Biogen in 2024 and withdrawn from the market. Replaced by lecanemab (Leqembi, full approval July 2023) and donanemab (Kisunla, full approval July 2024)**, with discussion of benefit magnitude, ARIA risk, Medicare registry coverage, and ongoing scientific debate
Mini-Mental State Exam described as the wellness visit test	Generalized to "cognitive assessment"; added Medicare's separate cognitive assessment and care planning visit
—	**Added:** blood-based Alzheimer's biomarker tests, first FDA-cleared in 2025
"Nothing has been proven to avoid or delay it"	**Substantially revised: WHO guidance issued July 2026 concludes up to 45% of dementia risk is attributable to modifiable factors**; the Lancet Commission's fourteen risk factors listed
Elder abuse "1 in 6"	Retained and sourced to WHO; added that financial exploitation is the most reported U.S. form and the Eldercare Locator number
—	**Added:** polypharmacy and anticholinergic medications as reversible causes; Medicare Medication Therapy Management; sleep apnea, depression, and hearing loss as dementia mimics; B12 depletion from metformin and acid reducers
—	**Added:** Medicare Part B coverage of

Original	Updated
	marriage and family therapists and mental health counselors, effective 2024; telehealth for mental health

Chapter 12 — Checkups and screenings

Original	Updated
Colorectal screening framed as beginning at 50	**Begins at 45 (USPSTF 2021, ACS 2018)** — the single largest guideline change in this chapter
Colorectal test list including **double-contrast barium enema**	Barium enema removed (no longer recommended); FIT-DNA every 1–3 years and blood-based tests added; flexible sigmoidoscopy options clarified
Mammography "every one to two years," starting age implied at 40+ generally	**USPSTF 2024: biennial screening for all women 40–74**; ACS annual option from 40; breast density notification and no-cost follow-up imaging added
Lung cancer screening "annually for smokers and past smokers"	**Annual low-dose CT for ages 50–80 with 20+ pack-years, currently smoking or quit within 15 years** (previously 55–80 and 30 pack-years)
Prostate: "PSA every two years starting at 50"	**Shared decision-making at 55–69; not recommended at 70+; earlier discussion at 45 for higher-risk men.** Added MRI-guided evaluation and active surveillance
A1C: "6.7 or above is considered diabetes"	**Corrected to 6.5%**
Triglycerides "150–199" listed as healthy	**Corrected: desirable is under 150; 150–199 is borderline high**
Diabetes screening "every three years minimum"	Specified per USPSTF: ages 35–70 with overweight or obesity, every three years
Immunizations: COVID, pneumococcal, flu, Td, shingles at 50+	**Pneumococcal now recommended at 50 (lowered from 65 in late 2024); RSV vaccine added — all adults 75+, and 50–74 at increased risk; high-dose/adjuvanted flu preferred at 65+; hepatitis B universal to 59; note that Part D now covers recommended vaccines at $0**
—	**Added:** hepatitis C one-time screening for all adults 18–79; abdominal aortic aneurysm

Original	Updated
	screening for men 65–75 who ever smoked; formal fall risk assessment
Osteoporosis: women at 65, men at 70	Clarified: recommended for women 65+; evidence insufficient for a blanket male recommendation, though many clinicians screen at 70
—	**Added:** information-blocking rules releasing results to portals immediately; the one-page medical summary; HIPAA authorization

Chapter 13 — Legal paperwork

Original	Updated
AARP/National Poll on Healthy Aging: "only 46% of people over 50 have advance directives"	**Pew Research, September 2025: 31% of all U.S. adults; 44% of adults in their 60s, 64% in their 70s, ~80% of those 80+**
—	**Added:** POLST/MOLST forms and how they differ from advance directives
—	**Added:** the durable vs. non-durable power of attorney distinction; institution-specific POA forms; Social Security Representative Payee requirement
—	**Added:** digital asset access, RUFADAA, and platform legacy tools
FormSwift cited as a source for legal forms	Replaced with CaringInfo (NHPCO) free state-specific forms, state health departments, hospitals, the ABA consumer toolkit, and Area Agencies on Aging
—	**Added:** where to store documents, who should get copies, and a review schedule

Glossary

- Corrected: **presbyopia** (age-related loss of near focus, not nearsightedness); **A1C** diabetes threshold (6.5%, not 6.7%); **triglycerides** (under 150 desirable); **dementia** (Alzheimer's 60–70% of cases); "None Anchored" typo corrected to **bone-anchored**.
- Removed: **aducanumab** as a current treatment.
- Updated: **Credit for Caring Act** (2025 version); generation year ranges; long-term care cost figures; Medicare part definitions with 2026 figures.
- Added: anti-amyloid antibody, ARIA, CLUE report, donut hole, durable power of attorney, Extra Help, FIT-DNA, FTC Funeral Rule, guaranteed issue, HIPAA authorization, hybrid long-term care policy, IRMAA, Medicare Prescription Payment

Plan, Medicare Savings Programs, non-medical caregiver, OTC hearing aids, Part D out-of-pocket cap, POLST/MOLST, Representative Payee, RSV vaccine, senior bonus deduction, SHIP, Shingrix, simplified issue, telematics/UBI, 988 Lifeline.

Items that were checked and did not require change

For completeness: the following were verified against current sources and found still accurate — Medicare's 20-day/80-day skilled nursing coverage structure; the October 15 – December 7 Annual Enrollment Period; the January 1 – March 31 Medicare Advantage Open Enrollment Period; the WHO elder abuse estimate of 1 in 6; the NEI finding that roughly half of people with glaucoma are undiagnosed; the American Optometric Association's annual exam recommendation after 60; the description of hearing physiology; the definitions and mechanics of term, whole, universal, and variable life insurance; the PMI automatic termination threshold of 78%; and the general categories of auto and homeowners insurance coverage.

Figures that could not be refreshed

Two visual elements in the original could not be updated from a current published source and should be replaced or removed if the design is rebuilt: the **"Percent of Seniors Experiencing Depression by Country"** chart, which was drawn from 2017 Statista data, and the **"First Experienced Symptom of Alzheimer's"** pie chart, drawn from a 2010 figure. The cost-of-living and climate charts should be regenerated from the current MERIC data series and current NOAA climate normals rather than reproduced as-is.