



LIMRA Retirement Income Institute

Redefining Advice: Integrating Healthcare Into Retirement Planning



LIMRA
Navigate With Confidence

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Introduction

Healthcare costs dominate the retirement conversation for many, and the data suggests they should. LIMRA's *2025 Protected Retirement Income and Planning (PRIP) Study*,¹ confirms that 62 percent of consumers working with a financial professional list healthcare cost as a top retirement concern, behind only inflation at 63 percent.

The 2024 Nationwide Retirement Institute® Health Care Costs in Retirement survey reinforces the picture: Nearly three-quarters of respondents say they fear their retirement healthcare costs will get out of control, and two-thirds wish they had a better understanding of Medicare coverage.²

Those concerns are well founded. According to the Peterson-KFF Health System Tracker, total U.S. healthcare spending reached \$5.3 trillion in 2024, or \$15,474 per person, consuming 18 percent of gross domestic product. The burden is concentrated among older Americans: Those 55 and older account for 54 percent of total health expenditures while representing just 31 percent of the population. On the employer side, average family premiums reached \$26,993 in 2025, marking 3 consecutive years of over 6 percent increases.³

The implications for retirement savings are significant. The Employee Benefit Research Institute's (EBRI) 2024 projection model estimates that a 65-year-old couple enrolled in Medigap will need \$366,000 in savings just to have a 90 percent chance of covering healthcare premiums, deductibles, and prescription drugs in retirement.⁴ For a couple with high prescription drug expenditures, that figure rises to \$428,000. These are not lifetime income figures; they are savings targets for healthcare alone, and they do not include long-term care.

Large lump-sum figures, presented without context, can paralyze rather than motivate. The EBRI methodology is analytically sound (these are present-value calculations, not nominal spending totals), but a household does not experience healthcare as a single expenditure. It's an ongoing cost, incurred only in years you are alive, and funded in the same way any recurring expense is funded: through income.

The planning response is not to accumulate \$366,000 in a dedicated healthcare bucket, but to build guaranteed income streams — delay claiming Social Security retirement benefits, annuities structured for lifetime payout — that cover \$1,200 to \$1,600 per month for as long as the client lives.

¹ Source: *Protected Retirement Income and Planning Study — Chapter 3: Mind the Gaps*, LIMRA, 2025.

² Source: "Stressed About Healthcare Costs? You're Not Alone," Nationwide Retirement Institute®, 2025.

³ Source: *How has U.S. spending on healthcare changed over time?* Peterson-KFF Health System Tracker, 2024.

⁴ Source: *2026 EBRI/Greenwald Research Retirement Confidence Survey*, EBRI and Greenwald Research, 2026.

This approach matches cash flow to how households actually experience expenses, creates optimization opportunities to reduce Income-Related Monthly Adjustment Amount (IRMAA)⁵ surcharges by managing the timing and character of other income, and produces what the retirement income literature calls a “license to spend”⁶; the reduced anxiety that comes from knowing healthcare costs are funded by durable income rather than uncertain drawdowns from a savings pool.

Meanwhile, the PRIP study reveals a notable conversation gap: 96 percent of financial professionals say they discuss physical health issues with clients, but only 44 percent of clients recall those conversations. On cognitive decline, a topic with enormous financial planning implications, 88 percent of advisors say they have raised it, but just 31 percent of consumers remember.⁷ This data point deserves more than a footnote. Financial management is among the first cognitive skills to deteriorate — often before diagnosis.⁸ By age 82, the probability of dementia or mild cognitive impairment exceeds 50 percent. The financial professional who built the integrated plan is the natural person the adult child calls when a parent’s judgment begins to slip — and that conversation, handled well, is how a client relationship becomes a family relationship.

The financial management profession has an opportunity to close a significant gap. Among respondents who work with a financial professional, 56 percent say they have not received advice on how and when to file for Medicare. Sixty-nine percent say that if a financial professional could not help them navigate their Medicare choices, they would probably switch to one who could.⁹

These findings matter, but the data alone does not explain why healthcare costs belong at the center of a financial plan. The cost of health insurance is linked to income, and every income decision a household makes simultaneously changes what it pays for healthcare.

The research literature documents the concerns people have about healthcare costs, and the structural reasoning explains why healthcare cost concerns will not diminish. Financial professionals need to provide their clients with integrated health insurance guidance, and they need to understand how the Affordable Care Act (ACA) and Medicare interact with their clients’ financial planning.

This represents a significant challenge and opportunity for the advisory profession. The financial professional who can deliver an integrated answer — connecting Medicare optimization, IRMAA bracket management, ACA subsidy coordination, and tax-efficient withdrawal sequencing into a single household-specific analysis — provides a service that is difficult to replicate through robo-advisors, generic planning tools, or single-domain specialists alone.

What follows is an overview of how the framework is established, and what financial professionals can do to help guide an underinformed, anxious client base.

The Stakes: What the Research Tells Us

The Net Income Imperative

The retirement planning conversation has historically been about income generation: optimizing Social Security claiming strategies, maximizing portfolio returns, and constructing withdrawal sequences. These are important capabilities, but they address only the gross income side of the equation.

The question that actually determines whether a client can afford to retire is not how much income can be generated, but how much income remains after taxes and healthcare costs. This is the net income question, and it is the one that most planning processes leave inadequately answered.

A household that generates \$100,000 in gross retirement income but pays \$25,000 in federal and state taxes and \$15,000 in healthcare premiums and out-of-pocket costs has \$60,000 in spendable cash flow. A different withdrawal strategy — one that uses Roth distributions to stay below IRMAA thresholds, coordinates health savings account (HSA) funds for healthcare expenses, and manages modified adjusted gross income (MAGI) to preserve ACA subsidies before Medicare eligibility — might produce the same gross income but yield \$72,000 or more in after-tax, after-healthcare cash flow. That \$12,000 annual difference, compounded over a 25-year retirement, is not a rounding error but the difference between a plan that works and one that does not.

⁵ Source: *SSA-44: Medicare Income-Related Monthly Adjustment Amount – Life-Changing Event*, Social Security Administration, 2025.

⁶ Source: *Guaranteed Income: A License to Spend*, LIMRA Retirement Income Institute, 2024.

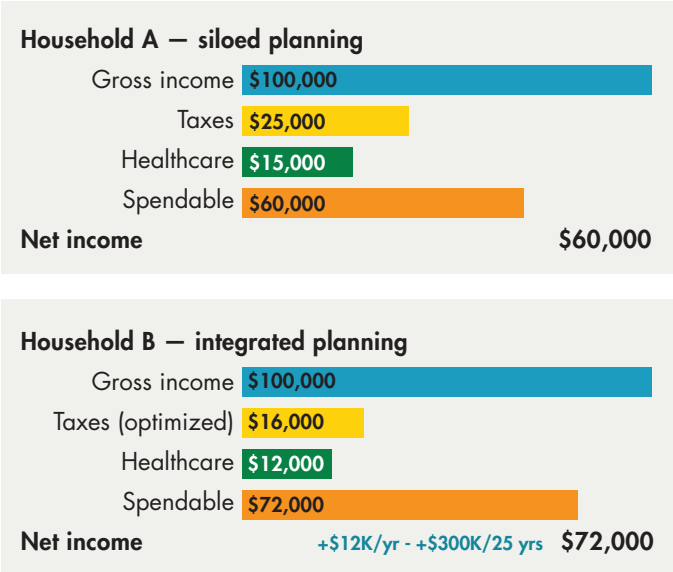
⁷ Source: *Protected Retirement Income and Planning Study — Chapter 3: Mind the Gaps*, LIMRA, 2025.

⁸ Source: *Aging, Cognitive Decline, and Financial Decision-Making*, LIMRA Retirement Income Institute, 2022.

⁹ Source: *Health Care Costs in Retirement Survey*, Nationwide Retirement Institute, 2024.

The financial professional who reframes the advisory conversation from “How much income can we generate?” to “How much income will you retain after taxes and healthcare costs?” addresses the question clients are fundamentally asking. That reframing — from gross to net — is the foundation of the approach this paper describes.

**Figure 1 — Gross Versus Net Income:
Same Income, Different Outcome**



Why Healthcare Pricing Is Linked to Income

Before examining the data, it’s worth stating the structural fact that makes everything in this paper inevitable rather than optional. In *National Federation of Independent Business v. Sebelius* (2012), Chief Justice Roberts described the economic logic with precision: Hospitals cannot turn patients away, they cannot absorb the cost of uncompensated care, so they pass it to insurers through higher rates, and insurers pass it to policyholders through higher premiums. Congress estimated the annual cost-shift at over \$1,000 per family.

The result is that the cost of providing healthcare to the uninsured is distributed across the premiums, taxes, and out-of-pocket expenses of those who are insured. This is not a political argument but an economic and accounting reality.

Once that reality is accepted, a second fact follows logically: It makes sense that the cost of health insurance is linked to income. Both the major mechanisms that determine what Americans actually pay for healthcare — the Advance Premium Tax Credit (APTC) under the ACA and IRMAA under Medicare — are income-based.

The APTC reduces premiums for those with lower income. IRMAA increases premiums for those with higher income. Both are calculated from the same number: MAGI. This single fact makes the APTC debate and IRMAA far less confusing than they appear, because they are two expressions of the same principle: What an individual pays for healthcare depends on what that individual earns.

That the IRS itself maintains separate MAGI definitions for Medicare’s IRMAA, ACA premium tax credits, and Roth IRA eligibility — each starting from adjusted gross income (AGI) but then “modified” by adding back different income components — is confirmation that health insurance costs are administered through the tax code. They are, in every functional sense, a tax matter and belong in the tax-and-income planning conversation.

That means the integration of traditional financial planning strategies and healthcare cost control is not a nice-to-have but an invariable feature of the planning landscape. Every withdrawal decision, every Roth conversion, every capital gain — anything that changes MAGI — simultaneously changes what the client pays for health insurance. It is not possible to optimize one without affecting the other, and the financial professional who understands this link does not treat healthcare as a separate item but as something woven into every income decision the client makes.

Income determines healthcare costs, and healthcare costs determine net income. That is the basis of this paper.

Healthcare Costs Are the Dominant Client Concern

The evidence is no longer anecdotal. The PRIP surveys over 3,500 consumers aged 45 to 75 alongside 500 financial professionals. The findings have been consistent:

- In the 2024 PRIP study, 82 percent of respondents cited inflation or cost of living and 70 percent cited healthcare costs as the top two issues having a negative impact on their spending in retirement or ability to save for retirement.¹⁰
- In the 2025 PRIP study, 62 percent of consumers working with a financial professional listed healthcare costs as a top retirement concern, behind only inflation at 63 percent. Financial professionals ranked healthcare costs lower — at 50 percent — revealing a perception gap between what clients worry about and what advisors prioritize.
- Both consumers and financial professionals identified estimating healthcare costs as the single most difficult task when planning for the transition into retirement.

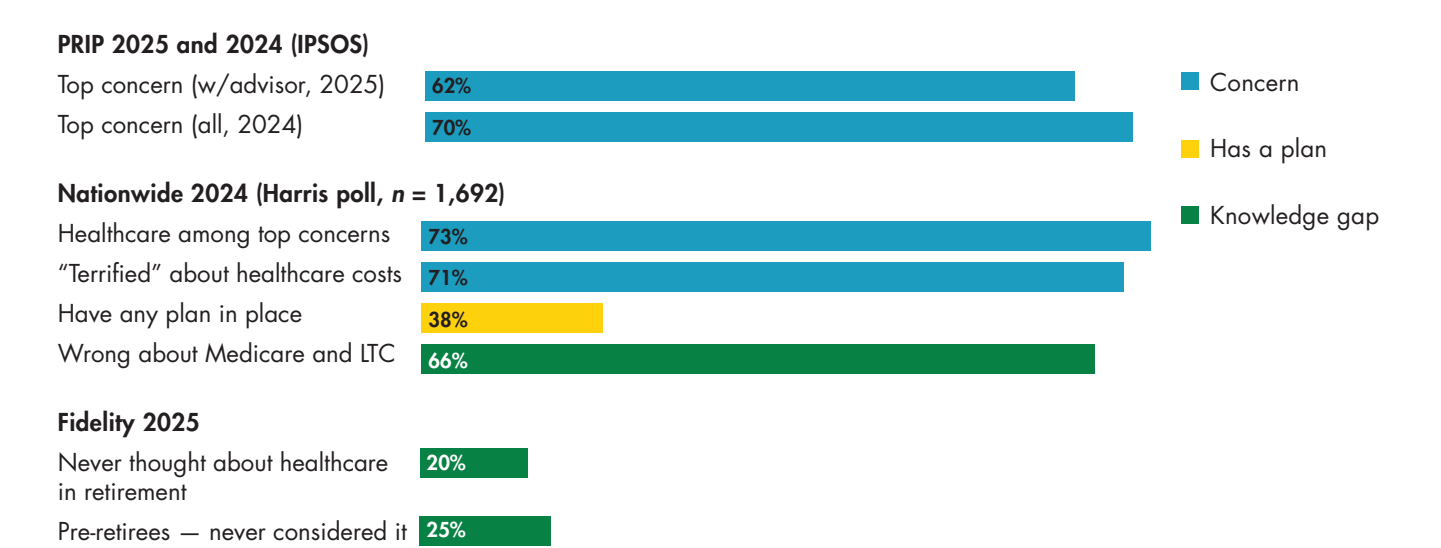
¹⁰ Source: *Protected Retirement Income and Planning Study*, LIMRA, 2024.

- A Jackson Financial study conducted with the Center for Retirement Research at Boston College found that nearly two-thirds of pre-retired investors underestimate their expected healthcare expenses in retirement.¹¹
- Fidelity’s 2025 research found that 1 in 5 Americans have never thought about their healthcare needs in retirement at all — a figure that rises to 1 in 4 among pre-retirees.¹²

The Nationwide Retirement Institute’s 2024 survey adds depth to this picture. Among all respondents, 73 percent list healthcare costs as one of their top concerns for retirement, 71 percent say they are “terrified” over how healthcare expenses could impact their savings, and more than 40 percent say medical expenses have “drastically reduced” their ability to save. Only 38 percent have any plan in place to cover those costs. When tested on Medicare knowledge, respondents averaged just 7 correct out of 16 questions — and 66 percent incorrectly believed or were unsure whether Medicare covers long-term care.

Meanwhile, we are in the midst of Peak 65, a historic demographic surge in which 4.1 million Americans are reaching age 65 each year through 2027.¹³ The volume of households entering Medicare, navigating ACA-to-Medicare transitions, and confronting healthcare cost decisions for the first time is unprecedented. The question for financial professionals is not whether clients need healthcare cost planning expertise, but who will provide it.

Figure 2 — Healthcare Cost Worry Index



¹¹ Source: *Security in Retirement*, Jackson Financial, 2025.

¹² Source: Fidelity Investments, *2025 Retiree Health Care Cost Estimate*: \$172,500 for a 65-year-old individual; \$330,000 for a couple (after-tax savings).

¹³ Source: *The Peak 65® Zone Is Here – Creating a New Framework for America’s Retirement Security*, LIMRA Retirement Income Institute, 2024.

Why the Knowledge Gap Exists

In the United States, health insurance has historically been sponsored by the employer. The choices were limited, the employee’s role was to pick one and enroll, and there was no reason to understand how premiums interact with a financial plan. For decades, employer-sponsored insurance shielded working Americans from the complexity of healthcare economics — and that shield extended to the advisors themselves, many of whom spent their careers at firms that provided group coverage.

Not everyone had that shield. Part-time workers, entrepreneurs/self-employed, and independent contractors have always navigated the individual market. They are the leading indicator of what the broader workforce is now confronting — and the ranks of Americans who must navigate healthcare decisions independently are growing, not shrinking.

Health Insurance as a Financial Contract

Health insurance is a financial contract. It has a price, terms, conditions, and a payout structure.

Whether healthcare is provided by an employer or purchased though an ACA marketplace, a healthcare plan is, in financial terms, an annually resettable option. Every year during open enrollment, the policyholder reassesses health status, income, and provider needs, and re-elects coverage. The contract reprices annually based on market conditions.

Medicare operates differently. Medicare Advantage resets annually through open enrollment. But Medigap guaranteed issue is effectively a one-time window; after the initial enrollment period, changing plans may require medical underwriting, which means the option to switch can be closed. Part D late enrollment penalties compound permanently. The reset conditions are constrained. Medigap reset conditions vary by state. Federal law guarantees a one-time open enrollment period (6 months from Part B enrollment at age 65), during which applicants cannot be denied or charged more based on health status. After that window closes, most states permit medical underwriting for Medigap applicants, effectively restricting the reset. However, a growing number of states have adopted birthday-rule provisions, which grant an annual open enrollment window — typically 30 to 63 days around the policyholder’s birthday — during which beneficiaries may switch Medigap plans without medical underwriting.

New York goes further: Medigap plans are community-rated, and open enrollment is available year-round, with no medical underwriting at any time. Connecticut, Massachusetts, and Maine also provide broader protection than the federal minimum. The practical implication is that the “restricted reset” characterization of Medigap is accurate as a federal default but not universal — and the advisor who knows the state-specific rules can identify flexibility that most clients (and many advisors) assume does not exist.

Once a household sees health insurance as a set of financial contracts with different pricing mechanisms and different reset conditions, the planning implications become clear. You evaluate the terms. You evaluate the price net of subsidies or surcharges. You evaluate whether the election is reversible. That is financial analysis — and it is precisely the kind of analysis a financial professional is trained to do.

The Advisor Gap: What Clients Are Not Getting

The PRIP study documents the worry, and the Nationwide Retirement Institute asks whether advisors are responding to it. The survey results are instructive.

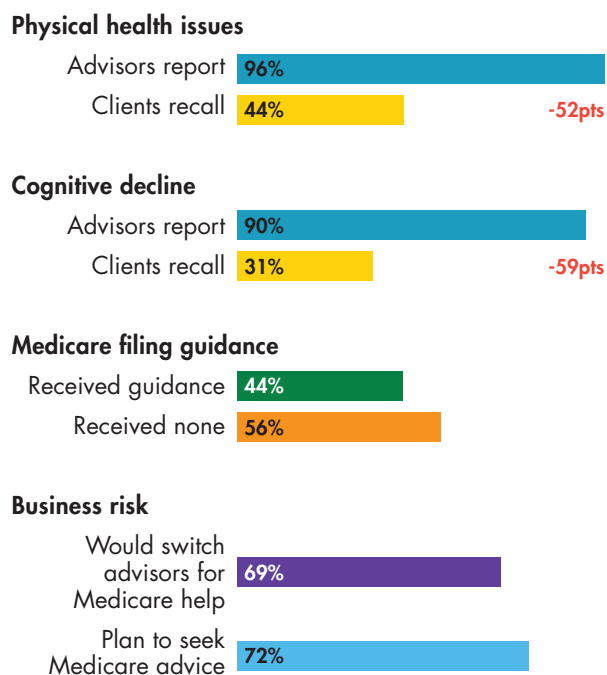
Fifty-six percent of consumers who work with a financial professional say they have not received advice on how and when to file for Medicare. These are not marginal cases; they are advised clients who have already engaged a professional for retirement guidance, and more than half report receiving no Medicare planning help.

The demand signal from clients is explicit. Sixty-nine percent say that if a financial professional could not help them navigate their Medicare choices, they would probably switch to one who could. And 72 percent of all respondents plan to ask about or work with a professional who can offer Medicare advice.

The PRIP data adds a second dimension to this gap. The conversation is happening, or at least advisors believe it is, but clients are not retaining it. The implication is that the current approach is not resonating; household-specific, dollar-denominated guidance resonates, while general discussion does not.

This is not a lack of effort but a gap in specificity. When healthcare cost planning moves from a generic conversation about “rising costs” to a specific, dollar-denominated analysis of how a client’s withdrawal strategy affects their Medicare premiums, ACA subsidies, and after-tax cash flow, the engagement changes materially, because the analysis is specific to the client’s financial situation, health coverage options, and retirement timeline.

Figure 3 — The Conversation Gap: Advisors Versus Client Recall



The Integration Opportunity

Financial services has historically organized itself around specialization: Insurance professionals handle health coverage, financial advisors manage investments and withdrawals, and tax professionals handle compliance. Each domain is deep and complex in its own right. The opportunity lies in recognizing that these domains interact far more than most planning processes account for, and that the professional who integrates across these boundaries delivers significant value.

An insurance broker does not typically evaluate how a client's choice of Medicare Advantage versus Medigap interacts with their withdrawal sequencing. A financial advisor constructing a withdrawal strategy may not consider how a Roth conversion can affect IRMAA surcharges on Medicare premiums 2 years later. The advisor who bridges these gaps occupies a distinctive and defensible position in the client relationship.

ACA's Advance Premium Tax Credit and Medicare IRMAA previously examined the interaction between taxes and health insurance, both ACA and Medicare, and demonstrated that coordinating across these domains consistently produced better outcomes.¹⁴ In several documented scenarios, clients could have retired earlier or with greater financial security when the planning process accounted for the interplay between withdrawal sequencing, healthcare cost management, and tax exposure.

Since the ACA's Advance Premium Tax Credit and Medicare IRMAA was published, the national debate around healthcare costs has only intensified, but the underlying math has not changed. The paper's central finding remains intact: A path to early retirement can exist, but only when the planning process accounts for how these pieces interact. The professional who delivers that coordination establishes a level of trust that is difficult to displace. The expiry of the enhanced Advance Premium Tax Credit at the end of 2025 has sharpened the urgency: Millions of early retirees and pre-Medicare households now face significantly higher marketplace premiums, making the connection between income strategy and insurance cost harder to ignore.

Where the Value Shows Up

The value of integrated healthcare cost planning is best illustrated through the scenarios that occur across client population situations where the professional who sees the full picture can make a decisive difference:

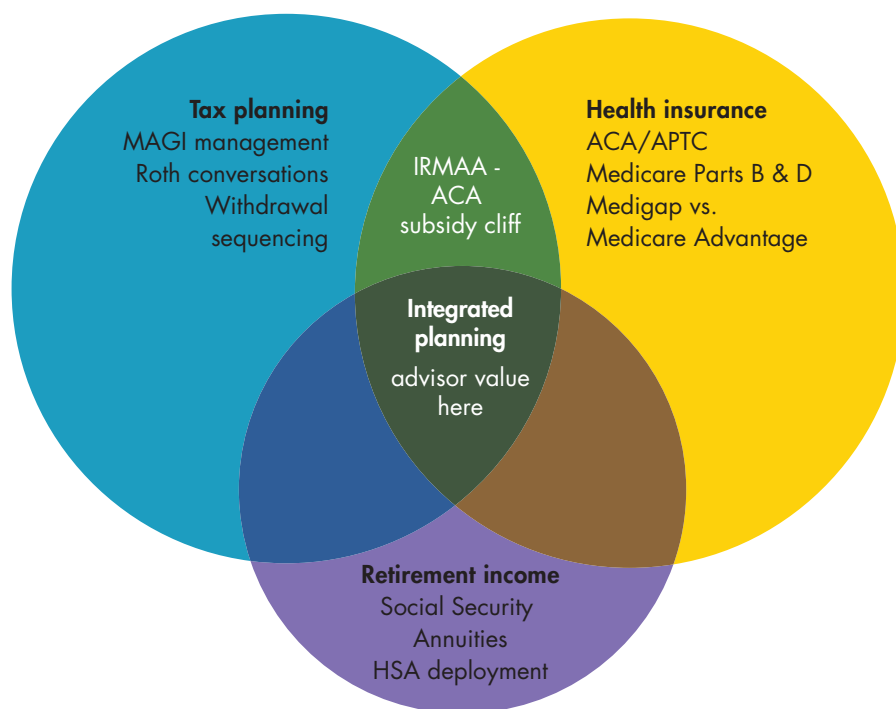
- **A 63-year-old early retiree considering a large IRA distribution:** The advisor who understands ACA subsidy mechanics can identify that the distribution would raise MAGI above the subsidy cliff — and restructure the withdrawal to preserve \$15,000 to \$25,000 in annual health insurance subsidies. That level of specificity is what distinguishes integrated planning from conventional advisory practice.
- **A newly retired couple planning a Roth conversion strategy:** The advisor who builds IRMAA awareness into the conversion sizing can prevent Medicare premium surcharges 2 years later — turning a technically sound tax strategy into an optimized one that accounts for downstream healthcare costs.
- **A Medicare-eligible client evaluating Medigap against Medicare Advantage:** For clients with financial constraints, superior health profiles, or different individual utility functions, Medicare Advantage may be the right answer — and state-specific regulations can preserve meaningful flexibility at lower cost. The advisor who works through those variables rather than defaulting to either option is the one who can account for savings differentials that EBRI estimates at up to \$224,000 per couple over the course of a retirement.

Each of these scenarios illustrates the value that integrated planning delivers and the kind of outcome that strengthens the advisory relationship over time.

¹⁴ Source: ACA'S Advance Premium Tax Credit and Medicare IRMAA, LIMRA Retirement Income Institute, 2023.

Figure 4 — Where Healthcare and Financial Planning Intersect

Both IRMAA and the ACA subsidy are calculated from MAGI — every income decision changes what the household pays for health insurance.



Consider one scenario in concrete dollar terms. A couple, both 63, retired in January 2026 with \$1.2 million in a traditional IRA and no pension. They plan to claim Social Security at 67 and need roughly \$80,000 per year in spending, funded from taxable savings. Their financial advisor recommends an aggressive Roth conversion: \$150,000 per year for the 2 pre-Medicare years, filling the lower tax brackets before required minimum distributions begin.

In a siloed practice, the conversion is executed without consulting the insurance side of the household. The couple enrolls in a marketplace Silver plan because they are not yet eligible for Medicare. But the \$150,000 conversion pushes their ACA MAGI well above 400 percent of the federal poverty level — the threshold above which, with the enhanced premium tax credit having expired at the end of 2025, subsidies drop to zero. The unsubsidized benchmark Silver premium for a couple in their early 60s can exceed \$30,000 per year. Federal income tax on the \$150,000 conversion, after the standard deduction, runs approximately \$15,300. The household's combined conversion-plus-coverage cost for the year is roughly \$45,300.

In an integrated practice, the advisor sizes the conversion differently. An \$80,000 conversion keeps ACA MAGI below the subsidy cliff. Premium tax credits reduce the annual marketplace premium to approximately \$8,000, the applicable percentage of income under the pre-enhancement subsidy schedule. Federal income tax on the smaller conversion is approximately \$5,200. Total cost is roughly \$13,200. The remaining \$70,000 in planned conversions is deferred to age 65, when the couple is on Medicare and the ACA subsidy is no longer a variable.

The single-year difference is \$32,100. Over 2 pre-Medicare years, the integrated approach preserves roughly \$44,000 in ACA subsidies alone, without changing the client's retirement lifestyle, risk tolerance, or long-term Roth conversion goal. The destination is the same, but the sequencing and the cost are very different. These figures are illustrative and will vary by geography, plan availability, and household circumstances, but the order of magnitude is representative and large enough to change the trajectory of a retirement plan. In addition, Federal taxes in the current year are lower by \$9,800 a year, these are deferred until the time when Roth conversion occurs.

Figure 5 — Integrated Versus Siloed Planning, the \$32,100 Difference

For a couple, both 63, as of Jan. 2026: \$1.2m IRA, no pension, Social Security at 67, ~\$80k/yr, pre-Medicare, after enhanced APTC expired Dec. 2025.

\$32,100

Single-year savings

~\$44,000

ACA subsidies 2 pre-Medicare years

Same

Long-term Roth goal unchanged

The Current Landscape and the White Space

An Integrated Approach: The 5-Step Framework

The path forward is a planning methodology that treats healthcare costs as a first-order variable — integrated into the retirement plan from the outset, not appended as an afterthought. The following 5-step framework, developed through decades of practice at the intersection of Medicare planning and financial advice, provides a structured approach that any financial professional can adopt to strengthen client outcomes and solidify relationships.

Step 1: Health Assessment as a Planning Foundation

Begin with health because it determines the single most important variable in retirement planning: duration — how long the plan must work. The task is to match the duration of the client's assets to the likely duration of their life. This estimate is not guesswork; it should be an informed assessment based on current health, family history of longevity, and lifestyle.

A healthy couple with long-lived parents need to plan for decades of expenses. A household facing chronic illness will make fundamentally different decisions. Everything else in retirement planning flows from this starting point.

New medical treatments are changing this picture. GLP-1 medications, advanced cancer therapies, and advances in cardiac and renal care may extend healthy years of life — personally welcome news that simultaneously increases the number of years the financial plan must fund. Modern medicine can increase both longevity and the accompanying financial risk if the plan does not account for it.

Step 2: Geographic Impact Analysis

Where a client lives shapes not only lifestyle but the financial structure of their retirement. Housing, property taxes, and cost of living are obvious inputs, but location also determines access to healthcare services, the cost of those services, state tax treatment of retirement income, and estate planning consequences. Two households with identical portfolios may have dramatically different after-tax income simply because they live in different states. A decision to relocate across state lines may simplify living expenses but introduce new legal and tax considerations that ripple through the entire plan.

Step 3: Healthcare-Integrated Cost Estimation

This is where the planning process becomes concrete, and where the greatest opportunity for differentiation exists. Healthcare is not simply one line item in the retirement budget; it is among the largest cost categories and one whose dollar amounts can vary widely depending on coverage decisions. Fidelity's estimate of \$330,000 for a couple is a useful benchmark, but the real planning value comes from understanding what drives that number and how to manage it.

The EBRI data reveals an insight that represents a major opportunity for advisors: Enrollees in Medicare Advantage plans generally have significantly lower healthcare savings targets than those in Medigap supplemental plans. For a 65-year-old man, the difference in required savings between Medicare Advantage and Medigap — to achieve the same probability of meeting healthcare expenses — can exceed \$126,000. For a couple, the differential can reach \$224,000. This is not a marginal consideration; it is a decision that materially alters the retirement income plan. The advisor who can guide this choice with confidence provides a service worth tens of thousands of dollars.

But the coverage decision is only half the equation. The other half is how those costs are funded. The EBRI figures are expressed as savings targets — lump sums that a household must accumulate to have a specified probability of covering healthcare expenses. That framing, while analytically useful, obscures an alternative approach that can materially change the retirement plan: converting the savings problem into an income problem.

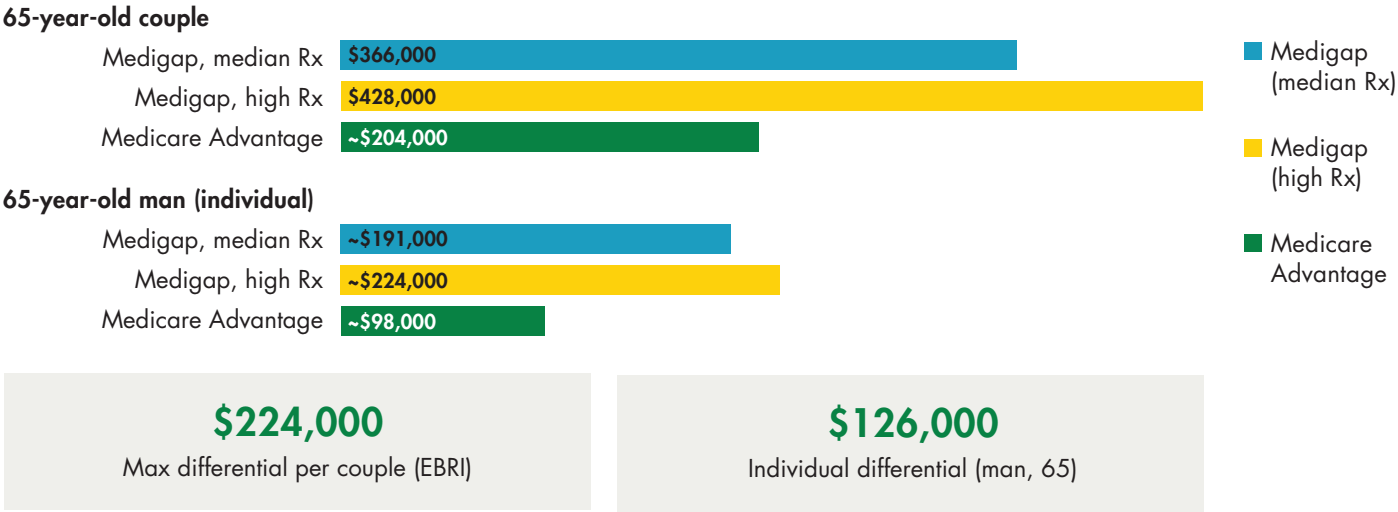
A client who delays Social Security claiming from 62 to 70 increases the monthly benefit by roughly 77 percent, a permanent, inflation-adjusted income stream that can absorb healthcare premiums and out-of-pocket costs for decades.

An annuity, structured within the broader plan, does the same; it transforms a portion of savings into guaranteed cash flow that arrives regardless of market conditions.

The client who relies solely on portfolio withdrawals to fund \$366,000 in healthcare costs is exposed to sequence-of-returns risk at precisely the moment when healthcare expenses are highest. The client whose protected income — Social Security and annuity payments — covers those annual costs has a fundamentally more resilient plan. The advisor who integrates healthcare cost estimation with protected income strategy is not just quantifying the problem but working toward solving it.

Figure 6 — Medigap Versus Medicare Advantage, Required Savings Targets

EBRI 2024: savings needed at age 65 for 90% probability of covering Medicare premiums, deductibles, and Rx. Present-value targets; LTC not included.



Step 4: After-Tax Income Coordination

With healthcare costs quantified, the next step is aligning income sources with expenses on an after-tax basis. This is the critical integration point where healthcare cost planning and financial planning converge. Social Security, pensions, IRA distributions, Roth withdrawals, annuity payments, dividends, and capital gains are all taxed differently. The mix of accounts and the sequence in which they are tapped directly shapes not only disposable income but also:

- IRMAA bracket exposure:** Medicare Part B and Part D premiums are income-tested using MAGI from 2 years prior. A Roth conversion or large capital gain in 2024 triggers higher premiums in 2026. Financial professionals who understand this lookback can sequence conversions to stay below IRMAA thresholds.

- ACA subsidy eligibility:** For clients retiring before 65, income management is critical. Drawing too much from a traditional IRA can eliminate ACA subsidies worth \$15,000 to \$25,000 annually. Conversely, using Roth withdrawals or after-tax savings can maintain subsidy eligibility.
- Social Security taxation:** Up to 85 percent of Social Security benefits can become taxable depending on combined income from other sources.¹⁵ Withdrawal sequencing that ignores this interaction can silently increase effective tax rates.
- HSA deployment:** Health savings accounts — now totaling 39 million accounts holding nearly \$147 billion in assets — offer a triple tax advantage that is uniquely suited to healthcare cost management in retirement. Strategic HSA use can fund Medicare premiums and out-of-pocket costs entirely tax-free.

¹⁵ Source: “Social Security income,” Internal Revenue Service, 2025.

Step 5: Gap Analysis and Ongoing Calibration

The final step compares projected after-tax income against projected expenses to determine whether the plan works. If it does, the client gains confidence in the durability of their retirement. If it does not, the framework identifies precisely where adjustments must be made. Retirement security depends less on the size of account balances than on the alignment of resources with obligations.

Critically, this is not a one-time exercise. Plans that are never revisited tend to fail quietly — because a tax rule changed, a health assumption proved wrong, or income arrived earlier or later than expected. Annual recalibration, tied to IRMAA lookback periods and ACA enrollment windows, keeps the plan responsive to real-world conditions.

Implementation Framework for Financial Professionals

Integrating healthcare cost planning into an existing advisory practice does not require rebuilding from scratch. It begins with adding healthcare cost questions — current coverage, MAGI trajectory, IRMAA bracket exposure — to the intake and annual review process. From there, the advisor incorporates IRMAA and ACA subsidy thresholds into withdrawal sequencing, establishes referral relationships or in-house capability for Medicare-specific guidance, and institutes an annual calibration protocol tied to the IRMAA 2-year lookback and ACA open enrollment windows. The progression is natural: awareness, then integration, then coordination, then ongoing refinement.

Planning domain	Estimated client value (per household)
IRMAA bracket management	\$3,000–\$12,000+ annually in avoided Medicare surcharges
ACA subsidy preservation (pre-65)	\$15,000–\$25,000 annually in preserved subsidies
Medicare coverage optimization	Up to \$224,000 per couple over retirement (EBRI)
HSA-funded healthcare costs	Tax-free healthcare spending; effective savings of 25–40% on medical expenses
Roth conversion sequencing	Reduced lifetime tax exposure while managing IRMAA/ACA interactions

Conclusion and Call to Action

The retirement planning landscape has changed. The three-legged stool of Social Security, pensions, and personal savings has lost a leg; only 14 percent of private industry workers retain access to defined-benefit plans, according to the Bureau of Labor Statistics.¹⁶

The responsibility for healthcare cost management has shifted to the individual, creating a client need that is as large as it is underserved.

For financial professionals, this shift represents the most significant growth opportunity in retirement planning today. The space between insurance, investments, and tax planning

is where the greatest client value lives — in avoided Medicare surcharges, preserved ACA subsidies, optimized coverage decisions, and thoughtfully sequenced withdrawals. It is also where the business case is strongest: Clients who receive integrated planning that demonstrably reduces their healthcare costs are unlikely to leave, more likely to deepen their engagement, and far more likely to refer.

Those who develop healthcare cost planning expertise — or integrate it through strategic partnerships — gain an edge that cannot be commoditized or undercut on price. The 5-step framework outlined in this paper provides a structured path from awareness to implementation, one that any practice can begin today.

¹⁶ Source: “Private Sector Workers See Boost in Retirement Plan Accessibility,” 401KSpecialist, 2025.

Author



Jae W. Oh, M.B.A., CFP®, is the owner and operator of GH2 Benefits, LLC, a full-service financial planning firm. He is the author of *Maximize Your Medicare*, the consumer guide now in multiple editions, and *Maximize Your Retirement*, translating regulatory complexity into actionable household strategy. Both books are written in plain-spoken English for practitioners and consumers alike.

He is the inventor of GH2 EDGE™, a customizable, patent-pending deterministic regulatory simulation engine that evaluates retirement income and decumulation strategies across 51 U.S. jurisdictions and over 80 candidate approaches.

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Additional Information

To further explore the insights highlighted in this paper, visit the LIMRA Retirement Income Institute, which offers a robust collection of research reports on today's most pressing retirement income issues. All reports are available to the public at no charge and can be downloaded directly from the institute's website: www.limraconsumer.com.

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