



LIMRA Retirement Income Institute

Redefining Advice: Integrating Healthcare Into Retirement Planning

Research Brief

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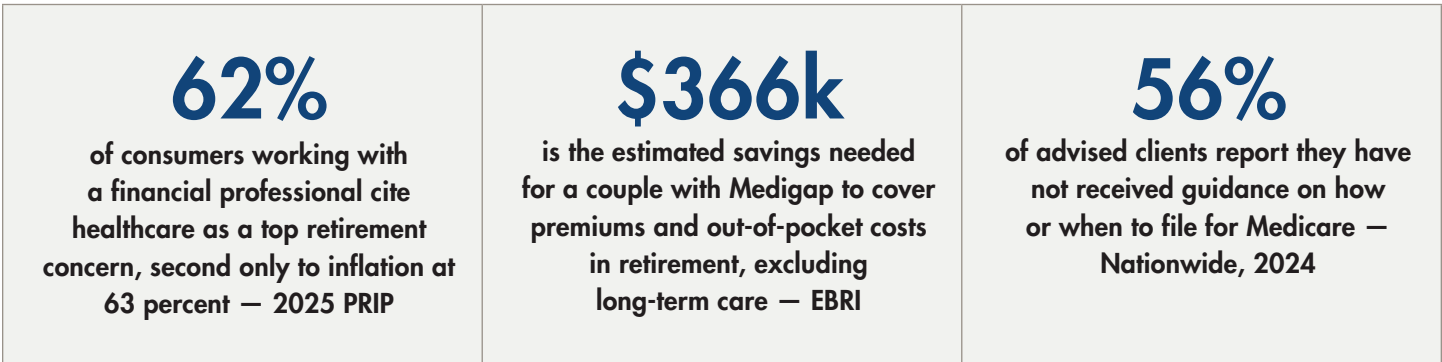
Healthcare costs in retirement are a well-documented concern. Survey after survey confirms that they rank among the financial worries clients carry into the advisory relationship — and the data supporting that concern is substantial. What is less well understood is the degree to which healthcare costs are not simply large but structurally connected to every other financial decision a household makes. How much a retiree pays for health coverage depends directly on income — and that dependency runs in both directions.

This paper examines that connection, the gap between client concern and advisor response that the research has consistently identified, and a planning methodology that treats healthcare costs as a first-order variable rather than a line item appended to the plan after the income strategy is set.

What the Research Consistently Shows

The concern itself is not new. Multiple national research studies, including Protected Retirement Income and Planning (PRIP),¹ the Nationwide Retirement Institute’s annual healthcare survey,² Fidelity’s retiree cost estimates,³ and the Employee Benefit Research Institute’s (EBRI) savings projections⁴ — have tracked it for years and arrived at the same conclusion: healthcare is the retirement cost clients worry about most and plan for least.

Figure 1 – Healthcare Costs and Planning



What makes these figures worth closer attention is the last one. The clients represented in that 56 percent are already engaged with a financial professional. The gap is not one of access but of scope, and the same research suggests the demand for broader guidance is explicit: 69 percent of consumers say that if their financial professional could not help them navigate Medicare, they would probably seek one who could.

The PRIP study adds a nuance worth noting. The conversation about health is happening — advisors report discussing physical health with clients at a rate of 96 percent. Clients recall those conversations at a rate of 44 percent. The implication is not that advisors are failing to raise the topic, but that the current approach — general discussion rather than household-specific analysis — is not producing the kind of engagement that clients retain.

The Structural Connection Between Income and Health Insurance Costs

The reason healthcare cost planning belongs inside the financial plan — rather than adjacent to it — is a matter of tax structure. Both primary mechanisms that govern what Americans pay for health coverage are income-based. The Advance Premium Tax Credit (APTC) under the ACA reduces premiums for lower-income households; the Income-Related Monthly Adjustment Amount (IRMAA) under Medicare increases premiums for higher-income households. Both are calculated from modified adjusted gross income (MAGI).

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: Fidelity Investments, *2025 Retiree Health Care Cost Estimate*: \$172,500 for a 65-year-old individual; \$330,000 for a couple (after-tax savings).
⁴ Source: *2026 EBRI/Greenwald Research Retirement Confidence Survey*, EBRI and Greenwald Research, 2026.

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*Every withdrawal decision, every Roth conversion, every capital gain changes MAGI — and therefore **changes what the client pays** for health insurance. It is not possible to optimize one without affecting the other.”*

The IRS maintains separate MAGI definitions for Medicare IRMAA, ACA premium tax credits, and Roth IRA eligibility — each derived from adjusted gross income but modified differently. This is confirmation, not complication: health insurance costs are administered through the tax code and belong in the tax-and-income planning conversation. The financial professional who understands this does not treat healthcare as a separate domain but as something woven into every income decision the household makes.

The Financial Scale of the Opportunity

The dollar magnitudes involved are larger than many households — or advisors — appreciate. EBRI estimates that a 65-year-old couple enrolled in Medigap will need \$366,000 in savings to have a 90 percent probability of covering healthcare premiums, deductibles, and prescription costs in retirement. For a couple with high prescription drug expenditures, that figure rises to \$428,000. These are not lifetime income estimates; they are savings targets for health coverage alone.

The coverage decision itself carries significant weight. EBRI’s analysis shows that the Medicare Advantage versus Medigap choice can produce a savings differential of up to \$224,000 per couple — not a marginal consideration, but one that materially alters the retirement income picture. The advisor who can guide that decision with confidence is providing a service worth tens of thousands of dollars.

Perhaps the clearest illustration comes from a single planning scenario. A couple, both 63, executing a \$150,000 Roth conversion in a year when they are still on ACA marketplace coverage — a sound tax strategy in isolation — may find that the conversion pushes their MAGI above the subsidy threshold. With the enhanced premium tax credit having expired at the end of 2025, the combined cost of conversion-year income tax and unsubsidized marketplace premiums can approach \$45,000 for a single year. An integrated approach that sizes the same conversion at \$80,000 reduces that figure to approximately \$13,000. Over two pre-Medicare years, the difference is roughly \$44,000 in preserved subsidies — without changing the household’s long-term retirement strategy or lifestyle.

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*The retirement destination is unchanged. The sequencing and the cost are **very different.**”*

The Relationship Dimension

There is a dimension to this work that extends beyond the planning deliverable. Healthcare cost planning, done well, tends to deepen the advisory relationship in ways that other planning work does not.

The analysis is inherently personal. It engages health history, family longevity, and geographic preferences alongside financial data. It surfaces concerns about cognitive decline, coverage gaps, and what Medicare actually covers that clients carry but rarely raise. And it produces outcomes that clients can see in dollar terms, which is the kind of specificity that stays with people.

The PRIP study’s finding on cognitive decline is worth reflecting on here. By age 82, the probability of dementia or mild cognitive impairment exceeds 50 percent. Financial management is among the first cognitive skills to deteriorate, often before diagnosis. The advisor who built an integrated plan that includes this dimension is a natural resource for the adult child navigating a parent’s changing circumstances. That conversation, handled thoughtfully, is how a client relationship becomes a family relationship.



*Clients who receive planning that demonstrably **reduces their healthcare costs** are unlikely to leave their advisory relationship, are more likely to deepen the engagement, and are far more likely to refer.”*

Where the Value is Created

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

A Framework for Integration

The full research paper develops a five-step planning methodology that any advisory practice can incorporate. The framework begins with a health and longevity assessment — because duration is the foundational variable in retirement planning — and moves through geographic analysis, healthcare-integrated cost estimation, after-tax income coordination, and annual recalibration. Each step is developed with supporting data, worked scenarios, and implementation guidance:

- **Health and longevity assessment**, establishing the planning horizon and its implications for income duration and coverage decisions
- **Geographic analysis**, accounting for state tax treatment, cost-of-living variation, and state-specific Medigap enrollment rules that can preserve flexibility most clients assume is unavailable
- **Healthcare-integrated cost estimation**, including the coverage choice analysis where the Medicare Advantage versus Medigap decision alone can produce a \$224,000 differential in required savings per couple
- **After-tax income coordination**, aligning withdrawal sequencing with IRMAA lookback periods, ACA subsidy thresholds, Social Security taxation, and HSA deployment into a coherent strategy
- **Gap analysis and annual recalibration**, tied to enrollment windows and lookback periods, so the plan remains responsive as health status, income, and tax rules evolve

Integrated Healthcare Planning for Peak 65

The 4.1 million Americans reaching age 65 each year through 2027 — the demographic surge known as Peak 65⁵ — represent an unprecedented volume of households confronting Medicare enrollment, ACA-to-Medicare transitions, and the full range of healthcare cost decisions for the first time. The expiration of the enhanced Advance Premium Tax Credit at the end of 2025 has made the connection between income strategy and health insurance cost more consequential for pre-Medicare households than it has been in years.

The financial professional who can work across the boundaries of insurance, tax, and investment planning — connecting these pieces into a household-specific analysis — offers something that is genuinely difficult to replicate through any single-domain channel. The research paper, *Redefining Advice: Integrating Healthcare Into Retirement Planning*⁶, provides the research foundation and practical framework for doing exactly that.

⁵ Source: *The Peak 65® Zone is Here – Creating a New Frameworks for America's Retirement Security*, LIMRA, 2024.

⁶ Source: *Redefining Advice: Integrating Healthcare Into Retirement Planning*, LIMRA, 2026.

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.

Jae is a Fellow at the LIMRA Retirement Income Institute. He earned a B.A. from the University of Michigan, Ann Arbor, and an M.B.A. from the University of Chicago Booth School of Business. He holds the CFP® designation and has advanced experience in financial markets on three continents.

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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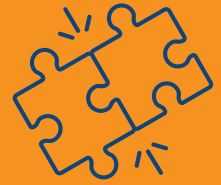
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