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The True Costs of Healthcare in Retirement

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Healthcare is, without question, one of the most consequential expenses a retiree will face. It can also be one of the most underestimated. For many, retirement planning has carefully factored in common variables such as income replacement, investments and portfolio allocation, taxes, and estate structures. However, often times, the true cost of healthcare and what retirees need to stay healthy in their later years is an afterthought, tucked somewhere between travel and discretionary spending. This can carry real financial risks. In this article, we shed light on this gap, highlighting misconceptions of anticipated healthcare costs in retirement and what our research tells us is more realistic.

Healthcare Costs Your Plan Should Account For

In 2025, the average 65-year-old retiring was projected to spend approximately \$172,500 on healthcare and medical expenses over the course of retirement. For couples, that combined figure reaches \$345,000¹, and these numbers do not include the increasing likelihood for long-term care needs.

Roughly 70% of people age 65 are projected to need some form of long-term care during their lifetime, with 20% needing it for over five years.² The current median annual cost of a semi-private nursing home room is approximately \$118,000, with private rooms running closer to \$135,000 per year.³ These costs will likely compound as healthcare inflation is expected to run at 5.8% annually over the long term, more than double the projected Social Security COLA of 2.4%.⁴

These are not remote risks to be addressed eventually. They are high-probability costs that should be considered and discussed as a part of every comprehensive retirement plan.

Navigating Medicare: A Foundation With Meaningful Gaps

Original Medicare, Parts A and B, provides a foundation of medical coverage for retirees, but may not be a complete solution.

Medicare Part A covers inpatient hospital care, skilled nursing facility stays, hospice, and some home health care. Part B covers services such as doctor visits, outpatient care, home health care, medical equipment, and preventive services.

Most individuals do not pay anything for Medicare Part A. If you are not eligible for a free Part A, you may be able to buy it, with a current deductible of \$1,736 per benefit period.

The base premium for Medicare Part B is currently \$202.90 per month and can change yearly. Depending on your income, you may pay a higher premium. Part B currently has a deductible of \$283 annually. After the deductible is met, the coinsurance is typically 20% with no maximum out-of-pocket limit. That unlimited exposure can be a commonly misunderstood feature of Original Medicare.

Both Parts A and B can lack in cost sharing and prescription drug coverage, which most retirees address by adding Part D, prescription drug coverage, alongside either a Medigap supplemental policy or a Medicare Advantage plan, which typically bundles all coverage into one.

The trade-off between these paths warrants serious analysis. While Medicare Advantage plans often carry lower monthly premiums, the coverage can be less extensive. Furthermore, many plans maintain restrictive provider networks, requiring the use of local medical providers or imposing additional costs for out-of-network care. For clients who place high value on provider flexibility, particularly those who may seek specialized care, this distinction matters considerably.

The IRMAA Factor: When Income Shapes Premiums

For clients whose retirement income places them above certain thresholds, an additional cost can enter the picture that adds another layer of complexity.

IRMAA, also known as the Income Related Monthly Adjustment Amount, is a surcharge applied to Part B and D premiums for higher-income beneficiaries, determined by your Modified Adjusted Gross Income (MAGI) from two years prior. An individual's MAGI for IRMAA purposes is calculated as Adjusted Gross Income plus any tax-exempt interest income, most commonly municipal bond interest. Typical income sources that feed into this figure include traditional IRA and 401(k) distributions, required minimum distributions (RMDs), Roth conversions, capital gains, dividends, pension income, etc. For 2026, surcharges begin for joint filers with MAGI above \$218,000 and scale across five tiers up to \$750,000, pushing total Part B premiums per person from the standard \$202.90 per month to as high as \$689.90 at the top tier.⁵

The Medicare two-year lookback period for IRMAA creates both a challenge and an opportunity. Because premiums are determined from income two years prior, clients approaching retirement have a meaningful planning window that rewards proactive coordination between tax strategy and healthcare cost management.

For example, if you are a high-income earner right up until retirement and drop tax brackets significantly at retirement due to lower income, you may wish to take advantage of entering a lower tax bracket and do Roth Conversions. While Roth Conversions can be a great planning tool, they can also increase your MAGI and thus raise your Medicare premiums due to IRMAA.

This is precisely why tax optimization and Medicare cost planning must be analyzed together. A Roth conversion that makes clear sense on a tax ledger may carry a premium cost that changes the calculus entirely. Or, it may still be the right move, once the full picture is modeled. Neither conclusion can be reached without integrated analysis.

How Park Avenue Capital Approaches Healthcare in Planning

At Park Avenue Capital, we build healthcare costs into every financial plan as a baseline expense in addition to your lifestyle spend rate. For clients with a projected AGI below \$410,000 (married filing jointly) or \$205,000 (single), we assume \$1,000 per month per client with a 5% annual COLA, reflecting healthcare's historically elevated inflation rate. For clients above the \$410,000 threshold, we increase that baseline to \$1,300 per month to better estimate the IRMAA surcharges that accompany higher income in retirement. These are intentional approximations, grounded in real data and experience from working with a wide range of retirement income profiles. used to ensure that healthcare does not become a blind spot in an otherwise thoughtfully constructed financial plan.

If you would like to review how healthcare costs are currently modeled in your plan, or if this is a conversation you have not yet had, we welcome the opportunity to walk through your projections together.

Lastly, for more in depth information on Medicare and IRMAA, the pages that follow break down each component in detail and present a healthcare cost case study for a retired couple.

¹ Fidelity Investments, *2025 Retiree Health Care Cost Estimate*, July 30, 2025

² Urban Institute, as cited in U.S. News & World Report, *Nursing Home Costs in 2026*, May 5, 2026

³ SeniorLiving.org, *Nursing Home Costs in 2026 by State and Type of Care*, May 2026

⁴ HealthView Services, *2026 Retirement Healthcare Costs Data Report*, February 5, 2026

⁵ Centers for Medicare & Medicaid Services, *2026 Medicare Parts A & B Premiums and Deductibles*

II. ORIGINAL MEDICARE, MEDIGAP, AND MEDICARE ADVANTAGE EXPLAINED

Original Medicare-Parts A + B

Original Medicare consists of Parts A and B. Part A, sometimes called hospital insurance, covers inpatient care in hospitals, skilled nursing facilities, hospice, and some home health care. Part B, sometimes called medical insurance, covers services such as doctor visits, outpatient care, home health care, medical equipment, and preventive services. Part D covers prescription drugs. Part D is in addition to Original Medicare, and you can purchase this coverage outright or through a Medicare Advantage Plan.

Most individuals do not pay anything for Medicare Part A due to previous Medicare tax payments during their, or their current or former spouse's, working years. If you are not eligible for a free Part A, you may be able to buy it with the monthly cost dependent on the number of credits accumulated during your or your spouse's working career. Part A has a current deductible of \$1,736 per benefit period. A benefit period is defined as the day you are admitted to inpatient care until 60 days after your last day of inpatient care. Inpatient stays have set copayments after the deductible is met and after the first 60 days.

The base premium for Medicare Part B is currently \$202.90 per month; this amount can change each year. Depending on your income, you may pay a higher premium. Part B currently has a deductible of \$283 which is paid once per year. After the deductible is met, the coinsurance is typically 20% of the service. That means that you will pay 20% of the cost, and insurance will cover the remaining 80%. There is no maximum out-of-pocket limit.

Medicare Part D-Prescription Drug Coverage

Medicare Part D premiums vary based on the plan you join, and the amount can change each year. Premiums are also driven by income. Most plans charge a deductible for prescription

drugs. If you do not sign up for both Parts A and B when you are first eligible for Medicare, you may be charged a penalty. Similarly, if you do not join a drug plan when you first get Medicare and lapse 63 days or more without creditable drug coverage, you may be charged a penalty. Penalties are not one-time but rather increase your monthly Medicare cost permanently.

Medigap (Medicare Supplemental Insurance)

Medicare Supplemental Insurance, often referred to as Medigap, is an additional insurance policy that can be bought from private companies to help individuals pay for out-of-pocket costs under Original Medicare. These policies and benefits are standardized across states and typically named by letters such as G or K. Premiums vary based on plan and can change each year. You must pay your Part B premium in order to keep your Medigap plan.

Medicare Advantage (Medicare Part C)

The alternative to Medigap is Medicare Advantage. Medicare Advantage, or Part C, is not a supplemental policy. Medicare Advantage is an alternative to Original Medicare, wherein you purchase benefits through a private health plan that is Medicare approved. These are considered bundled plans and include Medicare Parts A and B, and usually Part D as well. These plans typically have different out-of-pocket costs than Original Medicare, and include a maximum on out-of-pocket costs, limiting the need for Medigap. These plans tend to have extra benefits as well. Pre-approvals and preferred doctor networks are common requirements of Medicare Advantage Plans. Medicare Advantage premiums vary based on the plan that you join, and premiums can change each year. You must pay your Part B premium in order to keep a Medicare Advantage plan. One major caveat for Medicare Advantage is that while monthly premiums tend to be lower when compared to Original Medicare and Medigap, the coverage is often less extensive. Many Medicare Advantage plans have restrictive networks, often mandating you to use local medical providers or pay additional fees for any out-of-network care.

Sources:

[Parts of Medicare | Medicare](#)

III. EXPLAINING INCOME RELATED MONTHLY ADJUSTMENT AMOUNT (IRMAA)

IRMAA, or Income Related Monthly Adjustment Amount, is a surcharge on Medicare Parts B and D for those with high incomes. According to Medicare.org, approximately 8% of Medicare Part B participants are subject to IRMAA. IRMAA is charged based on your MAGI (Modified Adjusted Gross Income) from two years prior. If your income declines in the years following, and you meet certain criteria, you may petition a special ruling to adjust the IRMAA surcharge.

IRMAA Charges for 2026 (based on MAGI from 2024):

Filing Status: Single	Filing Status: Married Filing Jointly	Part B Premium	Part D
\$109,000- \$137,000	\$218,000- \$274,000	\$284.10	Your plan premium + \$14.50
\$137,001- \$171,000	\$274,001- \$342,000	\$405.80	Your plan premium + \$37.50
\$171,001- \$205,000	\$342,001- \$410,000	\$527.50	Your plan premium + \$60.40
\$205,001- \$500,000	\$410,001- \$750,000	\$649.20	Your plan premium + \$83.30
\$500,001+	\$750,000+	\$689.90	Your plan premium + \$91.00

Since Medicare requires a two-year lookback period, it is advantageous to strategically plan for large changes in income before you begin Medicare. For example, if you are a high-income earner right up until retirement and drop tax brackets significantly at retirement due to lower income, you may wish to take advantage of entering a lower tax bracket and do Roth Conversions. While Roth Conversions can be a great planning tool, they also increase your taxable income and thus increase your Medicare premiums due to IRMAA.

As mentioned previously, you have the right to appeal your IRMAA surcharge ruling for any given year. The form that you must file to appeal your surcharge with the Social Security Administration is form SSA-44. The form can be completed online at SSA.gov or it can be sent by fax or mail. To qualify for a special ruling, you must report a life event that resulted in a reduction in household income since the two-year lookback period. Qualifying life events

include marriage, divorce, death of a spouse, loss of income, and an employer settlement payment.

Sources

[Costs | Medicare](#)

[SSA - POMS: HI 01101.031 - How IRMAA is Calculated and How IRMAA Affects the Total Medicare Premium - 12/02/2025](#)

[Request to lower an Income-Related Monthly Adjustment Amount \(IRMAA\) | SSA](#)

IV. HEALTHCARE CASE STUDY

Facts:

- Roger and Serena are married and live in New York. They both retired a few years ago and are now ages 67 and 65, respectively.
- Both worked for 35+ years throughout their careers and are in line to be maximum Social Security benefit earners.
- They have an investment portfolio consisting of \$8M of Non-Qualified assets, \$4M of IRAs, 300k of bank cash, and \$3M of real estate between a primary home and a rental property.
- They have not filed for Social Security benefits yet, and Serena receives an annual pension of around \$200,000.
- Roger and Serena are each enrolled in Original Medicare (Parts A and B), have secured Part D prescription drug plans, and have obtained Medigap Plan G supplemental policies to help minimize out-of-pocket costs.
- In conjunction with their advisor, they elected to also execute a Roth Conversion this year of \$150,000 to strategically accelerate income forward while they are in a lower tax bracket than they are projected to be in once RMDs eventually begin.

- Projected MAGI, including the pension, portfolio income, and Roth Conversion for 2026 will be around 500k.

Healthcare Expense Assessment

Here is an approximate breakdown of the medical expenses to plan for at a minimum for Roger and Serena's retirement:

Medical Expense Category	Roger Monthly Healthcare Costs	Serena Monthly Healthcare Costs
Medicare Part A	\$0	\$0
Medicare Part B*	\$202.9	\$202.9
Medicare Part D	\$70	\$70
Medigap Plan G	\$400	\$400
IRMAA Charges (Part B + D)	\$529.2	\$529.2
Extra Costs	\$150	\$150
Totals	\$1,352	\$1,352

**Once you begin collecting Social Security benefits, many retirees elect to have Medicare Part B premiums deducted directly from their Social Security direct deposit*

The costs outlined above approximate to our standard approach to clients with high-income in retirement to adequately account for IRMAA charges in addition to Original Medicare premiums and overall costs. It is critical to note that the modeled outlay above do not reflect the expenses if a long-term care event were to occur. Medicare does not generally cover institutional care for a long-term care event, which requires adequate planning in terms of securing long-term care coverage whether through standalone coverage or a hybrid policy with permanent life insurance.

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