

Projected Savings Medicare Beneficiaries Need for Health Expenses Spike in 2021

Some Couples Could Need as Much as \$360,000 in Savings

By Paul Fronstin, Ph.D., and Jack VanDerhei, Ph.D., Employee Benefit Research Institute

AT A GLANCE

After declining in 2020, the predicted saving targets for Medicare beneficiaries to cover health premiums, deductibles, and certain other health expenses in retirement increased between 3 and 8 percent in 2021. These are close to the biggest increases we have seen since 2012.

Savings are needed to pay for premiums for Medicare Parts B and D, the Part B deductible, premiums for Medigap Plan G, and out-of-pocket spending for outpatient prescription drugs.

The data used in EBRI's analysis come from a variety of sources. EBRI employs a Monte Carlo simulation model for this evaluation that simulated 100,000 observations, allowing for the uncertainty related to individual mortality and rates of return on assets in retirement.

The analysis reveals:

- In 2021, a 65-year-old man needed \$79,000 in savings and a 65-year-old woman needed \$103,000 in savings for a 50 percent chance of having enough to cover premiums and median prescription drug expenses in retirement. For a 90 percent chance of having enough savings, the man needs \$142,000 and the woman needs \$159,000. This is up 9 percent from 2020.
- For a 50 percent chance of having enough to cover health care expenses in retirement, a couple with median prescription drug expenses needed \$182,000 in savings. For a 90 percent chance of having enough, the couple needed \$296,000 in savings. This is up 10 percent from 2020.
- At the extreme — a couple with drug expenses at the 90th percentile throughout retirement who wants a 90 percent chance of having enough money for health care expenses in retirement by age 65 — targeted savings were \$361,000 in 2021. This is higher than the \$325,000 required in 2020.
- The increases identified in this paper are due to a number of reasons. The Medicare Trustees increasing projected costs for Medicare Part D out-of-pocket expenses is one reason for the increase. Another reason is the substantial increase in the Medicare Part B premium.

Jack VanDerhei is Director of Research at the Employee Benefit Research Institute (EBRI). This *Issue Brief* was written with assistance from the Institute’s research and editorial staffs. Any views expressed in this report are those of the authors, and should not be ascribed to the officers, trustees, or other sponsors of EBRI, EBRI-ERF, or their staffs. Neither EBRI nor EBRI-ERF lobbies or takes positions on specific policy proposals. EBRI invites comment on this research.

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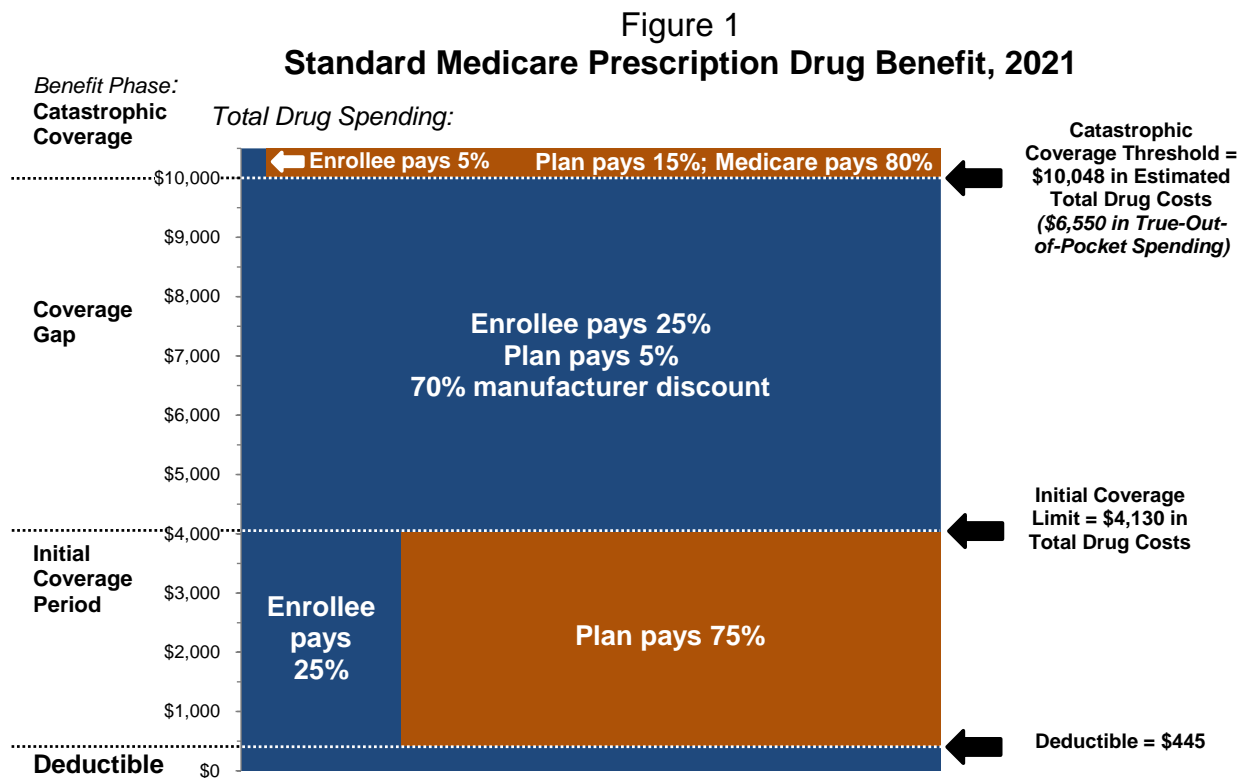
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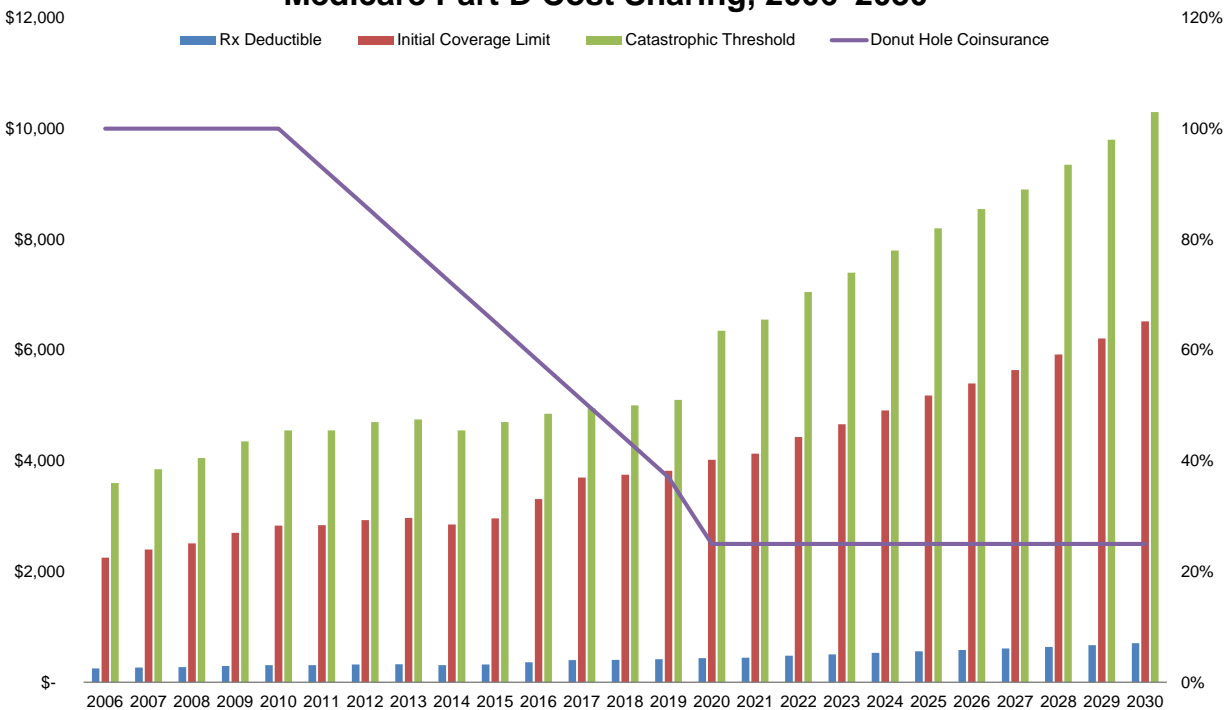
Introduction

Medicare was not designed to cover health care expenses in full. Deductibles for inpatient and outpatient services were part of the program when it was established in 1965. In addition, when outpatient prescription drugs were added as an optional benefit in 2003, the program included a then-controversial coverage gap known as the “donut hole” in which beneficiaries must pay out of pocket to cover the cost of prescription drugs once they have reached their initial benefit limit until they reach the out-of-pocket catastrophic coverage threshold, when the drug plan again helps pay for covered drugs (Figure 1). While the Patient Protection and Affordable Care Act of 2010 (ACA) included provisions to reduce the size of this coverage gap, the ACA did not eliminate it. This year, enrollees will pay 25 percent of the cost of prescription drugs when they are in the “donut hole” for both generic and brand-name drugs, though other forms of cost sharing increased (Figure 2).



Source: Kaiser Family Foundation, based on Part D benefit parameters for 2021, <https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit/>.

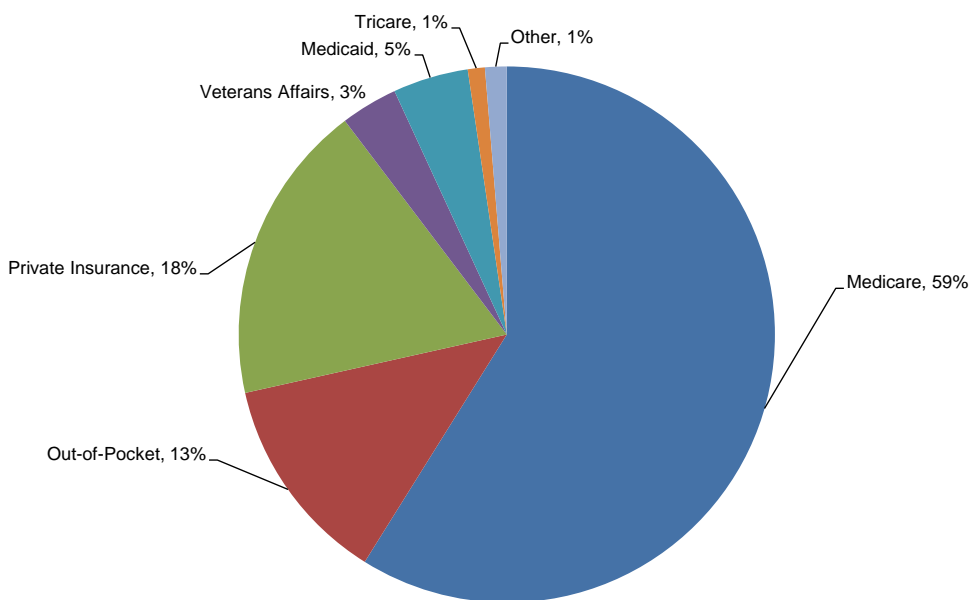
Figure 2
Medicare Part D Cost Sharing, 2006–2030*



Source: Table V.E2 in 2021 Medicare Trustees Report, <https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf>.
 * 2022–2030 are based on Medicare Trustees projections using intermediate estimates.

As of 2019, Medicare covered 59 percent of the cost of health care services for Medicare beneficiaries ages 65 and older, while out-of-pocket spending accounted for 13 percent of incurred costs, and private insurance covered 18 percent (Figure 3).

Figure 3
**Source of Payment for Incurred Health Care Expenses,
 Noninstitutionalized Population of Medicare Beneficiaries,
 Ages 65 and Older, 2019**



Source: EBRI estimates from the 2019 Medical Expenditure Panel Survey.

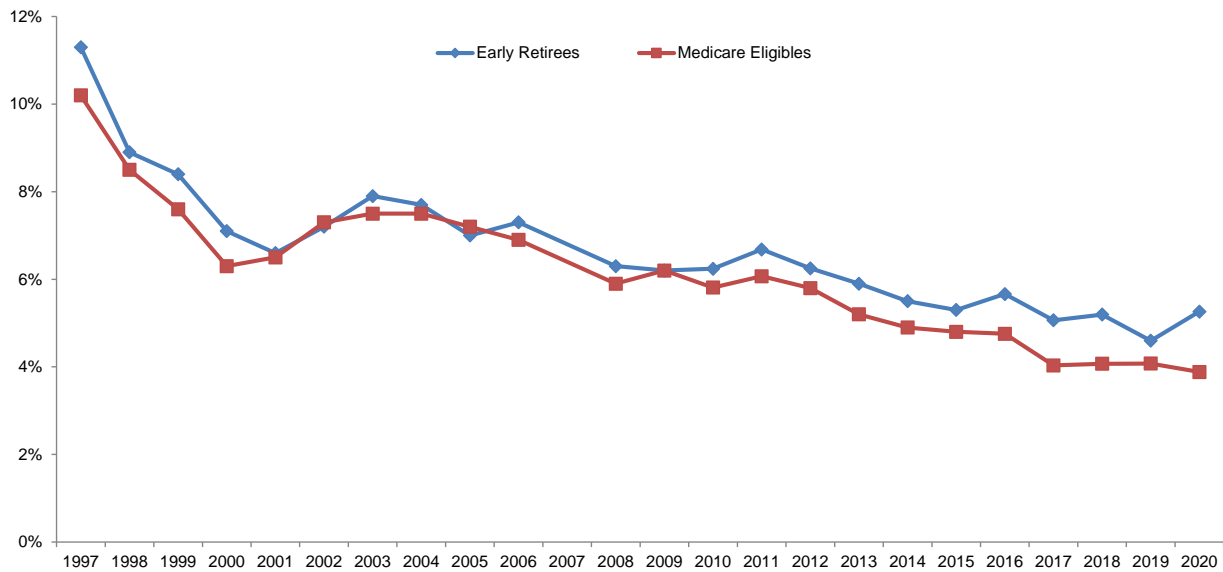
In the future, individuals are likely to have to pay greater shares of their overall health costs in retirement because of the financial condition of the Medicare program and cutbacks to employment-based retiree health programs, discussed in more detail below.

This study updates previous estimates by the Employee Benefit Research Institute (EBRI) on the savings needed to cover health insurance premiums and health care expenses in retirement going back to 2011. Unlike the decline in savings targets that we found in 2020 (Fronstin and VanDerhei 2020), this analysis finds that savings targets for a retiring 65-year-old increased between 3 and 8 percent in 2021 relative to the targets for a 65-year-old retiring in 2020. These are close to the biggest increases we have seen since 2012. This *Issue Brief* discusses trends in the availability of employment-based retiree health benefits, the model that we use to generate the savings targets, the findings, and reasons for the recent increase in savings targets.

Trends in Employment-Based Retiree Health Programs

Very few private-sector employers offer retiree health benefits, and the number offering them has been declining. The Agency for Healthcare Research and Quality (AHRQ) reported that in 2020, only about 4 percent of private-sector establishments offered health benefits to early retirees, down from only 10 percent for Medicare-eligible retirees in 1997 (Figure 4). Furthermore, about 5 percent of private-sector establishments offered health benefits to early retirees in 2020, down from 11 percent in 1997.

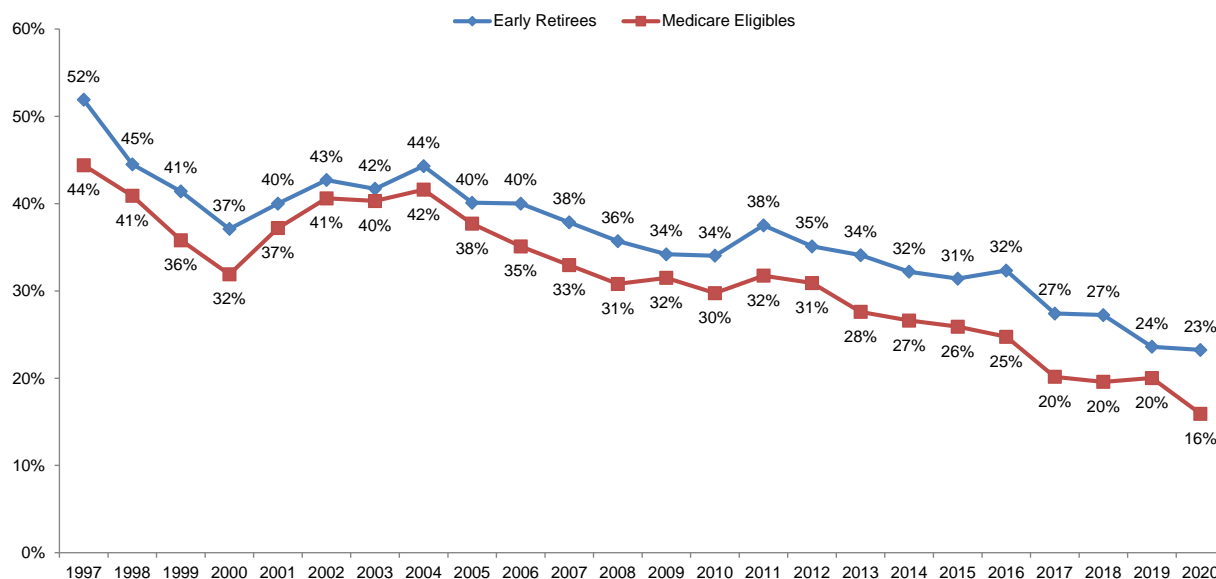
Figure 4
Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–2020



Source: EBRI estimates from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1.

Larger firms were much more likely than smaller ones to offer retiree health benefits. Among private-sector establishments with 1,000 or more workers, 16 percent offered health coverage to Medicare-eligible retirees, and 23 percent offered it to early retirees in 2020 (Figure 5). Even among larger firms, the percentage offering retiree health benefits to either early retirees or Medicare-eligible retirees has been declining.

Figure 5
Percentage of Private-Sector Establishments With
1,000 or More Employees Offering Health
Insurance to Retirees, 1997–2020

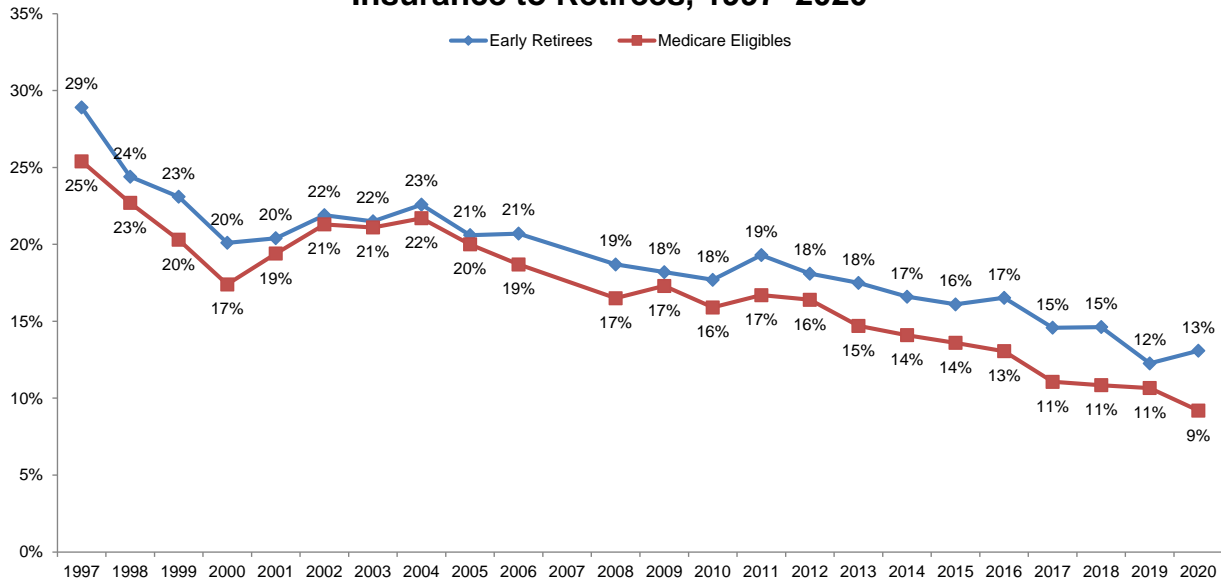


Source: EBRI estimates from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1.

As a result of the decline in the percentage of employers offering coverage, the percentage of workers at firms that offer coverage has declined as well. In 2020, 13 percent of workers were employed at establishments that offered health coverage to early retirees, down from 29 percent in 1997 (Figure 6). Similarly, 9 percent of workers were employed at establishments that offered health coverage to Medicare-eligible retirees, down from 25 percent in 1997. These statistics should not be interpreted as meaning that 9 percent of workers should expect supplemental health coverage to Medicare when enrolled in the program, nor should it be implied that 13 percent of workers should expect to receive health coverage if they retire before age 65. Many of these workers will not be eligible for retiree health coverage for a number of reasons. They may be part time; they may have not had enough years of service to qualify for the benefit; or new hires may not be eligible for coverage.

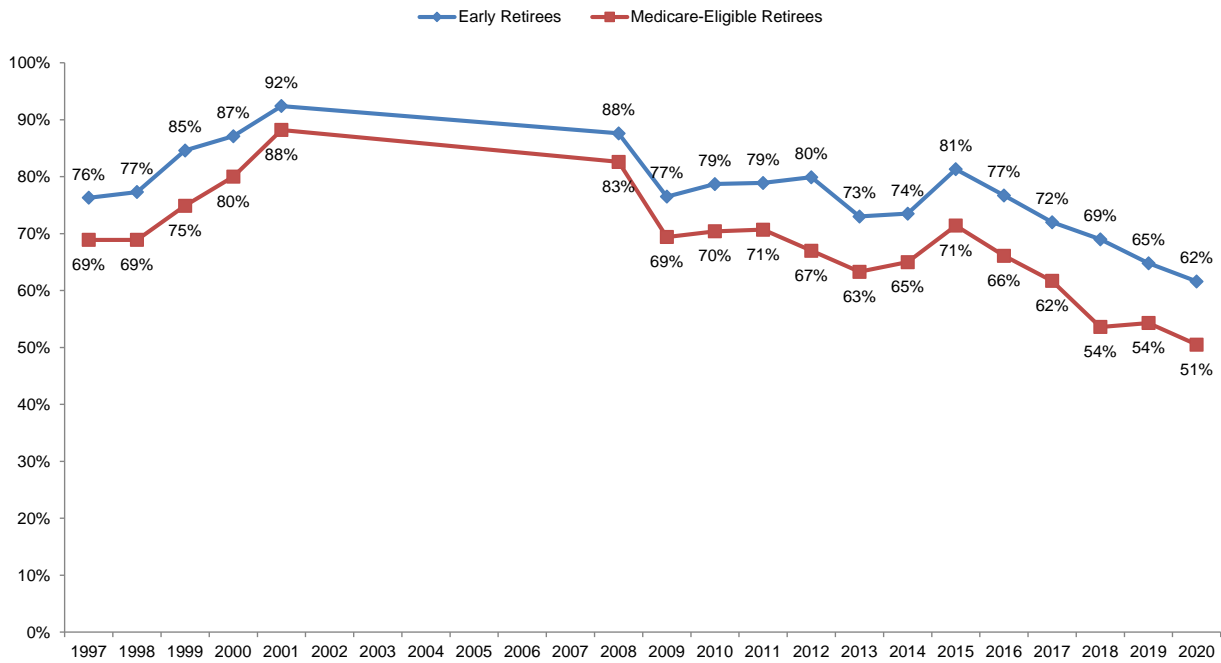
The AHRQ data show a similar trend among state and local government employers. Among state employers, after an increase in the late 1990s, the percentage offering retiree health benefits has been falling (Figure 7). The decline in the percentage of local government employers offering retiree health benefits started more recently. For example, in 2011, 85 percent of local government employers with 5,000–9,999 workers offered health coverage to early retirees (Figure 8). By 2020, it was down to 67 percent.¹

Figure 6
Percentage of Private-Sector Workers Employed by Establishments Offering Health Insurance to Retirees, 1997–2020



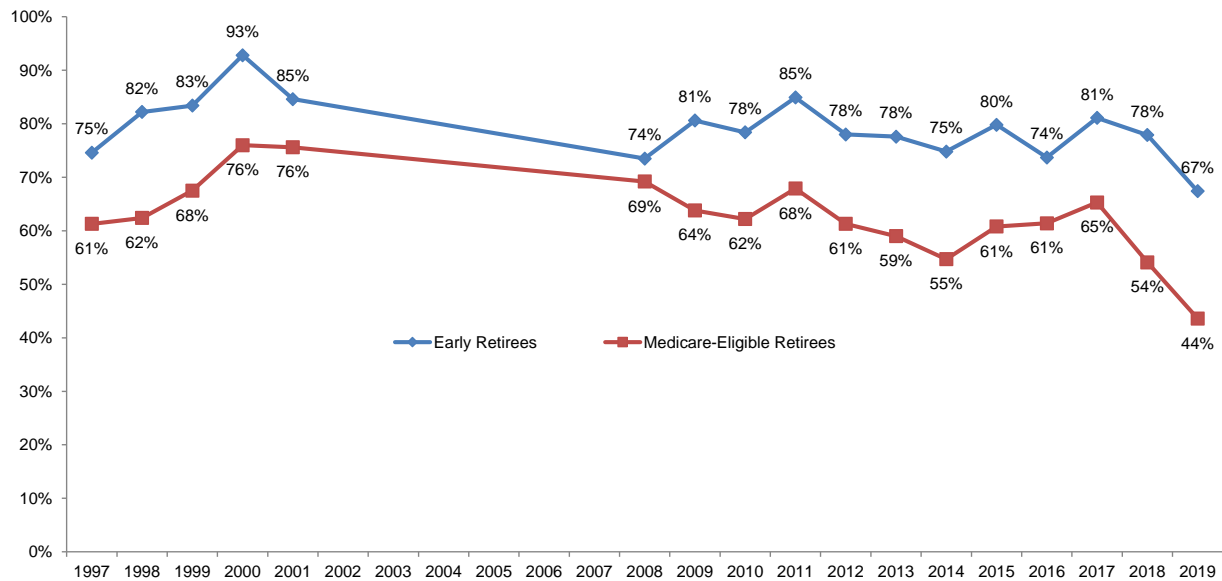
Source: EBRI estimates from various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1.

Figure 7
Percentage of State Government Employers Offering Health Insurance to Retirees, 1997–2020



Source: Various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1.

Figure 8
Percentage of Local Government Employers With 5,000–9,999 Workers Offering Health Insurance to Retirees, 1997–2020



Source: Various tables at http://meps.ahrq.gov/mepsweb/data_stats/quick_tables_search.jsp?component=2&subcomponent=1.

Assumptions Around Health Expenses in Retirement

For the purposes of this study, the health expenses for which savings would be accumulated are (i) premiums for Medicare Parts B² and D,³ (ii) the Part B deductible, (iii) premiums for Medigap Plan G,⁴ and (iv) out-of-pocket spending for outpatient prescription drugs. This analysis does not factor in the total savings needed to cover long-term-care expenses and other health expenses not covered by Medicare,⁵ nor does it take into account the fact that many individuals retire before becoming eligible for Medicare.

The study assumes that all individuals and couples have Medigap Plan G coverage in retirement — and thus treats all individuals and couples as having the Plan G premium as an expense. This approach takes away most of the uncertainty related to actual use of specific health care services over one’s lifetime. That is, instead of trying to predict when a Medicare beneficiary may use health care services and thus incur health expenses, which is highly dependent on whether the individual has reached their Medicare Part A⁶ deductible, this study assumes that beneficiaries have the most comprehensive health insurance coverage available that is supplemental to Medicare (i.e., Plan G) and thus pay premiums for this coverage on a regular basis, whether or not they use health care services. To address uncertainty related to out-of-pocket expenses incurred under Medicare Part B, we assume that all Medicare beneficiaries reach the Part B deductible, which was \$203 in 2021. The study also assumes that all Medicare beneficiaries have Medicare Part D to cover outpatient prescription drug expenses.

While premiums for Medigap Plan G and Medicare Part D are treated as health care expenses in retirement for the purposes of our model, the model also includes estimates on out-of-pocket spending for the Part B deductible (not covered by Medigap Plan G) and prescription drugs. Data from the Medical Expenditure Panel Survey (MEPS) were used for this part of the model. While it is currently possible for new Medicare beneficiaries to purchase Medigap insurance (e.g., Plan G) to completely avoid deductibles and other cost sharing associated with Medicare Parts A and B, it is not possible to avoid the deductibles and other cost sharing associated with Part D outpatient prescription drugs. Thus, under Part D, for expenses above the deductible, beneficiaries are responsible for 25 percent coinsurance on expenses between the deductible and the initial benefit limit. And once the initial benefit limit is reached, beneficiaries are in the donut hole until they reach the catastrophic limit, above which they pay 5 percent coinsurance. When outpatient prescription drug coverage was added to Medicare in 2006, beneficiaries in the donut hole paid 100 percent

coinsurance. When the ACA was enacted, it included a provision to phase in a reduction in the donut hole to 25 percent coinsurance by 2020.

Finally, while other EBRI studies consider expenses associated with long-term care and any spending for health care services not traditionally covered by Medicare, such as dental care, these expenses are not included in this study (VanDerhei 2019).

Modeling Technique and Data

Determining how much money an individual or couple will need in retirement to cover health insurance premiums and out-of-pocket expenses is a complicated process that depends on numerous variables. The amount of money a person will need will depend on the age at which he or she retires; length of life after retirement; the availability and source of health insurance coverage to supplement Medicare; health status and out-of-pocket expenses; the rate at which health care costs increase; and interest rates and other rates of return on investments. In addition, public policy will also affect spending on health care in retirement. While it is possible to derive a single number that an individual can use to set savings goals, a number based on average expenses will be too small for approximately one-half of the population.

Thus, this analysis uses a Monte Carlo simulation model⁷ that treats health insurance premiums and out-of-pocket health care expenses in retirement as known values but deals with the uncertainty of how long the individual or couple will survive and what rate of return they will achieve on their savings in retirement by simulating 100,000 observations for each source of supplemental coverage. In some of the simulated outcomes, the individual or couple will only survive a few years and thus will only have a relatively small aggregate value for health expenses in retirement. In other cases, they may live far longer than the life expectancy for an individual or couple at age 65 and generate a correspondingly larger aggregate value.

Because the aggregate value of savings for health expenses in retirement would be spent gradually over time in retirement, the proceeds available at age 65 could be invested until such time that each annual expenditure takes place. The simulation model in this analysis assumes rates of return with a median nominal value of 7.32 percent during retirement.⁸ In most cases, this results in present values of funds needed at age 65 that are smaller than the aggregate values in this paper.

These observations were used to determine targets for adequate savings to cover an individual's health costs 50 percent, 75 percent, and 90 percent of the time. Estimates are also jointly presented for a stylized opposite-sex couple, both of whom are assumed to retire simultaneously at age 65.

The data for this study came from a variety of sources. Data on Part B and D premiums, Part B and D deductibles, initial benefit limits, and catastrophic thresholds came from the 2021 Medicare trustees report.⁹ Medigap Plan G premiums were generated for new Medicare enrollees aged 65 in 2021 by metropolitan statistical area. Out-of-pocket spending on outpatient prescription drugs was derived from the 2019 Medical Expenditure Panel Survey (MEPS), the most recent year of data available.

Savings Targets to Cover Health Insurance Premiums and Out-of-Pocket Costs in Retirement

Figure 9 contains the savings estimates for a person who turns age 65 in 2021 and who purchases both Medigap Plan G to supplement Medicare and Medicare Part D outpatient prescription drug benefits. It also includes EBRI prior-year estimates. As discussed above, there will be uncertainty related to a number of variables, such as health care costs, longevity, and interest rates. Among people with Medicare Part D, there is also uncertainty related to health status and outpatient prescription drug use.

Projections of savings needed to cover out-of-pocket expenses for prescription drugs are highly dependent on the assumptions used for drug utilization. There are three sets of columns of estimates in Figure 9: In the first, prescription

drug use is at the median throughout retirement; in the second set, prescription drug use is at the 75th percentile throughout retirement; and in the third set, prescription drug use is at the 90th percentile throughout retirement. Under each set of columns, a comparison of the savings targets is presented for 2011–2021.

Figure 9
Savings Needed for Medigap Premiums, Medicare Part B Premiums and Deductibles, Medicare Part D Premiums, and Out-of-Pocket Drug Expenses for Retirement at Age 65 in 2011–2021

Chance of Having Enough Savings	Median Prescription Drug Expenses Throughout Retirement											Percentage Change Between 2020–2021
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	
Men												
50%	\$71,000	\$70,000	\$65,000	\$64,000	\$68,000	\$72,000	\$73,000	\$75,000	\$79,000	\$73,000	\$79,000	8%
75%	107,000	105,000	96,000	93,000	99,000	103,000	106,000	111,000	116,000	105,000	114,000	9%
90%	136,000	135,000	122,000	116,000	124,000	127,000	131,000	148,000	144,000	130,000	142,000	9%
Women												
50%	95,000	93,000	86,000	83,000	89,000	93,000	95,000	99,000	104,000	95,000	103,000	8%
75%	124,000	122,000	111,000	106,000	114,000	118,000	121,000	129,000	133,000	120,000	131,000	9%
90%	156,000	154,000	139,000	131,000	140,000	143,000	147,000	161,000	163,000	146,000	159,000	9%
Couple												
50%	166,000	163,000	151,000	147,000	158,000	165,000	169,000	174,000	183,000	168,000	182,000	8%
75%	231,000	227,000	207,000	199,000	213,000	221,000	226,000	240,000	248,000	225,000	245,000	9%
90%	287,000	283,000	255,000	241,000	259,000	265,000	273,000	296,000	301,000	270,000	296,000	10%
Chance of Having Enough Savings	75th Percentile of Prescription Drug Expenses Throughout Retirement											
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	
Men												
50%	\$80,000	\$79,000	\$74,000	\$72,000	\$76,000	\$79,000	\$81,000	\$83,000	\$83,000	\$76,000	\$81,000	7%
75%	120,000	119,000	108,000	104,000	110,000	113,000	116,000	123,000	118,000	108,000	115,000	6%
90%	154,000	153,000	137,000	129,000	138,000	139,000	144,000	156,000	146,000	132,000	142,000	8%
Women												
50%	107,000	106,000	97,000	93,000	99,000	102,000	105,000	110,000	107,000	98,000	104,000	6%
75%	140,000	139,000	125,000	119,000	127,000	128,000	133,000	143,000	134,000	122,000	131,000	7%
90%	176,000	176,000	156,000	146,000	156,000	156,000	162,000	178,000	163,000	147,000	158,000	7%
Couple												
50%	187,000	186,000	170,000	165,000	175,000	181,000	186,000	193,000	190,000	174,000	186,000	7%
75%	260,000	258,000	233,000	222,000	237,000	241,000	249,000	266,000	253,000	230,000	246,000	7%
90%	323,000	321,000	286,000	270,000	288,000	289,000	300,000	328,000	303,000	274,000	295,000	8%
Chance of Having Enough Savings	90th Percentile of Prescription Drug Expenses Throughout Retirement											
	2011	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	
Men												
50%	\$106,000	\$102,000	\$96,000	\$88,000	\$93,000	\$97,000	\$100,000	\$103,000	\$103,000	\$94,000	\$104,000	11%
75%	154,000	147,000	137,000	126,000	133,000	137,000	143,000	151,000	144,000	130,000	144,000	11%
90%	194,000	185,000	172,000	156,000	164,000	168,000	177,000	191,000	175,000	157,000	174,000	11%
Women												
50%	138,000	132,000	124,000	114,000	120,000	124,000	129,000	135,000	131,000	118,000	131,000	11%
75%	178,000	170,000	158,000	144,000	152,000	155,000	163,000	174,000	162,000	146,000	162,000	11%
90%	221,000	210,000	195,000	176,000	185,000	187,000	198,000	217,000	194,000	178,000	193,000	8%
Couple												
50%	244,000	234,000	220,000	202,000	213,000	221,000	229,000	238,000	234,000	212,000	235,000	11%
75%	332,000	317,000	295,000	270,000	284,000	293,000	306,000	325,000	306,000	276,000	306,000	11%
90%	407,000	387,000	360,000	326,000	342,000	349,000	368,000	399,000	363,000	325,000	361,000	11%

Source: Author simulations based on assumptions described in the text.

Separate estimates are presented for men and women. Because women have longer life expectancies than men, women will generally need larger savings than men to cover health insurance premiums and health care expenses in retirement regardless of the savings targets. Also, women will need greater savings than men even when both set the same goal — for example, of having a 90 percent chance of having enough money to cover health expenses in retirement.

Median Drug Expenses: As shown in Figure 9, in 2021 a man would need \$79,000 in savings and a woman would need \$103,000 if each had a goal of having a 50 percent chance of having enough money saved to cover health expenses in retirement. These are up 8 percent from 2020. If either instead wanted a 90 percent chance of having enough savings, \$142,000 would be needed for a man and \$159,000 would be needed for a woman, both 9 percent increases.

A couple both with median drug expenses would need \$182,000 to have a 50 percent chance of having enough money to cover health expenses in retirement. They would need \$245,000 to have a 75 percent chance of covering their expenses and \$296,000 to have a 90 percent chance of covering their expenses. These estimates are 8–10 percent higher than the savings targets estimated in 2020.

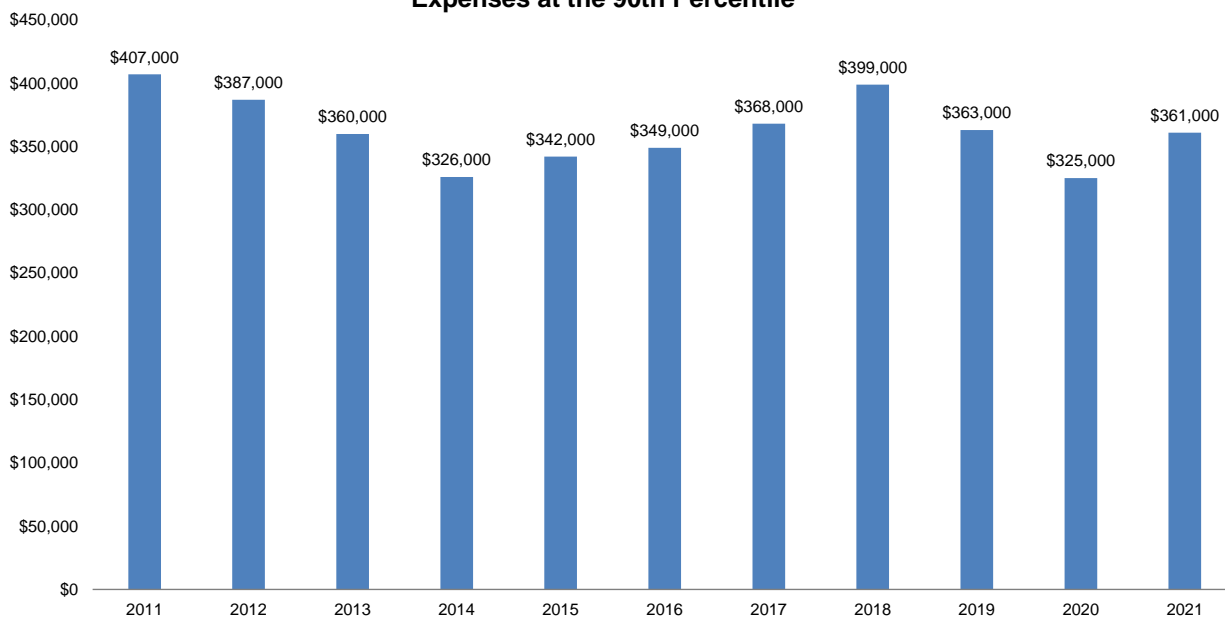
75th Percentile in Drug Expenses: For a man with drug expenditures at the 75th percentile throughout retirement, the amount of necessary savings would be \$81,000 in order to achieve a 50 percent chance of having sufficient money to cover health care expenses in retirement. For a woman in a similar situation, the savings target would be \$104,000. If either instead sought a 90 percent chance of having enough savings, the amounts rise to \$142,000 for a man and \$158,000 for a woman.

A couple both with drug expenses at the 75th percentile would need \$182,000 to have a 50 percent chance of having enough money to cover health care expenses in retirement. They would need \$245,000 to have a 75 percent chance of covering those expenses and \$296,000 to have a 90 percent chance of covering their expenses. These estimates are 8–10 percent higher than the savings targets estimated in 2020.

90th Percentile in Drug Expenses: The year-over-year change in required savings for individuals at the 90th percentile in drug spending at and throughout retirement ranges from 5–8 percent higher according to the EBRI model. In 2021, a man would need \$104,000 in savings and a woman would need \$131,000 if each had a goal of having a 50 percent chance of having enough money saved to cover health care expenses in retirement. If either instead wanted a 90 percent chance of having enough savings, \$174,000 would be needed for a man and \$193,000 would be needed for a woman.

A couple both with median drug expenses would need \$235,000 to have a 50 percent chance of having enough money to cover health care expenses in retirement. They would need \$306,000 to have a 75 percent chance of covering their expenses and \$361,000 to have a 90 percent chance of covering their expenses (Figure 10).

Figure 10
Savings Needed to Have a 90 Percent Chance of Having Enough Money for Medigap Premiums, Medicare Part B and D Premiums, Part B Deductibles, and Out-of-Pocket Drug Expenses for Retirement at Age 65 in 2011–2021 for a Couple With Drug Expenses at the 90th Percentile



Source: Author simulations based on assumptions described in the text.

Explaining the Changes in Savings Targets Between 2020 and 2021

There are two reasons for the increase in needed savings from 2020 to 2021. The first reason is related to the adjustment that is made each year to re-establish the baseline for out-of-pocket spending associated with prescription drug use. The Medicare Trustees increased projected costs for Medicare Part D out-of-pocket expenses, though premiums were projected to be lower. For example, in the 2020 trustees report, the 2029 Part D deductible projection was \$670 in the 2021 report, up from \$645 in the 2020 report, a 4 percent increase. Projecting these and other changes in Medicare Part D out-of-pocket spending over the course of one's lifetime results in a significant increase in savings targets for Medicare beneficiaries who would be impacted by such changes the most — Medicare beneficiaries with prescription drug spending at the 75th and 90th percentiles throughout retirement.

Out-of-pocket spending is also tied to the Medical Expenditure Panel Survey (MEPS), and 2019 data are now the most recent year of data available. Actual out-of-pocket spending at the 90th percentile was higher than projected for 2018 and 2019 when projections were based on 2017 data. As a result of this re-baselining, predicted estimates on out-of-pocket spending for prescription drugs increased for 2018 and beyond.

Also, on Nov. 12, 2021, the Centers for Medicare and Medicaid Services (CMS) released information on 2022 premiums, deductibles, and coinsurance amounts for the Medicare program.¹⁰ It announced that the Medicare Part B premium would increase from \$148.50 in 2021 to \$170.10 in 2022. This additional \$21.60 premium is a 15 percent increase and is responsible for 25–50 percent of the increase in our savings targets.

Conclusion

After declining in 2020, projected health care costs for Medicare beneficiaries are expected to rise again. Thus, individuals should be concerned about saving for health insurance premiums and out-of-pocket expenses in retirement. Medicare generally covers only about two-thirds of the cost of health care services for Medicare beneficiaries ages 65 and older, while out-of-pocket spending accounts for 12 percent. Furthermore, the percentage of private-sector establishments offering retiree health benefits has been falling. This is also true in the public sector.

It is also important to note that many individuals are likely to need more than the amounts cited in this report. This analysis does not factor in the total savings needed to cover long-term-care expenses and other health expenses not covered by Medicare, nor does it consider the fact that many individuals retire before becoming eligible for Medicare. However, some workers will need to save less than what is reported if they choose to work past age 65, thereby postponing enrollment in Medicare Parts B and D if they receive health benefits as active workers.

Changes to Medicare are clearly possible. Indeed, 2021 was a year that saw strong interest in Medicare from a public policy perspective. There was interest in lowering the Medicare eligibility age and in expanding Medicare benefits to include coverage for dental, vision, and hearing services. Yet none of these proposals survived the budget reconciliation process. The Build Back Better Act as passed by the U.S. House of Representatives includes several provisions that would lower prescription drug costs for Medicare beneficiaries, but they might not survive as the legislation moves through the Senate.

References

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Endnotes

¹ Because sample sizes for local government employers tend to be much smaller than for private-sector employers, there is more variation from year to year in the local government estimates.

² Medicare Part B covers outpatient medical services as well as preventive services, lab tests, x-rays, and durable medical equipment.

³ Medicare Part D covers outpatient prescription drugs.

⁴ Medigap Plan G covers the Medicare Part A deductible, Part B excess charges, Part B coinsurance for preventive care, Part A hospital and coinsurance costs for an extra year after Original Medicare benefits run out, Part B coinsurance and copayments, three pints of blood for approved procedures, Part A copayments or coinsurance for hospice care, coinsurance for a skilled nursing facility (SNF), and emergency coverage during foreign travel.

⁵ See VanDerhei (2006) for estimates of the impact of long-term-care expenses on the amounts needed for sufficient retirement income at the 50th, 75th, and 90th percentiles.

⁶ Medicare Part A covers inpatient services, skilled nursing facility care, certain nursing home care, hospice care, and home health services.

⁷ A technique used to estimate the likely range of outcomes from a complex process by simulating the process under randomly selected conditions a large number of times.

⁸ Nominal rates of return were assumed to follow a log-normal distribution with a mean of 1.078 and a standard deviation of 0.101. This provided a median nominal annual return of 7.32 percent.

⁹ See Table V.E2 in <https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf>

¹⁰ See <https://www.cms.gov/newsroom/fact-sheets/2022-medicare-parts-b-premiums-and-deductibles2022-medicare-part-d-income-related-monthly-adjustment>.