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Projected Savings Medicare Beneficiaries Need for Health Expenses Remained High in 2022

Some Couples Could Need as Much as $383,000 in Savings

By Jake Spiegel and Paul Fronstin, Ph.D., Employee Benefit Research Institute

AT A GLANCE

Health care costs in retirement can be considerable and may not necessarily be a salient issue for workers. To project how much Medicare beneficiaries may need to save to have a reasonable chance of meeting their health care spending requirements in retirement, the Employee Benefit Research Institute (EBRI) built a simulation model allowing for uncertainty due to mortality and rates of return on assets in retirement. EBRI has improved on previous iterations of this simulation model by incorporating recent changes to Medicare Part D enacted by the Inflation Reduction Act of 2022 and testing varying assumptions about Medicare Advantage and Medigap plans that Medicare beneficiaries may purchase.

EBRI's analysis finds:

- The predicted savings target for Medicare beneficiaries to cover premiums, deductibles, and prescription drugs in retirement remains high, and is sensitive to assumptions about premiums, prescription drug expenses, and usage of health care services.
- A 65-year-old man enrolled in a Medigap plan with average premiums will need to have saved $96,000 in order to have a 50 percent chance of having enough to cover premiums and median prescription drug expenditures, and a woman will need to have saved $116,000.
- To have a 90 percent chance of meeting their health care spending needs in retirement, a man will need to have saved $166,000, and a woman will need to have saved $197,000. Couples enrolled in a Medigap plan with average premiums, meanwhile, will need to have saved $212,000 to have a 50 percent chance of covering their medical expenditures in retirement and $318,000 to have a 90 percent chance.
- Representing an extreme case, a couple with particularly high prescription drug expenditures will need to have saved $383,000 to have a 90 percent chance of having enough money to cover their health care costs in retirement.
- Although there is significant individual-level variation, enrollees in Medicare Advantage plans generally have lower savings targets. A man enrolled in Medicare Advantage who has median drug expenditures and an average usage of health care services will need to have saved $56,000 to have a 50 percent chance of meeting their health care spending requirements in retirement, and he would need $96,000 to have a 90 percent chance. Meanwhile, a woman will need to have saved $67,000 to have a 50 percent chance and $113,000 to have a 90 percent chance of having enough to cover her health care costs in retirement. Couples will need to have saved $123,000 to have a 50 percent chance and $184,000 to have a 90 percent chance of covering their health care expenditures in retirement. Of course, there are other factors to consider when it comes to choosing a Medicare Advantage plan over traditional Medicare. Medicare Advantage plans often have limited networks or may require approval before certain medications or services are covered.

Jake Spiegel is a Health and Wealth Research Associate at the Employee Benefit Research Institute (EBRI). Paul Fronstin is Director of Health Benefits Research at EBRI. 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, Employee Benefit Research Institute-Education and Research Fund (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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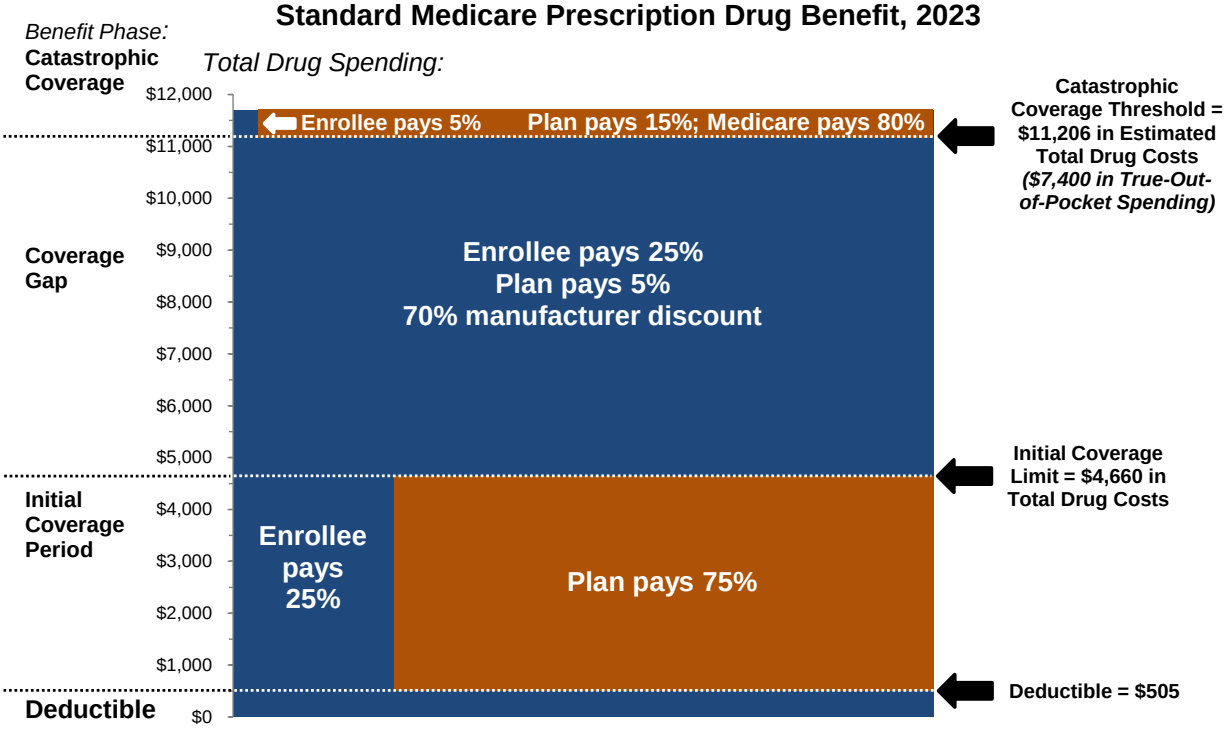
Introduction

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. In 2023 and 2024, 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). Most recently, the Inflation Reduction Act of 2022 included a provision that caps Medicare Part D out-of-pocket spending at $2,000 starting in 2025.

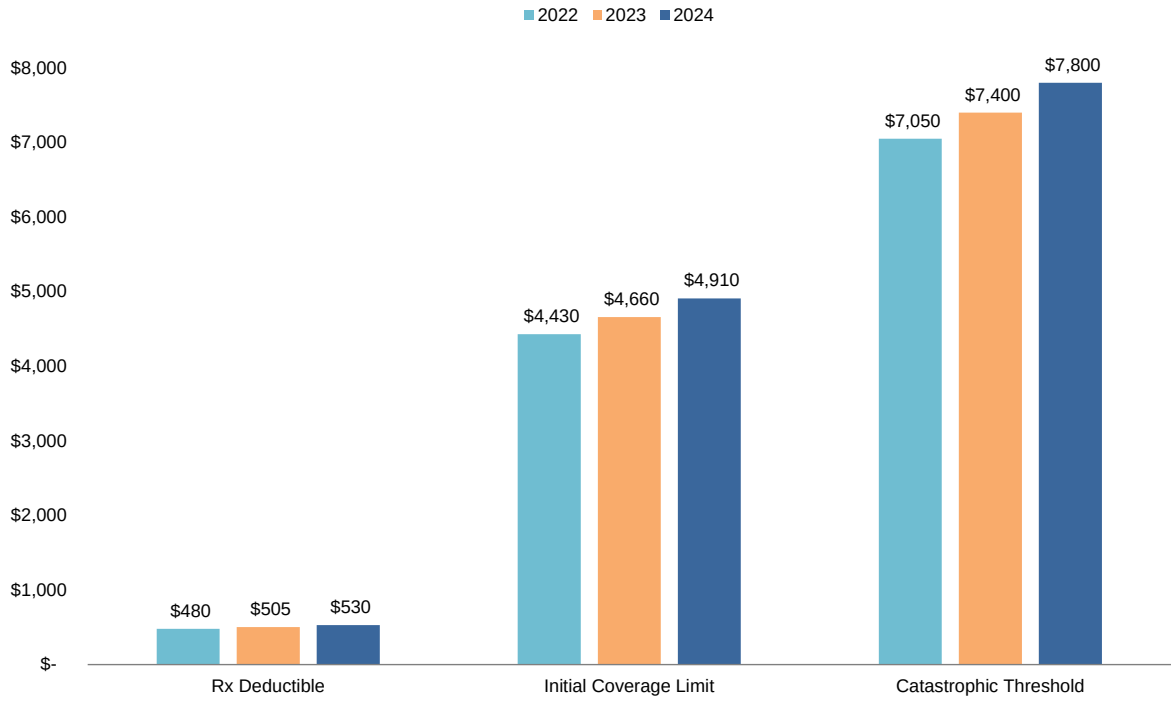
As of 2020, Medicare covered 60 percent of the cost of health care services for Medicare beneficiaries ages 65 and older, while out-of-pocket spending accounted for 12 percent of incurred costs, and private insurance covered 17 percent (Figure 3).

Figure 1
Standard Medicare Prescription Drug Benefit, 2023



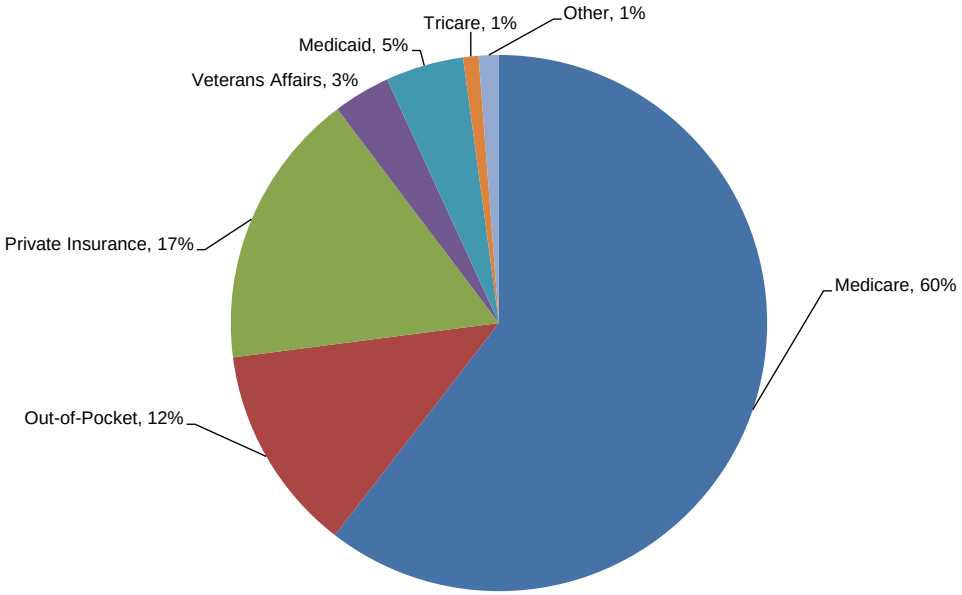
Source: Kaiser Family Foundation, based on Part D benefit parameters for 2023, https://www.kff.org/medicare/fact-sheet/an-overview-of-the-medicare-part-d-prescription-drug-benefit.

Figure 2
Medicare Part D Cost Sharing, 2022–2024



Source: Table V.E2 in 2022 Medicare Trustees Report, https://www.cms.gov/files/document/2022-medicare-trustees-report.pdf.

Figure 3
Source of Payment for Incurred Health Care Expenses, Noninstitutionalized Population of Medicare Beneficiaries, Ages 65 and Older, 2020



Source: EBRI estimates from the 2020 Medical Expenditure Panel Survey.

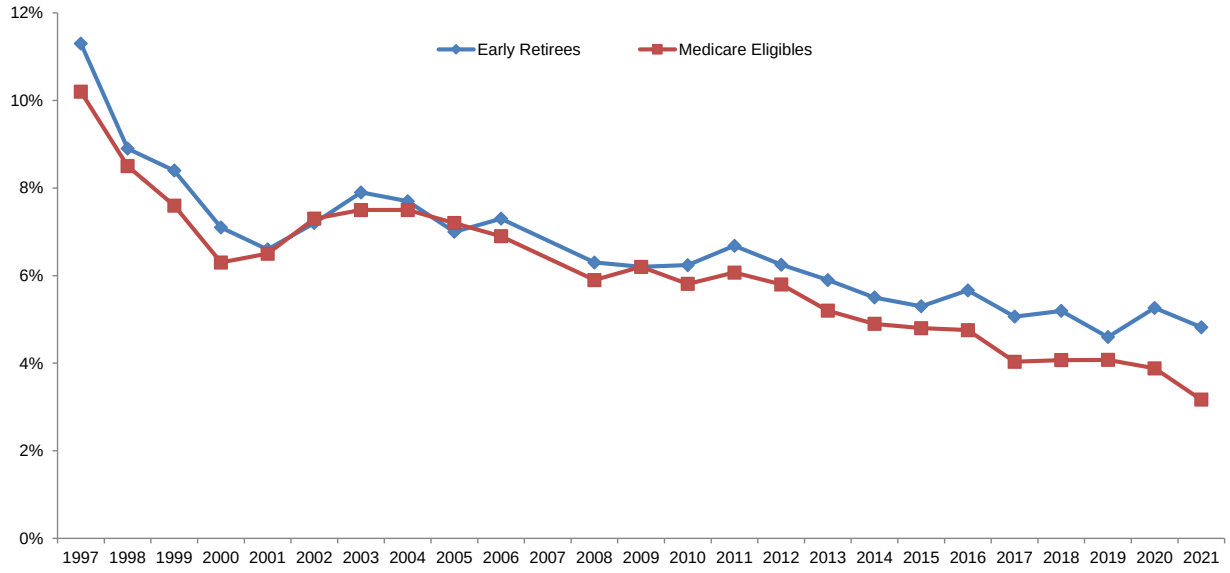
In the future, despite the introduction of the cap on Part D out-of-pocket spending, individuals may have to pay greater shares of their overall health costs in retirement because of the financial condition of the Medicare program and cutbacks to employment-based retiree health programs, discussed in 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. We have made a number of improvements to the prior model (Fronstin and VanDerhei 2022). First, we modified the model to account for the $2,000 cap on Medicare Part D out-of-pocket spending. Second, we are using a new source for Medigap premiums and are now conducting sensitivity analyses around the level of the premium. Third, a new component of the model estimates savings needed to cover the cost of health insurance premiums and out-of-pocket spending among Medicare enrollees who choose Medicare Advantage plans over the traditional Medicare program. As a result of these modifications, past estimates are not necessarily comparable to our most recent estimates. However, the new estimates are in the ballpark of prior estimates, and the bottom line is that savings needed to cover health care costs in retirement continue to remain a significant burden. The remainder of this *Issue Brief* discusses trends in the availability of employment-based retiree health benefits, the model that we use to generate the savings targets, changes to the model, the addition of Medicare Advantage, and the findings.

Trends in Employment-Based Retiree Health Programs

We focus on how much individuals need to save for health care expenses in retirement because fewer and fewer employers are offering retiree health benefits. The Agency for Healthcare Research and Quality (AHRQ) reported that in 2021, only about 5 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 3 percent of private-sector establishments offered health benefits to early retirees in 2021, down from 11 percent in 1997.

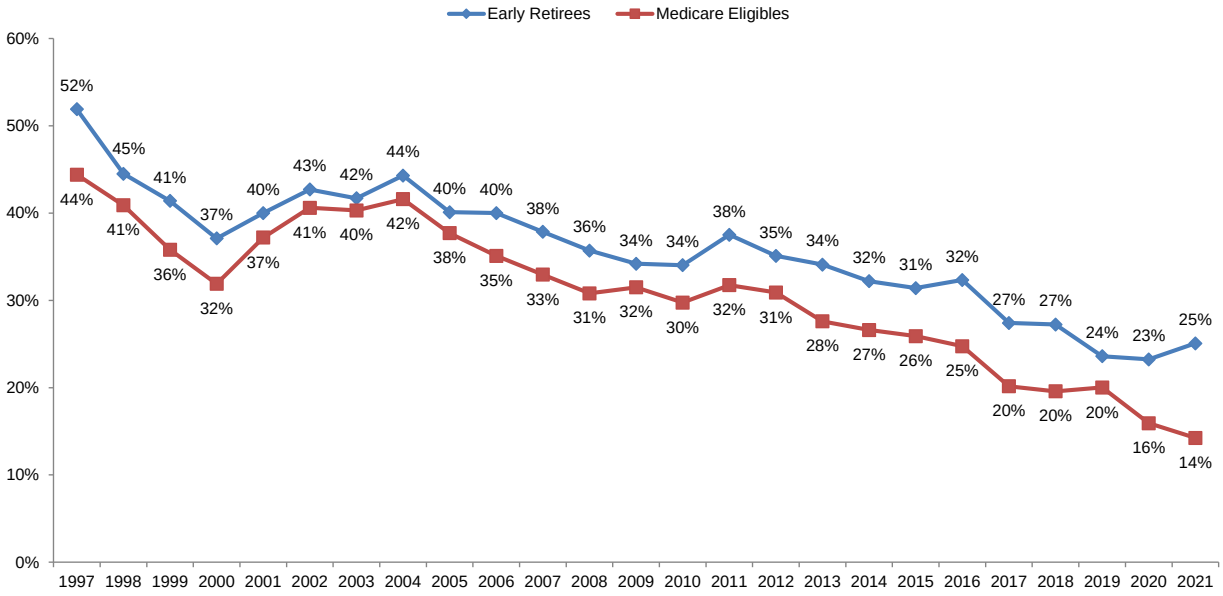
Figure 4
Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–2021



Source: EBRI estimates from various tables at https://datatools.ahrq.gov/meps-ic.

Larger firms were much more likely than smaller ones to offer retiree health benefits. Among private-sector establishments with 1,000 or more workers, 14 percent offered health coverage to Medicare-eligible retirees, and 25 percent offered it to early retirees in 2021 (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, 1997–2021

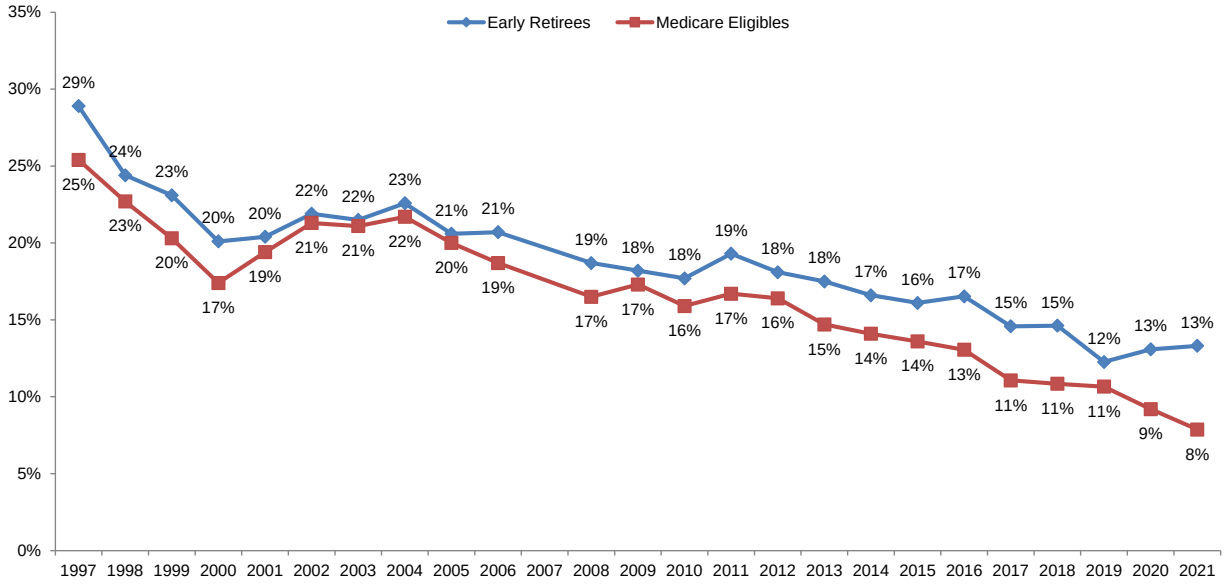


Source: EBRI estimates from various tables at https://datatools.ahrq.gov/meps-ic.

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 2021, 13 percent of workers were employed at establishments that offered health coverage to early retirees, down from 29 percent in 1997 (Figure 6). Similarly, 8 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 8 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 several reasons. They may be part time; they may not have had enough years of service to qualify for the benefit; or new hires may not be eligible for coverage.

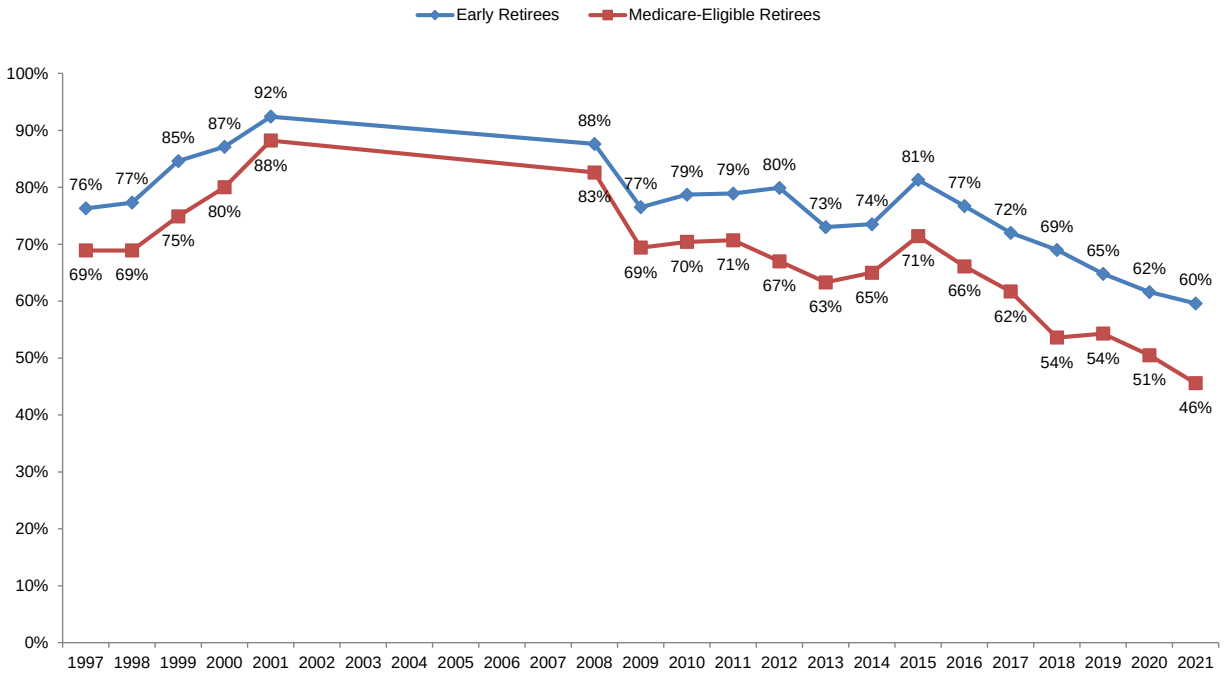
The AHRQ data show a similar trend among state and local government employers. Among state employers, after an increase in the late 1990s, the percentage offering retiree health benefits has been falling (Figure 7). The decline in the percentage of local government employers offering retiree health benefits 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 2021, it was down to 57 percent.[1]

Figure 6
Percentage of Private-Sector Workers Employed by Establishments Offering Health Insurance to Retirees, 1997–2021



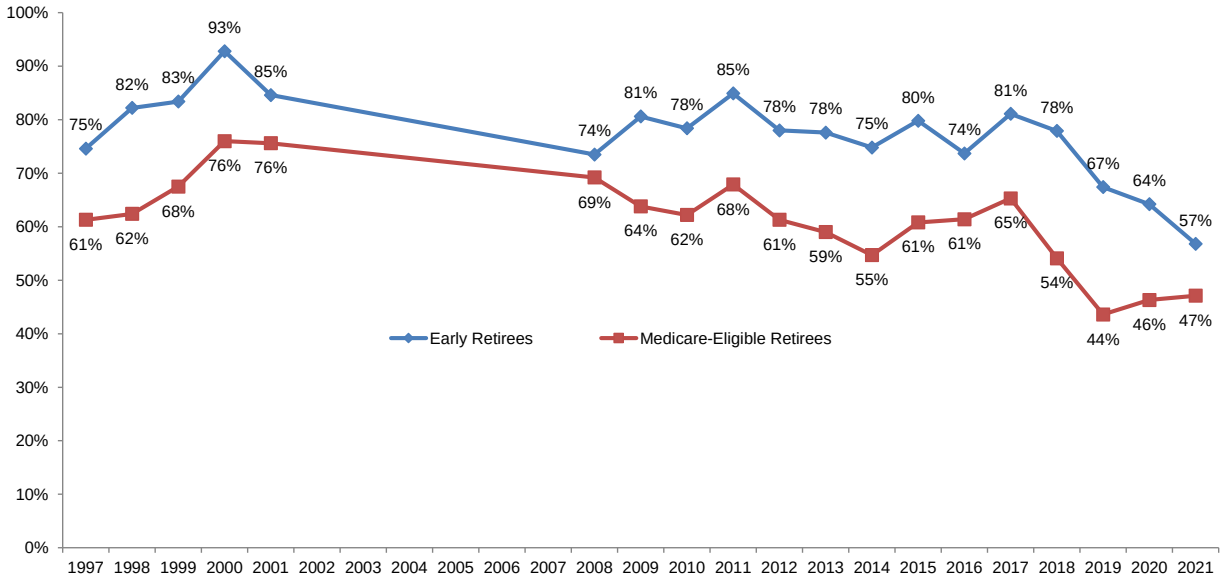
Source: EBRI estimates from various tables at https://meps.ahrq.gov/data_stats/summ_tables/insr/national/series_1/2021/ic21_ia_g.pdf.

Figure 7
Percentage of State Government Employers Offering Health Insurance to Retirees, 1997–2021



Source: https://www.meps.ahrq.gov/data_stats/summ_tables/insr/national/series_3/2021/ic21_iiia_g.pdf.

Figure 8
Percentage of Local Government Employers With 5,000–9,999 Workers Offering Health Insurance to Retirees, 1997–2021



Source: Various tables at https://datatools.ahrq.gov/meps-ic.

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 B[2] 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. We also examine out-of-pocket spending for outpatient prescription drugs and medical services among Medicare enrollees in Medicare Advantage plans. 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 either have Medigap Plan G to supplement traditional Medicare or enrollment in a Medicare Advantage plan. We do not provide estimates specific to enrollees with supplemental coverage from Veterans Affairs, Tricare, or Medicaid. Similarly, we do not provide estimates specific to enrollees without any form of supplemental coverage.[6] Among individuals with Medigap Plan G coverage in retirement, our model treats these 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 A[7] deductible, this study assumes that beneficiaries with Medigap 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 $233 in 2022. The study also assumes that Medicare beneficiaries with Medigap Plan G have Medicare Part D to cover outpatient prescription drug expenses.

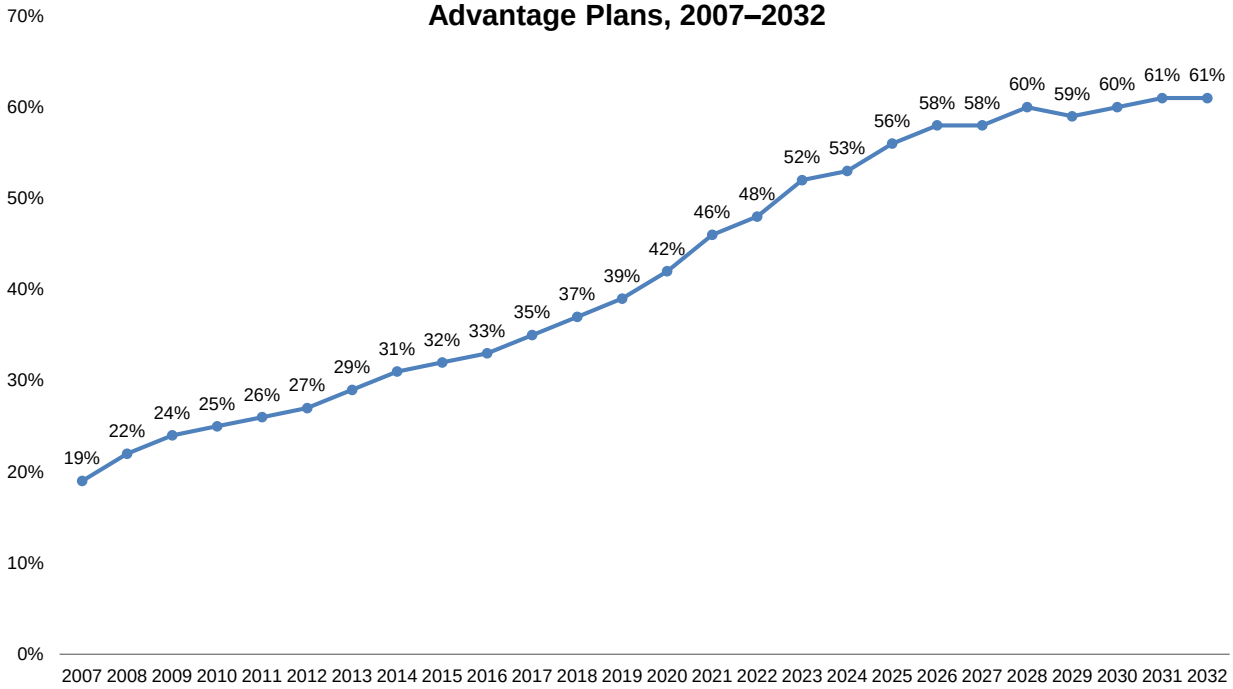
While premiums for Medigap Plan G and Medicare Part D are treated as health care expenses in retirement for the purposes of our model, the model also includes estimates on out-of-pocket spending for the Part B deductible (not covered by Medigap Plan G) and prescription drugs. Data from the Medical Expenditure 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. And a provision in the Inflation Reduction Act of 2022 will cap Medicare Part D out-of-pocket spending at $2,000 starting in 2025.

Enrollment in Medicare Advantage plans has been growing and is about to cross the 50 percent threshold (Figure 9). The Congressional Budget Office assumes that Medicare Advantage enrollment will reach 60 percent in less than a decade. We make several assumptions regarding premiums and out-of-pocket spending among Medicare Advantage plan enrollees. First, we assume that Medicare Advantage enrollees are all enrolled in zero-premium plans. This assumption is based on the fact that 69 percent of Medicare Advantage enrollees are in a zero-premium plan.[8] Medicare Advantage enrollees often make a tradeoff between premiums and out-of-pocket spending: Lower premium plans are usually associated with higher out-of-pocket spending, though in some cases, enrollees choose limited networks in order to drive premiums lower. To derive a range of possible out-of-pocket spending amounts for Medicare Advantage enrollees, we used the average in-network maximum out-of-pocket limit. Low users of health care were assumed to have reached 25 percent of the out-of-pocket limit. Medium users of health care were assumed to have reached 50 percent of the out-of-pocket limit. And high users of health care were assumed to have reached 75 percent of the limit.

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).

Figure 9
Percentage of Medicare Enrollees in Medicare Advantage Plans, 2007–2032



Source: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-enrollment-update-and-key-trends/

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 model[9] 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.[10] 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 2022 Medicare trustees report.[11] Medigap Plan G premiums were generated for new Medicare enrollees aged 65 in 2022. Out-of-pocket spending on outpatient prescription drugs was derived from the 2020 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 Among Traditional Medicare Enrollees

Figure 10 contains the savings estimates for a person who turns age 65 in 2022 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 for 2021. 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 two sets of results 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 90th percentile until 2025, when the $2,000 out-of-pocket spending cap takes effect.

Under each set of columns, a comparison of the savings targets is presented for 2021–2022. Separate estimates are shown for low, average, and high Medigap premiums, as are the percentage changes from 2021–2022 for each Medigap premium.

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 10, in 2022 a man would need $96,000 in savings and a woman would need $116,000 if each had a goal of having a 50 percent chance of having enough money saved to cover health expenses in retirement and they faced average Medigap premiums. If either instead wanted a 90 percent chance of having enough savings, $166,000 would be needed for a man and $197,000 would be needed for a woman.

A couple both with median drug expenses would need $212,000 to have a 50 percent chance of having enough money to cover health expenses in retirement. They would need $268,000 to have a 75 percent chance of covering their expenses and $318,000 to have a 90 percent chance of covering their expenses.

Maximum Drug Expenses: In 2022, a man would need $118,000 in savings and a woman would need $142,000 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, $200,000 would be needed for a man and $234,000 would be needed for a woman.

Figure 10

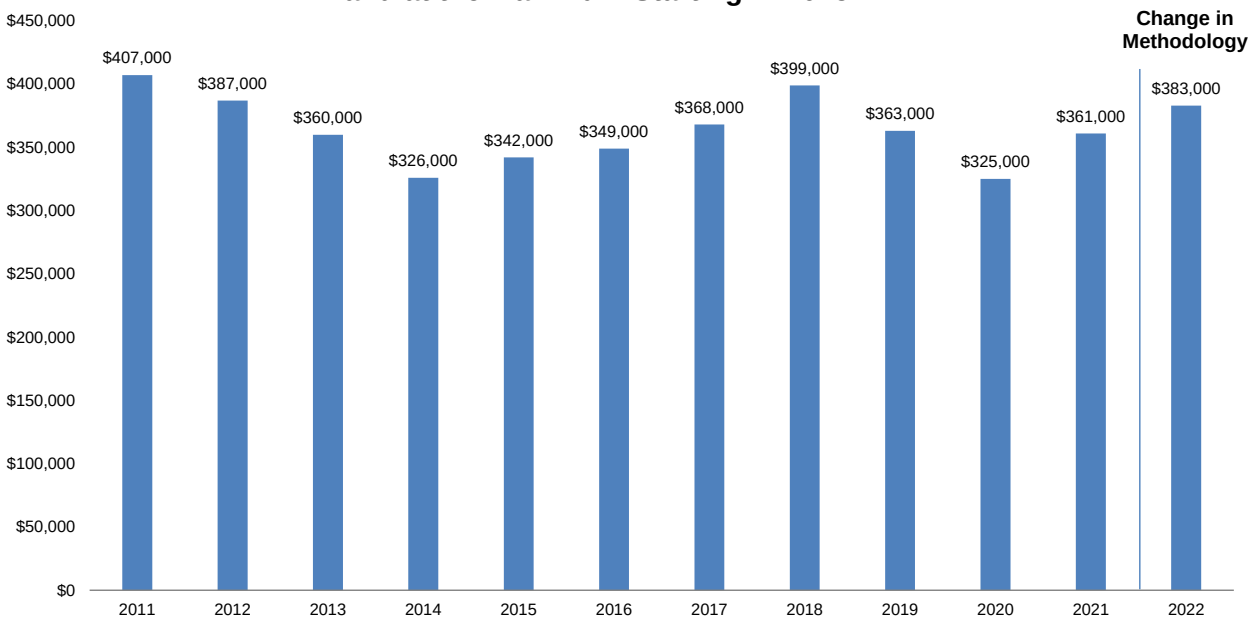
Savings Needed for Medigap Premiums, Medicare Part B Premiums and Deductibles, Medicare Part D Premiums, and Out-of-Pocket Drug Expenses for Retirement at Age 65 in 2022

	Medigap Premium		
	Low	**Average**	**High**
Chance of Having Enough Savings	**Median Prescription Drug Expenses Throughout Retirement**		
Men			
50%	$72,000	$96,000	$134,000
75%	104,000	137,000	193,000
90%	125,000	166,000	234,000
Women			
50%	88,000	116,000	163,000
75%	120,000	159,000	223,000
90%	148,000	197,000	276,000
Couple			
50%	160,000	212,000	297,000
75%	202,000	268,000	376,000
90%	240,000	318,000	447,000
Chance of Having Enough Savings	**Maximum Prescription Drug Expenses Throughout Retirement**		
Men			
50%	$95,000	$118,000	$157,000
75%	133,000	167,000	222,000
90%	159,000	200,000	267,000
Women			
50%	114,000	142,000	189,000
75%	152,000	191,000	256,000
90%	185,000	234,000	314,000
Couple			
50%	207,000	259,000	346,000
75%	260,000	325,000	433,000
90%	305,000	383,000	512,000

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

A couple with maximum drug expenses would need $259,000 to have a 50 percent chance of having enough money to cover health care expenses in retirement. They would need $325,000 to have a 75 percent chance of covering their expenses and $383,000 to have a 90 percent chance of covering their expenses (Figure 11).

Figure 11
Savings Needed to Have a 90 Percent Chance of Having Enough Money for Health Care Expenses in Retirement in 2011–2022 for a Couple With Drug Expenses at the 90th Percentile Through 2024 and at the Maximum Starting in 2025



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

Savings Targets to Cover Health Insurance Premiums and Out-of-Pocket Costs in Retirement Among Medicare Advantage Plan Enrollees

Figure 12 contains the savings estimates for a person who turned age 65 in 2022 and who enrolls in a Medicare Advantage plan instead of the traditional Medicare program. As mentioned above, because 69 percent of Medicare Advantage enrollees choose plans with no premium, we assume that there are no premiums for Medicare Advantage enrollees in our model. Medicare Advantage is still required to pay the Medicare Part B premium, so that is included in our model. When it comes to estimating out-of-pocket spending, we examine three types of Medicare Advantage enrollees: those with low use of health care services, those with average use, and those with high use, throughout retirement. Premiums for Part D plans and out-of-pocket spending on outpatient prescription drugs are modeled the same way they are modeled for traditional Medicare enrollees.

Median Drug Expenses: As shown in Figure 12, in 2022 a man would need $56,000 in savings and a woman would need $67,000 if each had a goal of having a 50 percent chance of having enough money saved to cover health expenses in retirement and they were average users of health care services. If either instead wanted a 90 percent chance of having enough savings, $96,000 would be needed for a man and $113,000 would be needed for a woman.

A couple both with median drug expenses would need $123,000 to have a 50 percent chance of having enough money to cover health expenses in retirement. They would need $155,000 to have a 75 percent chance of covering their expenses and $184,000 to have a 90 percent chance of covering their expenses.

Maximum Drug Expenses: In 2022, a man would need $78,000 in savings and a woman would need $94,000 if each had a goal of having a 50 percent chance of having enough money saved to cover health care expenses in retirement. If they instead wanted a 90 percent chance of having enough savings, $130,000 would be needed for a man and $151,000 would be needed for a woman.

A couple with maximum drug expenses would need $169,000 to have a 50 percent chance of having enough money to cover health care expenses in retirement. They would need $213,000 to have a 75 percent chance of covering their expenses and $249,000 to have a 90 percent chance of covering their expenses.

Figure 12

Savings Needed for Medicare Part B Premiums, Medicare Part D Premiums, and Out-of-Pocket Expenses for Retirement Among Medicare Advantage Enrollees at Age 65 in 2022

	Use of Health Care Services		
	Low	**Average**	**High**
Chance of Having Enough Savings	**Median Prescription Drug Expenses Throughout Retirement**		
Men			
50%	$34,000	$56,000	$78,000
75%	48,000	79,000	111,000
90%	58,000	96,000	134,000
Women			
50%	41,000	67,000	94,000
75%	56,000	92,000	128,000
90%	68,000	113,000	158,000
Couple			
50%	75,000	123,000	171,000
75%	94,000	155,000	216,000
90%	111,000	184,000	256,000
Chance of Having Enough Savings	**Maximum Prescription Drug Expenses Throughout Retirement**		
Men			
50%	$57,000	$78,000	$100,000
75%	78,000	109,000	140,000
90%	92,000	130,000	168,000
Women			
50%	67,000	94,000	120,000
75%	88,000	124,000	161,000
90%	106,000	151,000	196,000
Couple			
50%	120,000	169,000	218,000
75%	152,000	213,000	274,000
90%	176,000	249,000	321,000

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

The savings estimates for Medicare Advantage enrollees with average use of health care services are between 34 percent and 43 percent lower than they are for enrollees in the traditional Medicare program who pay an average premium for Medigap Plan G supplemental coverage. However, high users of health care need 16 percent lower savings if they choose a Medicare Advantage plan over traditional Medicare. Of course, there are other factors to consider when it comes to choosing a Medicare Advantage plan over traditional Medicare. Medicare Advantage plans often have limited networks or may require approval before certain medications or services are covered, and some Medicare Advantage plans require a premium. However, we also have not modeled the impact on savings needed of coverage of extra benefits — such as vision, hearing, and dental services — in Medicare Advantage plans.

Conclusion

The health care costs Medicare beneficiaries face in retirement can be significant, as Medicare was not intended to cover all the health care expenses beneficiaries might face. To help make these costs more salient, EBRI has developed a projection model for estimating the savings Medicare beneficiaries may need to achieve to have a reasonable chance of meeting their health care spending needs.

This year, EBRI updated its model to incorporate changes due to the Inflation Reduction Act of 2022, which caps Medicare Part D out-of-pocket spending at $2,000 starting in 2025. The model also now includes sensitivity analyses surrounding updated assumptions about Medigap plans, as well as developing savings targets for people enrolled in Medicare Advantage plans, which are an increasingly popular choice among Medicare beneficiaries.

The results from EBRI's projection model indicate that health care costs incurred by Medicare beneficiaries are high. Among Medigap enrollees, the projected savings targets are sensitive to assumptions about prescription drug expenditures and Medigap premiums. Among Medicare Advantage enrollees, the projected savings targets are sensitive to assumptions about prescription drug costs as well as the enrollee's usage of health care services. In general, savings targets tend to be lower for Medicare Advantage enrollees relative to Medigap enrollees, but there are tradeoffs for retirees to consider. For example, enrollees generally trade lower premiums for higher out-of-pocket spending, and some Medicare Advantage plans have narrower networks.

It is also important to note that the savings targets presented in this paper may not be representative for all Medicare beneficiaries. Long-term-care costs, for instance, can be considerable, and EBRI's projection model does not take into account costs that are not covered by Medicare, such as vision or dental services; in these cases, the savings targets presented here may underestimate how much retirees need to save. Conversely, if workers receiving health benefits through their employer choose to work past age 65 and postpone enrollment in Medicare Parts B and D, they will need to have saved less than the savings targets presented in this paper.

Finally, future legislative changes will impact the savings necessary to meet health care costs in retirement. The Inflation Reduction Act of 2022's provision on Medicare Part D spending indicated legislators' appetite for reforming Medicare. Other recent legislative proposals, such as lowering the Medicare eligibility age and expanding Medicare benefits to include dental, vision, and hearing expenses, may again impact retirees' savings targets.

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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] A 2021 report found that 10 percent of Medicare enrollees did not have a supplemental source of coverage. See https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries-in-2018.

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

[8] See https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2022-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings.

[9] This is 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.

[10] 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.

[11] See Table V.E2 in https://www.cms.gov/files/document/2021-medicare-trustees-report.pdf.

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