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Projected Savings Medicare Beneficiaries Need for Health Expenses Continued to Rise in 2024

Some Couples Could Need as Much as $428,000 in Savings

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

AT A GLANCE

The percentage of private-sector establishments offering health benefits has been falling. As access to retiree health benefits becomes increasingly rare, the responsibility for health care expenses in retirement will fall more on the shoulders of today's 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's model reflects recent legislative changes to Medicare Part D enacted by the Inflation Reduction Act of 2022, which caps out-of-pocket spending on prescription drugs at $2,000 in 2025 and tests 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 increased slightly relative to last year for Medicare beneficiaries who enroll in Medigap Plan G, 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 $109,000 to have a 50 percent chance of having enough to cover premiums and median prescription drug expenditures, and a 65-year-old woman will need to have saved $133,000.
- To have a 90 percent chance of meeting their health care spending needs in retirement, a man will need to have saved $191,000, and a woman will need to have saved $226,000. Couples enrolled in a Medigap plan with average premiums, meanwhile, will need to have saved $243,000 to have a 50 percent chance of covering their medical expenditures in retirement and $366,000 to have a 90 percent chance.
- Representing an extreme case, a couple with particularly high prescription drug expenditures will need to have saved $428,000 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 than they did in 2023 due to lower projections of health care cost inflation. A man enrolled in Medicare Advantage who has median drug expenditures and an average usage of health care services will need to have saved $57,000 to have a 50 percent chance of meeting his health care spending requirements in retirement, and he would need $98,000 to have a 90 percent chance. Meanwhile, a woman will need to have saved $69,000 to have a 50 percent chance and $116,000 to have a 90 percent chance of

having enough to cover her health care costs in retirement. Couples will need to have saved $125,000 to have a 50 percent chance and $188,000 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.

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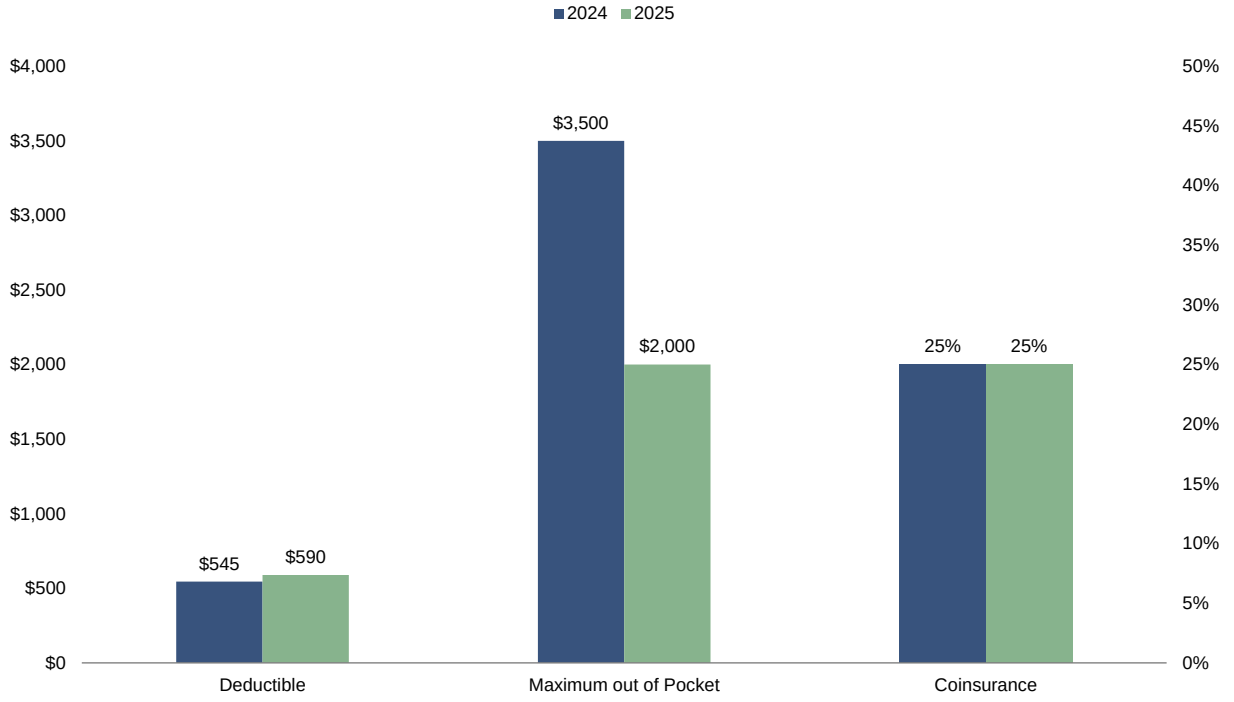
Introduction

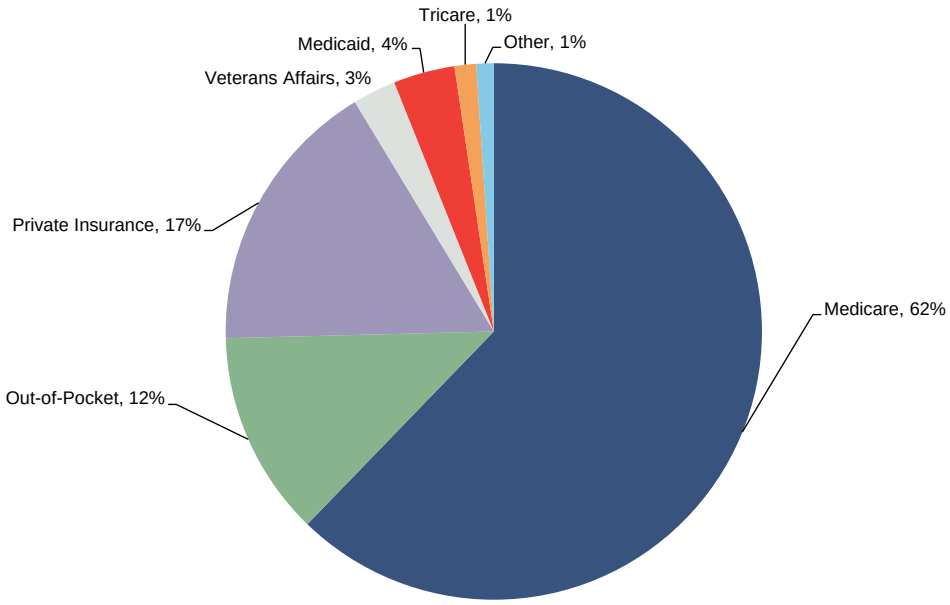
When the Medicare program was established nearly 60 years ago, it was not designed to cover health care expenses in full. Today, the program continues to impose cost sharing on beneficiaries when they use health care services. The program includes deductibles for inpatient and outpatient services. In 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. The Patient Protection and Affordable Care Act of 2010 (ACA) included provisions to reduce the size of this coverage gap but did not eliminate it. Coinsurance was reduced to 25 percent after a beneficiary reached their deductible, which was $545 in 2024 (Figure 1). The passage of the Inflation Reduction Act of 2022, however, addressed this coverage gap by initiating a two-year transition toward an out-of-pocket spending cap for beneficiaries. Starting in 2025, Medicare Part D out-of-pocket spending is capped at $2,000, inclusive of a $590 deductible.

Figure 1
Medicare Part D Cost Sharing, 2024–2025



Overall, as of 2022, Medicare covered 62 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 2).

Figure 2
Source of Payment for Incurred Health Care Expenses, Noninstitutionalized Population of Medicare Beneficiaries, Ages 65 and Older, 2022



Source: EBRI estimates from the 2022 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. For instance, current estimates project the Medicare trust fund to be insolvent by 2036, at which point revenues are projected to cover 89 percent of program costs.[1] The erosion of employment-based retiree health programs is discussed in more detail below.

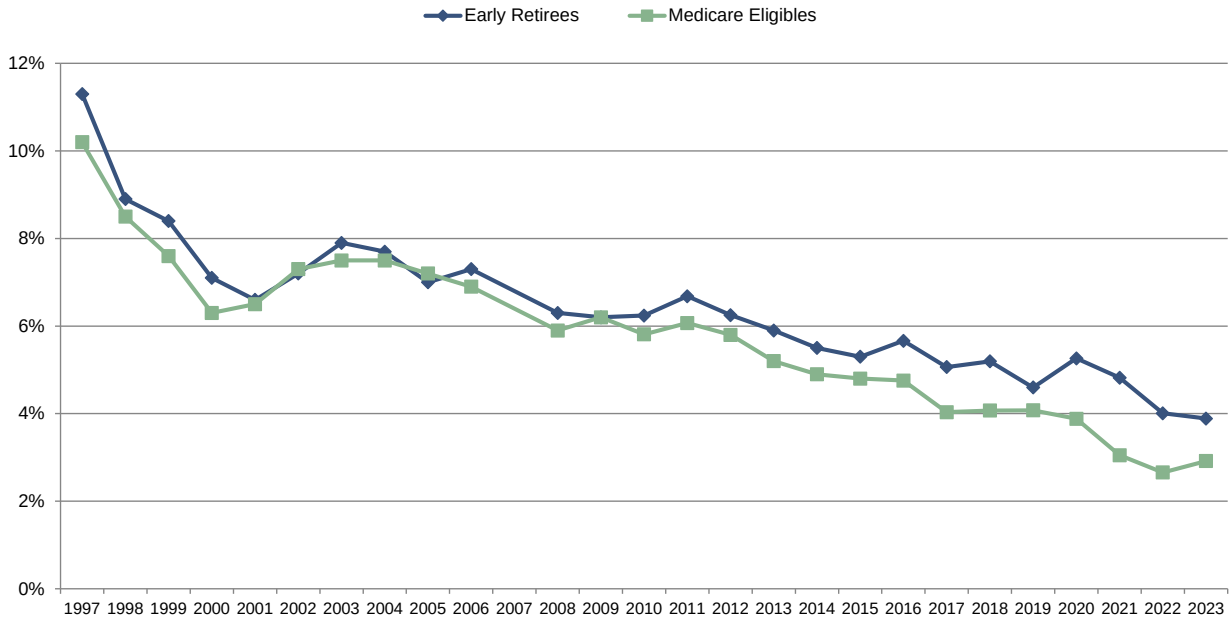
This study updates previous estimates by the Employee Benefit Research Institute (EBRI) on the savings needed to cover health insurance premiums and health care expenses in retirement. In previous reports (Spiegel and Fronstin 2024, Spiegel and Fronstin 2023), we made a number of improvements to the prior model (Fronstin and VanDerhei 2022). First, we modified the model to account for the phasing in of a $2,000 cap on Medicare Part D out-of-pocket spending. Second, we changed the source for Medigap premiums and started conducting sensitivity analyses around the level of the premium. Third, a new component of the model estimated 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 estimates produced since 2023. However, our updated model indicates that savings needed to cover health care costs in retirement continue to be 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

One of the reasons we focus on how much individuals need to save for health care expenses in retirement is because fewer and fewer employers are offering retiree health benefits. The Agency for Healthcare Research and Quality (AHRQ) reported that only 4 percent of private-sector establishments offered health benefits to early retirees in 2023,

down from only 11 percent for Medicare-eligible retirees in 1997 (Figure 3). Furthermore, about 3 percent of private-sector establishments offered health benefits to Medicare-eligible retirees in 2021, down from 10 percent in 1997.

Figure 3
Percentage of Private-Sector Establishments Offering Health Insurance to Retirees, 1997–2023



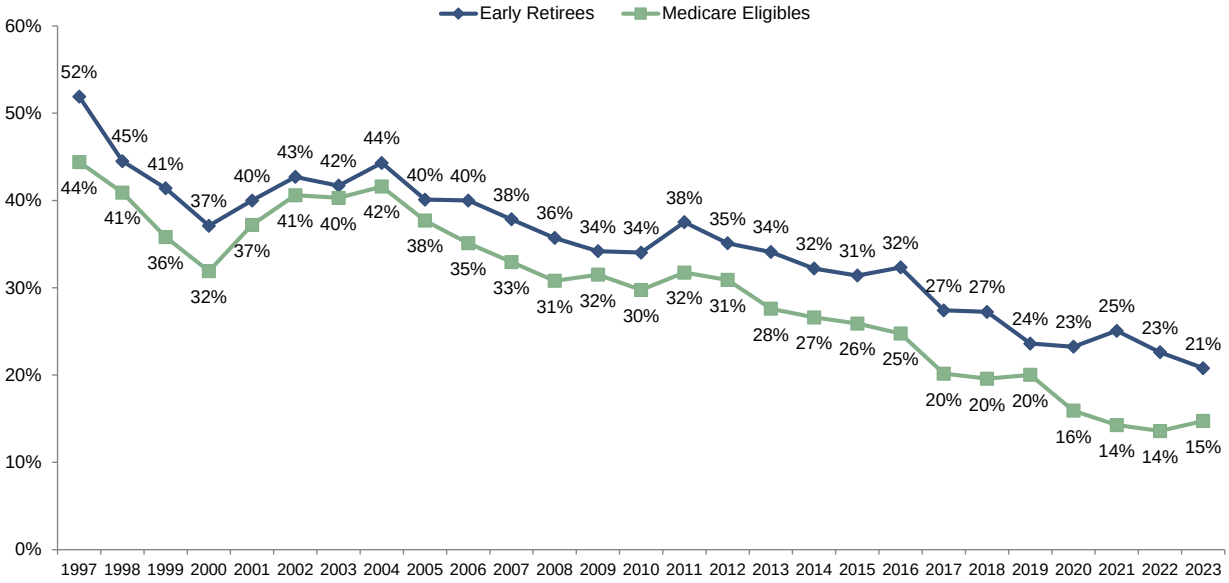
Source: EBRI estimates from various tables at https://datatools.ahrq.gov/meps-ic.

Larger firms were much more likely than smaller ones to offer retiree health benefits. Among private-sector establishments with 1,000 or more workers in 2023, 15 percent offered health coverage to Medicare-eligible retirees, and 21 percent offered it to early retirees (Figure 4). Even among larger firms, the percentage offering retiree health benefits to either early retirees or Medicare-eligible retirees has been declining.

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 2023, 11 percent of workers were employed at establishments that offered health coverage to early retirees, down from 29 percent in 1997 (Figure 5). 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 11 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 workers; they may not have had enough years of service to qualify for the benefit; or new hires may not be eligible for coverage.

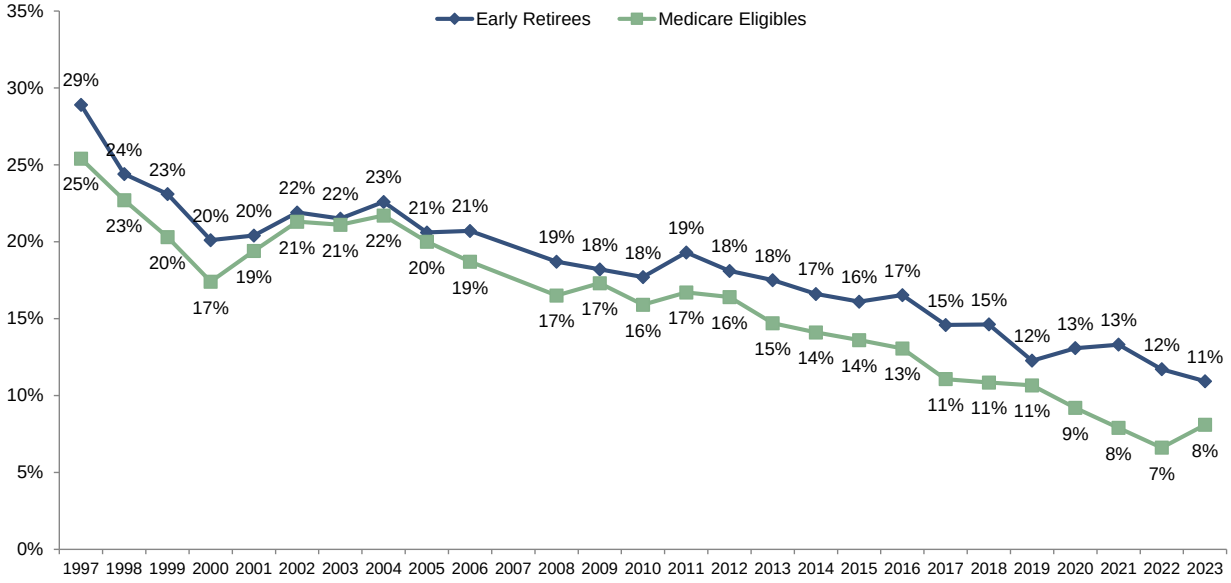
The AHRQ data show a similar trend among state and local government employers. Among state employers, after an increase in the late 1990s, the percentage offering retiree health benefits has been falling (Figure 6). The decline in the percentage of local government employers offering retiree health benefits 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 7). By 2023, it was down to 65 percent.[2]

Figure 4
Percentage of Private-Sector Establishments With 1,000 or More Employees Offering Health Insurance to Retirees, 1997–2023



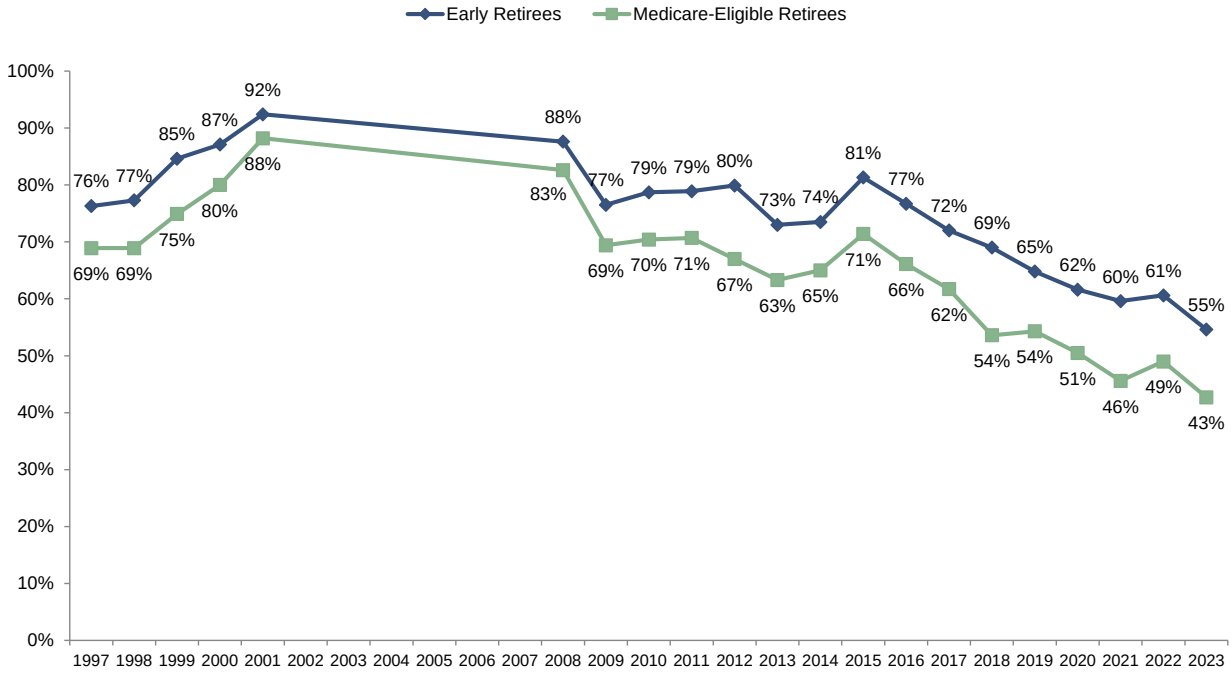
Source: EBRI estimates from various tables at https://datatools.ahrq.gov/meps-ic.

Figure 5
Percentage of Private-Sector Workers Employed by Establishments Offering Health Insurance to Retirees, 1997–2023



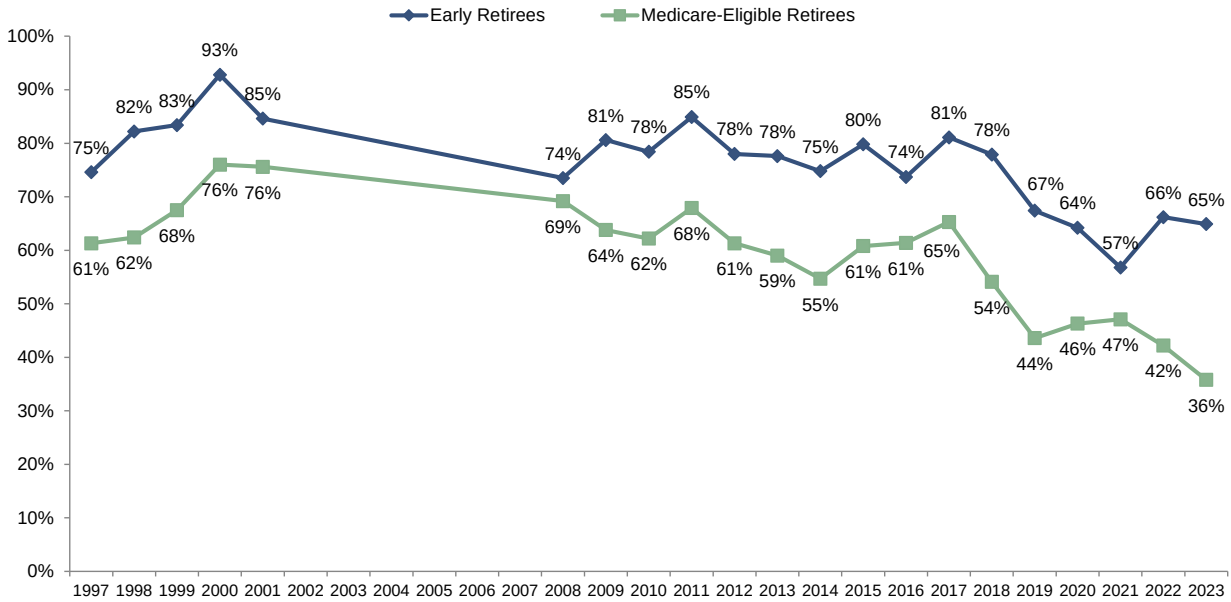
Source: EBRI estimates from various tables at https://datatools.ahrq.gov/meps-ic.

Figure 6
Percentage of State Government Employers Offering Health Insurance to Retirees, 1997–2023



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

Figure 7
Percentage of Local Government Employers With 5,000–9,999 Workers Offering Health Insurance to Retirees, 1997–2023



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[3] and D,[4] (ii) the Part B deductible, (iii) premiums for Medigap Plan G,[5] 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,[6] nor does it take into account the fact that many individuals retire before becoming eligible for Medicare.

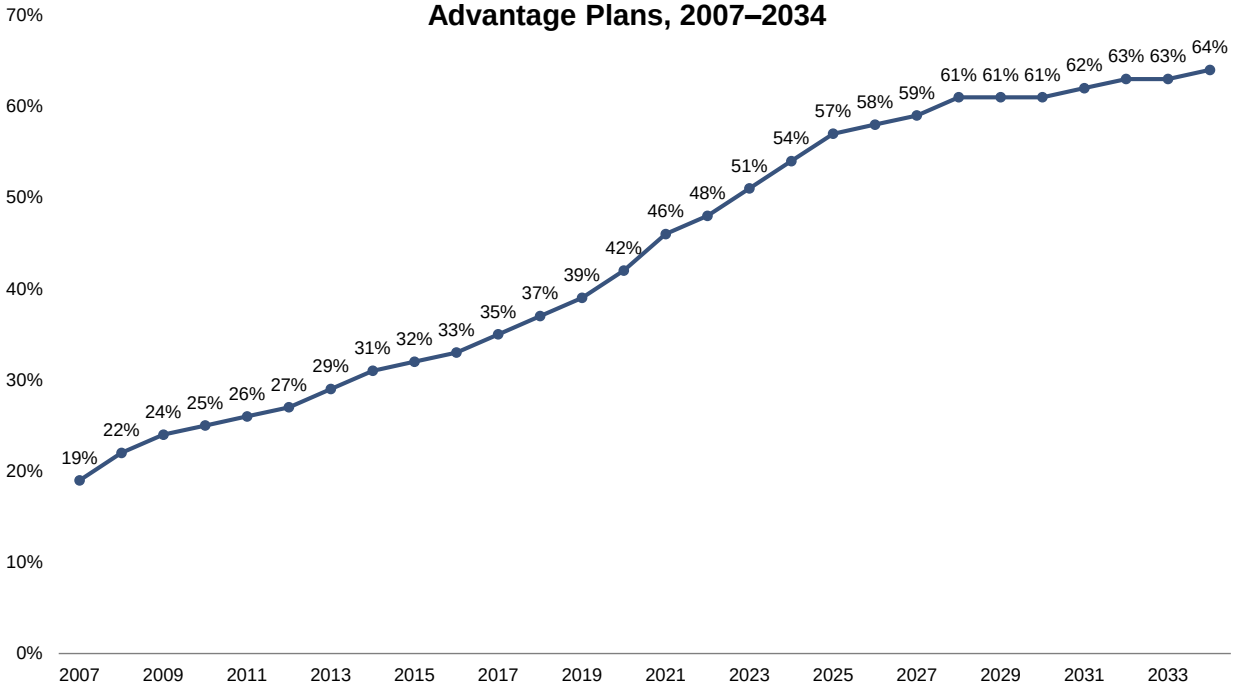
The study assumes that all individuals and couples either have Medigap Plan G to supplement traditional Medicare or enroll in a Medicare Advantage plan. We do not provide estimates specific to enrollees with supplemental coverage from Veterans Affairs, Tricare, or Medicaid. Similarly, we do not provide estimates specific to enrollees without any form of supplemental coverage.[7] 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[8] 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 $240 in 2024. 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 there is no longer any cost sharing. 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 slightly above the 50 percent threshold (Figure 8). 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 75 percent of Medicare Advantage enrollees were in a zero-premium plan in 2024.[9] 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 8
Percentage of Medicare Enrollees in Medicare Advantage Plans, 2007–2034



Source: https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-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[10] 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.[11] 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 2024 Medicare trustees report.[12] Medigap Plan G premiums were generated for new Medicare enrollees aged 65 in 2024. Out-of-pocket spending on outpatient prescription drugs was derived from the 2022 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 9 contains the savings estimates for a person who turns age 65 in 2024 and who purchases both Medigap Plan G to supplement Medicare and Medicare Part D outpatient prescription drug benefits. 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. Separate estimates are shown for low, average, and high Medigap premiums.

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 2024 a man would need $109,000 in savings and a woman would need $133,000 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, $191,000 would be needed for a man and $226,000 would be needed for a woman.

A couple both with median drug expenses would need $243,000 to have a 50 percent chance of having enough money to cover health expenses in retirement. They would need $307,000 to have a 75 percent chance of covering their expenses and $366,000 to have a 90 percent chance of covering their expenses.

Maximum Drug Expenses: In 2024, a man would need $131,000 in savings and a woman would need $158,000 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, $224,000 would be needed for a man and $262,000 would be needed for a woman.

A couple with maximum drug expenses would need $290,000 to have a 50 percent chance of having enough money to cover health care expenses in retirement. They would need $363,000 to have a 75 percent chance of covering their expenses and $428,000 to have a 90 percent chance of covering their expenses (Figure 10).

Figure 9

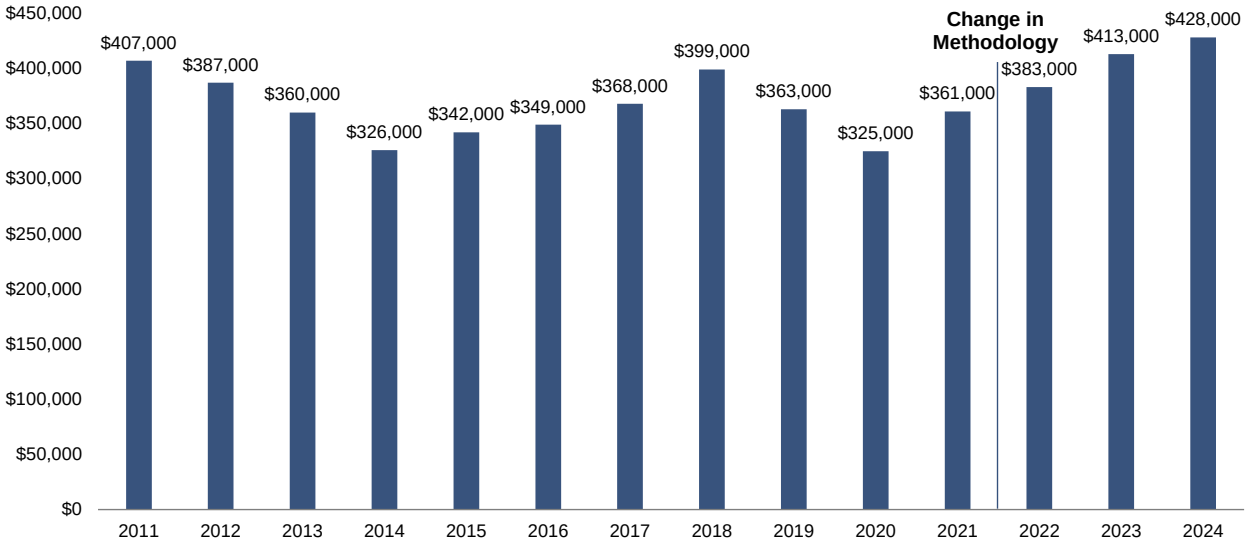
Savings Needed for Medigap Premiums, Medicare Part B Premiums and Deductibles, Medicare Part D Premiums, and Out-of-Pocket Drug Expenses for Retirement at Age 65 in 2024

	Medigap Premium		
	Low	**Average**	**High**
Chance of Having Enough Savings	**Median Prescription Drug Expenses Throughout Retirement**		
Men			
50%	$79,000	$109,000	$145,000
75%	114,000	158,000	209,000
90%	138,000	191,000	254,000
Women			
50%	96,000	133,000	176,000
75%	132,000	183,000	242,000
90%	163,000	226,000	300,000
Couple			
50%	175,000	243,000	321,000
75%	222,000	307,000	407,000
90%	264,000	366,000	485,000
Chance of Having Enough Savings	**Maximum Prescription Drug Expenses Throughout Retirement**		
Men			
50%	$101,000	$131,000	$167,000
75%	142,000	186,000	237,000
90%	170,000	224,000	286,000
Women			
50%	122,000	158,000	202,000
75%	163,000	214,000	274,000
90%	199,000	262,000	336,000
Couple			
50%	221,000	290,000	368,000
75%	278,000	363,000	463,000
90%	327,000	428,000	548,000

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

Figure 10

Savings Needed to Have a 90 Percent Chance of Having Enough Money for Health Care Expenses in Retirement in 2011–2024 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 11 contains the savings estimates for a person who turned age 65 in 2024 and who enrolls in a Medicare Advantage plan instead of the traditional Medicare program. As mentioned above, because 73 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 11, in 2024 a man would need $57,000 in savings and a woman would need $69,000 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, $98,000 would be needed for a man and $116,000 would be needed for a woman.

A couple both with median drug expenses would need $125,000 to have a 50 percent chance of having enough money to cover health expenses in retirement. They would need $158,000 to have a 75 percent chance of covering their expenses and $188,000 to have a 90 percent chance of covering their expenses.

Maximum Drug Expenses: In 2024, a man would need $79,000 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 $170,000 to have a 50 percent chance of having enough money to cover health care expenses in retirement. They would need $214,000 to have a 75 percent chance of covering their expenses and $250,000 to have a 90 percent chance of covering their expenses.

The savings estimates for Medicare Advantage enrollees with average use of health care services are between 34 percent and 47 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 22 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.

Figure 11

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 2024

	Use of Health Care Services		
	Low	**Average**	**High**
Chance of Having Enough Savings	**Median Prescription Drug Expenses Throughout Retirement**		
Men			
50%	$35,000	$57,000	$78,000
75%	50,000	81,000	112,000
90%	61,000	98,000	136,000
Women			
50%	43,000	69,000	94,000
75%	58,000	94,000	130,000
90%	71,000	116,000	160,000
Couple			
50%	78,000	125,000	172,000
75%	98,000	158,000	218,000
90%	116,000	188,000	259,000
Chance of Having Enough Savings	**Maximum Prescription Drug Expenses Throughout Retirement**		
Men			
50%	$57,000	$79,000	$100,000
75%	79,000	109,000	140,000
90%	93,000	130,000	168,000
Women			
50%	68,000	94,000	120,000
75%	89,000	125,000	161,000
90%	107,000	151,000	196,000
Couple			
50%	122,000	170,000	218,000
75%	154,000	214,000	273,000
90%	178,000	250,000	322,000

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

Conclusion

The health care costs Medicare beneficiaries face in retirement can be significant. Medicare was not intended to cover all the health care expenses beneficiaries might face, and access to retiree health benefits has been falling. To help stakeholders understand what retirees will need to cover health costs in retirement, 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.

EBRI's model incorporates 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 includes sensitivity analyses surrounding updated assumptions about Medigap plans, as well as 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, the enrollee's usage of health care services, and projections of health care cost inflation. 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 consider 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, 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] See https://www.cms.gov/files/document/2024-medicare-trustees-report.pdf. Predicting changes to the generosity of Medicare benefits is outside the scope of this paper.

[2] 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.

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

[4] Medicare Part D covers outpatient prescription drugs.

[5] 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.

[6] 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.

[7] A 2024 report found that 11 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/.

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

[9] See https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2024-premiums-out-of-pocket-limits-supplemental-benefits-and-prior-authorization/.

[10] 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.

[11] 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.

[12] See Table V.E2 in https://www.cms.gov/oact/tr/2024.