

Estimating the Cost of an Out-of-Pocket Maximum in Traditional Medicare

Policy Brief

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Abstract

Traditional Medicare's (TM) lack of an out-of-pocket maximum, a feature of Medicare Advantage plans, means that OOP costs can accumulate rapidly for beneficiaries without supplemental coverage. To increase affordability for TM beneficiaries, Congress could establish an out-of-pocket maximum. We used data from the 2022 CMS Master Beneficiary Summary File and performed a simple analysis of the share of non-dual TM beneficiary spending over various OOP caps of Parts A and B spending. The analysis assumed no impact of the cap on beneficiaries' choice of supplemental plans and assumed no impact on utilization patterns. From this analysis, we estimate that a \$1,000 out-of-pocket cap on Parts A and B spending would benefit 44% of non-dual TM beneficiaries and cost \$44 billion in 2025, whereas a \$10,000 cap would benefit 3.1% of beneficiaries and cost \$8 billion. An out-of-pocket maximum on Part A and B spending greater than \$4,000, would benefit less than 10% of qualified beneficiaries and cost between \$8–19 billion in 2025. While our analysis gives a ballpark estimate of the costs of OOP caps for Parts A and B, a more detailed analysis should account for likely behavioral effects of OOP caps on beneficiaries' plan choice or utilization patterns.

Background

The typical benefit package in Medicare – known as traditional Medicare (TM) – is limited, including only hospital (Part A) and physician services (Part B). While TM began subsidizing optional prescription drug coverage (Part D) in 2006, it still lacks coverage for popular services – including vision, dental, and hearing aids – and requires substantial cost sharing.

Out-of-pocket (OOP) costs can add up quickly in TM. For example, consider a patient receiving a hip or knee replacement in 2024, with total 90-day expenditures averaging around \$30,000 (including approximately \$13,000 for the initial hospital visit and \$3,600 for physician services).^{1,2} TM beneficiaries without supplemental coverage would be responsible for a \$1,632 Part A deductible for the initial hospital stay; a \$240 Part B deductible; and \$670 in coinsurance for Part B; totaling over \$2,500 in OOP costs. A beneficiary with another hospitalization 60 days after discharge would again be responsible for the Part A deductible. There is also no limit on OOP spending for a particularly expensive episode.

To increase affordability for Medicare beneficiaries, Congress could establish an OOP maximum for TM beneficiaries—OOP maximums are required in Medicare Advantage (MA). An OOP cap could be

¹ Dummit LA, Kahvecioglu D, Marrufo G, et al. Association Between Hospital Participation in a Medicare Bundled Payment Initiative and Payments and Quality Outcomes for Lower Extremity Joint Replacement Episodes. *JAMA*. 2016;316(12):1267–1278. doi:10.1001/jama.2016.12717

² Miller DC, Gust C, Dimick JB, Birkmeyer N, Skinner J, Birkmeyer JD. Large variations in Medicare payments for surgery highlight savings potential from bundled payment programs. *Health Aff (Millwood)*. 2011;30(11):2107–2115. doi:10.1377/hlthaff.2011.0783

set at a variety of levels (e.g. \$5,000) and could apply to only medical or medical and prescription drugs. In this policy brief, we estimate the cost of various OOP maximum limits for Parts A and B among non-dually eligible Traditional Medicare beneficiaries.

Results

Exhibit 1 shows the proportion of non-dual TM beneficiaries who would have benefitted from each cap in 2022. A \$1,000 OOP maximum would benefit 44% of non-dual enrollees, but a cap greater than \$4,000 would impact less than 10% of non-dual TM beneficiaries.

Exhibit 1. Share of non-dual Traditional Medicare beneficiaries who exceed the cap at each level.

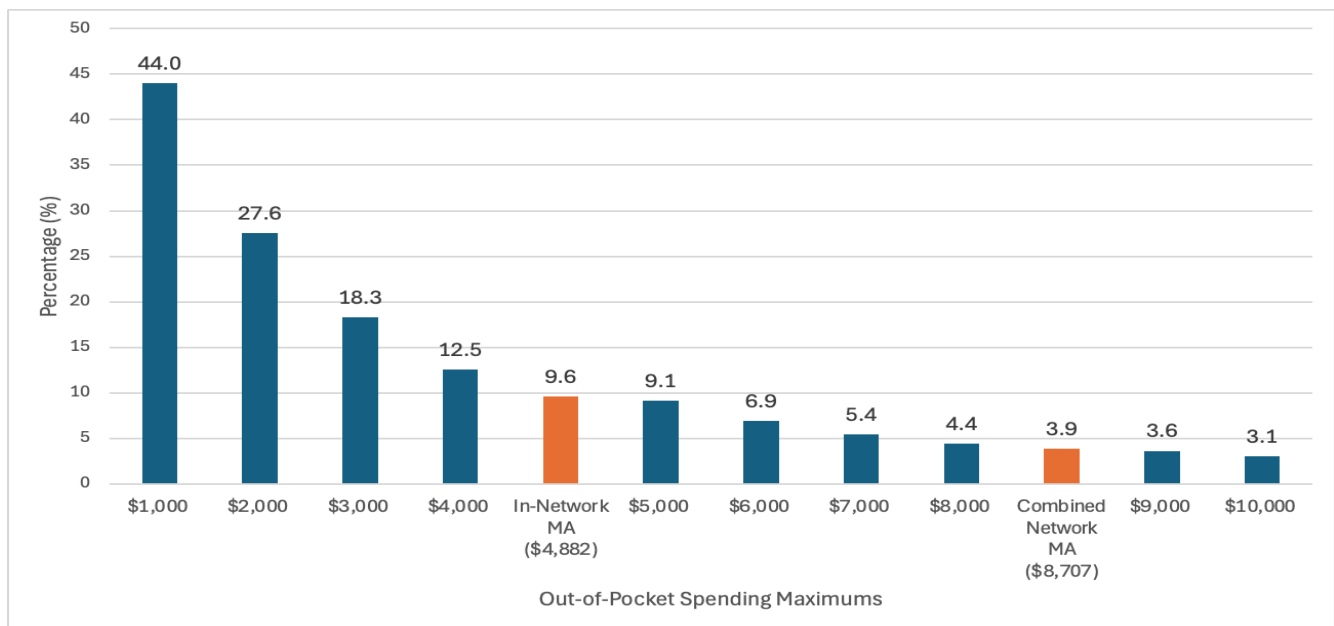


Exhibit 2 shows CMS’s additional spending per non-dual beneficiary at each cap level. On average, CMS would spend \$251.73 to \$1,343.46 for the \$10,000 and \$1,000 caps respectively. Although the beneficiaries who would benefit from larger caps are very high spenders, the estimate decreases as the cap becomes larger because the majority of beneficiaries' spending would fall below the cap and thus CMS's additional cost would be zero.

Exhibit 2. Average additional annual Medicare spending per beneficiary by cap.

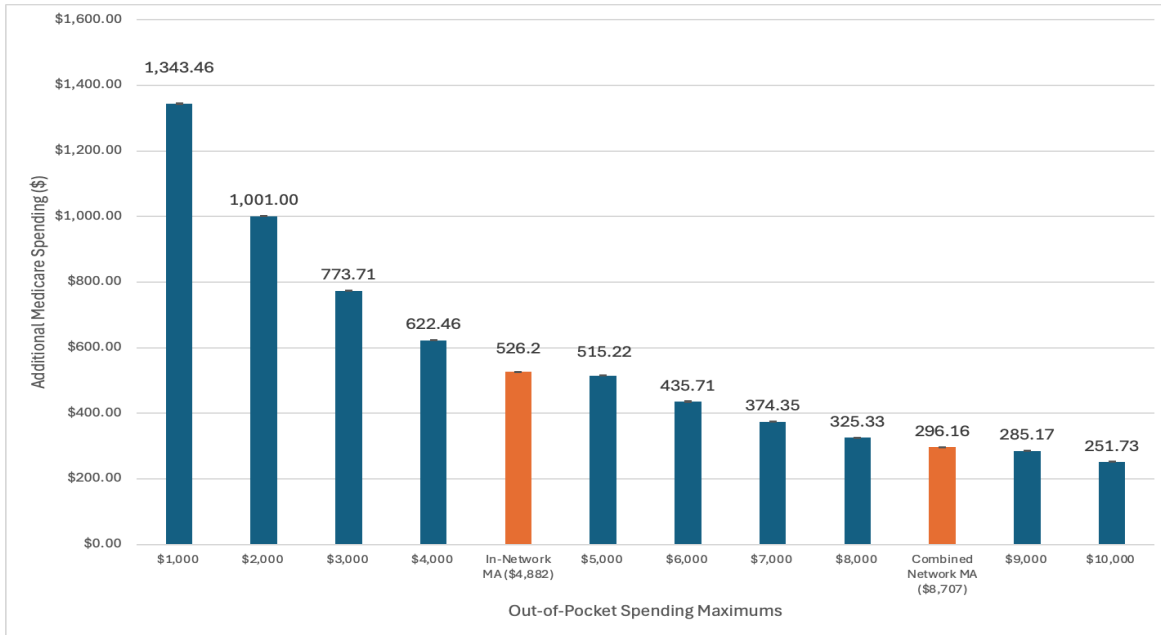
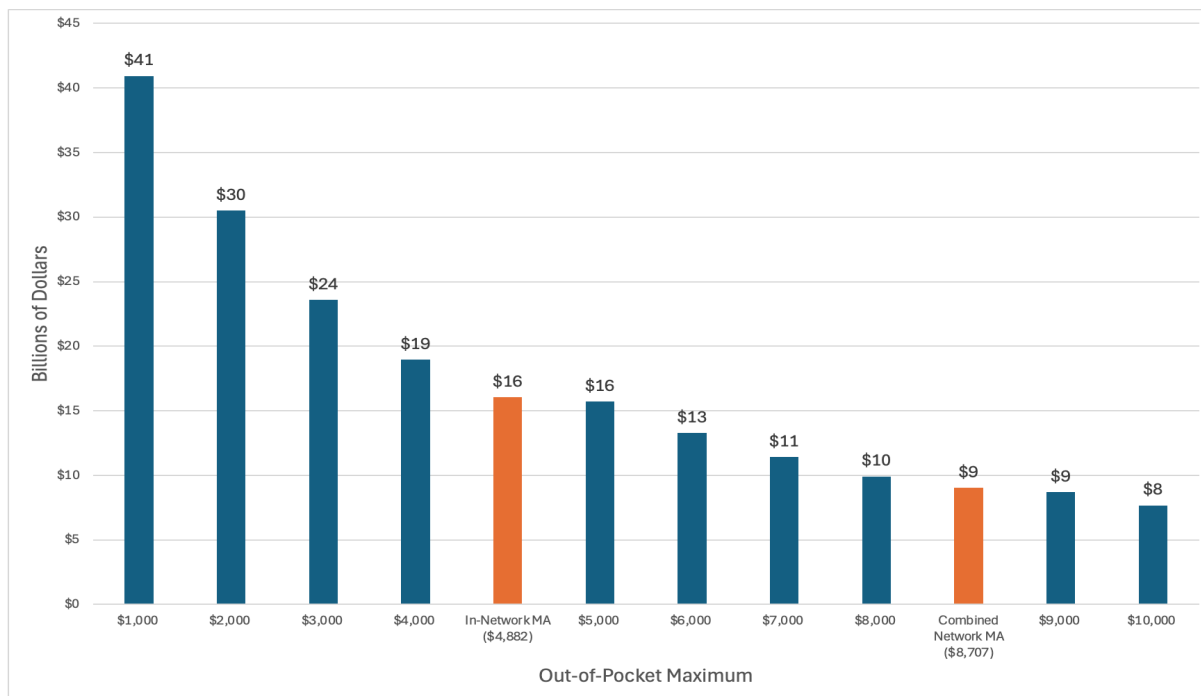


Exhibit 3 shows our estimates for expenditures associated with various OOP caps. We estimate that a \$1,000 OOP cap on Parts A and B would cost \$41 billion in 2025. Projected costs fall rapidly at higher OOP cap levels as the share of beneficiaries who would benefit from the higher caps is relatively flat in the upper range of the estimate.

Exhibit 3. Estimated cost of capping out-of-pocket medical spending for Traditional Medicare beneficiaries at various levels for 2025.



Note: The orange bars represent the average out-of-pocket maximums in Medicare Advantage for in-network (\$4,882) and both in-network and out-of-network (\$8,707) services in 2024 calculated by the [Kaiser Family Foundation](#).

Conclusion

We estimate an OOP cap of \$1,000 on Part A and B services would cost the federal government \$41 billion in 2025, whereas caps of \$5,000 and \$10,000 would cost \$16 billion and \$8 billion respectively. These OOP maximums could benefit 3% to 44% of non-dual TM beneficiaries depending on the cap level.

The analysis has important limitations. We assumed no impact of OOP caps on beneficiaries' choice of supplemental plans or utilization patterns. These assumptions are unlikely to hold in reality. For instance, caps on OOP spending would decrease Medigap premiums, which would likely shift beneficiary enrollment patterns in Medicare; we do not account for shifts in enrollment from

Medicare Advantage to TM, Medigap to no supplemental coverage, and no supplemental coverage to Medigap. In addition, by reducing cost sharing for some beneficiaries, OOP caps would likely increase utilization in TM. OOP caps may also influence states' regulations of the Medigap market. For example, OOP caps may increase states' likelihood of mandating guaranteed issue and community rating in Medigap. While this work gives a ballpark estimate of the costs of OOP caps for Parts A and B, a more detailed analysis should account for the broader potential impact of OOP caps.

Appendix Methods

Our analysis included traditional Medicare beneficiaries while excluding those without at least one month of Part A and Part B enrollment, dual-eligibility status in January, and those without any spending data. Our final sample comprised 24.5 million beneficiaries.

Using the 2022 CMS Master Beneficiary Summary File, beneficiary-level spending was categorized into Medicare Spending, Out-of-Pocket Spending, Other Spending, and Total Spending. The expenditure data included any Part A or Part B spending on acute care, anesthesia, ambulatory surgery center, dialysis, durable medical equipment, evaluation and management, home health, hospital outpatient, hospice, imaging, other inpatient, other procedures, other Part B carrier, physician office spending, Part B drug, skilled nursing facilities, and laboratory tests.

We created 12 caps, where we calculated how much each beneficiary would have saved in out-of-pocket spending at each OOP maximum level. Our caps ranged from \$1,000–10,000 at thousand-dollar intervals with two additional caps representing the average MA in-network OOP maximum (\$4,882) and the average MA in-network and out-of-network OOP maximum (\$8,707) in 2024.³

We then calculated the cumulative additional Medicare spending (or beneficiary savings) at each cap level. Finally, to bring these estimates to 2025 dollars, we factored in the estimated growth in TM enrollment (2.0% annually) and expenditure per beneficiary (5.3% annually) from 2022–2025.⁴

³ Kaiser Family Foundation. Medicare Advantage in 2024: Premiums, Out-of-Pocket Limits, Supplemental Benefits, and Prior Authorization. Published August 8, 2024. Accessed October 25, 2024.

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

⁴ Centers for Medicare & Medicaid Services. Projected National Health Expenditure Data. Published September 10, 2024. Accessed October 25, 2024.

<https://www.cms.gov/data-research/statistics-trends-and-reports/national-health-expenditure-data/projected>

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