



Modernizing Medicare Cost Sharing

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BACKGROUND

Since at least the Simpson-Bowles Commission in 2010, proposals to modernize Medicare cost sharing have generally focused on three key areas: 1) deductibles, 2) coinsurance/copays, and 3) an annual cap on out-of-pocket (OOP) expenses. Several entities have modeled different options within these three areas. For purposes of this article, the default policy position is the 2024 budget option proposed by the Congressional Budget Office (CBO). Tables 1 and 2 highlight current law and how the CBO “reform policy” would change current law for Medicare Parts A and B, respectively. Table 3 highlights several budgetary projections for implementing similar reform policies and highlights deviations from the CBO baseline policy.

CURRENT LAW AND REFORM POLICIES

CBO’s proposed reforms would affect both Parts A and B of Medicare.

MEDICARE PART A

Under Medicare Part A, beneficiaries are responsible for the cost-sharing obligations

captured in table 1 under “Current Law.” CBO’s proposed reforms appear to the right.

Under current law, Part A beneficiaries are subject to a deductible based on hospital use. Any hospitalization (e.g., inpatient, psychiatric, rehabilitation, or long-term care) is subject to a \$1,736 deductible. In addition, each subsequent hospitalization is subject to additional deductibles. If a hospital stay exceeds 60 days, then through 90 days, coinsurance is \$434 per day. If a hospital stay exceeds 90 days, then through 150 days, coinsurance is \$868 per day. If a hospital stay exceeds 150 days, the beneficiary is responsible for 100 percent of the cost.¹

CBO’s policy reform contemplates a unified deductible for Parts A and B set at \$850. Coinsurance would default to 20 percent of the allowed amount for any inpatient days in excess of 60.²

Under current law, most Part A services outside of inpatient hospital benefit periods are not separately subject to deductible requirements. Skilled nursing facility (SNF) stays have no cost sharing for the first 20 days, a \$217 copay for days 21-100, and 100 percent cost for 100 or more days.³ Both home health and hospice have no cost-sharing obligations under current law.

TABLE 1 MEDICARE PART A: CURRENT LAW AND REFORM POLICIES

Medicare structural component	Current law ^a		CBO proposed reforms ^b
Part A	\$1,736	Deductible (if hospitalization is necessary)	\$850 Combined deductible for Parts A and B
<i>Inpatient hospital</i>			
Days 1–60	\$1,736	Deductible (per benefit period)	20% Coinsurance
Days 61–90	\$434	Copay (per day)	20% Coinsurance
Days 91–150 (reserve)	\$868	Copay (lifetime reserve)	20% Coinsurance
Days 150+	100%		20% Coinsurance
<i>Inpatient psychiatric</i>			
Same as inpatient			
<i>Inpatient rehabilitation facility</i>			
Same as inpatient			
<i>Long-term care hospital</i>			
Same as inpatient (for purposes of cost-sharing obligations)			
<i>Skilled nursing facility</i>			
Days 1–20	\$0		
Days 21–100	\$217	Copay (per day)	20% Coinsurance
Days 100+	100%		20% Coinsurance
<i>Home health</i>			
Episode	\$0 ^c		20% Coinsurance
<i>Hospice</i>			
Stay	\$0 ^d		20% Coinsurance

^a This column, except where noted: Centers for Medicare and Medicaid Services (CMS), “2026 Medicare Parts A & B Premiums and Deductibles,” November 14, 2025, <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-a-b-premiums-deductibles>.

^b This column: Congressional Budget Office (CBO), “Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance,” December 12, 2024, <https://www.cbo.gov/budget-options/60904>.

^c Section 1861 of the Social Security Act, Social Security Administration, accessed September 12, 2026, https://www.ssa.gov/OP_Home/ssact/title18/1861.htm.

^d Centers for Medicare and Medicaid Services (CMS), “Hospice Care,” accessed September 12, 2026, <https://www.medicare.gov/coverage/hospice-care>.

Under the reform policy, all SNF days would cost 20 percent of the allowed per diem, and both home health and hospice services would be subject to 20 percent coinsurance.⁴

MEDICARE PART B

Under Medicare Part B, beneficiaries are responsible for the cost-sharing obligations captured in table 2 under “Current Law.” CBO’s proposed reforms appear in the column on the right.

TABLE 2 MEDICARE PART B: CURRENT LAW AND REFORM POLICIES

Medicare structural component	Current law ^a		CBO proposed reforms ^b
Part B	\$283 ^c		Combined \$850 deductible
<i>Professional</i>			
Visit	20%	Coinsurance	20% Coinsurance
<i>Outpatient</i>			
Visit/stay	20%	Capped at inpatient deductible \$1,736	20% Coinsurance; no cap
<i>Ambulatory surgical center</i>			
Stay	20%	Coinsurance	20% Coinsurance
<i>Dialysis (end-stage renal disease)</i>			
Service	20%	Coinsurance	20% Coinsurance
<i>Durable medical equipment</i>			
Item	20%	Coinsurance	20% Coinsurance
<i>Ambulance</i>			
Transport	20%	Coinsurance	20% Coinsurance
<i>Clinical lab</i>			
Service	\$0 ^d		20% Coinsurance
<i>Federally Qualified Health Centers/Rural Health Centers</i>			
Visit	20%	Coinsurance	20% Coinsurance
<i>Part B drugs</i>			
Drug	20%	Coinsurance	20% Coinsurance

^a This column, except where noted: Centers for Medicare and Medicaid Services (CMS), “Outpatient Medical & Surgical Services & Supplies,” accessed September 12, 2026, <https://www.medicare.gov/coverage/outpatient-medical-surgical-services-supplies>.

^b This column: CBO, “Change the Cost-Sharing Rules.”

^c CMS, “2026 Medicare Parts A & B.”

^d Section 1833 of the Social Security Act, Social Security Administration, accessed September 12, 2026, https://www.ssa.gov/OP_Home/ssact/title18/1833.htm.

Unlike services covered by Part A, all Part B services are currently subject to a deductible of \$283.⁵ All Part B services, except for clinical lab services, are also subject to 20 percent coinsurance under current law and would therefore experience no change under the reform policy.⁶ Under current law, there are no cost-sharing obligations for clinical lab services;⁷ this would change to 20 percent coinsurance under the reform policy.⁸ The hospital outpatient coinsurance is capped at the inpatient deductible (\$1,736) under law,⁹ and this protection would be repealed under the reform policy.¹⁰

Under Original Medicare (OM), there is no annual OOP cap. However, Medicare Advantage (MA) beneficiaries may have an annual in-network OOP cap up to \$9,250 and a combined in-and-out-of-network cap of \$13,900.¹¹ Most MA plans set OOP limits below this maximum. The reform policy would establish a new OM OOP cap of \$8,500.¹²

AUTHORITY FOR POLICY REFORM

Conventional wisdom suggests that implementing Medicare policy reforms requires legislative action. Although certain MA value-based insurance design demonstrations were implemented through the authority of the Center for Medicare and Medicaid Innovation, or CMS Innovation Center, broader Medicare benefit redesign would likely require congressional approval.

BUDGETARY IMPACTS

Several iterations of CBO's reform policy have been contemplated over the past sixteen years. As noted in the introduction, the origin of this proposed reform can formally be traced back to the Simpson-Bowles deficit reduction commission, which scored policy savings of \$110 billion over the ten-year budget window.¹³ Table 3 lists the Simpson-Bowles and successor proposals

TABLE 3 BUDGETARY MODELING OPTIONS AND POLICY DEVIATIONS FROM TABLES 1 AND 2

Proposal	Year	Budgetary impact (\$/years)	Policy deviations
Medicare Cost Cap Act of 2026, S. 4886 ^a	2026	?	\$5,000 OOP cap only Introduced by Sen. Lisa Blunt Rochester (D-DE) with 16 cosponsors as of this writing
Urban Institute ^b	2026	+\$15B/10	\$5,900 OOP cap (estimated median level in MA plans for 2026)
Congressional Budget Office ^c	2024	-\$20B/10	None (see tables 1 and 2)
		-\$116B/10	Cost sharing unchanged from current law Medigap policies barred from paying any of the first \$850 and coverage limited to 50 percent of the next \$7,650
		-\$129B/10	See tables 1 and 2 and the options above
Kaiser Family Foundation ^d	2016	-\$50B/10	Medigap coverage of the deductible limited to 50 percent
Bipartisan Policy Commission ^e	2013	-\$300B/10	Professional visits exempted from deductible

(continued)

TABLE 3 (Continued)

Proposal	Year	Budgetary impact (\$/years)	Policy deviations
Medicare Payment Advisory Commission ^f	2012	\$0	Secretarial authority for value-based copayments No change to aggregate beneficiary cost sharing
Burr-Coburn ^g	2012	-\$31B/10	Bundled with premium support and competitive bidding
Lieberman-Coburn ^h	2011	-\$371B/10	20 percent coinsurance to \$5,500 5 percent coinsurance to \$7,500 Medigap policies barred from paying any of the \$550 deductible or the \$7,500 Income-scaled OOP cap: Beneficiaries with income above \$85,000 individual / \$170,000 joint have a \$12,500 cap, rising to \$17,500 above \$107,000/\$214,000 and \$22,500 above \$160,000/\$320,000
Simpson-Bowles ⁱ	2010	-\$110B/10	Coinsurance dropped to 5 percent once OOP exceeds \$5,500

^a Medicare Cost Cap Act of 2026, S. 4886, 119th Cong. Retrieved from <https://www.congress.gov/bill/119th-congress/senate-bill/4886>.

^b Bowen Garrett and John Holahan, "Adding a Maximum Out-of-Pocket Cap to Medicare Part A and Part B: Effects on Beneficiary and Program Spending," Urban Institute, June 3, 2026, <https://www.urban.org/research/publication/adding-maximum-out-pocket-cap-medicare-part-a-and-part-b>.

^c CBO, "Change the Cost-Sharing Rules."

^d Juliette Cubanski, Tricia Neuman, Zachary Levinson, Gretchen Jacobson, Monica Brenner, and James Mays, "Modifying Medicare's Benefit Design: What's the Impact on Beneficiaries and Spending?," Kaiser Family Foundation, June 29, 2016, <https://www.kff.org/medicare/modifying-medicare-benefit-design-whats-the-impact-on-beneficiaries-and-spending/>.

^e Bipartisan Policy Center, *A Bipartisan Rx for Patient-Centered Care and System-Wide Cost Containment*, April 2013, <https://bipartisanpolicy.org/wp-content/uploads/2019/03/BPC-Cost-Containment-Report.pdf>.

^f Medicare Payment Advisory Commission, "Reforming Medicare's Benefit Design," chap. 1 in *Report to the Congress: Medicare and the Health Care Delivery System*, June 2012, https://www.medpac.gov/wp-content/uploads/import_data/scrape_files/docs/default-source/reports/jun12_entirereport.pdf.

^g Avik Roy, "Burr-Coburn: The Best Medicare Reform Proposal Yet," *Forbes*, updated May 1, 2012, <https://www.forbes.com/sites/aroy/2012/02/16/burr-coburn-the-best-medicare-reform-proposal-yet/>.

^h Avik Roy, "Tom Coburn and Joe Lieberman's Impressive New Medicare Reform Proposal," *Forbes*, updated July 23, 2011, <https://www.forbes.com/sites/aroy/2011/06/28/tom-coburn-and-joe-liebermans-impressive-new-medicare-reform-proposal/>.

ⁱ National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, <https://www.govinfo.gov/content/pkg/GOVPUB-PR-PURL-gpo1606/pdf/GOVPUB-PR-PURL-gpo1606.pdf>.

with their budgetary impact and most significant policy changes.

Different iterations of the reform have been estimated to generate savings as high as \$371 billion over the budget window.¹⁴ Proposed by former Senators Tom Coburn (R-OK) and Joe Lieberman

(D/I-CT) in 2011, the proposal offering the highest level of savings would have barred Medigap policies from paying any of the combined Parts A and B deductible and limited Medigap coverage of coinsurance to 50 percent. Their proposal included additional significant structural reforms, including competitive bidding for MA, and a

defined contribution often referred to as “premium support.”¹⁵ Many would argue that the incremental reform of modernizing Medicare cost sharing is a necessary precursor to larger reforms.

Some reform options, such as the recently released report by the Urban Institute, have contemplated adding to the deficit. The Urban Institute models the OOP cap at \$5,900, a figure chosen because it represents the estimated median level in MA plans for 2026. The Urban Institute estimate also models the standard table 1 and 2 options, but the lower OOP cap offsets all those savings and adds additional spending. In addition, the Urban Institute estimate includes a current microsimulation that accounts for behavioral responses, which may also contribute to the cost estimate.¹⁶ CBO’s 2024 estimate also includes a microsimulation, but it dates back to 2019 and thus predates the recent rapid growth in MA enrollment.¹⁷

Finally, several US senators introduced the Medicare Cost Cap Act of 2026 in June, for which a score is not yet available. This legislation would establish an OOP cap (\$5,000 in 2028) as a component of the Medicare basic benefit, and it does not contemplate any of the main drivers of savings from tables 1 and 2.¹⁸ Notably, the bill also does not include any conforming amendments to the statutory language around the MA OOP. Under section 1852(a)(1)(B)(i) of the Social Security Act, MA organizations must cover Parts A and B benefits with cost sharing that does not exceed, or is at least actuarially equivalent to, cost sharing in OM in the aggregate. A new OM OOP cap could prompt CMS to reevaluate MA cost-sharing standards.

ADDITIONAL CONSIDERATIONS

CBO’s policy reform prompts additional debate when comparisons are made between OM and MA. Under current law, the OOP cap under MA is an important competitive advantage and

marketing tool leveraged by MA plans to attract beneficiaries. Although instituting an OOP cap under the basic benefit ensures greater parity across the full Medicare program, it fundamentally removes an important lever from the MA toolbox.

From a budgetary perspective, the unified deductible is considerably lower than the current law’s Part A hospital deductible and therefore could have an adverse impact on the solvency of the Part A trust fund. Reforms addressing other Part A services, such as the 20 percent coinsurance on the first twenty days of SNF stays and new cost-sharing obligations for post-acute home health and hospice care, will generate new Part A savings, but it remains unclear whether those savings are enough to fully offset the loss generated by the lower combined deductible.

NOTES

1. Centers for Medicare and Medicaid Services (CMS), “2026 Medicare Parts A & B Premiums and Deductibles,” November 14, 2025, <https://www.cms.gov/newsroom/fact-sheets/2026-medicare-parts-b-premiums-deductibles>.
2. Congressional Budget Office (CBO), “Change the Cost-Sharing Rules for Medicare and Restrict Medigap Insurance,” December 12, 2024, <https://www.cbo.gov/budget-options/60904>.
3. CMS, “2026 Medicare Parts A & B.”
4. CBO, “Change the Cost-Sharing Rules.”
5. CMS, “2026 Medicare Parts A & B.”
6. CBO, “Change the Cost-Sharing Rules.”
7. Section 1833 of the Social Security Act, Social Security Administration, accessed September 12, 2026, https://www.ssa.gov/OP_Home/ssact/title18/1833.htm.
8. CBO, “Change the Cost-Sharing Rules.”
9. Centers for Medicare and Medicaid Services (CMS), “Outpatient Medical & Surgical Services & Supplies,” accessed September 12, 2026, <https://www.medicare.gov/coverage/outpatient-medical-surgical-services-supplies>.
10. CBO, “Change the Cost-Sharing Rules.”
11. Centers for Medicare and Medicaid Services (CMS), “Medicare Advantage Rates & Statistics,” last modified February 23, 2026, <https://www.cms.gov/medicare/payment/medicare-advantage-rates-statistics>.
12. CBO, “Change the Cost-Sharing Rules.”

13. National Commission on Fiscal Responsibility and Reform, *The Moment of Truth*, December 2010, 37, <https://www.govinfo.gov/content/pkg/GOVPUB-PR-PURL-gpo1606/pdf/GOVPUB-PR-PURL-gpo1606.pdf>.
14. Avik Roy, "Tom Coburn and Joe Lieberman's Impressive New Medicare Reform Proposal," *Forbes*, updated July 23, 2011, <https://www.forbes.com/sites/aroy/2011/06/28/tom-coburn-and-joe-liebermans-impressive-new-medicare-reform-proposal/>.
15. Roy, "Impressive New Medicare Reform Proposal."
16. Bowen Garrett and John Holahan, "Adding a Maximum Out-of-Pocket Cap to Medicare Part A and Part B: Effects on Beneficiary and Program Spending," Urban Institute, June 3, 2026, <https://www.urban.org/research/publication/adding-maximum-out-pocket-cap-medicare-part-a-and-part-b>.
17. CBO, "Change the Cost-Sharing Rules."
18. Medicare Cost Cap Act of 2026, S. 4886, 119th Cong. Retrieved from <https://www.congress.gov/bill/119th-congress/senate-bill/4886>.



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