Original Medicare Modernization – The Role of a Cost Sharing Cap

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BACKGROUND

A common critique of Original Medicare (OM) is its lack of protection against high out-of-pocket costs due to the lack of an annual limit on Medicare cost sharing.[1] Enrollment in Medicare Advantage (MA) plans, which are required by law to include annual cost sharing limits, has now grown to 55% of beneficiaries eligible to enroll in MA (beneficiaries enrolled in both Medicare Part A and Part B).[2] The popularity of MA reflects the additional benefits that MA plans offer at little to no additional cost to beneficiaries (i.e., benefits that are not included in the basic OM benefit design). These include lower cost sharing (including caps well below the statutory requirement), Part B and D premium discounts, and supplemental coverage for dental, hearing, vision, and other services. Adding a cost sharing limit to OM would better align the benefit with MA and other modern health insurance plans, provide protection against high medical costs for beneficiaries who lack comprehensive supplemental coverage, and reduce incentives for those beneficiaries to forego or delay care.

For the purpose of this analysis, we are defining terms as follows:

Cost sharing: Deductibles, coinsurance, and copayments applicable under Part A or B. This does not include liability for services not covered by Medicare. Note that Medicare Advantage and some legislative proposals, including S4886 referenced below, refer to this liability as Medicare Out-of-Pocket ("MOOP") but the definition in the bill is consistent with our term "cost sharing." This amount can be paid entirely by the beneficiary out-of-pocket, as discussed below, or may be paid in part or in full by supplemental insurance (e.g. Medicaid, employer-sponsored insurance (ESI), Medigap).

Out-of-Pocket (OOP): The portion of cost sharing paid directly by the beneficiary, excluding costs paid by supplemental insurance. (Note that this concept is *not* the same concept as true out-of-pocket (TrOOP) in Medicare Part D, which includes specific types of liability for which the beneficiary is not responsible and which are not applicable to Parts A and B.)

This issue brief focuses on the potential budgetary and beneficiary impacts of a range of possible cost sharing caps in OM for Medicare Part A and Part B services. Prescription drug spending under Part D has been excluded from the analysis. The levels were chosen to include:

- The Medicare Out-of-Pocket (MOOP) as defined in S4886 ($5,000),[3]
- the MOOP as defined in HR3911 ($6,700),
- a trended value derived from CBO analysis ($8,600),[4] and
- the statutorily-defined MA MOOP ($9,250).

These values represent a broad range of potential legislative targets.

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RESULTS

We used a microsimulation model to estimate program and beneficiary impacts for cost sharing limits in this range. The addition of a cost sharing maximum would increase program expenditures because Medicare would cover cost sharing that was previously financed by individuals or secondary insurance, and some beneficiaries would receive care that would otherwise have been foregone.

Table 1 shows the estimated budgetary impacts for each cap. We have included estimates for four subcategories: Federal OM Expenditures, Federal MA Expenditures, Part B Premium Collections, and Federal Medicaid Expenditures.

Federal OM Expenditures include the additional costs associated with implementing the cost sharing caps for OM beneficiaries. Federal MA Expenditures include additional costs associated with increased benchmarks for MA plans, which are set based on OM spending levels. Part B premiums are set as a percentage of total Part B spending. As Part B spending rises under a cost sharing maximum, premiums will increase. Part B Premium Collections represent the additional revenue that will be collected from Medicare beneficiaries via higher Part B Premiums. Finally, Federal Medicaid Expenditures include Original Medicare cost sharing liability previously covered by Medicaid shifting to being covered directly via the proposed caps.

TABLE 1: BUDGETARY IMPACTS, FISCAL YEARS 2026-2035 (BILLIONS)

Budget Category	FY 2026-2035 Level of Cost Sharing Maximum			
	$5,000	$6,700	$8,600	$9,250
Federal OM Expenditures	300.1	230.7	179.3	166.2
Federal MA Expenditures	420.0	326.1	255.7	237.7
Part B Premium Collections	-173.3	-134.7	-105.8	-98.4
Federal Medicaid Expenditures	-48.6	-38.1	-29.7	-27.4
Total Impacts	**498.2**	**384.0**	**299.5**	**278.0**

- We estimate that the addition of an OM cap would increase Federal expenditures by approximately $275 billion under the $9,250 cap and $500 billion under the $5,000 cap over the 10-year window of FY 2026 to FY 2035. According to the 2025 Medicare Trustees Report,[5] estimated Medicare Part A and Part B expenditures for 2026 are $1.1 trillion. The range of increases in Federal expenditures are between 1.5% and 2.7%.

- The increase in Federal Medicare expenditures (OM+MA) ranges from approximately $400 to $720 billion with offsetting increases in Part B premium collections of between $100 and $175 billion. The additional outlays would be further offset by reductions in Federal spending on Medicaid for individuals dually-eligible for the two programs.

- Regardless of the level of the cap, about 41% of the new outlays would go directly towards providing this new benefit to OM beneficiaries, while the remaining 59% would go to additional payments to MA plans via higher fee-for-service benchmarks. Since MA benchmarks are based on OM spending, increases to the latter flow through to the former mechanically. This analysis does not consider other possible reforms to MA payment that may serve to offset MA spending increases due to higher spending in OM. The relative

magnitude of the MA versus OM budgetary impacts over the projection period are driven by several factors, including greater MA enrollment and higher average per capita payments for MA beneficiaries.[6]

- We estimate that the addition of a cap would increase total per capita health expenditures for the OM Medicare population by between 0.3% and 0.6% as a result of additional care – potentially needed care that would have been foregone. It is concentrated among beneficiaries whose total Part A and Part B cost sharing exceeds the cap, especially those without supplemental coverage or with partial supplemental coverage. These estimates may overstate federal spending if some beneficiaries leave more generous Medigap plans and face more cost sharing below the cap, reducing utilization.

Medicare beneficiaries would see varying changes to their out-of-pocket liability depending on their level of health care spending, the level of the cap, and the existing generosity of their supplemental coverage. In general, beneficiaries with generous supplemental coverage – those with Medigap plans F or G or Medicaid, for instance – would likely see minimal to no impact from the implementation of an OM cap.

However, the beneficiaries with highest financial risk due to lacking supplemental coverage would see substantial benefits. We estimate that approximately 9% of Medicare beneficiaries lack supplemental coverage, corresponding to more than 3 million individuals. Table 2 outlines the financial benefits to these beneficiaries.

TABLE 2: BENEFICIARY IMPACTS FOR THOSE LACKING SUPPLEMENTAL COVERAGE, CALENDAR YEAR 2026

	CY 2026			
	Level of Cost Sharing Maximum			
	$5,000	$6,700	$8,600	$9,250
Total Beneficiaries	3,042,000			
# (%) of Impacted Beneficiaries	260,000 (9%)	143,000 (5%)	83,000 (3%)	72,000 (2%)
Average Decrease in Beneficiary Out-of-Pocket Liability	-$233	-$159	-$108	-$97
Average Decrease in Beneficiary Out-of-Pocket Liability Conditional on Being Impacted	-$2,730	-$3,387	-$3,981	-$4,078

- We estimate that nearly 10% of individuals without supplemental coverage would have total cost sharing liability exceeding $5,000 in 2026, while a much smaller 2% would have total cost sharing in excess of $9,250.
- On average, beneficiaries with no supplemental coverage would experience a reduction in beneficiary out-of-pocket liability of between $100 ($9,250 cap) and $230 ($5,000 cap). However, these amounts include the majority of beneficiaries with little to no change in their out-of-pocket liability. For impacted beneficiaries, the reduction in out-of-pocket liability would range between $4,100 ($9,250 cap) and $2,700 ($5,000 cap).
- Note that not all of the benefit of a cost sharing cap would accrue to beneficiaries, even those without supplemental coverage, because not all cost sharing is ultimately collected by providers. Our estimates reflect that a portion of total cost sharing under current law is not collected, and we assume that the same

proportion would remain uncollected under a cap. The result is that we estimate both patient out-of-pocket and uncollected cost sharing are reduced. The benefit to providers is not captured in Table 2.

- For these at-risk beneficiaries, protection from high out-of-pocket costs would represent a critical improvement over the status quo.

METHODS

The modeling is based on the 2021 and 2022 Medicare Current Beneficiary Survey (MCBS), which is a comprehensive survey of the Medicare population, including utilization and health outcomes, linked to enrollment and claims data.[7] These data have been trended and controlled to estimates of aggregate spending, utilization, and demographic characteristics as published by HHS, CMS, and the CBO. After adjustment and projection, we derived a beneficiary-level file for FY 2026 to 2035 which is consistent with CBO estimates of Medicare spending by covered service category. Importantly, the dataset includes information on supplemental coverage, including ESI, Medigap, and Medicaid (based on survey-reported types of coverage, utilization, and spending by payer in the MCBS). The file includes spending by broad category of service (inpatient, outpatient, physician, skilled nursing, home health, and lab) and by payer (Medicare, Medicaid, patient out-of-pocket, ESI, etc.). For each record, we can identify the payers of required cost sharing. For instance, individuals with ESI or Medigap coverage have a portion, or all, of their cost sharing paid for by supplemental coverage. We identify beneficiary out-of-pocket liability as the portion of cost sharing not covered by third party payers. For example, if 65% of Original Medicare cost sharing liability were paid by an ESI plan with the remaining 35% paid directly out-of-pocket by the beneficiary under current law, this same proportion is applied to the estimated cost sharing under the proposed caps.

In order to model the cost sharing caps described above, we calculated the revised Original Medicare cost sharing liability and distributed the cost sharing liability under the proposed cap according to the non-Medicare distribution of spending inherent in the base file described above. As a result, reductions in beneficiary cost sharing liability are shared proportionately across all payers, including beneficiary out-of-pocket as well as supplemental coverage under ESI, Medigap, etc. Uncollected cost sharing is treated the same as all other payers for these purposes. For the caps modeled, beneficiary cost sharing liability is simply capped at the value of the cost sharing limit.

KEY ASSUMPTIONS

The modeling described above requires a number of key assumptions, which include the following:

- We assume that the cost sharing limit, or "cap," would apply to all Original Medicare cost sharing liability, whether or not paid directly by that individual (beneficiary out-of-pocket liability) or by another third party.
- We assume that implementation of the policies would have begun in 2026.
- Based on prior research which has shown that MA plan bid increases only partially match benchmark increases, we have assumed that bids would rise by half as much as benchmarks rise.
- We assume that under the cap, beneficiary cost sharing liability will be paid according to the same distribution of payers currently observed via the MCBS. For example, if a beneficiary's ESI coverage paid 90% of required OM cost sharing liability, we assume that the new, reduced cost sharing liability would also be paid 90% via ESI coverage.

DISCLOSURES

This work was supported by West Health. ARC maintains full editorial and analytical control.

Guidelines issued by the American Academy of Actuaries require actuaries to include their professional qualifications in all communications with respect to actuarial services. Ryan Brake and Edward Armentrout are members in good standing of the American Academy of Actuaries and meet the qualification standards for performing the analyses in this brief.

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NOTES

[1] Center on Budget and Policy Priorities. (2025, January 10). *Growth in Medicare Advantage raises concerns.* Retrieved from https://www.cbpp.org/research/health/growth-in-medicare-advantage-raises-concerns

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