Modern Medicaid ALLIANCE

Medicaid Cost-Sharing Would Make Care Less Accessible

The proposed policies included in the House reconciliation package – *One Big Beautiful Bill Act (H.R. 1)* – will destabilize providers and hospitals serving local communities, burden states and **lead to more than 7.8 million Americans losing their Medicaid coverage and benefits.**[1]

What's In The Bill

H.R. 1 requires states to impose cost-sharing of up to $35 per service on Medicaid expansion enrollees with household incomes between 100-138% of the Federal Poverty Level (FPL), capped at 5% of the household income, calculated monthly or quarterly.[2] In addition to being administratively burdensome for states to implement, this will create an additional financial barrier to care for people who already struggle to afford basic needs.

Case Study: Cost-Sharing Discouraged Care In Utah

In Utah, the introduction of nominal Medicaid copayments led to reduced use of essential health services. After the state implemented copays of $2–$3 for physician visits, outpatient care and prescription drugs, utilization of these services declined. Hospital admissions also dropped after the introduction of a $220 copay for inpatient care. The findings underscore how even small out-of-pocket costs can discourage Medicaid enrollees from seeking needed care.[3]

Why This Matters

For people with low incomes, even minor additional costs can mean skipping a doctor's visit or medication. Research shows that **cost-sharing leads to lower preventive care utilization**, **worse health outcomes** and **higher rates of emergency room use**.[4] The impact of this policy will be felt most acutely by those living with multiple chronic conditions or serious diseases.

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[1] https://www.cbo.gov/publication/61461
[2] https://www.kff.org/tracking-the-medicaid-provisions-in-the-2025-budget-bill/
[3] https://www.cbpp.org/research/the-effects-of-copayments-on-the-use-of-medical-services-and-prescription-drugs-in-utahs#:~:text=The%20findings%20of%20our%20analyses,applied%20to%20poor%20Medicaid%20patients.
[4] https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/

- While some services would be exempt from cost-sharing, broad categories of services needed to treat chronic conditions (e.g. cancer, asthma) would have new cost-sharing. Even relatively small amounts of cost-sharing in the range of $1 to $5 are associated with **reduced use of care, including on medically necessary services**.[5]
- The bill also allows providers to deny services if individuals cannot afford the cost-sharing, a major departure from current law.
- It is unclear if states or health plans will reduce provider payments in anticipation of a larger patient contribution. When patients cannot pay for care or forego care, the provider will face a revenue loss.
- While much of the focus has been on the millions of people who would lose coverage because of the bill, this provision also warrants attention because it will create new barriers to care. Even if people remain enrolled, they may lose access to life-saving care or prescriptions.
- A 5% cost-sharing cap may seem modest, but even for someone at the highest income level eligible for Medicaid expansion — $21,597 for a single adult (138% of the federal poverty level) — **it could mean up to $1,079 in out-of-pocket costs annually**.
- Implementing cost-sharing programs can be a complex undertaking for state Medicaid programs, given each individual's cost-sharing limits are based on their income and can fluctuate throughout the year, especially for seasonal workers.
- Additionally, calculating when monthly or quarterly caps have been met across different provider and pharmacy claims adds significant administrative complexity across the health care spectrum.

[5] https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/