Changes to Medi-Cal Under the OBBBA and the CA Budget: Cost-Sharing

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H.R. 1, also known as the "One Big Beautiful Bill Act," (OBBBA) cuts approximately $1 trillion from Medicaid which will result in an estimated 10 million individuals and families losing health coverage across the nation. Just before the OBBBA's passage, California finalized its budget, which includes additional cuts to the Medi-Cal (Medicaid) program. This fact sheet discusses the changes that both the OBBBA and the final California budget introduced regarding the imposition of cost-sharing (such as deductibles, coinsurance, and copayments) on Medi-Cal beneficiaries.

Historically, under the federal Medicaid Act, states have been allowed to charge certain beneficiaries only limited cost-sharing.[1] The protections currently in place vary by beneficiaries' income levels, with beneficiaries at the lower end of the income spectrum shielded from higher out-of-pocket costs. More specifically, states are allowed to impose only "nominal" deductibles, copayments, and similar charges on outpatient and hospital services for beneficiaries under 100% of the federal poverty level (FPL).[2] As for prescription drugs, states are allowed to impose different cost sharing amounts for preferred and non-preferred drugs. For non-preferred prescription drugs, states can charge $8 for people with income equal to or below 150% of FPL and 20% of the cost for people with higher income; for preferred drugs, states are limited to a $4 charge for all beneficiaries.[3] While states are prohibited from imposing cost-sharing on emergency services, they may charge twice the nominal amount for non-emergency use of the emergency room on beneficiaries under 150% FPL and may impose higher cost-sharing on those over 150% FPL, if certain conditions are met.[4]

The OBBBA maintains existing state flexibility to impose certain levels of cost-sharing, while adding a new provision that *requires* all expansion states (and the District of Columbia) to impose cost-sharing on Medicaid expansion adults with income over 100% FPL.[5] This new cost-sharing requirement goes into effect October 1, 2028 and will only apply to Medicaid expansion populations in states, like California, that have opted to expand the program.[6] Specifically, the provision requires cost-sharing of more than $0 per service for any adult with income between 100 and 133% FPL. The OBBBA also re-affirms state flexibility to allow providers to refuse to provide a service to individuals with income over 100% FPL if the individual cannot pay the cost sharing amount.[7]

The new provision exempts the following key services from the new cost-sharing requirements:

- Primary care services;
- Mental health and substance use disorder services;
- Services provided by a Federally Qualified Health center (FQHC), Rural Health Clinic (RHC), or Community Behavioral Health Clinic (CBHC);
- All other services and applicable groups previously exempted from cost-sharing (see footnote 1 for a complete list of exempted services).[8]

The OBBBA also places certain limitations on the new cost-sharing requirements. First, state cost-sharing amounts for any service imposed under the new provision cannot exceed $35. Second, cost-sharing imposed on prescription drugs may not exceed the current limits for those services.[9] Lastly, as is currently the case for optional cost-sharing, the OBBBA specifies that aggregate cost-sharing under the new provision shall be capped at 5% of a household's family income calculated on a monthly or quarterly basis.[10]

The new cost-sharing requirement will potentially have a significant impact on access to services in the Medi-Cal program. Since 2022, California has elected not to impose cost-sharing on benefits and services, in an effort to remove barriers to medically necessary care.[11] Under the OBBBA, however, the State will be required to impose a minimum level of cost-sharing on some covered services. It is unclear what amount of cost-sharing California will impose, as the law simply requires an amount between $0 and $35; depending on how these provisions are implemented by the federal and state governments, Medi-Cal beneficiaries may be subject to substantially higher out-of-pocket costs for services they need, which will likely increase rates of delayed and foregone care.[12]

The final California budget also introduced a key change to cost-sharing in Medi-Cal. During the COVID-19 pandemic, California enacted legislation prohibiting Medi-Cal managed care plans (MCP) from imposing cost-sharing and other utilization barriers on COVID-19 diagnostic and screening testing services. Now that the federal public health emergency declaration has ended, California has opted to permit Medi-Cal MCPs to impose cost-sharing on these testing services in an effort to cut costs in the Medi-Cal program.[13] It remains to be seen how the Department of Health Care Services (DHCS) will implement these new MCP flexibility and whether the department will impose specific limitations on the cost-sharing amounts associated with COVID-19 testing and screening services.

ENDNOTES

[1] States are prohibited from using their cost-sharing flexibility to impose premiums and cost-sharing on: mandatory eligible children under 18 (except for infants under age 1 with incomes above 133% FPL); children in federally funded foster care; children with disabilities (except those eligible under the Family Opportunity Act with incomes above 150% FPL); persons in institutions who have only a personal needs allowance; women eligible through the Breast and Cervical Cancer Treatment Program; individuals in hospice care; and individuals who have ever been served through the Indian Health Services programs. Similarly, states cannot impose cost-sharing on the following services: services furnished to "pregnant women"; emergency services; provider-preventable services; family planning services and supplies; and preventive services for children under 18 and adults who receive Alternative Benefits Plans. 42 U.S.C. § 1396o-1(b)(3)(B); 42 USC 1396u-7(b)(5); 42 C.F.R. § 440.347(a)(9); 45 C.F.R. § 156.115(a)(4). NHeLP strives to use gender inclusive language to reflect the scope of people with various health needs and reproductive experiences. We employ "women" in limited instances when referencing statutory or regulatory terms or the scope of cisgender women-centered research. More inclusive legal terms and research are needed.

[2] 42 U.S.C. § 1396o(a)(3). *See also id.* § 1396o-1(a)(2); 42 C.F.R. § 447.52(b)(1) (setting nominal amount at $4 for outpatient services and $75 for inpatient stay in 2013). The Secretary of HHS is to increase allowable nominal cost sharing each year by the percentage increase in the medical care component of the consumer price index. *See* 42 U.S.C. § 1396o(h) (added by DRA § 6041(b))*;* 42 C.F.R. §§ 447.52(b)(1), 447.53(b), 447.54(b) (each providing for annual increases in maximum allowable amount, beginning October 1, 2015).

[3] 42 U.S.C. § 1396o-1(c).

[4] 42 U.S.C. §§ 1396o(a), 1396o-1(e); 42 C.F.R. § 447.54(b).

[5] An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14, Pub. L. No. 119-21, § 71120 (2025) ["OBBBA"]. OBBBA will not apply these requirements to individuals who fall within the expansion population, but are enrolled in a waiver that doesn't cover the entire expansion population. *See id.* (to be codified at 42 U.S.C. §§ 1396o(k)(3)(B)).

[6] OBBBA, § 71120(a)(2) (amending 42 U.S.C. § 1396o) (to be codified at 42 U.S.C. §§ 1396o(k)(2)(A) and 1396o(k)(3)).

d[7] *Id.* § 71120(a)(2) (amending 42 U.S.C. § 1396o) (to be codified at 42 U.S.C. § 1396o(k)(2)(C)).

[8] *Id.* (to be codified at 42 U.S.C. § 1396o(k)(2)(B)(i)).

[9] *Id.* (to be codified at 42 U.S.C. § 1396o(k)(2)(B)(ii)(I)).

[10] *Id.* (to be codified at 42 U.S.C. § 1396o(k)(2)(B)(iii)).

[11] *See* Dep't of Health Care Servs., Medi-Cal Eligibility & Covered California – FAQs, **https://www.dhcs.ca.gov/services/medi-cal/eligibility/Pages/Medi-CalFAQs2014a.aspx** (last visited August 5, 2025).

[12] Under the OBBBA, states will also have the option to permit providers to deny services to individuals who cannot afford to pay for the new cost-sharing requirements. This process, known as enforceable cost-sharing represents yet another barrier to care that many other states will be eager to adopt. OBBBA, § 71120(a)(2) (amending 42 U.S.C. § 1396o).
[13] Welf. & Inst. Code § 14132.994. The final California budget will also require the imposition of $30 monthly premiums to be charged to certain immigrants aged 19 to 59 enrolled in California's state-funded Medi-Cal program starting in 2027. *Id.* § 14007.5(e).