OBBBA and Its Impact on Health Care: Access to Care: Cost-Sharing, Premiums, and Retroactive Eligibility

Héctor Hernández-Delgado, Director, Services Practice Area
Abbi Coursolle, Senior Attorney

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- Webinar is being recorded
- Slides were sent out in advance to those registered
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- Webinar is being closed captioned

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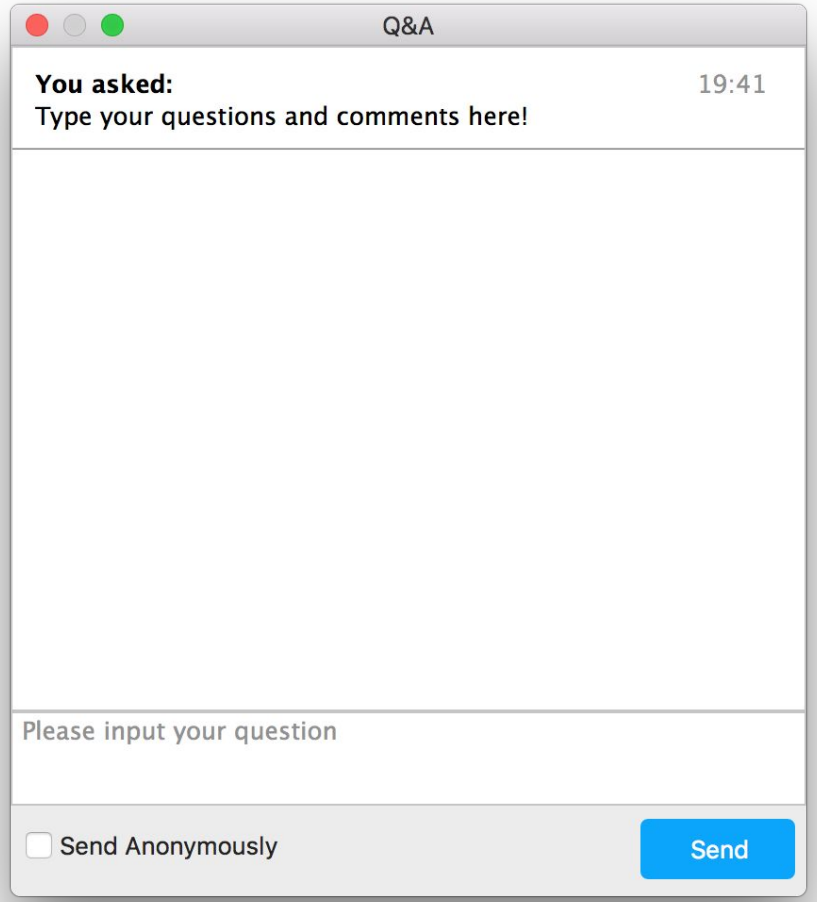

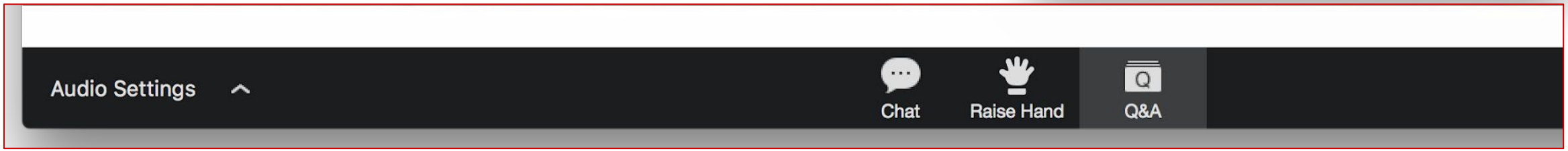

Medicaid Cost-Sharing and Premium Policy (Pre-OBBBA)

Questionable Effectiveness of Cost-Sharing and Premiums

- Cost-sharing = copayments, coinsurance, deductibles
- Studies indicate that cost-sharing and premiums imposed on low-income individuals:
  - Reduce enrollment in Medicaid
  - Reduce overall use and adherence of services and health expenditures (both essential and non-essential)
  - Generally lead to worse health outcomes in key areas, particularly for individuals with disabilities, chronic conditions, and behavioral health conditions
  - Cause financial hardship
  - Shifts costs from federal and state governments to providers and beneficiaries
  - Does not equate to higher efficiency in health care (higher costs down the road)

Pre-OBBBA Medicaid Premium and Cost-Sharing Provisions

- Premiums are generally prohibited for beneficiaries under 150% FPL
- States may only impose cost-sharing on certain categories of beneficiaries and on certain services
- Cost-sharing amounts must be nominal for beneficiaries at or below 100% FPL
- Providers are prohibited from refusing services to beneficiaries at or below 100% FPL based on inability to pay cost-sharing up-front
- Aggregate = 5% of household income (monthly or quarterly)

Pre-OBBBA Medicaid Premium and Cost-Sharing Provisions

Beneficiaries exempt from premiums and cost-sharing (except for non-preferred Rx and non-emergency use of ED):

- Mandatory eligible children under 19
- Children in foster care
- Children with disabilities
- Persons in institutions who have only a personal needs allowance
- At state option, person receiving HCBS subject to share of cost
- Women eligible through the Breast and Cervical Cancer Treatment Program
- Individuals in hospice care
- Individuals who have received services through Indian Health Services (IHS) programs

Pre-OBBBA Medicaid Premium and Cost-Sharing Provisions

Services exempt from cost-sharing:

- Services furnished to pregnant women
- Emergency services
- Provider-preventable services
- Family planning services and supplies
- Preventive services (including well-child services and immunizations)

Pre-OBBBA Medicaid Premium and Cost-Sharing Provisions

Maximum Allowable Copayments			
	Below 100% FPL	101%-150% FPL	Over 150% FPL
Outpatient Services	$4	10% of service cost	20% of service cost
Institutional Services	$75 per admission	10% of the total agency cost of stay	20% of the total agency cost of stay
Preferred Drugs	$4	$4	$4
Non-Preferred Drugs	$8	$8	20% agency cost of drug
Non-Emergency Use of ED	$8	$8	No limit

Pre-OBBBA Medicaid Note: Shares of Cost / Spend Down Programs

- States have the option to allow certain higher income populations qualify for Medicaid by spending down / incurring medical expenses that are sufficient to bring their incomes to a level at or below the state-set medically needy income level. *See* 42 C.F.R. § 435.811(a).
  - Currently, 35 states and D.C. have such programs.

Medicaid Cost-Sharing and Premium Policy (Post-OBBBA)

How did OBBBA change cost-sharing and premium policy?

- OBBBA does not repeal previous cost-sharing or premium provisions. States continue to be allowed to impose limited cost-sharing and premiums based on the previous rule
- But, OBBBA eliminates option to charge premiums for expansion adults

"Beginning October 1, 2028, the State plan shall provide that in the case of a specified individual (as defined in paragraph (3)) who is eligible under the plan, no enrollment fee, premium, or similar charge will be imposed under the plan."

How did OBBBA change cost-sharing and premium policy?

- Added policy re: cost-sharing:
  - States now required to impose cost-sharing to expansion populations between 100% FPL and 133% FPL
  - Cost-sharing must be more than $0 but less than $35 for many services (except Rx – old limits apply)
  - Effective date = October 1, 2028
- OBBBA also reinforces state flexibility to allow providers to refuse services to expansion populations based on inability to pay for cost-sharing up front
- Aggregate limit of 5% household income continues to apply

Services exempted from new cost-sharing requirement

- 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

Remaining Questions and Advocacy Opportunities

- How narrow will the new cost-sharing requirement be interpreted? Will states be required to apply cost-sharing to all non-exempt services?
- How much flexibility will states be afforded to determine applicable services and cost-sharing amounts?
- How will new requirement interact with previous policy (still law) limiting cost-sharing to nominal amounts?
- Are there opportunities to make exempt services and populations broader?

Changes to Medicaid Retroactive Eligibility

Reduction in Retroactive Medicaid Eligibility Period

- Effective January 1, 2027

- Previously entitled to three months of "retroactive Medicaid eligibility" (RME) prior to application if otherwise eligible
  - Medicaid Expansion population: reduced to one month
  - All other categories: reduced to two months

Reduction in Retroactive Medicaid Eligibility Period

- Impact
  - Particularly important in states that have not expanded Medicaid; sudden significant medical needs trigger ABD Medicaid application
  - Loss of coverage = possibility for incurring substantial medical debt
  - Increased uncompensated care costs for hospitals and other safety net providers

- "Mass change" exception applies
  - No right to hearing to challenge denial of 3 months of coverage
  - Should be allowed to appeal if evaluated under wrong eligibility category

- *However*, with the loss of this eligibility period, more important than ever to appeal an erroneous termination and preserve the right to reinstatement from the initial application or termination

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Héctor Hernández-Delgado
Director, Services Practice Area
hernandez-delgado@healthlaw.org

Abbi Coursolle
Senior Attorney
coursolle@healthlaw.org