FAQs: OBBBA Changes to Medicaid Cost-Sharing

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Last summer, the President signed the "One Big Beautiful Bill Act" (OBBBA) into law.[1] Section 71120 of OBBBA amended the provisions of the Medicaid Act governing premiums and cost-sharing.[2] This FAQ summarizes what advocates need to know about the changes.

When Do the Cost-Sharing Changes Go into Effect?

The changes go into effect on October 1, 2028.[3]

Do the Changes Apply to All Beneficiaries?

No. The cost-sharing changes apply to individuals who have household income above 100% of the federal poverty level (FPL) and are enrolled under the adult expansion population.[4] OBBBA uses the term "specified individuals" to refer to individuals affected by the changes. This FAQ does the same.

The OBBBA Cost-Sharing Changes Affect "Specified Individuals."

Specified individuals are enrolled under the adult expansion population and have household income above 100% of FPL.

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[1] *See* An Act to provide for reconciliation pursuant to title II of H. Con. Res. 14 (OBBBA), Pub. L. No. 119-21, 139 Stat. 72 (2025).
[2] *See id.* § 71120, 139 Stat. at 315 (codified at 42 U.S.C. §§ 1396o(a), (k), 1396o-1(a)(1), 1396a(a)(14)).
[3] 42 U.S.C. § 1396o(k)(2).
[4] *Id.* § 1396o(k)(2), (3). The changes also apply to individuals who have household income above 100% of FPL, fall within the adult expansion population, and are enrolled under a section 1115 waiver that provides minimum essential coverage to the entire expansion population. *Id.* Thus, all specified individuals have income between 100% and 133% of FPL (138% with the standard 5% disregard). *See id.* § 1396a(a)(10)(A)(i)(VII), 1396a(e)(14)(I)(i).

What Is the Law in Effect Prior to October 1, 2028?

States are currently permitted to impose cost-sharing (*i.e.*, a deduction, copay, or similar charge) on specified individuals, subject to certain limits.

For services generally, states cannot charge specified individuals more than 10% of the cost of the item or service.[5] Moreover, some individuals and services are exempt from cost-sharing. The exemptions that are potentially relevant to specified individuals include:

- Services provided to pregnant individuals that are related to the pregnancy or any medical condition that could complicate the pregnancy, and counseling, pharmacotherapy, and covered outpatient drugs for cessation of tobacco use by pregnant individuals;[6]
- emergency services;[7]
- family planning services and supplies;[8]
- services provided to individuals receiving hospice care;[9]
- American Indians who are receiving or have ever received items or services from an Indian health care provider or through referral under contract health services;[10] and
- FDA-approved vaccines for adults recommended by the Advisory Committee on Immunization Practices and their administration.[11]

The limits differ for non-emergency use of the emergency room and outpatient prescription drugs. For non-emergency use of the emergency room, states can currently charge specified individuals twice the "nominal" amount (*i.e.*, up to $8.00 (2x$4.00 nominal amount) per

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[5] *Id.* § 1396o-1(a)(1), (b)(1)(B)(i); *see* 42 C.F.R. § 447.52(b)(1).
[6] 42 U.S.C. §§ 1396o-1(b)(3)(B)(iii), 1396o(a)(2)(B); 42 C.F.R. § 447.56(a)(2)(iv).
[7] 42 U.S.C. §§ 1396o-1(b)(3)(B)(vi), 1396o(a)(2)(D); 42 C.F.R. § 447.56(a)(2)(i).
[8] 42 U.S.C. §§ 1396o-1(b)(3)(B)(vii), 1396o(a)(2)(D); 42 C.F.R. § 447.56(a)(2)(ii).
[9] 42 U.S.C. §§ 1396o-1(b)(3)(B)(iv), 1396o(a)(2)(E); 42 C.F.R. § 447.56(a)(1)(ix).
[10] 42 U.S.C. §§1396o(j), 1396o-1(a)(1), (b)(3)(B)(x); 42 C.F.R. § 447.56(a)(1)(x).
[11] 42 U.S.C. §§ 1396o-1(b)(3)(B)(xiv), 1396o(a)(2)(J). In addition, federal regulations prohibit states from imposing cost-sharing for provider-preventable conditions. 42 C.F.R. § 447.56(a)(2)(v).

federal regulations) if certain conditions are met.[12] But, states cannot charge individuals who are otherwise exempt from cost-sharing (as described above) more than the nominal amount.[13]

For outpatient prescription drugs, states are free to identify "preferred" (*i.e.*, more cost-effective) and "non-preferred" drugs and impose different cost-sharing based on that designation.[14] For non-preferred drugs, states cannot charge specified individuals more than a nominal amount, which federal regulations set at $8.[15] However, states must have an exemption process for people who have a specific need for a non-preferred drug.[16] For example, a state could designate certain antidepressents as non-preferred and charge $8 for them; the state could designate other antidepressants as preferred and charge $4 for them. If a provider decides that a particular patient has a medical need for a non-preferred drug, then the state cannot charge that individual more than $4 for that drug. Further, states cannot impose cost-sharing on preferred drugs for individuals who are otherwise exempt from cost-sharing (as described above).[17]

[12] 42 U.S.C. § 1396o-1(e)(1), (2)(A); *see* 42 C.F.R. § 447.54(b) (setting the maximum amount at $8 for non-emergency use of the emergency room in 2013). The Secretary is to increase the amount each year by the percentage increase in the medical care component of the consumer price index. 42 U.S.C. § 1396o(h); 42 C.F.R. § 447.54(b) (indicating the increase begins October 1, 2015). CMS has never provided notice of an increase.
[13] 42 U.S.C. § 1396o-1(e)(1), (2)(B).
[14] *Id.* § 1396o-1(c)(1); 42 C.F.R. § 447.53.
[15] 42 U.S.C. § 1396o-1(c)(2)(A); 42 C.F.R. § 447.53(b) (setting the maximum amount at $8 for non-preferred drugs and $4 for preferred drugs in 2013). Thus, CMS appears to have established a different "nominal" amount for prescription drugs. The Secretary is to increase the amount each year by the percentage increase in the medical care component of the consumer price index. 42 U.S.C. § 1396o(h); 42 C.F.R. § 447.53(b) (indicating the increase begins October 1, 2015). CMS has never provided notice of an increase.
[16] *See* 42 U.S.C. § 1396o-1(c)(3); 42 C.F.R. § 447.53(e).
[17] 42 U.S.C. § 1396o-1(c)(1)(b); 42 C.F.R. § 447.53(a), (d).

Current Cost-Sharing Limits for Specified Individuals (States choose the actual amount for each service, if any, up to these limits.)	
Service	**Amount**
General	10% of service cost
Outpatient prescription drug	Preferred – up to $4 Non-preferred – up to $8
Non-emergency use of ED	Up to $8
Maximum total cost-sharing	No more than 5% of quarterly or monthly household income

The Medicaid Act sets a strict limit on total out-of-pocket costs for families. Specifically, total cost-sharing and any premiums for the whole household cannot exceed 5% of quarterly or monthly (as specified by the state) family income.[18] For a single adult at 138% of FPL ($22,025 in 2026), a quarterly cap would be $275. States must have a process in place to track household cost-sharing that does not rely on individuals knowing when they have met the aggregate cap.[19]

States can allow providers to deny services to specified individuals who do not pay the required cost-sharing up front, so long as the individuals are not in a group that is exempt from cost-sharing.[20] Even if a state elects that option, providers are free to reduce or waive cost-sharing on a case-by-case basis.[21]

What Exactly Are the Changes Effective October 1,2028?

OBBBA directs states to impose **some** cost-sharing on specified individuals. Under a plain reading of the statute, each state determines: 1) the care, items, or services subject to cost-sharing; and 2) the amount of the cost-sharing up to $35.[22]

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[18] 42 U.S.C. § 1396o-1(b)(1)(B)(ii); 42 C.F.R. § 447.56(f).
[19] 42 C.F.R. § 447.56(f)(2).
[20] 42 U.S.C. § 1396o-1(d)(2); 42 C.F.R. § 447.52(e)(1).
[21] 42 U.S.C. § 1396o-1(d)(2); 42 C.F.R. § 447.52(e)(3).
[22] 42 U.S.C. § 1396o(k)(2)(A), (B)(ii)(I).

There are exceptions. For outpatient prescription drugs, states cannot exceed the existing limit of a nominal amount ($8) for non-preferred drugs.[23] States cannot impose any cost-sharing on individuals or services that are currently exempt from cost-sharing (as described above).[24] In addition, states cannot impose any cost-sharing on the following services when they are provided to specified individuals:

- primary care services;
- mental health care services;
- substance use disorder services; or
- services provided by a federally qualified health center (FQHC), certified community behavioral health clinic, or rural health clinic.[25]

The 5% aggregate cap on household cost-sharing will continue to apply.[26] States can continue to permit providers to deny care, items, or services to specified individuals who do not pay the required cost-sharing. Again, even in states that do allow this, providers remain free to reduce or waive cost-sharing on a case-by-case basis.[27]

Did OBBBA Affect Premiums?

No. Prior to OBBBA, the Medicaid Act prohibited states from imposing premiums (*i.e.*, any enrollment fee or similar charge) on individuals enrolled in the adult expansion population.[28] OBBBA made the prohibition even more explicit for specified individuals. The law requires state plans to provide that "no enrollment fee, premium, or similar charge will be imposed" on specified individuals.[29]

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[23] *Id.* § 1396o(k)(2)(B)(ii)(II).
[24] *Id.* § 1396o(k)(2)(A), (B)(i). This prohibition appears to mean that states will no longer be able to charge specified individuals who are otherwise exempt from cost-sharing for non-preferred prescription drugs or non-emergency use of the emergency room.
[25] *Id.* § 1396o(k)(2)(B)(i).
[26] *Id.* § 1396o(k)(2)(B)(iii).
[27] *Id.* § 1396o(k)(2)(C).
[28] *See id.* §§ 1396o(a)(1), 1396o-1(b)(1)(A); 42 C.F.R. § 447.55(a).
[29] *See* OBBBA § 71120(a)(2) (codified at 42 U.S.C. § 1396o(k)(1)).

What Can Advocates Do to Protect Specified Individuals from Heightened Cost-Sharing?

As a result of OBBBA, states are going to be facing significant reductions in federal Medicaid funding. State agencies or legislatures may try to increase cost-sharing as a way to decrease Medicaid spending. This would be short-sighted. Advocates can raise the following points to push back on such proposals:

- A large body of research consistently demonstrates that cost-sharing reduces access to necessary services for low-income individuals and has a negative effect on health outcomes, causing higher rates of hospitalization and emergency care.[30]
- Likewise, research shows that imposing cost-sharing for non-emergency use of the emergency room does not reduce emergency room use among Medicaid beneficiaires.[31] Cost-sharing does nothing to address the root causes of non-emergency visits to the emergency room, such as unmet health needs and lack of access to primary care settings.[32]

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[30] *See, e.g.*, Madeline Guth et al., KFF, *Understanding the Impact of Medicaid Premiums & Cost-Sharing: Updated Evidence from the Literature and Section 1115 Waivers* (2021), https://www.kff.org/medicaid/issue-brief/understanding-the-impact-of-medicaid-premiums-cost-sharing-updated-evidence-from-the-literature-and-section-1115-waivers/; Samantha Artiga et al., KFF, *The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings* (2017), https://www.kff.org/medicaid/issue-brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/; David Machledt & Jane Perkins, Nat'l Health Law Program, *Medicaid Premiums and Cost Sharing* (2014), https://healthlaw.org/resource/medicaid-premiums-and-cost-sharing/.

[31] *See, e.g.*, Mona Siddiqui et al., *The Effect of Emergency Department Copayments for Medicaid Beneficiaries Following the Deficit Reduction Act of 2005*, 175 JAMA INTERNAL MED. 393 (2015), https://jamanetwork.com/journals/jamainternalmedicine/fullarticle/2091743; Karoline Mortenson, *Copayments Did Not Reduce Medicaid Enrollees' Nonemergency Use of Emergency Departments,* 29 HEALTH AFFS. 1643 (2010), https://www.healthaffairs.org/doi/10.1377/hlthaff.2009.0906; David J. Becker et al., *Co-payments and Use of Emergency Department Services in the Children's Health Insurance Program,* 70 MED. CARE RSCH. REV. 514 (2013), https://pubmed.ncbi.nlm.nih.gov/23771877/.

[32] *See, e.g.*, CMS, CMCS Informational Bulletin, *Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings* (Jan. 16, 2014),

- The available evidence does not support the idea that heightened Medicaid cost-sharing leads to state savings.[33] In any case, the vast majority of any reductions in utilization and expenditures for Medicaid expansion adults would go back to the federal government, while the problems higher cost-sharing causes – medical defaults, worse population health, and higher administrative costs to track cost-sharing – will largely stay with the state. Indeed, states should consider the additional administrative burden and expense associated with imposing different cost-sharing on specified individuals.
- States have considerable flexibility to determine how to meet the OBBBA cost-sharing requirement. For example:
    - If a state is currently charging specified individuals a nominal amount for non-preferred outpatient prescription drugs, the state has already met the new OBBBA requirement.
    - A state can charge specified individuals $.01 for a single service that is not otherwise exempt from cost-sharing.

Further, it is possible that advocates will need to explain to state officials that the OBBBA changes require some reductions in cost-sharing. If a state is currently requiring specified individuals to pay 10% of the cost of the service, the $35 cap under OBBBA will result in lower cost-sharing for more expensive services. For example, prior to October 1, 2028, a state could charge a beneficiary $50 for a $500 MRI or CT scan. Once the OBBBA requirement goes into effect, states will only be able to charge a maximum of $35 for that same service. In addition, some services that are not currently exempt from cost-sharing (*e.g.*, primary care and behavioral health services) will be exempt.

Please contact NHeLP if you would like to consult with us as your state considers implementation of OBBBA section 71120.

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https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/downloads/CIB-01-16-14.pdf; David Machledt, Nat'l Health Law Program, *Reducing Medicaid Emergency Department Use: Increase Accessibility, Not Copays* (2014), https://healthlaw.org/resource/reducing-medicaid-emergency-department-use-increase-accessibility-not-copays/.

[33] *See, e.g.*, Samantha Artiga et al., *supra* note 30.