

New Expenses for Adults on Medicaid: Cost Sharing Requirements Under H.R. 1

H.R. 1 Implementation Explainer: October 2026

The 2025 budget reconciliation law (H.R. 1) imposes major new restrictions that will make it significantly more difficult for eligible adults to enroll in the Affordable Care Act's (ACA's) Medicaid expansion and, once enrolled, to access the health services they need. One new requirement is for states to impose mandatory cost sharing for ACA Medicaid expansion adults, obligating enrollees to pay copays and other out-of-pocket expenses in order to receive health care services; this change is estimated to cause a \$7.4 billion cut to Medicaid beneficiary care over 10 years. Below is a detailed explanation of Medicaid cost sharing and the implications of H.R. 1's cost sharing mandate on consumers, health care providers and state Medicaid programs. A companion explainer examines new eligibility hurdles for adults in the ACA expansion, including strict work mandates and more frequent eligibility checks.

Mandatory Medicaid cost sharing requirements under H.R. 1: Reduced access to care, worse health outcomes and increased financial burden for low-income populations.

Cost sharing is a tool used by health plans to shift some of the cost of care onto consumers, intended to encourage prudent use of health care services. Previous federal rules gave states the option to impose cost sharing on certain Medicaid populations,¹ but H.R. 1 marks the first time the federal government has required states to impose cost sharing on any Medicaid enrollees: Beginning October 1, 2028, cost sharing up to \$35 is mandatory for adults in the ACA Medicaid expansion (or “expansion-like” programs) with incomes between 100% and 138% federal poverty level (FPL).² Table 1 (page 3) outlines H.R.1's new requirements and exemptions in comparison with current cost sharing rules.

Proponents of cost sharing for Medicaid argue that small Medicaid copayments or fees give beneficiaries a personal stake in avoiding wasteful care. In reality, research consistently shows cost sharing reduces access to care and worsens health outcomes — without cutting overall spending.³ Even “minimal” charges can be a barrier: After core expenses like food, rent and transit, most low-income individuals have almost no flexible cash for unexpected costs,⁴ and 18% of U.S. adults report they could cover less than \$100 in an emergency using their savings;⁵ for these Americans, a copay that looks nominal on paper can be enough to deter necessary care. The Congressional Budget Office (CBO) expects as much:

It projects **H.R. 1's cost sharing requirements will save the federal government \$7.4 billion over 10 years (2025–34).**⁶ These savings would come both by making care harder to obtain and from eligible individuals dropping out of the program as costs make participation prohibitive.

Cost sharing applied to low-income populations leads to:

- **Fewer primary and preventive care services.** High-value preventive care — routine screenings, early interventions and vaccinations — prevent costly chronic conditions and emergency room visits down the road.⁷ Even low levels of cost sharing, such as copays in the \$1–\$5 range, burden low-income individuals enough to delay or forgo preventive care entirely.⁸ One study on cost sharing and vaccine uptake found that each additional dollar of copayment decreased flu vaccination among Medicaid beneficiaries by up to 6 percentage points.⁹
- **Greater use of hospital and high-cost health care services.** As vulnerable patients on strict budgets avoid basic medical care over nominal fees, the need for costlier and more intensive intervention goes up. Cancer screening studies, for example, found that copays led to later-stage diagnoses and worse prognoses.¹⁰ These health declines ultimately drive higher inpatient hospital utilization, while decreasing outpatient use.¹¹ Studies also find that copayments meant to discourage nonemergency visits do not decrease emergency department use.¹²
- **Reduced chronic disease management and worse medication adherence.** Cost burdens may push patients with chronic care needs to skimp on essential services: In one study, copays caused people at high risk for heart attack or stroke to cut back on the statins and blood pressure medications that keep them well.¹³ Conversely, copay elimination led to improved medication adherence and reduced total cost of chronic disease care.¹⁴
- **Medical debt for the family, with poorer health outcomes for children.** When **Montana** instituted a premium for expansion adults (2% of household income), nearly 60% failed to pay and 30% were subject to consequent debt collection.¹⁵ Beneficiaries may struggle to get out of debt: In **Michigan**, 27% of beneficiaries were in “consistent failure to pay” status, subjecting them to wage garnishment.¹⁶ Even though children are typically exempt from cost sharing, the financial squeeze on caretakers forces trade-offs — delayed well-child visits, or cuts to food, housing and utilities — that affect the whole family.¹⁷
- **Medicaid disenrollment when care becomes too expensive.**¹⁸ When **Oregon** imposed Medicaid copays (ranging from \$5 for outpatient visits to \$250 for inpatient admissions) and premiums (between \$6 and \$20 a month), nearly two-thirds of individuals lost their coverage, many as a direct result of cost sharing burdens.¹⁹ In **Michigan**, cost sharing pushed healthier enrollees to drop coverage disproportionately, leaving a sicker and costlier risk pool behind.²⁰

- **Additional state administrative cost, without corresponding savings.** Any reductions in Medicaid costs achieved by dissuading unnecessary care are largely washed out by increased state spending toward worse health outcomes and higher-cost service use. In fact, a large body of evidence finds that cost sharing either yields no difference in total costs or causes costs to *increase*.²¹ And any revenue gain from fee collection comes at an administrative cost as states must track provider-collected fees to ensure no enrollee exceeds their total out-of-pocket limit.²² For example, a former cost sharing program in **Arizona** cost the state an estimated \$16 million (2006 dollars) to administer but pulled in only \$5.6 million in fees (in premiums and copays).²³

Table 1: Cost Sharing for Adult Medicaid Recipients

	Outpatient care	Inpatient hospital	ED use in non-emergencies	Prescription drugs	Premiums
Cost sharing allowed but not required: Up to 20% of the cost of the service					
>150% FPL	Up to 20% of service cost	Up to 20% of cost service	No max amount	Preferred: up to \$4 Non-preferred: up to 20%	Allowed for certain individuals ²⁴
Cost sharing allowed but not required: Up to 10% of the cost of the service					
101–150% FPL	Up to 10% of service cost	Up to \$75/stay	Up to \$8	Preferred: up to \$4 Non-preferred: up to \$8	Prohibited without a waiver
New cost sharing requirement for expansion adults effective October 1, 2028 Cost sharing required: States must charge more than \$0 and up to \$35 per service					
100–138% FPL — ACA Expansion Adults Only	Between \$0.01 and \$35/service	Between \$0.01 and \$35/stay	Between \$0.01 and \$35/service	Preferred: up to \$4 Non-preferred: up to \$8	Prohibited
Cost sharing allowed but not required: Nominal amounts only					
<100% FPL	Up to \$4	Up to \$75/stay	Up to \$8	Preferred: up to \$4 Non-preferred: up to \$8	Prohibited without a waiver

APPLICABLE AT EVERY INCOME LEVEL	EXEMPTIONS
Aggregate cap. Total out-of-pocket-costs (premiums and cost sharing) capped at 5% of monthly or quarterly household income. Provider discretion. Providers must be allowed to reduce or waive cost sharing on a case-by-case basis. States may allow providers to deny services to enrollees for nonpayment (but not for enrollees <100% FPL). State tracking and reduced paperwork. States must track charges without relying on enrollee paperwork; state tracking must ensure that cost sharing obligations stop once the individual/family reaches aggregate cap.	Exempt populations (regardless of income):²⁵ Children under 18 years (or up to 21 years at state discretion), pregnant individuals (for pregnancy-related services), people in institutions with a personal needs allowance, individuals receiving hospice care, American Indians obtaining services through American Indian health programs, and individuals eligible for Medicaid through the breast and cervical cancer early detection program. Exempt services (regardless of income):²⁶ Emergency care, pregnancy-related care, family planning services and supplies, preventive services for children under age 18 years, and provider-preventable services (for example, a health care-acquired condition occurring during a hospital stay). Additional exempt services for ACA expansion adults 100–138% FPL: Primary care, mental health and substance use disorder services; care provided at federally qualified health centers, behavioral health clinics and rural health clinics.

Impact on states and early state responses

While H.R. 1’s new requirements may reduce current cost sharing burdens on Medicaid expansion adults in some states — prohibiting premiums, cutting the maximum hospital-stay fee to \$35 and exempting more services — overall, the law substantially increases cost sharing burdens by imposing a mandatory floor nationwide.

As of January 2026, 19 states have already imposed cost sharing for Medicaid expansion enrollees, but only **North Carolina** and **Pennsylvania** currently set cost sharing that would meet all of H.R. 1’s new requirements (see map); 13 other of these states would have to newly establish cost sharing in certain categories to comply (for example, outpatient care or prescription drugs), while four other such states (AK, MI, UT, WV) must lower current inpatient hospital copays to at or below the \$35 statutory maximum.²⁷ Finally, 21 states and Washington, D.C., do not have any current cost sharing in place and will need to establish cost sharing for the expansion population by October 1, 2028.

H.R. 1 grants states significant leeway in determining new out-of-pocket health care costs for Medicaid expansion enrollees. Ahead of implementation, states may need to:

- **Set cost sharing levels.** H.R. 1 allows for cost sharing anywhere between \$0.01 and \$35 per service. States are not bound by their current levels and can choose to set different cost sharing amounts for Medicaid expansion adults 100%–138% FPL than they do for other Medicaid enrollees. Early state action shows states making a range of choices. For example, **North Carolina** has set copayments at the maximum level (\$35/service),²⁸ while **California** lawmakers introduced a bill capping copayments for expansion adults at \$0.01 for non-emergency services, the lowest amount allowable under H.R. 1.²⁹
- **Define the scope of non-exempt services subject to cost sharing.** H.R. 1 does not require states to impose copays on all non-exempt services, and states have some discretion to define the scope.³⁰
- **Establish any cost sharing variations.** Cost sharing under H.R. 1 does not have to be the same for all services or for all enrollees. States may consider setting targeted or tiered copays (for example, higher copays for low-value services or reduced copays for lower income levels).³¹
- **Structure cost sharing collection.** H.R. 1 does not dictate how states should collect payments from Medicaid enrollees. Historically, some states collect copays at the point of care, while others use individual health accounts to bill enrollees separately.³² **Nebraska** legislators have proposed a different approach: A 2026 bill would have allowed (but did not require) Medicaid managed care organizations (MCOs) to cover out-of-pocket expenses on behalf of their enrollees (Governor Jim Pillen vetoed the measure).³³
- **Decide whether providers may deny services for nonpayment.** States may allow providers to deny services for nonpayment or states may require providers to treat patients no matter their ability to pay at the point of service.
- **Determine how to track aggregate costs.** States must keep track and suspend cost sharing when a household's cost sharing expenditure reaches the 5% monthly or quarterly limit. States can track this internally or they can contractually require Medicaid MCOs or vendors to track member cost sharing.³⁴

Centers for Medicare & Medicaid Services (CMS) has not issued guidance on how states should be approaching these decisions and, given that cost sharing requirements do not come into effect until 2028, many states have yet to begin implementation. Assuming states retain the flexibility offered under H.R. 1 and other federal statutes,

implementation choices will determine to what degree new requirements will affect beneficiaries and providers, along with how costly this new system will be for states to adopt. High copays on common procedures, office visits and diagnostic tests may keep people from necessary care and push more enrollees toward the aggregate household limit, raising the burden on states to track out-of-pocket costs and notify providers and patients when this limit is reached. Lower copays reduce administrative complexity and expand access to care,³⁵ a particular advantage given that cost sharing obligations arrive alongside other H.R. 1 changes that add administrative cost and complexity to Medicaid, including work reporting requirements.

Other implementation choices may mean difficult trade-offs: For example, point-of-service copay collection shifts administrative strain from states to providers but risks making Medicaid participation too costly for providers. Similarly, setting contractual obligations on MCOs to track cost sharing eases state burden but may drive up MCO capitation rates.

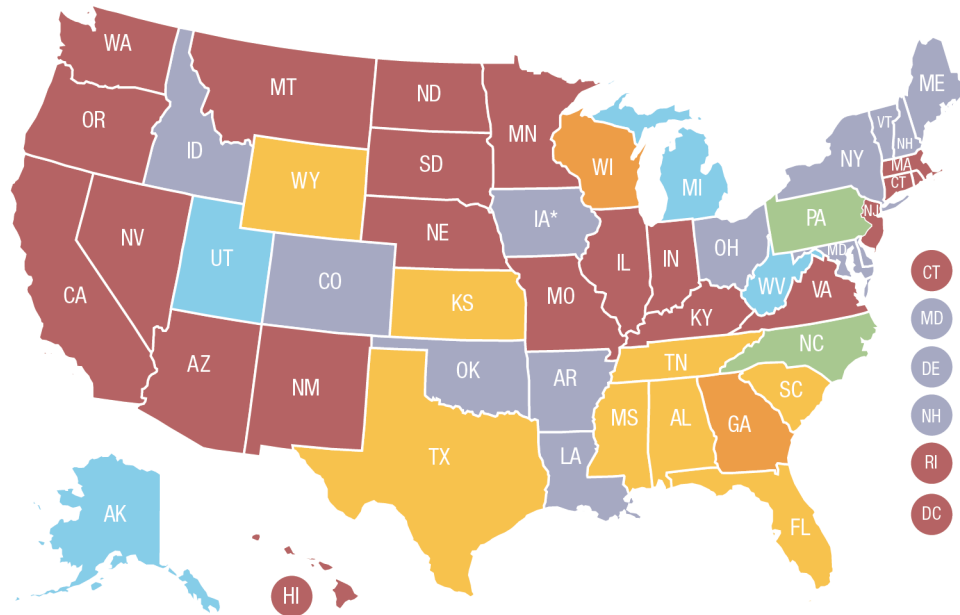
Continued cost sharing for other Medicaid-eligible adults

Aside from Medicaid expansion adults in the 100%–138% FPL band, H.R. 1 leaves cost sharing unchanged for all other Medicaid-enrolled adults:

- States may continue to impose existing cost sharing on Medicaid expansion adults below 100% FPL or on adults at any income level that enter Medicaid through a different pathway — for example, parents/caretaker relatives with dependent children who qualify for Medicaid under Section 1931 and live in one of the 19 states that charges cost sharing for this eligibility group.³⁶
- H.R. 1’s cost sharing rules reach adults with “expansion-like” coverage in non-expansion states offering minimum essential coverage through a waiver — but only for the 100–138% FPL band. Since **Georgia’s** and **Wisconsin’s** expansion-like coverage is capped at 100% FPL, neither state is subject to these changes and current cost sharing rules in these states remain in place.

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State Cost Sharing Landscape Post-H.R. 1



- State cost sharing rules already comply with H.R. 1 [2 states]
- State must lower hospital copays to comply with H.R. 1 [4 states]
- State has cost sharing in place, but must establish in one or more categories to comply with H.R. 1 [13 states]
- State must establish cost sharing for the expansion population, 100–138% FPL (21 states and Washington, D.C.)
- State offers expansion-like coverage, but not to enrollees 100–138% FPL (2 states)
- State has no expansion or expansion-like coverage in place [8 states]

**State may have to cease premiums currently imposed by waiver authority*

Source: Families USA analysis of KFF data. See Anna Mudumala and Jennifer Tolbert, "Understanding Medicaid Cost Sharing and Policy Changes from the 2025 Reconciliation Law," KFF, May 21, 2026, <https://www.kff.org/medicaid/understanding-medicaid-cost-sharing-and-policy-changes-from-the-2025-reconciliation-law/>.

State efforts to go beyond H.R. 1.

Beyond the choices H.R. 1 leaves to states, some states are moving to impose cost sharing sooner than the law requires or are seeking to set premiums otherwise prohibited under the law, compounding the harm of cost sharing for their residents.

- **Pushing for earlier adoption.** Kentucky passed a bill that will require implementation of cost sharing requirements no later than January 1, 2027, more than a year earlier than required by H.R. 1.³⁷ In a proposed structural realignment of their Medicaid expansion program, Indiana has stated it wants to adopt Medicaid copayments “as soon as practicable.”³⁸

- **Seeking to use section 1115 waivers to expand premiums beyond the statute.** **Montana** has proposed monthly premiums of 2%–4% of gross income for all expansion enrollees, with disenrollment for nonpayment,³⁹ and **New Hampshire** is seeking CMS approval to charge expansion enrollees above 100% FPL \$60–\$100/month, by household size.⁴⁰ Because H.R. 1 explicitly prohibits premiums for expansion adults, CMS likely lacks authority to approve either request.⁴¹ However, CMS has not denied these waivers nor moved against **Iowa's** existing waiver, the only active state premium program (\$5–\$10/month for beneficiaries below 150% FPL).⁴² Outside of premiums, states are less likely to pursue waivers to increase cost sharing beyond federal maximums — for example, to force H.R. 1's higher copays on other Medicaid beneficiaries — because these types of waivers require states to follow strict, narrow approval criteria under a different waiver authority (§ 1916[f]);⁴³ these prerequisites have generally dissuaded states from pursuing such waivers and no state has a current waiver to go beyond federal cost sharing maximums.⁴⁴

Impact on Medicaid enrollees

Asking Medicaid enrollees to shoulder more of the cost of care will make it harder for people to obtain services. A 2025 KFF analysis estimates the average expansion enrollee uses 15.5 services a year, which are potentially subject to H.R. 1 cost sharing and could owe up to \$542 annually if their state charges the maximum for all non-exempt services.⁴⁵ About 31% of expansion enrollees, however, would see no new out-of-pocket costs, because either they do not utilize any services in a typical year or they only utilize exempt services (for example, primary care or family planning).⁴⁶ That split underscores a larger point: Cost sharing does not affect all beneficiaries equally. Because it is essentially a tax on health care consumption, those in poorer health and who use the most care, bear the greatest burden.

Certain populations will be particularly vulnerable to H.R. 1's cost sharing:

- **Adults 50–64** make up just 23% of Medicaid enrollees but, because of greater health needs and service utilization, comprise 42% of Medicaid spending.⁴⁷ KFF estimates the average older adult would have to spend \$736 per year if their state sets cost sharing at H.R. 1's maximum; for single enrollees at 100% FPL, this would be nearly 5% of their income.⁴⁸
- **People with chronic conditions** comprise three-quarters of adults on Medicaid and account for 69% of all spending on adult enrollees.⁴⁹ Higher spending reflects increased health care needs, which result in more health care visits, greater use of acute care and an increased likelihood of using long-term care. Individuals with three or more chronic conditions could pay up to \$1,248 per year (based on max cost sharing implementation), more than twice the average estimated costs for expansion enrollees.⁵⁰

- **People with disabilities** are more likely to be on Medicaid than other insurance types, and more than one in five Medicaid enrollees has a disability.⁵¹ People with disabilities often need more frequent care. For example, adults with severe functional disabilities average 17.5 outpatient visits a year versus just 8.6 for those without disabilities.⁵²
- **People with long-term care needs** have intensive home-based care or institutional care needs as well as higher rates of emergency department use and hospitalizations but they have lower rates of primary and preventive care (services that would, under H.R. 1, come cost-free).⁵³ KFF estimates that nearly 400,000 Medicaid enrollees who need long-term care services will be subject to cost sharing requirements established by H.R. 1.⁵⁴
- **Medically frail individuals seeking an exemption from work reporting (“community engagement”) requirements** may require frequent, extensive medical documentation to support or sustain their exemption. See this discussion in our companion explainer, [New Barriers to Medicaid Eligibility and Enrollment: Work Reporting Requirements and More Frequent Eligibility Redeterminations Under H.R. 1](#). Added cost sharing barriers due to H.R. 1 could delay or derail the very appointments needed to document medical frailty, jeopardizing access to Medicaid for the populations most in need of health coverage.

Impact on providers and patient care.

Even under H.R. 1’s cost sharing mandate, providers continue to use discretion to waive or reduce cost sharing for their patients. Copays collected at the point of care rely on provider enforcement — yet there is little evidence on whether providers actually collect copays, and none on whether they deny care over nonpayment.⁵⁵ Since nominal cost sharing is often small relative to a service’s total cost, providers may find it more sensible, financially and clinically, to simply waive costs rather than to turn a patient away.

That said, state officials may have concerns about federal scrutiny around H.R. 1 implementation and may set additional enforcement requirements or documentation mandates to protect against potential compliance flags (such as requiring strict copay collection at the point of service or explicitly requiring that providers deny treatment for nonpayment). This kind of overly rigorous oversight could prevent providers from exercising their right to waive nominal cost sharing when their patients experience financial difficulties. In addition, given enhanced scrutiny on certain health care practices, some providers may be worried about their offices showing a pattern of waiving patient cost sharing responsibilities.⁵⁶ These dynamics may nudge the health care system toward more stringent fee-collection policies — placing greater cost onus on low-income patients and leading to greater administrative burden at provider offices.

Asking providers to jump through additional administrative hoops to support Medicaid cost sharing creates opportunity for:

- **Discriminatory practices**, where health systems or practitioners limit access to patients who cannot pay for their care.⁵⁷
- **Shifts in service delivery** that minimize obligations to collect patient copays but reduce access to needed services (for example, scheduling more zero-cost encounters).⁵⁸
- **Improper fee collection**, where providers charge copays that are not owed (for example, if the patient has reached their quarterly maximum or is exempt based on Medicaid enrollment status).

In addition, Medicaid providers are often already stretched thin with low reimbursement⁵⁹ and multiple administrative hurdles to Medicaid participation.⁶⁰ The additional time burdens on providers and their staff to collect copays — along with new paperwork requests to help patients prove their health status and exemption eligibility from Medicaid work requirements — may push providers to stop serving Medicaid patients altogether.

Next steps for advocates:

- **Ensure states implement the minimum cost sharing permitted under federal law**, especially for non-exempt services that support high-value care. H.R. 1 exempts preventive services from cost sharing for expansion enrollees — but the doctor visit that precedes many of them (for example, a pre-colonoscopy consult⁶¹) may still carry a copay. It is important for policymakers to recognize these distinctions. Advocates can highlight the need to keep cost sharing low to support health and to lower downstream costs.
- **Monitor state implementation and request cost and evaluation data.** Advocates will play an essential role in ensuring states properly exclude all exempt populations and services and properly track cost sharing without requiring enrollee paperwork. Advocates should also ask states to publicly report how many people lose or leave coverage because of cost sharing and to report the administrative costs to the state for tracking each enrollee's aggregate limit. Finally, advocates should ask their states to compare utilization rates for specific high-value services — cancer screenings, chronic disease medication fills, primary care visits — before and after implementation.
- **Educate Medicaid enrollees on cost sharing obligations.** H.R. 1 does not require states to conduct any consumer outreach on this issue, but education is critical as new cost sharing rules do not apply evenly to all services, settings and beneficiaries, and they may change with income fluctuations depending on state implementation.

Past cost sharing programs highlight the challenges of keeping consumers informed: A survey in Iowa found that fewer than 40% of impacted enrollees were aware of cost sharing obligations.⁶²

- **Document the impact of cost sharing on access to care.** Advocates will play an essential role in documenting the experience of Medicaid enrollees in accessing care after cost sharing changes come into effect. Advocates can highlight stories for policymakers and the media on how cost sharing has affected access to care, including for patients needing to document medical frailty under Medicaid work requirements.
- **Ensure states reduce hurdles to Medicaid provider participation.** Cost sharing mandates will add new administrative burden for providers and their staff. Recognizing this, states should ensure providers maintain the right to waive or reduce cost sharing for their patients. In addition, advocates can remind states of how they can reduce other hurdles that make it difficult for providers to participate in Medicaid, including state paperwork burdens and restrictive managed care policies.⁶³
- **Protect low-income residents from medical debt.** Cost sharing puts low-income consumers at greater risk of medical debt. Advocates can encourage their states to enact protections to safeguard against medical debt for health care consumers, such as barring wage garnishment for medical debt (New York bans it outright; California does so for certain low-income patients) and prohibiting medical debt from appearing on credit reports (14 states have done so).⁶⁴

Endnotes

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⁴² All Iowa Health and Wellness Plan (IHAWP) members can receive free health care if they choose to take specific steps to protect their health and complete what are known as “healthy behaviors.” During the first year of coverage, there are no monthly premiums (termed “contributions”) for any IHAWP members. After that, some members may be responsible for a monthly contribution if they decide not to complete the Healthy Behaviors Program requirement (a health risk assessment plus a wellness exam or dental exam). Beginning in year two, non-exempt members with incomes above 50% and up to 100% FPL owe \$5/month. Non-exempt members with incomes more than 100% and up to 133% FPL owe \$10/month. Premiums are waived every subsequent year if the member completes the Healthy Behaviors Program requirement in the prior year. Iowa Health & Human Services, “Member Contributions,” Iowa Health & Wellness Plan, accessed October 12, 2026, <https://hhs.iowa.gov/medicaid/plans-programs/iowa-health-wellness-plan/member-contributions>; According to KFF, CMS has granted section 1115 waiver approval in recent years to

eight states to charge premiums to enrollees below 150% FPL: AZ, AR, GA, IN, IA, MI, MT, and WI; Guth et al., “Understanding the Impact of Medicaid Premiums & Cost-Sharing.”

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