Health Groups Foresee Medicaid Copays' Unintended Consequences

Jul 9, 2025, 4:11 PM EDT

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Reporter

- **Copays could lead patients to forgo care, policy watchers say**
- **Nationwide requirement included in Republicans' tax law**

A provision in Republicans' sweeping tax-and-spending package that requires the nationwide adoption of copays for certain Medicaid beneficiaries will deter patients from receiving routine care and lead to a greater administrative burden on medical providers, health policy watchers say.

Section 71120 of the new **tax law** modifies cost-sharing obligations for all Medicaid beneficiaries with incomes above 100% of the federal poverty level, or $15,650 per year for a single adult. Although the law provides exceptions for primary, prenatal, and emergency care, starting in October 2028, affected beneficiaries could see copays as high as $35 for routine specialty visits, diagnostic exams, and other nonemergency services.

The new law set off alarm bells for health researchers like Katherine Hempstead, senior policy officer at the Robert Wood Johnson Foundation and former head of New Jersey's Center for Health Statistics, who pointed out that the cost-sharing policy comes amid a rash of administrative changes to the Medicaid program and Affordable Care Act, including work requirements, eligibility redeterminations, and the elimination of special enrollment periods.

"All these kinds of things are introducing friction and making these programs harder to get into and harder to stay into, and less attractive to be in," Hempstead said.

The health research firm KFF estimates the average affected beneficiary could pay **$542** in annual copays in scenarios where patients pay $35 per visit.

According to Priya Chidambaram, a senior policy manager at KFF, adults over the age of 50 and those with three or more chronic conditions would be disproportionately affected, paying an estimated $736 and $1,248 in additional fees per year, respectively.

“Thirty-five dollars is a lot,” said Hempstead. “I mean, that’s higher than copays in a lot of commercial health plans.”

“There are lots of reasons to be concerned about this, because there have been **tons and tons of studies** that looked at the impact of cost sharing. Those studies found that just a little bit of cost sharing makes a huge difference—people will indiscriminately forgo care,” she said.

Hidden Expenses

The move to introduce cost-sharing requirements came amid a push from conservative lawmakers and policy scholars to stem Medicaid’s ballooning costs.

Federal spending on Medicaid was projected to grow to over **$900 billion** per year by 2034 before President Donald Trump signed the law last week, according to the Paragon Institute, a conservative health policy think tank.

Former President Joe Biden’s policies “led to a surge of wasteful federal Medicaid expenditures and the House budget resolution would largely reverse the fiscal impact of his policies,” Paragon CEO Brian Blase said in a position paper released this February.

The law is projected to usher in **$1 trillion** in savings for the federal Medicaid program over 10 years, including **$13 billion** from the cost-sharing requirements.

Health policy researchers caution that the face value gains of cost sharing could be offset by the downstream costs of patients deferring routine care.

“It’s problematic because their conditions will get worse and potentially more expensive to the system,” said Joan Alker, executive director and co-founder of the Georgetown Center for Children and Families.

Burden on Providers

The cost-sharing requirements also drew the attention of the American Medical Association, which raised concerns the policy would force Medicaid beneficiaries “to make difficult choices between needed health care and other necessities, such as food and rent.”

The AMA said in a **letter** to Senate leaders John Thune (R-S.D.) and Chuck Schumer (D-N.Y.) that it feared the changes could lead to “delays in treatment, increases in emergency room visits and hospitalizations, and other expensive forms of care.”

A reduction in the number of patients seeking care could also disproportionately affect doctors in states that reimburse on a fee-for-service basis, said Chidambaram.

Although most states pay providers primarily on a per-member-per-month basis, “if fewer people are coming in to use services,” doctors in states like Alaska, Vermont, and Wyoming, which operate much of their program through fee-for-service, “may see a decrease in the costs that are coming to them,” she said.

“It’s also hard for providers because they end up needing to collect a pretty decent payment,” said Hempstead. “Thirty-five dollars is a decent share of an average office visit, so if they’re needing to do collections to get that, they’re going to be less interested in participating in the Medicaid program because they’re effectively getting a big rate cut.”

The law also gets rid of protections that prevent doctors from turning away patients who can’t afford copays at the point of service, said Alker.

“I think there are a lot of providers out there who don’t know about all the things that landed on their doorstep and the tough choices that they’re going to have to make,” Alker said.

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