pcc primary care collaborative

The Toll of Cost-Sharing: Policy Options to Improve Access and Affordability in Primary Care

Nov. 2026

The United States is facing unprecedented rates of chronic physical and mental illness.[1] To reverse this trend, more people need to connect to primary care and build relationships with trusted clinicians who address their needs holistically and work with them to achieve better health outcomes. Yet in today's U.S. health care system, requiring even a nominal copayment, coinsurance or deductible for primary care can deter patients from seeking care. This can cause crucial primary care relationships to either never form or face disruption.

This brief will discuss federal policy options and outline key insights from research and practice regarding the impact of primary care cost-sharing on care, affordability, health outcomes and the bottom line.

Federal Public Policy Options

Medicare

Combine Cost-sharing Relief with Hybrid Primary Care Payment

Policy experts and primary care stakeholders alike have recommended shifting payment for primary care from existing fee-for-service reimbursement to a hybrid payment approach. Hybrid payment typically involves a monthly prospective payment for some set of usual primary care services and fee-for-service payment for other services.

To support broad uptake of hybrid payment, most proposals eliminate or defray cost-sharing for services included in the payment bundle. ***H.R. 9693, the Patients First Act of 2026***, introduced by leaders of the House GOP and Democratic Doctors Caucuses, proposes to do just that, establishing a hybrid payment available to independent primary care and removing all cost-sharing for the bundled payment.

> *"At a time when we need to be reducing the burdens and barriers for patients… to enter care, we also need to be talking about how we build a different payment system that better supports primary care practices."*
>
> *Sophia Tripoli, Families USA*
> ***The Toll of Cost-Sharing Webinar***

1 Steven H. Woolf, "US Life Expectancy and Increasing Mortality Rates: An Analysis of the Crisis," Milbank Quarterly, September 23, 2026, *https://doi.org/10.1111/1468-0009.70118*.



Eliminate Cost-sharing for Between-Visit Primary Care (i.e. APCM)

Another more immediate (if less broad-reaching) reform would be to remove cost-sharing for between-visit care. In a 2025 Request for Information released by CMS alongside the annual Medicare physician payment rule, regulators requested comment on the possibility of removing cost-sharing for preventive components of the Advanced Primary Care Management (APCM) services.[2] However, the agency has not, to date, proposed removing them. Lawmakers could pursue targeted legislative changes instructing the agency to fully eliminate APCM cost-sharing and cost-sharing for the associated behavioral health integration (BHI) add-on codes.

Private and Employer Coverage

Require Plans to Cover Primary Care Visits without Cost-sharing

Federal lawmakers have introduced legislation, ***H.R. 9257/S. 4754 the Primary Care and Behavioral Health Access Act of 2026*** to require commercial and employer-sponsored health plans to cover three primary care and three behavioral health visits without copays, coinsurance or deductibles. If enacted, this legislation would build on current statutory provisions which require coverage and prohibit cost-sharing for certain identified preventive services. These provisions, enacted in 2010, enjoy substantial public support across the political spectrum.[3]

Enable High-Deductible Health Plans to Cover More Primary Care Cost-sharing Pre-Deductible

In 2024, 38.8 million people were enrolled in Health Savings Account (HSA)-eligible High-Deductible Health Plans (HDHPs). Each enrollee is liable for the full cost of most primary care services until the sizable deductible (a minimum of $1750 for individuals and $3500 families) is met. In general, enrollees in plans that

2 "CY 2026 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies; Medicare Shared Savings Program Requirements; and Medicare Prescription Drug Inflation Rebate Program; Proposed Rule," available at ***https://www.govinfo.gov/content/pkg/FR-2025-07-16/html/2025-13271.htm***

3 Ashley Kirzinger et al., "5 Charts About Public Opinion on the Affordable Care Act," KFF, September 22, 2026, ***https://www.kff.org/affordable-care-act/5-charts-about-public-opinion-on-the-affordable-care-act/***.

cover costs prior to the deductible are not eligible to make tax-advantaged contributions to the HSA. However, regulation and law establish safe harbors from that prohibition. Under these safe harbors, HDHPs have the option to cover certain preventive and chronic care, direct primary care and telehealth services before patients reach their deductible. Policymakers could consider expanding HSA-HDHP safe harbors, enabling plans to cover the full range of primary care services, including in-person visits and between-visit care management like APCM.

Options for Private Payers, Employers and State Plans



Eliminating barriers to better health for Americans, like cost-sharing, will require leadership and change from federal policymakers. But private plans and state policymakers need not make their customers or constituents wait for action from the federal government.

To support better health, commercial payers and public employee plan sponsors can take a variety of steps to remove cost-sharing burdens facing primary care in order to support better health. Private employers can work with their plan administrators to take similar steps.

Options include:

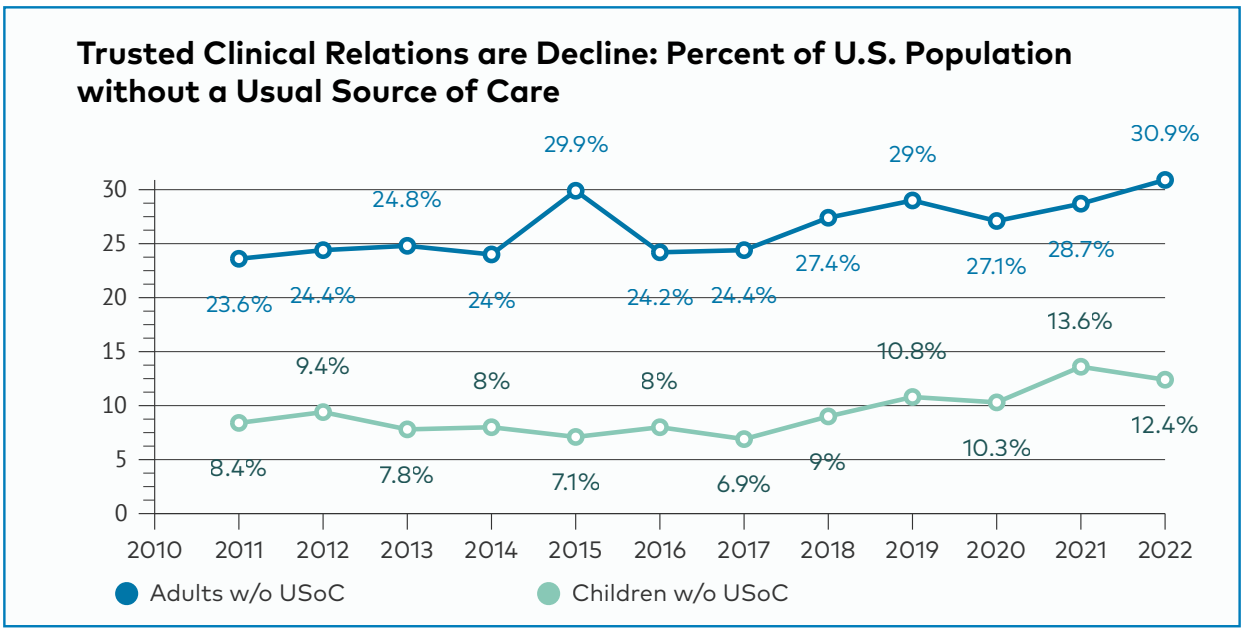
- Expanding plan offerings that feature zero or minimal cost-sharing for primary care and behavioral health services
- Eliminating cost-sharing for an individual's chosen source of primary care
- Covering APCM and BHI add-on codes without cost-sharing
- For plans and employers offering HSA-HDHPs, leveraging the safe harbor for chronic care management to cover more chronic disease-related services

For more on where Americans get health coverage today, see Appendix A.

> *"Building and maintaining those [primary care] relationships requires people to actually be able to access care and that's where cost-sharing becomes so important because we know that even nominal cost-sharing...that cost can be prohibitive and discourage people from seeking care."*
>
> *Janay Johnson, American Heart Association*
>
> ***The Toll of Cost-Sharing Webinar***

Cost-Sharing's Impact on Access and Innovation

Today, millions of Americans struggle to access primary care. Evidence — including the Milbank Memorial Fund's latest Primary Care Scorecard — shows that nearly one-in-three of American adults now lack any usual source of care.[4, 5] This decline is also evident for children.[6]



The evidence also suggests that cost-sharing is a driver in the erosion of those relationships. The National Academies of Science, Engineering and Medicine's 2021 report, *Implementing High-Quality Primary Care*, cited falling numbers of overall primary care visits among commercially insured individuals and tied that trend to the growing prevalence of high-deductible plans.[7]

Simultaneous with declining access and rising cost-sharing, Medicare payment reform has also been challenged by cost-sharing barriers. Reforms aimed at scaling proven chronic care and integrated behavioral health in-between visits are reaching just a fraction of eligible beneficiaries. Medicare's cost-sharing for those services has been repeatedly cited as a principal barrier to their adoption by researchers, stakeholders and CMS itself.[8 9]

4 "Percentage of adults without a usual source of health care (MEPS Data)." Milbank Memorial Fund, "Percentage of adults without a usual source of health care (MEPS Data) | 2026 Primary Care Scorecard Data Dashboard," September 15, 2026, **https://www.milbank.org/primary-care-scorecard/**.

5 National Association of Community Health Centers, HealthLandscape, and American Academy of Family Physicians. "Closing the Gap: How Community Health Centers Can Address the Nation's Primary Care Crisis," 2023. **https://www.nachc.org/wp-content/uploads/2023/06/Closing-the-Primary-Care-Gap_Full-Report_2023_digital-final.pdf**.

6 "Percentage of children without a usual source of health care (MEPS)" Milbank Memorial Fund, "Percentage of adults without a usual source of health care (MEPS Data) | 2026 Primary Care Scorecard Data Dashboard," October 19, 2026, **https://www.milbank.org/primary-care-scorecard/**.

7 Ishani Ganguli et al., "Declining Use of Primary Care Among Commercially Insured Adults in the United States, 2008–2016," Annals of Internal Medicine 172, no. 4 (February 3, 2020): 240–47, **https://doi.org/10.7326/m19-1834**.

8 Primary Care Collaborative, "PCC, BHN Feedback to CMS on Proposed 2027 MPFS - PCC," PCC, September 14, 2026, **https://thepcc.org/letters/pcc-bhn-feedback-to-cms-on-proposed-2027-mpfs/**.

9 National Academies of Sciences Engineering, and Medicine, "Response to the Centers for Medicare & Medicaid Services CY 2027 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment and Coverage Policies Proposed Rule," The National Academies Press, 2026, **https://doi.org/10.17226/29554**.

America's Affordability Crisis: The Impact of Primary Care Cost-sharing

In recent months, affordability has dominated the national policy conversation. Affording access to care is a major concern across demographics and age groups, ranging from seniors to middle age to young adults.[10, 11] This growing conversation has emerged as Americans are shouldering growing health-related costs, both in terms of their monthly budgets today and their long-term health trajectory in the future.

An analysis of out-of-pocket spending, published September 2026, found that U.S. households shoulder twice the out-of-pocket burden as other Organization for Economic Co-Operation and Development (OECD) countries studied.[12] The costs due at the point of care and subsequent bills lead many patients to forgo primary care and that forgone care can impact patients' lives beyond the immediate here and now.

Cardiovascular disease provides a powerful example of how health issues that go unaddressed in primary care can progress over time to potentially avoidable – and expensive – acute or specialty care.

Cardiovascular disease is the leading cause of mortality in the U.S, yet its risk factors can be addressed in primary care, potentially forestalling many of its costly health consequences. Unfortunately, according to an American Heart Association Presidential Advisory, in May 2025, more than one in three adults reported going without some form of needed medical care due to cost over the previous year. The Advisory specifically noted that high out-of-pocket costs were driving lower adherence to treatment even among atherosclerotic heart disease patients.[13] These regrettable realities may have contributed to the $400 billion in cardiovascular disease medical costs and lost productivity that the U.S. experienced in 2019.[14]

10 Teresa A. Keenan, "Health Care Affordability in 2024 Among Adults Ages 40–64," January 10, 2025, https://doi.org/10.26419/res.00876.001.

11 Judith Graham, "Lack of Affordability Tops Older Americans' List of Health Care Worries," KFF Health News, April 15, 2026, https://kffhealthnews.org/aging/health-care-costs-older-americans-worry-election-issues/.

12 Irene Papanicolas, et al., "Cross-country differences in household healthcare spending." Health affairs scholar, 4, no.9, qxag234 (September 2026). https://academic.oup.com/healthaffairsscholar/article/4/9/qxag234/8781118

13 Dhruv S. Kazi et al., "Health Care Affordability in the United States, From Crisis to Action: A Presidential Advisory From the American Heart Association," Circulation 153, no. 22 (April 30, 2026): e1369–89, https://doi.org/10.1161/cir.0000000000001442.

14 Dhruv S. Kazi et al., "Forecasting the Economic Burden of Cardiovascular Disease and Stroke in the United States Through 2050: A Presidential Advisory From the American Heart Association," Circulation 150, no. 4 (June 4, 2024): e89–101, https://doi.org/10.1161/cir.0000000000001258.

How High Cost-sharing Worsens Health Outcomes and Stifles Chronic Disease Prevention

Since the launch of the RAND Health Insurance Experiment in the 1970s, evidence has repeatedly shown that cost-sharing reduces use of services — regardless of whether they are high-value or low- to no-value.[15] Recent research confirms what five decades of evidence has repeatedly proven. A 2022 systematic review found that higher cost-sharing burdens are associated with fewer lower cost outpatient ambulatory care visits and increased use of expensive inpatient care.[16] Experience with increasingly common HSA-HDHPs also reveals reductions in office visits and preventive services.[17]

Beyond the impact of cost-sharing on care overall, cost-sharing for certain non-visit-based primary care activities has presented a particular policy challenge. In primary care, evidence-based care management and integration interventions can make the difference in patient care experience and outcomes. These approaches rely on members of the team, not just the treating clinician. A nurse or community health worker calling to make sure a patient understands prescription details or a team member coordinating and arranging specialty care or community resources can make the difference between better outcomes and an unnecessary hospital stay or worse.

Acknowledging that per-visit payment for Evaluation and Management visits fails to adequately support such activities, Medicare has established payment for multiple care management, community health and behavioral health integration services between visits.[18] Yet documentation, patient consent and cost-sharing requirements for these services present unique burdens. The clinician must secure written consent from the patient and disclose that the patient may be subject to cost-sharing.

An analysis of one such payment innovation, Medicare's Psychiatric Collaborative Care Model, captures the challenges these consent and cost-sharing requirements pose for a variety of services:

> *"Although cost-sharing is commonly required for subspecialty visits, tests, or procedures, none of these services requires special documentation of consent, and for all other medical and surgical interventions, information about cost-sharing is covered by a general consent that is usually provided to patients as they are checking into their clinic visit."*[19]

15 Robert Brook et al., "The Health Insurance Experiment: A Classic RAND Study Speaks to the Current Health Care Reform Debate," RAND, May 20, 2026, ***https://www.rand.org/pubs/research_briefs/RB9174.html***.

16 Nicole Fusco et al., "Cost-sharing and Adherence, Clinical Outcomes, Health Care Utilization, and Costs: A Systematic Literature Review," Journal of Managed Care & Specialty Pharmacy 29, no. 1 (April 7, 2022): 4–16, ***https://doi.org/10.18553/jmcp.2022.21270***.

17 Rajender Agarwal, Olena Mazurenko, and Nir Menachemi, "High-Deductible Health Plans Reduce Health Care Cost and Utilization, Including Use of Needed Preventive Services," Health Affairs 36, no. 10 (October 1, 2017): 1762–68, ***https://doi.org/10.1377/hlthaff.2017.0610***.

18 "Care Management | CMS," n.d., ***https://www.cms.gov/medicare/payment/fee-schedules/physician/care-management***; "Community Health Integration Services," Medicare, n.d., ***https://www.medicare.gov/coverage/community-health-integration-services***.

19 Jonathan Kaplan, Jeffrey Rado, and Neda Laiteerapong, "Mandatory Documented Consent and Cost-Sharing Impede Access to Collaborative Care Psychiatry," Journal of General Internal Medicine 38, no. 16 (September 12, 2023): 3616–17, ***https://doi.org/10.1007/s11606-023-08394-y***.

Medicare care management services like Transitional Care Management and Chronic Care Management successfully allow patients to avoid unnecessary acute care and lead to overall savings, but barriers persist to adoption of these services due to similar consent and cost-sharing requirements.[20] [21]

More recently, Medicare has begun paying for new Advanced Primary Care Management (APCM) services and covering BHI through new add-on codes billed with APCM. Compared to prior care management services, this approach offers several innovations to remove administrative burden and target resources to primary care.[22] Yet analyzing APCM's first year of implementation, PCC's new report, *APCM: Ensuring the Bundled Payment Delivers Better Health*, indicates that consent and cost-sharing barriers remain a commonly identified barrier to adoption.[23]

Addressing Primary Care Cost-sharing: What Is to Be Gained

For Medicare, Medicaid plans and employers, the rising cost trends have been driven by inpatient care, outpatient care delivered at medical facilities and drug costs.[24]

By contrast, primary care receives less than 5% of the health care dollar, and primary care provides roughly half of physician office visits.[25,26] Given that primary care can improve health and avoid unnecessary acute care and drug costs, investing a fraction of a fraction of overall health budgets to address primary care cost-sharing represents a potentially fruitful business strategy.

> *"Policymakers and industry leaders need to understand how cost-sharing in primary care is ultimately undermining the important work of building a healthier country through primary care."*
>
> *Dr. Raymond Tsai, Purchaser Business Group On Health*
>
> ***The Toll of Cost-Sharing Webinar***

20 MacKenzie L. Hughes et al., "Transitional Care Management Associated With More Healthy Days at Home, Lower Spending After Hospital Discharge," Health Affairs 44, no. 6 (June 1, 2025): 731–38, *https://doi.org/10.1377/hlthaff.2024.01287*.

21 John Schurrer et al., "Evaluation of the Diffusion and Impact of the Chronic Care Management (CCM) Services: Final Report" (Mathematica Policy Research, November 2, 2017), *https://www.cms.gov/priorities/innovation/Files/reports/chronic-care-mngmt-finalevalrpt.pdf*.

22 Primary Care Collaborative, "Chronic Care in Medicare: How Congress Can Strengthen the New APCM," PCC, August 26, 2026, *https://thepcc.org/factsheet/chronic-care-in-medicare-how-congress-can-strengthen-the-new-apcm/*.

23 Ann Kempski et al., "Advanced Primary Care Management: Ensuring the Bundled Payment Delivers Better Health", Primary Care Collaborative, October 29, 2026, *https://thepcc.org/reports/advanced-primary-care-management-ensuring-the-bundled-payment-delivers-better-care.*

24 Deana Bell et al., "2026 Milliman Medical Index," May 2026, *https://media.milliman.com/v1/media/edge/images/millimaninc5660-milliman6442-prod27d5-0001/media/Milliman/PDFs/2026-Articles/2026_Milliman-Medical-Index.pdf*.

25 Milbank Memorial Fund, "2026 Primary Care Scorecard Data Dashboard," October 19, 2026, *https://www.milbank.org/primary-care-scorecard/*.

26 CDC. 2019. "FastStats - Physician Office Visits." Center for Disease Control and Prevention. 2019. *https://www.cdc.gov/nchs/fastats/physician-visits.htm*.

Selected Care Management and Integration Services	Service Summary	To Learn More
Chronic Care Management (CPT Codes 99490, 99439, 99491, 99437, 99487, 99489)	Clinical staff time or time of physician or other qualified health professional managing a patient's 2+ chronic conditions, including recording health information, care planning, managing transition and coordinating/sharing patient health information within and outside the practice.	***MLN909188 – Chronic Care Management Services***
Transitional Care Management (CPT Codes 99495 and 99496)	Comprehensive set of services designed to make sure patients get coordinated and continuous care as they transition from an inpatient health care setting (like a hospital, skilled nursing facility, or rehabilitation facility) back to their community (which could be their home, an assisted living facility, or another outpatient environment).	***MLN-908628-Transitional Care Management Services***
Psychiatric Collaborative Care Model (CPT Codes 99492, 99493, 99494, HPCCS G2214)	Behavioral health care manager activities, in consultation with a psychiatric consultant and directed by the treating physician or other qualified health care professional.	***MLN989432-Behavioral Health Integration Services***
General BHI-Care Management Services for Behavioral Health Conditions (CPT Code 99484)	Care management services for behavioral health conditions involving at least 20 minutes of clinical staff time per calendar month under a physician or other qualified health care professional's direction.	***MLN989432-Behavioral Health Integration Services***
Care Management Services for Behavioral Health Conditions (HCPCS Code G0323)	Care management services for behavioral health conditions covering at least 20 minutes of clinical psychologist or clinical social worker time per calendar month.	***MLN989432-Behavioral Health Integration Services***
Advanced Primary Care Management	Combines elements of several existing care management and communication technology-based services, including chronic care management, transitional care management, virtual check-ins and interprofessional consultations; available to source of primary care; no tracking of minute-by-minute staff time.	***CMS Website: Advanced Primary Care Management Services***
APCM- add-on for General BHI (HCPCS Code G0570)	For General BHI services delivered to patients for which the practitioner billed APCM; no tracking of minute-by-minute staff time.	***MLN989432-Behavioral Health Integration Services***
APCM- add-on for CoCM (HCPCS Codes G0568 and G0569)	For Psychiatric Collaborative Care Model services delivered to patients for which the practitioner billed APCM; no tracking of minute-by-minute staff time.	***MLN989432-Behavioral Health Integration Services***

To the extent public and private payers and purchasers remove care cost-sharing barriers, substantial evidence confirms that patients and the health care delivery system respond. A review of the evidence by University of Michigan researchers concluded that eliminating cost-sharing for preventive services clearly increased their utilization.[27] Another 2013 systematic review characterized the research available on primary care at the time as follows: "studies evaluating reducing or eliminating cost-sharing found that total costs did not rise."[28]

More recently, the Centers for Medicare and Medicaid Innovation (CMMI) has granted participants in several payment models, including the ACO REACH model, the option to eliminate or reduce cost-sharing for Part B services for participating beneficiaries. This innovation has been welcomed by the ACO and patient advocacy communities. In its CY 2027 proposed rule, CMS has proposed expanding this cost-sharing support option from CMMI's time-limited model tests to the permanent statutory MSSP program which served 12.6 million Original Medicare beneficiaries in 2026.

Private sector initiatives that have eliminated cost-sharing present a powerful test case and opportunity to learn about the impact of primary care cost-sharing relief. The results have been encouraging. Health plans and employers alike have produced positive Return-on-Investment (ROI), even cost-savings, from eliminating primary care cost-sharing:

- Deployment of advanced primary care at a major employer without cost-sharing led to a 30 percent reduction in cost trend.[29]
- Another large employer's health plan eliminated cost-sharing for pediatric primary care visits, expanding primary care access, significantly reducing ER and specialist services – all without increases in overall costs.[30]
- In Medicare Advantage, one national health plan paired senior-focused advanced primary care practices with zero or limited cost-sharing for primary care. The initiative increased primary care utilization and improved chronic condition care – especially among underserved populations.[31]

27 Hope C. Norris et al., "Utilization Impact of Cost-Sharing Elimination for Preventive Care Services: A Rapid Review," review-article, by A. Mark Fendrick, Medical Care Research and Review, 2021, *https://doi.org/10.1177/10775587211027372*.

28 Nicole Fusco et al., "Cost-sharing and Adherence, Clinical Outcomes, Health Care Utilization, and Costs: A Systematic Literature Review," Journal of Managed Care & Specialty Pharmacy 29, no. 1 (April 7, 2022): 4–16, *https://doi.org/10.18553/jmcp.2022.21270*.

29 Premise Health, "New Study Finds Advanced Primary Care With Premise Health Saves Employers and Unions 30% on Total Healthcare Costs for Attributed Members," October 10, 2024, *https://www.premisehealth.com/resources/success-stories/new-study-finds-advanced-primary-care-with-premise-health-saves-employers-and-unions-30-on-total-healthcare-costs-for-attributed-members/*.

30 Martín-J. Sepúlveda et al., "Elimination of the Out-of-Pocket Charge for Children's Primary Care Visits: An Application of Value-Based Insurance Design," The Journal of Pediatrics 175 (May 14, 2016): 195–200, *https://doi.org/10.1016/j.jpeds.2016.04.017*.

31 Primary Care Collaborative, "Make Medicare Beneficiaries Healthier by Strengthening Primary Care," PCC, March 6, 2025, *https://thepcc.org/issue_briefs/make-medicare-beneficiaries-healthier-by-strengthening-primary-care/*.; Kaylyn E. Swankoski et al., "Senior-Focused Primary Care Organizations Increase Access for Medicare Advantage Members, Especially Underserved Groups," Health Affairs 43, no. 9 (September 1, 2024): 1225–34, *https://doi.org/10.1377/hlthaff.2023.01357*.

APPENDIX A: Where Americans Get Health Coverage and Associated Cost-sharing Barriers

Traditional Medicare

In 2026, 33.2 million Americans are enrolled in Traditional Medicare. [32] The 2026 Part B deductible is $283, after which beneficiaries pay 20% coinsurance for Part B services, including physician visits and other outpatient care. [33] Most beneficiaries cover all or a portion of these costs through Medicare supplemental coverage (Medigap), Medicaid benefits or retiree coverage. Yet a sizable number - 3.5 million enrollees in 2023 - lacked any supplemental coverage and shouldered these costs alone. [34]

Medicare Advantage

As of 2025, 78.1% of Medicare Advantage enrollees enjoyed zero cost-sharing for primary care visits. [35] However, the share of enrollees who did face cost-sharing was higher among plans offered in high-poverty counties and zero premium plans.

Employer-Sponsored Insurance

In 2025, employer-sponsored insurance covered 154 million people under 65. Cost-sharing for physician office visits varied by both firm size and plan type. Among covered workers, those at smaller firms were more likely than workers at larger firms to have a copayment for in-network primary care visits (72% vs. 64%), but less likely to have coinsurance for primary care (7% vs. 27%). Among workers with copayments, the average primary care copayment is also slightly higher at smaller firms ($29 vs. $26). [36]

Individual Market Plans

In 2024, 21.7 million Americans, about 6% of the population, had private individual-market health insurance, either through the ACA Marketplace or purchased directly from an insurer or broker. While not all Marketplace plans apply deductibles to primary care, the average annual deductible in 2026 reached $3,786.[37]

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32 The Henry J. Kaiser Family Foundation [KFF]. "Total Number of Medicare Beneficiaries by Type of Coverage | KFF State Health Facts." KFF, September 11, 2025. https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&selectedDistributions=traditional-medicare-enrollment&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

33 "What Is the Medicare Deductible for 2025?," November 25, 2025. https://www.ncoa.org/article/what-is-the-medicare-deductible/.

34 Ochieng, Nancy, Juliette Cubanski, and Tricia Neuman. "A Snapshot of Sources of Coverage Among Medicare Beneficiaries." KFF, December 19, 2025. https://www.kff.org/medicare/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries/.

35 Jiang, Changchuan, Chuan Angel Lu, Lesi He, Arthur S. Hong, Xin Hu, Megan Mullins, Boshen Jiao, and Joshua M. Liao. "Primary Care Cost Sharing in Medicare Advantage." JAMA Health Forum 7, no. 7 (July 10, 2026): e262232. https://doi.org/10.1001/jamahealthforum.2026.2232.

36 The Henry J. Kaiser Family Foundation [KFF]. "2025 Employer Health Benefits Survey." KFF, October 14, 2026. https://www.kff.org/health-costs/2025-employer-health-benefits-survey/.

37 McGough, Matt, Jared Ortaliza, Justin Lo, and Cynthia Cox. 2026. "What We Know so Far About 2026 ACA Marketplace Enrollment, Premiums, and Deductibles." KFF, May 19. *https://www.kff.org/affordable-care-act/what-we-know-so-far-about-2026-aca-marketplace-enrollment-premiums-and-deductibles/*.

High-Deductible Health Plans (HDHP)

A growing proportion of individuals rely on a particular type of coverage - HDHPs. Enrollees in these plans can pair their coverage with a personal account such as an HSA or Health Reimbursement Arrangement (HRA). In 2023, 41.7% of privately insured people under age 65 were enrolled in an HDHP, with enrollment rates increasing alongside family income and educational level.[38] In 2027, the minimum annual deductible for an HDHP will be $1,750 for self-only coverage and $3,500 for family coverage. [39]

Medicaid

In 2025, about 19.8 million people were enrolled through Medicaid expansion, representing nearly one-quarter of Medicaid enrollment nationwide. [40] Historically Medicaid has had no mandatory cost-sharing requirements. Following the passage of HR 1, as of October 1, 2028, Medicaid programs must require Medicaid expansion enrollees with incomes between 100% and 138% of the federal poverty level to pay between $0–$35 in cost-sharing. Although certain primary care, behavioral health and community health center services are exempted from this cost-sharing, individuals may be subject to cost-sharing for other needed care that results from their primary care visit. [41]

38 Cohen, Robin, and Elizabeth Briones. 2024. "Enrollment in High-Deductible Health Plans Among People Younger Than Age 65 With Private Health Insurance: United States." National Health Statistics Reports Number 214: 2019–23. ***https://www.cdc.gov/nchs/data/nhsr/nhsr214.pdf***.

39 U.S. Office of Personnel Management. "Plan Types," n.d. ***https://www.opm.gov/healthcare-insurance/healthcare/plan-information/plan-types/***.

40 The Henry J. Kaiser Family Foundation [KFF]. "Medicaid Expansion Enrollment | KFF State Health Facts." KFF, August 18, 2026. ***https://www.kff.org/medicaid/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.***

41 Callow, Andrea. "Medicaid Cost Sharing Changes Under the One Big Beautiful Bill Act (OBBBA): A Comprehensive Review of Policies in 41 Expansion States," 2026. ***https://www.aarp.org/content/dam/aarp/ppi/topics/health/coverage-access/medicaid-cost-sharing-changes-under-one-big-beautiful-bill-act-obbba-comprehensive-review-policies-41-expansion-states.doi.10.26419-2fppi.00403.001.pdf.***

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