SOLVING MEDICAL ASSISTANCE BENEFITS

Removing the Healthcare Barriers that Trap People in Poverty

POLICY BRIEF

Erik Randolph

Director of Research

GEORGIA CENTER FOR OPPORTUNITY

Revised April 17, 2025

Introduction

Even after passage of the Affordable Care Act of 2010, the United States healthcare system suffers from unaffordable insurance rates and benefit cliffs when recipients transition off public programs. A consumer-driven, market-based risk equalization system relying on American entrepreneurship and innovation solves these problems and more by providing U.S. citizens the health coverage system they deserve.

Medical assistance programs in the U.S. aim to support individuals and families who cannot afford health insurance, whether their employers offer coverage or not. Only the very wealthy can afford not to have insurance. While there are other public coverage programs—such as Medicare and the Indian Health Service—this briefing focuses only on Medicaid, the Children's Health Insurance Program (CHIP), and subsidies for purchasing insurance through government-run Health Insurance Exchanges (HIX) pursuant to the Affordable Care Act.

At the most basic level, insurance is about spreading risk across a vast number of customers. For example, fire insurance compensates for property loss due to a fire. Premiums contributed by policyholders who did not experience fires enable insurers to pay claims for losses. Policyholders are willing to pay the premiums because there is always the risk of a devastating fire. Insurers rely heavily on probability and statistics to determine the premiums, which form the actuarial basis[1] for the policy.

With some differences, health insurance works the same way. In addition to insuring against the risk of major illnesses, medical conditions, and emergency care, health insurance usually covers screenings and preventative care not typically found with other insurance products. Other important differences are outlined in the section below on obstacles to what people really want with health insurance.

Employees with employer-sponsored coverage often pay a premium share, but there are also deductibles (requiring payments before the insurance kicks in), coinsurance (paying a percentage of a rendered service), and copays (paying a fixed fee).

Medicaid, CHIP, and HIX

Enacted in 1965, Medicaid is a joint federal-state program that originally covered individuals with disabilities and families of low means with dependent children. But Medicaid has been expanded numerous times to cover more of the population,

[1] As used in this briefing, the actuarial basis is the financial risk and related costs of healthcare expenses used by insurers to determine premiums and cost-sharing obligations of the insured.

including the most recent expansion allowing states to cover all adults up to 138 percent of the Federal Poverty Level (FPL) pursuant to the Affordable Care Act (2010).

Medicaid is often presented together with the Children's Health Insurance Program, another joint federal-state program enacted in 1997. CHIP provides coverage for children under 19 whose families fall within their state's FPL limit, which varies by the child's age and who do not qualify for Medicaid. Table 1 summarizes the basic income eligibility limits for both Medicaid and CHIP as a percent of FPL as of April 2025.[2] The table shows the limit ranges by category for all states and the District of Columbia.

Table 1

STATE VARIANCE OF MEDICAID AND CHIP INCOME ELIGIBILITY LIMITS AS A PERCENT OF FPL

	Children Medicaid Ages 0-1	*Children Medicaid Ages 1-5*	*Children Medicaid Ages 6-18*	*CHIP*	*Pregnant Women Medicaid*	*Parent/ Caretaker Medicaid*
maximum	375%	319%	319%	400%	375%	216%
average	217%	195%	190%	260%	200%	77%
median	206%	170%	167%	250%	195%	68%
minimum	139%	133%	133%	185%	133%	13%

For Medicaid, federal law allows for cost sharing above 100 percent of FPL, but at or below 150 percent of FPL, the cost sharing cannot include premium shares.[3] CHIP allows states to charge premiums or enrollment fees, but only 18 states do.[4]

The third program covered in this briefing is the subsidy program for individual and family health insurance coverage through HIX. The primary subsidy is the premium tax credit for consumers,[5] but there are also mandates on insurers that benefit

---

[2] Table data from Centers for Medicare and Medicaid Services, U.S. Department of Health and Human Services, "Medicaid, Children's Health Insurance Program, & Basic Health Program Eligibility Levels" webpage, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html. Income limits for the Medicaid expansion states pursuant to the Affordable Care Act are not shown in the table.

[3] 42 U.S. Code 1396o

[4] Tricia Brooks, Jennifer Tolbert, Anna Mudumala, Amaya Diana, Allexa Gardner, Aubrianna Osorio, and Shoshi, *Medicaid and CHIP Eligibility, Enrollment, and Renewal Policies as States Resume Routine Operations Following the Unwinding of the Pandemic-Era Continuous Enrollment Provision*, KFF, April 1, 2025, Table 28: https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-report. In 2020, 30 states charged premiums or enrollment fees: Tricia Brooks, Lauren Roygardner, Samantha Artiga, Oliva Pham, and Rachel Dolan, *Medicaid and CHIP Eligibility, Enrollment, and Cost Sharing Policies as of January 2020: Findings from a 50-State Survey*, KFF, March 2020, Table 14: https://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility,-Enrollment-and-Cost-Sharing-Policies-as-of-January-2020.pdf.

[5] The subsidy consists of a monthly advance premium tax credit paid directly to the insurance company, but recipients must reconcile the subsidy with their federal income tax filing. If the advance payments were too little, the taxpayer receives a refund. If too much, the taxpayer will owe the difference.

purchasers with incomes over 100 percent but under 250 percent of FPL by shifting those costs to others. The subsidies are not accessible to those who qualify for Medicaid, CHIP, or have been offered health insurance from their employer unless it can be shown that the employer's policy is inadequate or unaffordable. Eligibility starts above 100 percent of FPL, and the premium tax credit is based on the Second Lowest Cost Silver Plan and a sliding scale.[6] The law originally capped the tax credit at 400 percent of FPL, but Congress removed the upper limit for Tax Years 2021 through 2025.[7]

When and why medical assistance benefit cliffs occur

Benefit cliffs occur when adults lose Medicaid or children lose CHIP due to increased income above eligibility limits, leading to transitions into private insurance, HIX plans, or, in some cases, no coverage at all.

Coming off Medicaid and CHIP onto employer-sponsored plans can have a benefits loss because of premium shares, deductibles, coinsurance, and copayments. In 2024, for example, 19 percent of employees were ineligible for their employer's health benefits. Twenty-five percent of those eligible did not take up the benefits offered to them, and workers who did take up their employer's plan paid on average 16 percent of the cost of the premium for single coverage plan, or $1,368 annually, and 25 percent for family coverage, or $6,296 annually.[8]

If employer's plans are deemed inadequate or unaffordable, or if the family or individual is not offered an employer's plan, they may access coverage through HIX. However, the out-of-pocket costs may still be perceived as and can indeed be unaffordable despite the subsidies

Table 2
ANNUAL COST SHARING LIMITS FOR HIX PLANS

Income Level (FPL)	*Individual*	*Family*
100% to 200%	$3,050	$6,100
201% to 250%	$7,350	$14,700
250% and above	$9,200	$18,400

[6] The Affordable Care Act created a tiered system of Platinum, Gold, Silver, Bronze, and Catastrophic plans, which are in descending order of how much of health care costs they cover with Platinum covering the most and Catastrophic covering the least with the latter also having limiting criteria for participation. The act also created regional HIX rating areas throughout the country, and the details of each insurer's plan and its costs are specific to each rating area. The Second Lowest Cost Silver Plan (SLCSP) of each rating area forms the basis for the Premium Tax Credit. A sliding scale was established by the Act and determines the amount of premium share of the SLCSP the tax filer must pay, which increases as a percent of the tax filer's modified adjusted gross income based on the prior year's FPL, up to a maximum of 8.5 percent for Tax Years 2021 through 2025, but otherwise a maximum of 9.5 percent. The difference between the cost of the SLCSP and the tax filer's calculated premium share of the SLCSP is the amount of the subsidy, provided the subsidy does not exceed the cost of the SLCSP.

[7] Public Law 117—2, March 11, 2021, and Public Law 117—169, August 16, 2022

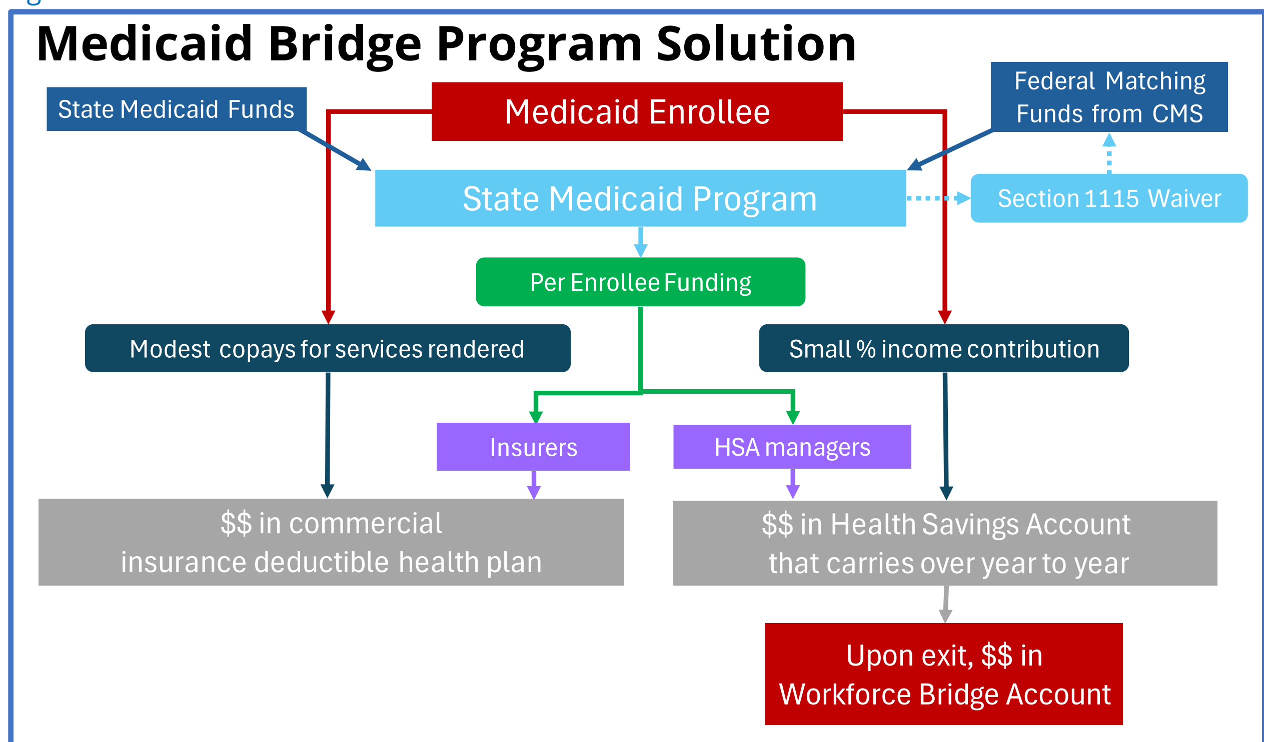
[8] Gary Claxton, Matthew Rae, Aubrey Winger, and Emma Wager, Employer Health Benefits: 2024 Annual Survey, KFF, pp. 64, 68, and 83: https://files.kff.org/attachment/Employer-Health-Benefits-Survey-2024-Annual-Survey.pdf.

to lower out-of-pocket costs.[9] Consistent with Medicaid rules, premium shares ease in on a sliding scale starting at 150 percent of FPL. Table 2 provides the HIX out-of-pocket cost limits for 2025.[10]

Bridge program solution

A Medicaid bridge program, such as one adopted by the state of Indiana with a Section 1115 waiver approved by the federal Centers for Medicare and Medicaid Services (CMS), can ease the situation for individuals exiting Medicaid.

Figure 1



The state's Healthy Indiana Plan (HIP) splits Medicaid benefits into two parts. The first part is a standard commercial insurance plan with deductibles. The second part is a health savings account (HSA) that allows enrollees to carry over funds year to year. Program participants contribute a small percentage of their income to the health savings account and may use the funds in their accounts to pay out-of-pocket health-

---

[9] For an explanation of subsidies to lower out-of-pocket costs, see Louise Norris, "The ACA's cost-sharing subsidies," healthinsurance.org webpage, posted January 15,2024: https://www.healthinsurance.org/obamacare/the-acas-cost-sharing-subsidies.

[10] Table 2 data from Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight, Memorandum, "Premium Adjustment Percentage, Maximum Annual Limitation on Cost Sharing, Reduced Maximum Annual Limitation on Cost Sharing, and Required Contribution Percentage for the 2025 Benefit Year ," December 15, 2023: https://www.cms.gov/files/document/2025-papi-parameters-guidance-2023-11-15.pdf.

related expenses, including deductibles and copays, that are not covered by the deductible plan.[11]

When exiting Medicaid, HIP allows participants to keep a portion of their Health Savings Account in a new account called a Workforce Bridge Account, which was approved by CMS in 2020. The intention is to help the person with higher out-of-pocket expenses during the transition until the person can become more financially established.[12] Figure 1 provides a schematic of how the bridge program would work.

Two important features of the Indiana program are working with commercial insurers and health savings account managers. About two-thirds of Medicaid enrollees nationwide receive their benefits from private Managed Care Organizations (MCOs),[13] and Indiana is no exception. These states opt to provide Medicaid coverage through contracts with MCOs, compensating them with a negotiated per-enrollee rate instead of using a fee-for-service model. This arrangement means that enrollees are already receiving benefits from private insurers. The new features in Indiana are allowing for deductibles and utilizing HSAs to incentivize good economic behavior and to bridge out of the program with some extra money to handle future out-of-pocket medical expenses.[14]

What system people deserve and its obstacles

A bridge program will ease the situation for individuals, but it is a partial and interim solution. The Georgia Center for Opportunity has published several reports on a comprehensive and permanent solution, and these next three sections are based on those reports.[15]

---

[11] Seema Verma and Brian Neale, "Healthy Indiana 2.0 Is Challenging Medicaid Norms", *Health Affairs*, August 29, 2016: https://www.healthaffairs.org/content/forefront/healthy-indiana-2-0-challenging-medicaid-norms.

[12] Indiana State Government Press Release, "Feds Approve Indiana's Innovative HIP Workforce Bridge Program," June 3, 2020: https://events.in.gov/event/feds-approve-indianas-innovative-hip-workforce-bridge-program.

[13] KFF, "Medicaid Managed Care Tracker" webpage, accessed November 1, 2024: https://www.kff.org/statedata/collection/medicaid-managed-care-tracker.

[14] For more information, see *Health Indiana Plan Evaluation Plan*, Final, prepared for Indiana Family and Social Services Administration, Lewin Group, February 24, 2022: https://www.in.gov/fssa/hip/files/2021-2030HIPEvaluationDesign.pdf. Because the COVID-19 pandemic delayed the start of the Workforce Bridge Account, the report could not evaluate its implementation.

[15] Erik Randolph, *A Real Solution for Health Insurance and Medical Assistance*, Georgia Center for Opportunity, January 2018: https://georgiaopportunity.org/wp-content/uploads/2018/02/WEB-A-Real-Solution-for-Health-Insurance-.pdf and Erik Randolph, *What Does An Ideal Solution To The Health Insurance Crisis Look Like? Principles for Policymakers when Crafting a Federal Waiver Application*. Georgia Center for Opportunity, July 2019: https://foropportunity.org/wp-content/uploads/2019/07/19-057-GCO-HealthCare-Ideal2.pdf.

When it comes to a health coverage system, the following characteristics will serve people the best:

- Freedom to choose insurers and providers of their care
- Ability to shop for health insurance with real choices among many insurers
- The right coverage when needing medical care
- Coverage for routine screening and preventative care
- Quality care
- Innovation
- Access to the most appropriate and advanced treatments
- Portability of plans
- Continuance of a plan when becoming sick and unable to work

However, the current system presents barriers to these characteristics, weakening the economic principles that support market functionality and complicating the search for solutions if not addressed.

The obstacles are as follows:

- Pre-existing conditions that prevent attaining affordable insurance
- Lack of universal coverage where not all citizens have health coverage
- Third-party payor system that separates consumer behavior from costs
- Opaque pricing that hides the cost of medical services beforehand
- Cream skimming where insurers prioritize healthy individuals for coverage
- Adverse selection that raises costs for insurers, distorting the market
- Lack of portability where losing a job means losing health coverage

Comprehensive and permanent solution

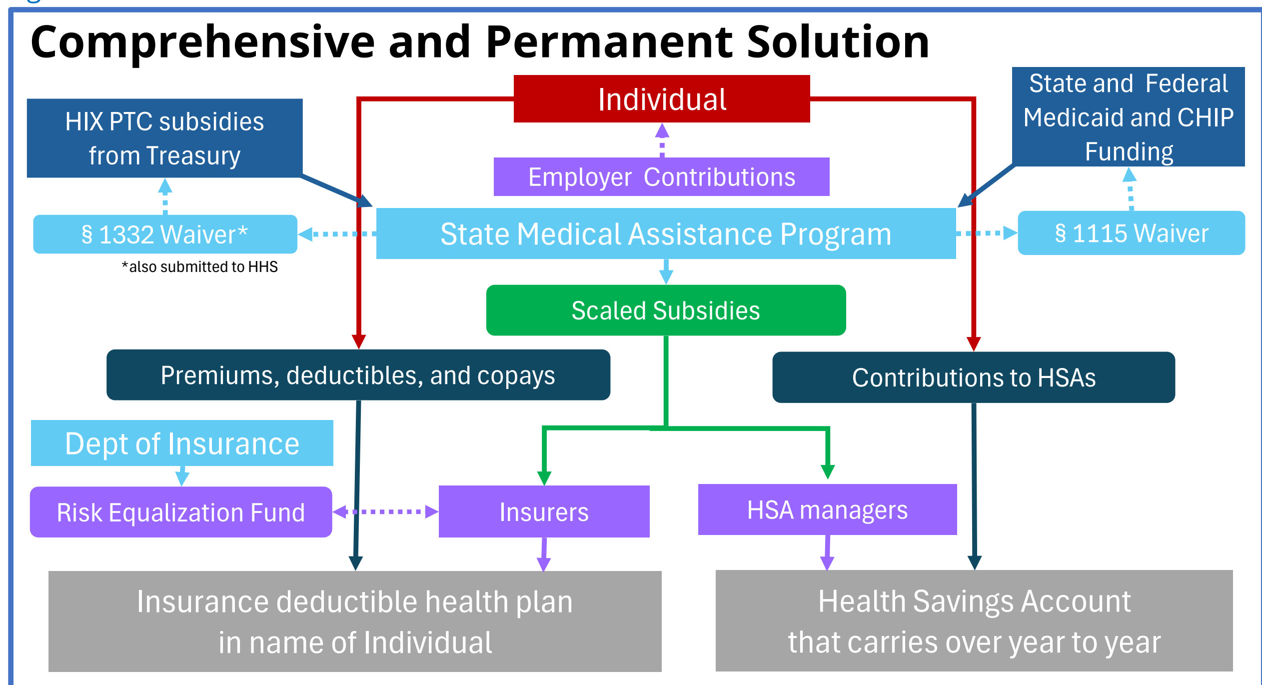
Despite being a partial solution, Indiana's bridge program can be used as a building block for states to adopt a comprehensive and permanent solution. A consumer-driven, market-based risk equalization system relying on American entrepreneurship and innovation solves the most vexing problems of pre-existing conditions, universal coverage, third-payor system, cream skimming, adverse selection, and portability while preserving quality of care for a health system that provides the most advanced treatments.[16]

[16] See Regina E. Herzlinger, ed., *Consumer-Driven Health Care: Implications for Providers, Payers, and Policymakers*, San Francisco: Jossey-Bass, A Wiley Imprint, 2004, and Regina Herzlinger, *Who Killed Health Care?* McGraw-Hill, 2007. The idea of consumer-driven, market-based risk equalization was pioneered in Switzerland and successfully adapted by the Netherlands. See also various writings of Avik Roy, including his The Apothecary blog, such as Avik

A consumer-driven, market-based risk equalization system approaches the problem from an actuarial basis, and a state could easily adopt the principles to its circumstances. The mechanics are all behind the scenes, out of view of consumers, giving them a seamless experience.

Figure 2 gives a schematic of how a comprehensive and permanent solution would work. Note the similarities to the Healthy Indiana Plan.

Figure 2



As the name suggests, central to this solution is a risk equalization fund among insurers. Each insurer puts money into the fund, and money is returned to insurers based on a risk-assessment formula. True actuarial costs are calculated regionally, independent of any insurer's portfolio, to assess risk differences, with insurers managing higher-risk portfolios receiving more from the fund than those with lower risk portfolios. An impartial overseer, such as a state's insurance department that already regulates insurance companies, acts as a referee. The basic idea is equalizing risks without rewarding inefficient insurers.

Roy, "Why Switzerland Has the World's Best Health Care System," *Forbes*, April 28, 2011, and Avik Roy, "Switzerland: A Case Study in Consumer-Driven Health Care," *Forbes*, December 26, 2012. See also Robert E. Leu, Frans F. H. Rutten, Werner Brouwer, Pius Matter, and Christian Rütschi, *The Swiss and Dutch Health Insurance Systems: Universal Coverage and Regulated Competitive Insurance Markets*, Pub. No. 1220, Commonwealth Fund, January 2009: https://www.commonwealthfund.org/publications/fund-reports/2009/jan/swiss-and-dutch-health-insurance-systems-universal-coverage-and.

An important requirement is that policies must be written in the name of individuals. Employers may still pay for the policies, but the employees would own them, allowing them to keep their insurance if they lose or change employment.

The current premium tax credit and the HIX rating areas will work well with the proposed comprehensive solution, and states can create such a system using a Section 1332 waiver of the Affordable Care Act, which has flexibility for states to adopt more meaningful, comprehensive, and permanent solutions, in addition to a Section 1115 waiver. States will be able to combine the HIX subsidies, including funds for the premium tax credit, with Medicaid and CHIP funds to use as sliding-scale subsidies to enable everyone to afford health insurance and health savings accounts.[17]

Understanding what's behind the scenes

This proposed solution relies on proven practice and on how insurance works. At a basic level, an insurer's revenue, which is primarily driven by premiums, must exceed the payouts for claims, otherwise the company risks insolvency. Because this proposed solution addresses the issue from an actuarial basis, it protects the solvency of insurers while maximizing benefits to consumers. Insolvency helps no one, especially insured individuals depending on the protection that the insurance provides. In contrast, the status quo system is showing stress as insurers are forced to adopt tactics that undermine the basic characteristics of a system that people deserve, which was outlined in a prior section of this briefing.

For example, suppose a fire insurer could somehow know in advance which customers would not have fires and selects only those customers. This would enable the company to offer below market rates, leaving higher cost individuals to be picked up by other insurers, causing their competitors' rates to be higher. Cream skimming is a common issue in the health insurance industry, where insurers assess potential clients to estimate costs to their portfolio, avoiding high-risk customers or charging them significantly higher premiums—a practice not strictly cream skimming but a natural outcome of how health insurance has developed in America.

High Risk Pools, which are not the same as Risk Equalization Systems, are one way states have tried to address the negative consequences from these practices. In a High Risk Pool, insurance is offered to those with medical conditions that make

---

[17] As statutorily written, the combination of Section 1332 and Section 1115 waivers will allow states to undertake the proposed permanent and comprehensive solution outlined in this briefing. Executive Orders 13985, 14009, and 14036 issued in 2021 and their impact on HHS regulations added potentially problematic stipulations, but those executive orders were revoked on January 20, 2025.

attaining insurance on their own unaffordable. This approach relies heavily on subsidies from the government and places individuals with serious health conditions in a stressful and untenable position until they get enrolled in the program. Additionally, there are always those who miss the eligibility cutoff and continue to suffer with exorbitantly priced or unaffordable health insurance.

Reinsurance is a common industry tool to distribute an insurer's risk, protecting them against a surge in claims or a single large claim that exceeds their financial capacity. Reinsurance can be thought of as insurance for insurance companies.

Risk Equalization Systems work similarly to the way reinsurance works, but the mechanics are different. An actuarial basis is calculated for an entire demographic group within a geographical area, which serves as a guide for evaluating the risk characteristics of each insurer. All insurers put money into a fund, and then those with higher risk portfolios receive money from the fund to compensate them for serving higher risk customers. This equalization levels the playing field, solving the problems of cream skimming, pre-existing conditions, and the unwillingness of insurers to take on higher cost individuals.

This approach promotes fair competition with pricing based on true actuarial costs while leveraging all the advantages of private insurance. When coupled with a subsidy system to assist low-income families in purchasing insurance, it solves the issues of portability and universal coverage. When universal coverage is achieved, so is the problem of adverse selection solved. Finally, it avoids the severe pitfalls of nationalized health systems, such as Great Britain's National Health Service or the Canadian Health Care System, that are bureaucratic, stifle innovation, sacrifice quality of care, and have long waiting lists to get care, which explains why wealthy individuals from those countries avoid their own healthcare systems and travel to the United States for meeting their healthcare needs.[18]

---

[18] John C. Goodman, Gerald L. Musgrave, and Devon M. Herrick, with a foreword by Milton Friedman, *Lives at Risk: Single-Payer National Health Insurance around the World*, Lanham: Rowman & Littlefield Publishers, published in cooperation with the National Center for Policy Analysis, 2004, especially pp. 38, 69, 131, 132. For wealthy consumers traveling to the U.S. for their care, see Tricia J. Johnson and Andrew N. Garman. "Demand for international medical travel to the USA." Tourism Economics, Vol. 21, No. 5, October 2015, pp 1061-1077: https://journals.sagepub.com/doi/10.5367/te.2014.0393; Randi Druzin, "Crossing the Border for Care," U.S. News, August 3, 2016: https://www.usnews.com/news/best-countries/articles/2016-08-03/canadians-increasingly-come-to-us-for-health-care; Danny Buckland, "200,000 Desperate Britons Go Abroad for Medical Care as NHS Waiting Lists Spiral," Express, April 14, 2015, updated April 24, 2015: http://www.express.co.uk/news/uk/570305/Britons-NHS-waiting-lists-medical-treatment.

Conclusion

Individuals experience benefit cliffs coming off public programs, such as Medicaid, because of the unaffordability of care. Individuals are then faced with out-of-pocket costs that come in the form of premium shares, deductibles, coinsurance, and copays. The unaffordability is impacting employers, which explains why they are purchasing policies that shift more of the cost to their employees. The unaffordability problem is also true for individuals receiving subsidies for policies through the government-run Health Insurance Exchanges.

Problems with the health insurance system lie at the heart of the problem that have unique obstacles preventing the market to function properly. These obstacles include pre-existing conditions, opaque pricing, separation of consumer behavior from pricing, lack of portability, cream skimming, and adverse selection. Nationalized health systems, such as in Great Britain and Canada, are poor options because they introduce other problems that are more bureaucratic, stifle innovation, having long waiting lists, and sacrifice quality of care.

A temporary and partial solution to Medicaid benefit cliffs is for states to submit waiver requests to the federal government allowing them to structure their program with the combination of deductible health plans and health savings accounts. The plan would include the ability of Medicaid participants to keep unused funds in their health savings accounts when they become no longer income eligible for Medicaid to help them defray out-of-pocket expenses.

A permanent and comprehensive solution strengthens the private health insurance system to make it into a consumer-driven, market-based risk equalization system relying on American entrepreneurship. States submit waiver requests to the federal government to allow them to restructure the health insurance industry to equalize risk among insurers and capture federal funds to create a sliding scale to help low-income individuals afford healthcare. This solution is based on practice and how insurance works from behind the scenes making for a seamless consumer experience. Insurers participate in an equalization fund based on true actuarial costs that levels the playing field, and policies are in the name of individuals. This enhanced system solves the unique obstacles facing the industry, including pre-existing conditions, opaque pricing, separation of consumer behavior from pricing, lack of portability, cream skimming, adverse selection, and uninsured individuals.