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Introduction

New York's little-known Advanced Premium Tax Credit Premium Program (APTC-PP), enacted in 2013, made health care coverage more affordable for thousands of low-income New Yorkers each month before it quietly ended as planned in 2015. Though it pales in comparison to many other Affordable Care Act (ACA) implementation tasks, the APTC-PP represented a creative solution to one challenge posed by the ACA: how to leverage new federal funds without harming low-income consumers. The program's design—a state subsidy layered on top of federal subsidies for Qualified Health Plan (QHP) coverage through New York State of Health (NYSOH), the state's Exchange or Marketplace—offers some lessons that may be useful in the future, as policymakers grapple with questions of the affordability of health coverage.

Background

From the moment the ACA was approved in 2010, complex decisions with tight deadlines began piling up for New York policymakers—whether to set up a state Exchange or rely on a federal one, which benchmark plan to pick as the basis for essential health benefits for individuals and small groups, and what standards to set for the QHPs that would offer coverage, to name just a few. One category of decisions involved whether to realign or eliminate home-grown affordable health insurance programs, supported all or in part by state funding, once the ACA made new types of federal funding available—for example, increased matching funds for states that expanded Medicaid eligibility, and premium and cost-sharing subsidies for QHPs. In the case of the State's Healthy NY program,[1] which provided a modest subsidy and stripped-down benefits to individuals not eligible for Medicaid, the decision was a comparatively easy one; individual enrollees would receive better and more affordable coverage through the Exchange. However, whether to continue funding the Family Health Plus (FHP) program, a Medicaid expansion implemented in 2000 through State legislation[2] and amendments to existing Medicaid waivers, was a more difficult decision.

FHP expanded Medicaid eligibility criteria from the Medicaid level to up to 100 percent of the Federal Poverty Level (FPL) for single adults and childless couples, and up to 150 percent FPL for parents. New York reported 338,229 adults with children enrolled in FHP in 2012, along with 93,080 adults without children.[3] Certain ACA provisions, however, provided strong incentives for New York to redesign its public programs. Unlike the mainstream Medicaid Managed Care program, FHP was financed through State and federal funds, with no local share. The ACA offered much higher federal matching payments to states that increased Medicaid eligibility to 138 percent FPL, and also provided deep premium and cost-sharing subsidies for QHPs purchased through the Exchange by the remaining FHP population: parents earning 138–150 percent FPL, the top of the programs' eligibility bracket.[4] As implementation deadlines drew closer, the question became how to take advantage of this new federal funding (the APTC) without creating hardships for FHP enrollees—or those who would become eligible for the program—and the APTC-PP emerged as the answer.

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Framework for the APTC-PP

The APTC-PP was adopted in March 2013 as part of an extensive set of amendments needed to implement the ACA.[5] Carefully timed to coordinate with expanded Medicaid eligibility adopted by New York and the availability of Exchange coverage with subsidies, the statute first suspended any new enrollment in FHP beginning on January 1, 2014, but it allowed parents already enrolled in FHP who did not meet the new federal Medicaid eligibility level to stay on the rolls through the end of 2014, when the FHP program would be repealed outright. To head off hardships that would result from moving from the $0 premium FHP to QHP coverage with less generous subsidies, the legislation authorized the State to supplement the federal QHP payments to plans, with State premium subsidies for two groups of new QHP enrollees: parents who *would* have been eligible to enroll in FHP in 2014, and the grandfathered FHP 2014 parents who would need to replace their FHP coverage with QHPs in 2015. Finally, the legislation directed state officials to seek federal financial participation in the program as part of the Medicaid waiver process in order to further reduce New York Medicaid costs.

The Mechanics of the APTC-PP

With only a few months until the premium subsidies were scheduled to flow—and a mountain of other ACA implementation tasks on their plate—State officials needed to act quickly. Crafting the APTC-PP as a "Designated State Health Program" like FHP in an extension application for its existing Medicaid Section 1115 waiver[6] won federal financial participation for the program, limiting its cost to New York. Actually providing the subsidies required the state to use Medicaid program tools, leverage new capabilities developed as part of the implementation of the ACA, and tap into the collaborative process already underway with participating health plans certified as QHPs. The main tool for implementing the APTC-PP was the new automated, integrated enrollment system NYSOH implemented as the core of its operations, which coordinated subsidy and enrollment eligibility not just for QHPs, but for all public programs—Child Health Plus, Medicaid Managed Care, and FHP. These capabilities allowed New York to take on several tasks necessary to implement the APTC-PP: 1) identifying potential APTC-PP QHP enrollees; 2) helping them enroll in the silver plans[7] necessary to access the subsidy; 3) calculating the difference between the federal premium subsidy and the monthly cost of the plan; 4) notifying the QHP of the member's enrollment in the APTC-PP program; and 5) facilitating the payment of the additional subsidy to the QHP. This last task was undertaken by eMedNY, the Medicaid system used to collect encounter data, process claims, and make electronic payments to health plans. APTC-PP enrollment data relayed to health plans, which paralleled enrollment notification and confirmation data exchanged by NYSOH and QHPs, was a key step, since it alerted health plans of which members were eligible for APTC-PP; otherwise health plan systems would have recorded the absence of a premium payment from their new member, which could have triggered disenrollment. The remittances of the additional subsidy from eMedNY to QHPs, when coupled with the federal APTC payment, brought the enrollee premium down to $0 and made up the difference to the plan.

The amount of federal APTC payments and State APTC-PP payments varied based on the size of the household, the household's income,

and the QHP selected. Figure 1 provides an example of how the program worked in the case of a hypothetical four-person household in Brooklyn (two adults and two children) with annual earnings at the higher end of the APTC income limit (150 percent FPL, or $36,375 annually), enrolling in the lowest-cost silver plan for a couple in 2015. With a total monthly premium of $743.50 for the plan, the APTC would cover $512.19 per month and the APTC-PP provided the remaining $231.31. State officials' preliminary estimates of the costs of these monthly premium subsidies[8] indicate total expenditures of $36.8 million for the life of the program. About $1.3 million in expenses were incurred as the program was getting off the ground in state fiscal year 2014, $17.6 million over the full state fiscal year 2015, and $17.8 million for the final nine months of the program in state fiscal year 2016.

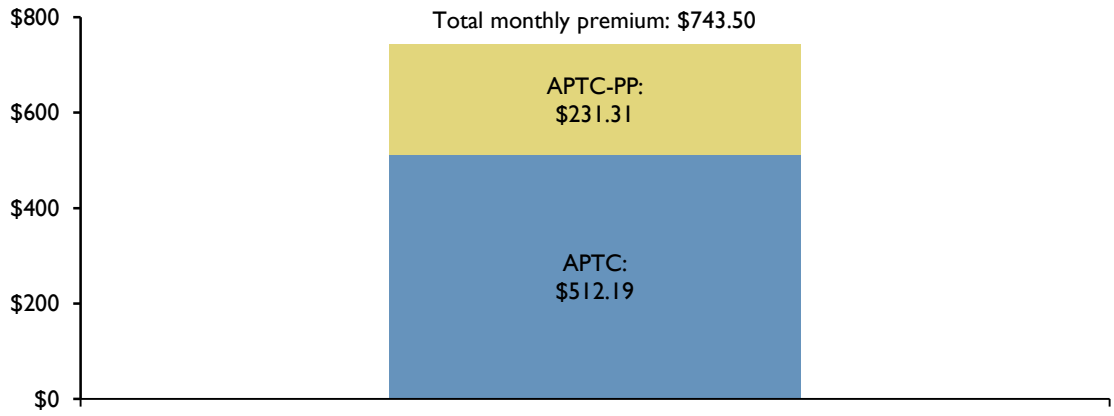
APTC-PP Enrollment

All told, monthly enrollment reports provided by the state show combined monthly enrollment of nearly 160,000 New Yorkers over the life of the program. Monthly enrollment (Figure 2) started slowly at inception, reaching 2,000 members in its first month, but grew to over 10,000 in May 2014 and to 13,000 by the end of that year. The second-year enrollment data shows the impact of the grandfathered FHP population entering the program: monthly enrollment numbers climbed steadily from 15,500 in March 2015 to nearly 19,000 members in October 2015, the start of the 2016 open enrollment cycle for NYSOH.

Lessons from the APTC-PP

Originally established on an open-ended basis, the APTC-PP ultimately became the bridge to a new state program, the Basic Health Program (BHP), an option allowed to states under the ACA to cover Exchange-eligible enrollees in households earning less than 200 percent FPL, offering reduced premiums and less cost sharing than QHPs.[9] Since the BHP provides a 95 percent matching rate for a group of legal immigrants formerly enrolled in Medicaid without federal support, the program is another example of the fiscal considerations that are part of policy decisions. In the 2016 initial open

Figure 1. Example of Federal and State Premium Subsidies for a Two-Adult, Two-Child Household in 2015 with APTC-PP



Source: NYSOH View Plans Now tool, https://nystateofhealth.ny.gov/individual.

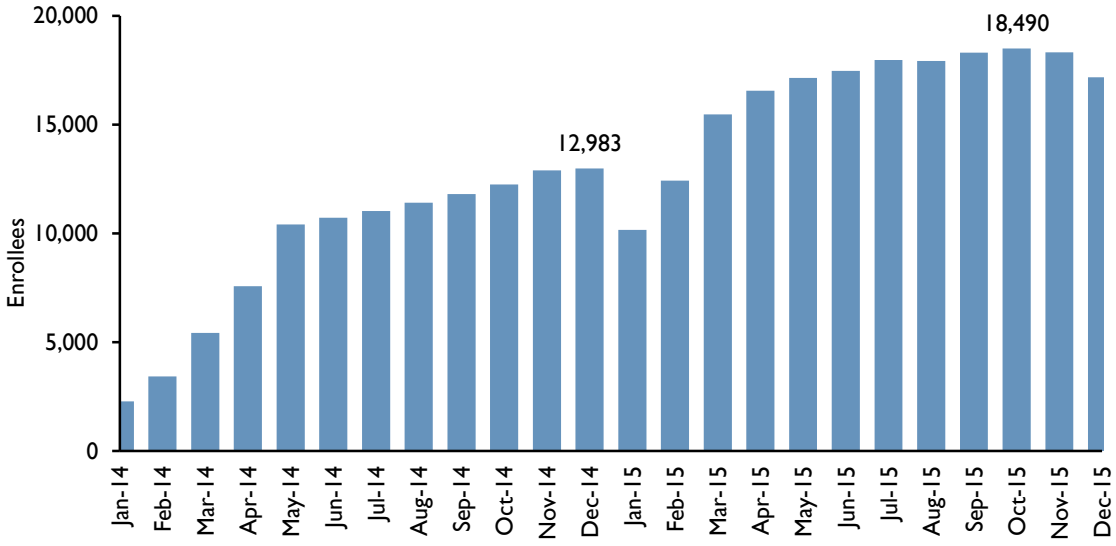
enrollment period for NYSOH, APTC-PP enrollees, including some formerly enrolled in FHP, were enrolled instead in New York's BHP, known as the Essential Plan, with $0 premium payments for this income group, but slightly higher cost sharing than they would have had under the FHP program.

While the implementation of the BHP closed the books on New York's APTC-PP, this experiment offers some other lessons in the context of State options to increase the affordability of coverage in the Exchange for those enrollees not eligible for the BHP, to assist underserved groups such as residents not meeting "lawfully present" standards and thus ineligible to purchase coverage through the Exchange, and perhaps to extend coverage to children currently covered under the Child Health Plus (CHP) program. If changes are made to the federal CHIP statute or federal funding is not renewed when it is set to expire next year, families with children in CHP might face higher premiums, and would incur sharply increased cost-sharing expenses if enrolled in QHPs.[10]

Subsidizing Premiums. The adequacy of federal premium subsidies has been debated since the creation of the ACA, and the affordability question is now coming into sharper focus as enrollment data accumulates and the characteristics of those still lacking coverage become known. One recent analysis of the remaining uninsured[11] noted that while increased outreach might be successful in enrolling lower-income people currently without coverage but eligible for Medicaid or deep ACA premium and cost-sharing subsidies, increasing coverage for moderate-income uninsured is unlikely to be successful without additional subsidies. In New York, for example, BHP enrollees whose earnings push them above the 200 percent FPL level for the BHP would see premiums rise from $20 per month to over $100 for a QHP.[12]

With the APTC-PP, New York executed a premium subsidy program that worked alongside QHP coverage to increase affordability. Because of the short period for implementation and the temporary nature of the APTC-PP, State officials were unable to fully integrate systems used for

Figure 2. APTC-PP Monthly Enrollment, 2014 and 2015



Source: New York State Division of the Budget and New York State of Health.

federal and State subsidy payments. With the comparatively small enrollment, the investment required for such an undertaking would not have been cost-effective either. The fact that State officials and health plans were occupied with the entire range of ACA implementation duties, rather than just managing a premium subsidy program, also increased the degree of difficulty. But with the cooperation of health plans seeking to avert hardships for their FHP enrollees and recognizing that increased federal funding would help keep New York under its self-imposed Medicaid spending cap, elbow grease replaced sophisticated data exchanges in some cases, helping the program to work. For example, a health plan might manually record the enrollment of an APTC-PP member after receiving notification from NYSOH, and shut off a late premium notice that its main system would generate to account for the missing portion of the premium, since it was unable to electronically manipulate the notification so the enrollee's status was automatically updated. With longer lead time and a scale that justified a greater investment, however, improvements could be made to better integrate and support the data exchanges necessary for a more seamless state subsidy program, a functionality that could perhaps be considered as New York continues work on the information system that will replace eMedNY.[13]

Subsidizing Cost Sharing. The APTC-PP brought premiums down to $0, but it did not provide subsidies to offset additional cost sharing that FHP enrollees encountered with their new QHP coverage. As shown in Table 1, although out-of-pocket maximums for APTC-PP enrollees were capped at $1,000 and preventive care is free under ACA requirements, State rules for FHP provided that members could not be denied services if unable to afford cost-sharing amounts owed to providers. But even if New York policymakers had determined that coupling the APTC-PP with additional cost sharing made sense despite the additional cost, the design of the federal cost-sharing reduction (CSR) payment mechanism would have made that a more difficult undertaking for both the State and health plans.

Under the ACA, QHP enrollees in households earning up to 400 percent FPL are eligible for sliding-scale premium subsidies, but CSRs are available only to households earning less than 250 percent FPL. The payment sent to health plans includes both of these two subsidies, but the CSR payments are adjusted after the policy year through a complex reconciliation process[14] that involves reprocessing all of a member's claims from the previous year. The process is designed to account for minor differences in cost-sharing benefit designs, and also to reduce

Table 1. Cost Sharing in Family Health Plus and Qualified Health Plans

	FHP	QHP 100–150% FPL
Deductible	$0	$0
Maximum OOP	Inability to pay	$1,000
Inpatient	$25	$100
PCP Copay	$5	$10
Specialist Copay	$5	$20
Drug Copay	$3/$6	$6/$15/$30

OOP: out-of-pocket costs. PCP: primary care physician.

Source: New York State Department of Health. March 1, 2014. Medicaid Managed Care/ Family Health Plus/ HIV Special Needs Plan Model Contract, and New York State of Health. Invitation and Requirements for Insurer Certification and Recertification for Participation in 2017, Attachment B.

federal outlays based on actual experience, compared to estimates when the advanced payment was made. If the member spent less out-of-pocket than estimated in the advance payment, health plans must repay that amount; if the member's cost sharing exceeded estimates, the CSR payment to the plan might be supplemented. Since the process is complicated—one of the experts we spoke with aptly described it as "pseudo-re-adjudication"—many health plans rely on vendors to oversee the reconciliation.

A Different Approach: The Massachusetts ConnectorCare Program

Adding a state cost-sharing subsidy adds another layer of complexity, but Massachusetts did just that: it piggy-backed both a premium and a cost-sharing subsidy on top of the federal processes in place through its ConnectorCare program, administered by its exchange, the Massachusetts Health Connector.

ConnectorCare was designed to preserve the more generous affordability standards that Massachusetts had in place before the adoption of the ACA, through its landmark 2006 reform.[15] Under the program, the Health Connector contracts with a subset of plans offering QHPs in the market, selected through a competitive bidding process, and provides additional premium and cost-sharing subsidies on a sliding-scale basis (the "State Wrap") for enrollees in five income groups: 0–100 percent FPL, 100–150 percent FPL, 150–200 percent FPL, 200–250 percent FPL, and 250–300 percent FPL. Premium subsidies are based on the lowest-cost ConnectorCare plan; in 2016 estimated premiums ranged from $0 per month for enrollees earning less than 150 percent FPL to $123–$226 per month for enrollees at the highest end of the eligibility scale, depending on the cost of the plan they selected. In contrast, the NYSOH premium contributions for the lowest-priced silver plan in Albany for an individual at 300 percent FPL (about $35,300 in household income) was about $261 per month.[16] The Massachusetts cost-sharing subsidies resulted in plans with actuarial values of 95–99 percent, with maximum out-of-pocket costs of $250–$1,500 and the elimination of deductibles and coinsurance for all enrollees.[17]

About 164,400 people were enrolled in ConnectorCare plans as of April 2016,[18] at an estimated cost of about $200 million.[19] For the fiscal year that begins July 1, 2016, lawmakers proposed a budget of $190.7 million for ConnectorCare, $94 million of which is earmarked for the state premium subsidy, for which Massachusetts receives a federal match through its Medicaid Section 1115 waiver,[20] except for a subset of enrollees who are low-income, legal residents but do not meet federal Medicaid eligibility requirements. Some unique factors gave Massachusetts a leg up on other states contemplating a premium and cost-sharing subsidy program.

Although the Health Connector had a famously difficult first year,[21] the ConnectorCare program and the responsibilities of health plans were incorporated in exchange planning and QHP procurement from the start, and built on a previous Medicaid expansion known as CommonwealthCare. Procurement documents outlining QHP responsibilities set out a detailed two-step formula for the reconciliation of both federal and state cost-sharing subsidies.[22] The Health Connector is in the midst of the cost-sharing reduction reconciliation with participating ConnectorCare plans for the first years of the program, and it has budgeted for a $10 million return of payments from plans. Finally, unlike NYSOH, the Health Connector

collects enrollee premiums and then remits them to QHPs. So, even though there might be three sources of premiums for health plans to track for some ConnectorCare enrollees—APTCs, state subsidies, and member payments—the HealthConnector is the source of two of those payments, and directs the payment of the third.

Conclusion

The APTC-PP was a creative approach to maximizing available federal funding—conceived and executed within months of the passage of enabling legislation—that protected FHP-eligible enrollees from higher premiums that could have led to the loss of coverage, and provided a glide path to similar coverage offered through the BHP. Because of the way that FHP enrollment was reported, and the eligibility of the "would have been eligible for FHP" individuals for APTC-PP assistance, it is difficult to gauge the number of individuals eligible for assistance who did not receive it and as a result were forced to drop coverage. But as Figure 1 shows, enrollees in the APTC-PP received a significant benefit—more than $2,800 in annual premium savings for the hypothetical family highlighted—and Figure 2 shows that thousands of people accessed this benefit each month during the life of the program.

The program also served as a trial run for what could be a more enduring premium subsidy program, albeit one that would need to be implemented on a larger scale in order to justify necessary investments. Obviously, this type of QHP premium subsidy program carries none of the complexity of programs used by most states to reduce Medicaid costs by subsidizing employer-sponsored coverage for eligible beneficiaries, since it involves neither group coverage nor Medicaid beneficiaries, and so avoids complicated cost-benefit calculations, benefit wraps, direct payments to providers to reduce cost-sharing, and other features of the Medicaid programs.[23] Populations that might be considered for this type of program include noncitizens, children enrolled in the next iteration of CHIP, or QHP enrollees facing a cliff as they move from a deeper level of subsidy to a less generous one.

Subsidizing cost-sharing with state payments using the federal CSR payments, however, would be more complicated, though Massachusetts has undertaken that task. Another approach to consider would be to sidestep the painstaking CSR payment and reconciliation process, and instead provide a premium subsidy covering the difference between the silver level plan necessary for the APTC, and a "platinum plus" plan with a high actuarial value. A platinum level plan carries an actuarial value of 88 to 92 percent of a typical enrollee's expenses and, for the lowest-income enrollees, the combination of APTCs and CSRs would bring that value closer to 95 percent to eliminate some but not all of the cost-sharing required at the level. Establishing a standardized plan at a higher actuarial value—somewhere between a platinum plan and $0 cost sharing provided under CHP coverage, or QHP coverage for American Indians[24]—would be easier to implement.

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