

COMMITTEE MEETING EXPANDED AGENDA**SELECT COMMITTEE ON PATIENT PROTECTION AND
AFFORDABLE CARE ACT****Senator Negrón, Chair
Senator Sobel, Vice Chair****MEETING DATE:** Monday, February 11, 2013**TIME:** 2:00 —5:00 p.m.**PLACE:** *Pat Thomas Committee Room, 412 Knott Building***MEMBERS:** Senator Negrón, Chair; Senator Sobel, Vice Chair; Senators Bean, Brandes, Flores, Gibson, Grimsley, Legg, Simmons, Smith, and Soto

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Public Testimony		
2	Presentations on the State's Option to Expand Medicaid Eligibility Joan Alker, M.Phil Research Associate Professor, Health Policy Institute Greg Mellowe, Director of Health Research and Analysis, Florida Center for Fiscal and Economic Policy		Presented
3	Presentation: Economic Impacts of the Patient Protection and Affordable Care Act in Florida A Report Sponsored by the Florida Hospital Association		Presented
4	Panel Discussion on Medicaid Expansion Impacts on Florida's Hospitals		Discussed
5	Medicaid Expansion Impacts in Other States Tarren Bragdon, President & CEO, Foundation for Government Accountability Mary Mayhew, Commissioner, Maine Department of Health and Human Services		Presented
6	Committee Member Discussion of the State's Option to Expand Medicaid Eligibility		
7	Other Related Meeting Documents		



Joan Alker is co-executive director at the Georgetown Center for Children and Families and for the past ten years a Research Associate Professor at the Georgetown University Health Policy Institute. Her work focuses on health coverage for low-income children and families, with an emphasis on Medicaid, CHIP and the ACA. She has authored numerous reports and studies on a range of issues including Medicaid waivers, children's coverage, premium assistance and is the principal investigator of a multi-year study on Florida's Medicaid program.

A frequent speaker and commentator, Alker has over twenty years of experience working on issues affecting low-income families. She holds a Master of Philosophy in politics from St. Antony's College, Oxford University and a Bachelor of Arts with honors in political science from Bryn Mawr College.



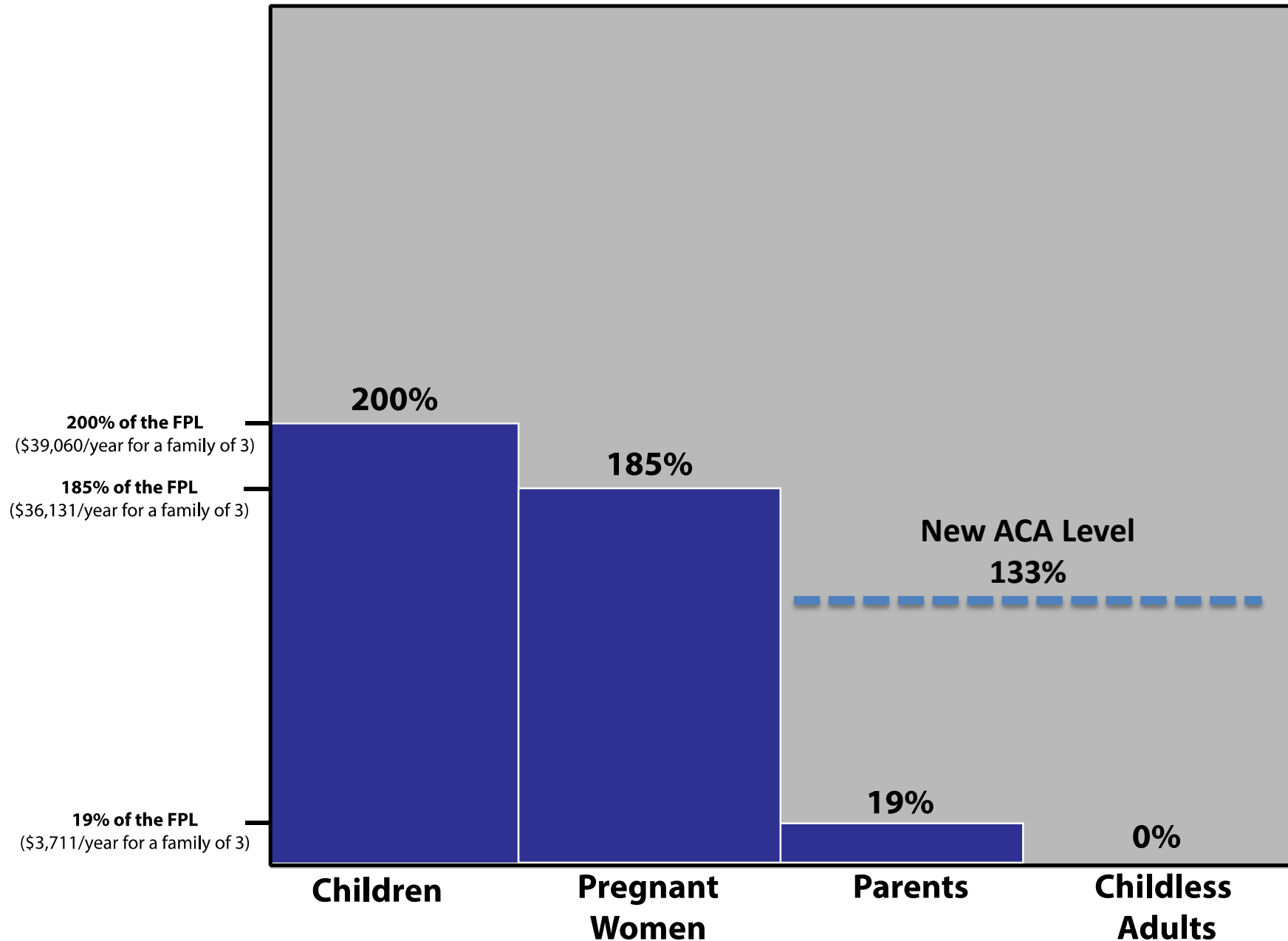
Georgetown University
Health Policy Institute
CENTER FOR CHILDREN
AND FAMILIES

Florida's Medicaid Choice Under the ACA

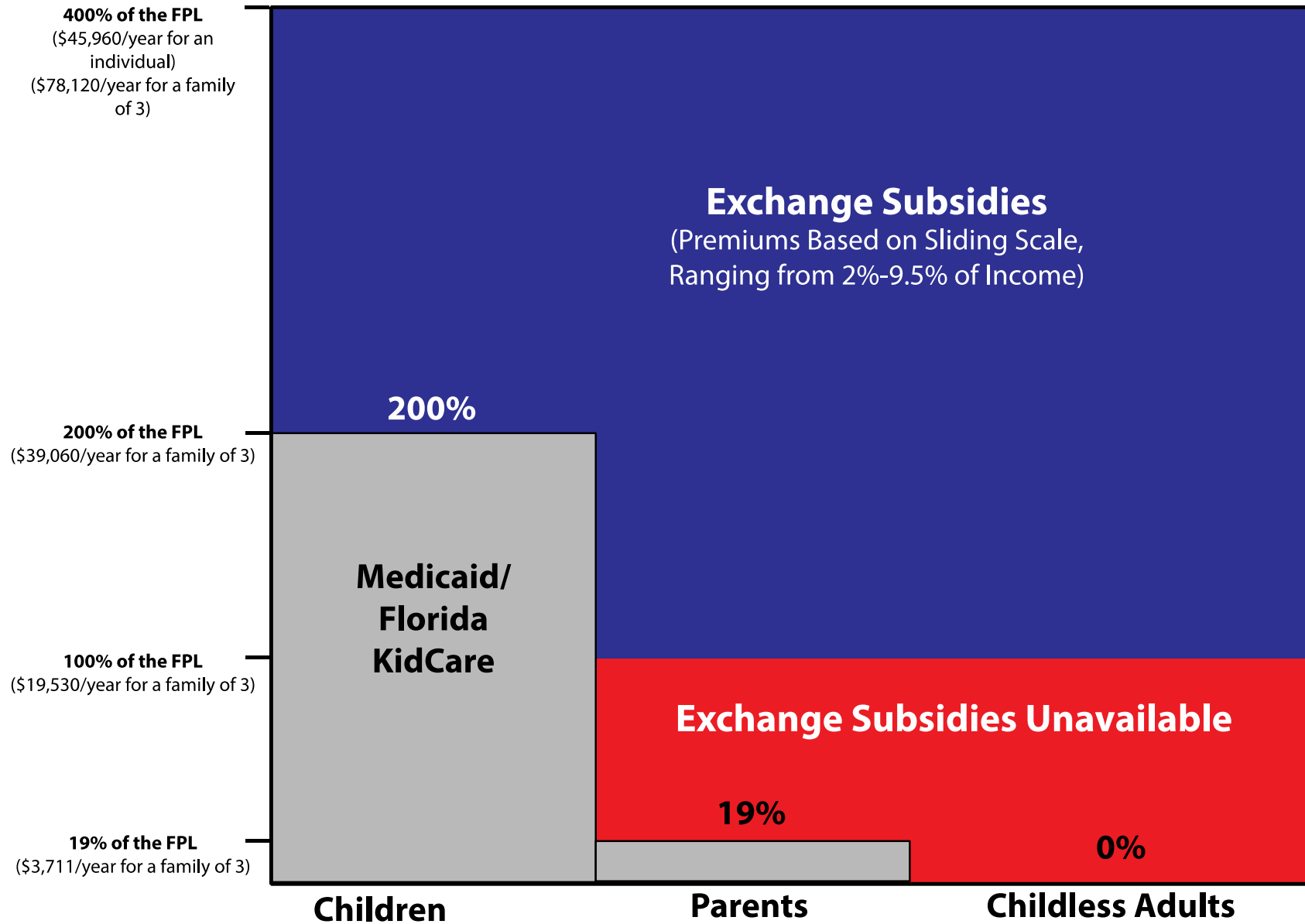
Joan Alker
Research Associate Professor
Georgetown University Health Policy
Institute

Select Committee on PPACA, Tallahassee
February 11, 2013

Florida Medicaid eligibility levels



Who will remain uncovered without broader Medicaid coverage?



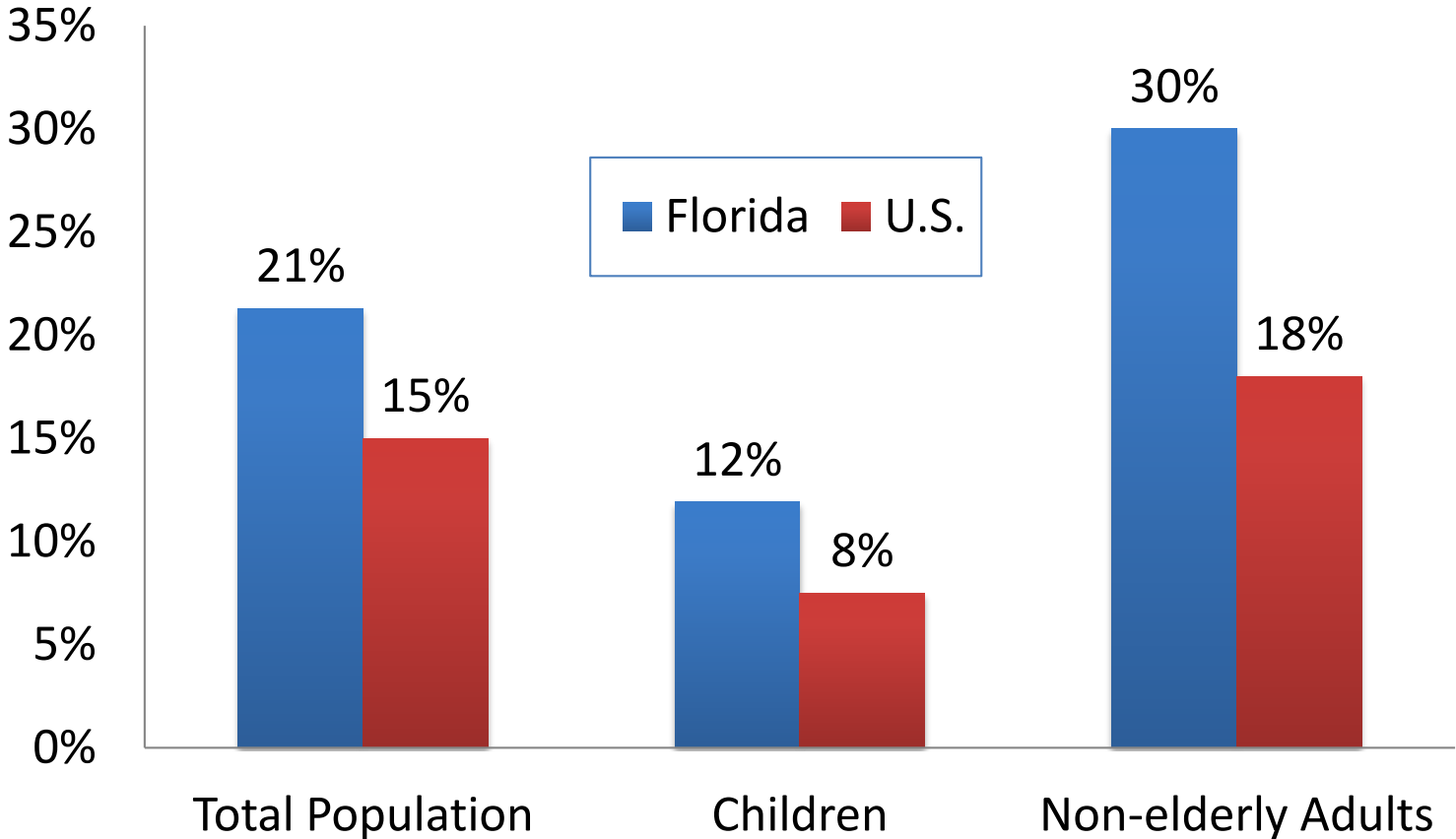
Medicaid coverage improves access and saves lives

- Children in Medicaid have similar access to a regular source of care and same levels of well-child visits as privately insured;
- Mortality declined by more than 6% for newly covered adults in Medicaid;
- Recent comprehensive Oregon study found adult expansion resulted in improved financial security, health status, access to regular source of care, access to prescription drugs.



WHAT IS AT STAKE IN FLORIDA'S CHOICE?

Rate of uninsured in Florida compared to the United States



Uninsured Adults in Florida

	Percent of Uninsured Adults	2011 State Ranking in Percent of Uninsured Adults	Number of Uninsured Adults	2011 State Ranking in Number of Uninsured Adults
Florida	29.5%	50 th	3,388,306	49 th
National	21.0%	--	40,455,941	--

Florida vs. Neighboring States: Rate of Uninsured Adults in 2011

Florida	29.5%
Alabama	20.8%
Georgia	26.8%
Louisiana	25.5%
South Carolina	23.5%
Texas	30.9%

Uninsured Children in Florida

	Percent of Uninsured Children	2011 State Ranking in Percent of Uninsured Children	Number of Uninsured Children	2011 State Ranking in Number of Uninsured Children
Florida	11.9%	48th	475,112	49th
National	7.5%	--	5,527,657	--

Florida vs. Neighboring States: Rate of Uninsured Children in 2011

Florida	11.9%
Alabama	5.3%
Georgia	9.5%
Louisiana	5.8%
South Carolina	8.4%
Texas	13.2%



WHAT'S AT STAKE FOR FLORIDA'S HOSPITALS?

Florida's hospitals at risk

- ACA: significant cuts to Medicaid and Medicare Disproportionate Share Hospital (DSH) funding.
 - DSH programs provide funds to hospitals that serve many low-income patients and thus provide a high level of uncompensated care.
 - ACA assumed much uncompensated care would go away due to increased coverage.
 - FL: \$1.2 billion reduction over 10 years (Urban Inst.)

Florida Low Income Pool

- Florida's Medicaid 1115 five-county waiver includes a fund of \$1 billion federal dollars known as the "Low Income Pool" (LIP).
- LIP funds go to providers (mainly hospitals and health centers) serving large numbers of uninsured persons.
- LIP and the waiver due to expire June 30, 2014.



HOW MANY PEOPLE WILL GET COVERAGE & HOW MUCH WILL IT COST?

How many Floridians would gain coverage?

- We estimate that 800,000 to 1,295,000 adults and children would gain coverage if the state extended Medicaid to parents and other adults below 133% FPL.

Why would children get coverage?

- Coverage is being extended for parents and adults – the “newly eligible”
- But we know that more current eligibles will get enrolled as a result of the “welcome mat” effect. Most of these “eligible but unenrolled” will be children. Parents must enroll their children before they can get coverage.



Preliminary estimates of new Medicaid eligibles/enrollees by County

County	Percent of Total State Medicaid Enrollment	Low Estimate	High Estimate
Broward	8.24%	65,900	106,700
Duval	5.11%	40,900	66,200
Highlands	0.57%	4,600	7,400
Hillsborough	7.32%	58,500	94,700
Indian River	0.58%	4,700	7,500
Martin	0.45%	3,600	5,800
Miami-Dade	18.32%	146,600	237,300
Nassau	0.29%	2,400	3,800
Okeechobee	0.28%	2,300	3,700
Orange	6.54%	52,300	84,700
Osceola	2.23%	17,800	28,800
Palm Beach	5.61%	44,900	72,600
Pasco	2.28%	18,200	29,500
Pinellas	4.10%	32,800	53,200
Polk	3.75%	30,000	48,600
Seminole	1.47%	11,700	19,000
St. Lucie	1.51%	12,100	19,600
Volusia	2.59%	20,700	33,500

States have flexibility in covering new adults

- They can go into managed care without a waiver;
- They can be offered differing benefits packages tied to a commercial benchmark and EHB;
- New federal rules add additional cost-sharing flexibility for adults
- Obscure premium assistance option allows subsidies for individual coverage in exchange

Different federal matching rates apply

- “Newly eligible” are funded at 100% federal cost for FY2014-2016; tapers down to 90% over the next seven years;
- Current eligibles get regular Medicaid match rate (59%) or CHIP match rate (71%)
- Participation rates are likely to go up even without Medicaid extension because of new “culture of coverage”



WHAT'S AT STAKE FOR FLORIDA'S BUDGET AND WHY ARE SO MANY NUMBERS FLYING AROUND?

Why are there so many different estimates?

- Assumptions about enrollment are key
- Assumptions about matching rates can be key
- State estimates only include costs and no offsetting savings
 - Uninsured people are getting some care today at taxpayer expense.
- Some studies look at revenues and jobs generated

Offsetting savings in estimate

- State support for safety-net institutions (public hospitals, health centers)
- State services for people with mental health issues, substance abuse problems, HIV/AIDS
- Medicaid eligibility changes due to health insurance exchange availability
 - Medically needy population
 - Others (e.g., pregnant women above 150% FPL)

Florida's Medically Needy Program

- Those enrolled have very high medical bills and must “spend down” to become eligible
- Children's eligibility (and pregnant women) can not be changed due to the ACA maintenance of effort;
- As of 2014 many adults would likely be eligible for Medicaid expansion or new premium tax credits.

Projecting future state costs (2020)

	BEST ESTIMATE
NEW STATE COSTS PER YEAR	
Cost of Medicaid Coverage for Newly Eligible Population	\$300 million
Cost of Medicaid Coverage for New Enrollment by Currently Eligible Population	\$100 million
Cost of Continuing Higher Primary Care Payment Rates for Physicians	\$200 million
TOTAL NEW STATE COSTS PER YEAR	\$600 million
OFFSETTING STATE SAVINGS PER YEAR	
State/Local Support for Safety Net Providers	\$200 million
State Mental Health, Substance Abuse Programs	\$250 million
Medicaid Eligibility Changes, e.g., Medically Needy Program	\$250 million
TOTAL OFFSETTING STATE/LOCAL SAVINGS PER YEAR	\$700 million
NET STATE/LOCAL SAVINGS PER YEAR	\$100 million

Impact on Florida's budget

- If the state chose to make no offsetting savings *total new costs would likely represent no more than a 1% increase in the state share of Medicaid spending from 2014-2016 and no more than 4% increase in the later years.*

Economic stimulus of federal funding

- Potential for ~ \$26 billion in new federal dollars over 10 years according to Social Services Estimating Conference
- These dollars move into Florida's economy providing jobs and services and revenue

Bottom line

- Florida incurs few costs for adults newly eligible for Medicaid, slightly higher costs for new enrollment by those already eligible
 - FL likely to incur some admin costs; 90% match currently available for IT systems
- But savings due to more coverage should more than offset costs
- New coverage has positive effects for health and quality of life

For More Information

- Joan Alker:
 - jca25@georgetown.edu
- Our website:
 - ccf.georgetown.edu
 - hpi.georgetown.edu/floridamedicaid
- Say Ahhh! Our child health policy blog:
 - www.theccfblog.org/



**Preliminary Georgetown University Estimates of New
Medicaid Eligibles/Enrollees by County**

County	Percent of Total State Medicaid Enrollment	Low Estimate	High Estimate
Alachua	1.05%	8,400	13,600
Baker	0.16%	1,300	2,100
Bay	0.99%	7,900	12,800
Bradford	0.17%	1,400	2,200
Brevard	2.30%	18,400	29,800
Broward	8.24%	65,900	106,700
Calhoun	0.09%	700	1,200
Charlotte	0.61%	4,900	7,900
Citrus	0.69%	5,500	8,900
Clay	0.73%	5,800	9,500
Collier	1.27%	10,100	16,400
Columbia	0.46%	3,700	6,000
Desoto	0.24%	1,900	3,100
Dixie	0.12%	900	1,500
Duval	5.11%	40,900	66,200
Escambia	1.79%	14,300	23,200
Flagler	0.43%	3,400	5,500
Franklin	0.07%	500	900
Gadsden	0.37%	2,900	4,700
Gilchrist	0.10%	800	1,300
Glades	0.04%	300	500
Gulf	0.08%	600	1,000
Hamilton	0.11%	800	1,400
Hardee	0.23%	1,800	2,900
Hendry	0.34%	2,700	4,400
Hernando	0.95%	7,600	12,300
Highlands	0.57%	4,600	7,400
Hillsborough	7.32%	58,500	94,700
Holmes	0.16%	1,300	2,100
Indian River	0.58%	4,700	7,500
Jackson	0.32%	2,600	4,200

County	Percent of Total State Medicaid Enrollment	Low Estimate	High Estimate
Jefferson	0.08%	600	1,000
Lafayette	0.04%	300	500
Lake	1.47%	11,800	19,100
Lee	3.00%	24,000	38,800
Leon	1.06%	8,400	13,700
Levy	0.26%	2,100	3,400
Liberty	0.05%	400	600
Madison	0.14%	1,200	1,900
Manatee	1.46%	11,700	19,000
Marion	1.95%	15,600	25,200
Martin	0.45%	3,600	5,800
Miami-Dade	18.32%	146,600	237,300
Monroe	0.22%	1,800	2,900
Nassau	0.29%	2,400	3,800
Okaloosa	0.74%	5,900	9,600
Okeechobee	0.28%	2,300	3,700
Orange	6.54%	52,300	84,700
Osceola	2.23%	17,800	28,800
Palm Beach	5.61%	44,900	72,600
Pasco	2.28%	18,200	29,500
Pinellas	4.10%	32,800	53,200
Polk	3.75%	30,000	48,600
Putnam	0.62%	5,000	8,000
Santa Rosa	0.58%	4,600	7,500
Sarasota	1.32%	10,600	17,100
Seminole	1.47%	11,700	19,000
St. Johns	0.51%	4,100	6,600
St. Lucie	1.51%	12,100	19,600
Sumter	0.29%	2,300	3,700
Suwannee	0.30%	2,400	3,900
Taylor	0.14%	1,100	1,900
Union	0.08%	700	1,100
Volusia	2.59%	20,700	33,500
Wakulla	0.13%	1,100	1,700
Walton	0.23%	1,900	3,000
Washington	0.16%	1,300	2,100

Note: Whether enrollment falls closer to the low or high estimate will depend on participation rates.

Florida's Medicaid Choice: Understanding Implications of Supreme Court Ruling on Affordable Health Care Act

Key Points *As a result of the recent U.S. Supreme Court ruling, Florida must decide whether or not to extend Medicaid coverage to persons with incomes below 133 percent of the federal poverty level – a decision that has significant consequences:*

- » An estimated 800,000 to 1,295,000 uninsured adults and children in Florida will gain coverage if the state moves forward.
- » The state can expand coverage without assuming any new net costs by achieving savings in other areas of the state's budget. In fact, overall state costs are likely to be reduced by some \$100 million annually because some safety net programs will become less necessary.
- » If the state does not expand coverage, Florida's hospitals will lose federal revenue without offsetting gains in coverage for their patients.

Florida's Experience with

**MEDICAID
REFORM**

OVERVIEW

On June 28, 2012, the U.S. Supreme Court handed down its much-anticipated decision on the constitutionality of the Patient Protection and Affordable Care Act, the major health care reform law passed by Congress in 2010.¹ Much to the surprise of most observers, the Court ruled that the entire act was constitutional with one exception – the federal Department of Health and Human Services' authority to enforce the Act's mandatory expansion of Medicaid coverage benefits.² This feature of the Act extends Medicaid coverage to adults with incomes less than 133 percent of the federal poverty level (FPL) -- equivalent to \$14,856 for a single person or \$25,390 for a three-person family.

The practical consequence of the Court's ruling is that states now have a choice as to whether to extend coverage to these low-income adults.

Reducing the number of uninsured Americans is a key aim of the Affordable Care Act as the United States moves toward a system of universal coverage on January 1, 2014.

The Act includes two principal means to reduce the number of uninsured Americans:

- » Federally funded tax credits for insurance premiums to be offered to individuals to purchase coverage through health insurance exchanges, which the Congressional Budget Office estimates will cover between 20 million and 25 million persons;
- » An expansion of the Medicaid program to adults with incomes below 133 percent of the federal poverty level, which, prior to the Supreme Court decision, was estimated to cover 16 million to 17 million persons.³

In Florida, an estimated 1.295 million uninsured adults would be newly eligible to gain coverage if the state elects to extend coverage.⁴ In addition, adults and children who are currently eligible but not enrolled in Medicaid are more likely to gain coverage should the state take up the Medicaid option – 500,000 children and 250,000 adults in Florida fall into this category.⁵ Many of these children and adults are likely to sign up for Medicaid in 2014 even if the state opts against extending new coverage.

The new Medicaid coverage comes with an unprecedented infusion of federal matching dollars – the federal government picks up 100 percent of the cost for the newly eligible population from 2014 to 2016, and federal support tapers down to 90 percent in 2020.⁶ The state's own estimates show no costs for the newly eligible adults for the first three years and comparatively modest costs through 2023.⁷

The federal government has made clear that states can opt in and out of covering this newly eligible population at any time. Thus, Florida could pick up the expansion population in 2014 and withdraw from participation when the state had to start putting up matching dollars.

Under Florida law, any major change to Medicaid requires action by the Legislature. An extension of Medicaid eligibility to new populations and any other modification of program eligibility clearly fall under this requirement.

WHAT DOES THE SUPREME COURT'S DECISION MEAN FOR FLORIDA'S MEDICAID PROGRAM?

No doubt constitutional legal scholars and courts will debate the legal implications of the Supreme Court decision in decades to come. For the purposes of thinking about Florida's implementation of the Affordable Care Act, however, the ruling has two key outcomes specific to Medicaid:

1) It appears that other Medicaid provisions of the Act remain intact with important consequences – especially for Florida's children.

The Act also requires that eligibility levels for children covered by Florida Medicaid and the Children's Health Insurance Program (CHIP) must remain stable until October 1, 2019. Florida currently covers these children at a combined Medicaid/CHIP eligibility level of 200 percent FPL and thus cannot lower this threshold. And the state cannot make it harder for children to enroll during this time period; for example, states may not add new premiums, as Florida attempted to do in 2011.⁸

The Act includes a requirement that the state must align and simplify eligibility for all children in Medicaid, regardless of age, at 133 percent of FPL as of January 1, 2014. In Florida, this means that children over age 5 who are currently covered in Healthy Families between 100 and 133 percent of the federal poverty level must be transferred to Medicaid by January 1, 2014. The state will continue to receive the higher CHIP match rate for these children, often called the "stairstep kids," after they move to Medicaid. (Figure 1)

The state also needs to adopt a new nationally uniform and simpler way of calculating income, known as Modified Adjusted Gross Income (MAGI), for the purposes of determining Medicaid and CHIP eligibility for all non-disabled populations by January 1, 2014. This will affect primarily children and parents who are currently covered. Persons over 65 and those who are disabled are not affected by this change.

2) Florida must make a choice on whether or not to extend Medicaid coverage to adults with incomes less than 133 percent of the poverty level – a decision with important consequences for low-income individuals and Florida's health system.

If Florida chooses not to move forward with this new Medicaid option, a gap in coverage will ensue for some of the poorest adults. (Figure 2)

The Affordable Care Act offers tax credits for insurance premiums to those with incomes between 100 percent and 400 percent of FPL if they are not otherwise eligible for Medicaid. No credits are provided if income is less

FIGURE 1: CHILDREN'S COVERAGE IN FLORIDA, 2014

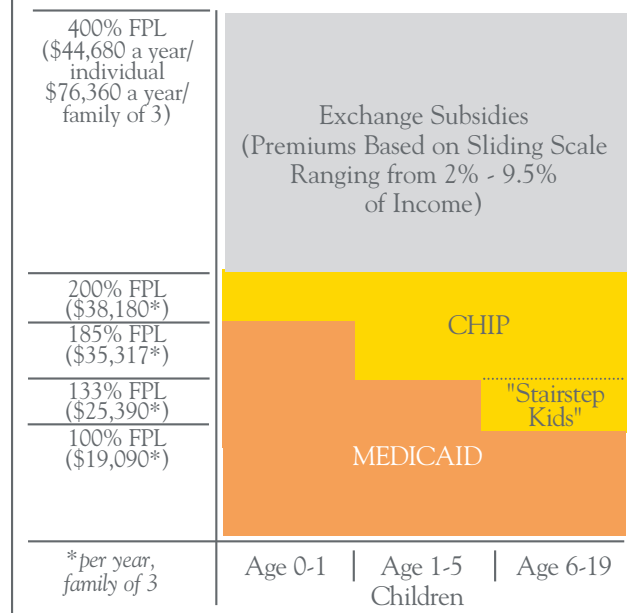
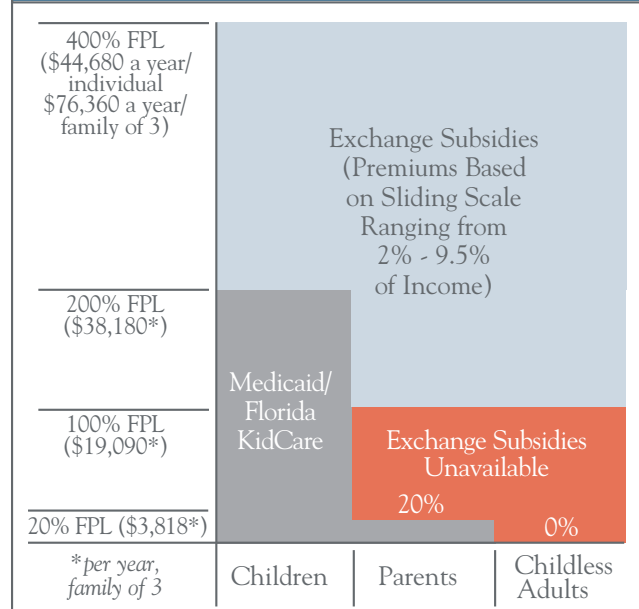


FIGURE 2: WHO WILL REMAIN UNCOVERED WITHOUT BROADER MEDICAID COVERAGE?



than 100 percent of FPL, since the law assumed this group would be eligible for Medicaid.

But Florida has relatively parsimonious Medicaid coverage for adults, and does not currently provide Medicaid coverage for most adults with incomes below 100 percent of FPL.

The result of rejecting the Medicaid expansion will be that childless adults with incomes between 0 percent and 100 percent FPL would have no affordable coverage while those at higher incomes would have access to federal tax credits.⁹

Florida currently only covers parents with incomes of 20 percent FPL or less.¹⁰ Thus a hole in coverage between 20 percent and 100 percent of FPL would exist. The Urban Institute estimates that just fewer than a million Floridians - 995,000 - would fall into this gap and remain uninsured.¹¹ The vast majority of those would gain insurance should the state choose to extend Medicaid coverage

WHAT DOES THE SUPREME COURT DECISION MEAN FOR FLORIDA'S HOSPITALS?

The Supreme Court's decision places hospitals, particularly those serving large numbers of uninsured persons, at significant new risk in states where Medicaid coverage is not extended.

The Affordable Care Act included significant cuts to payments under the Medicare and Medicaid Disproportionate Share Hospital (DSH) funding programs, which are designed to provide funding for hospitals that provide a high level of uncompensated care to patients without insurance coverage.

The Act stipulates that \$22 billion¹² must be cut from Medicaid DSH between FY2014 and FY2022 – a reduction of approximately 50 percent. The Act also cuts Medicare DSH payments by approximately 75 percent starting in FY2014.¹³

The Secretary of HHS has broad discretion in determining how the Medicaid DSH cuts will be allocated to states; as of yet no guidance has been issued by HHS to address this question. However, it is clear from the size of the cut in federal dollars that Florida's hospitals can expect to see significant reductions.

The theory behind the cuts, which helped to pay for the new coverage, was that the move to universal coverage – especially to those populations that would be newly served by the Medicaid program – would result in significantly less uncompensated care for hospitals.

Hospitals in states that choose not to move ahead with the extension of Medicaid are now at significant risk because the DSH cuts will occur regardless.

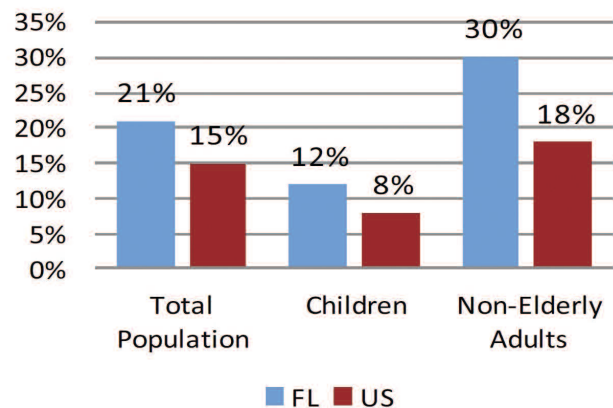
While precise estimates on the impact on Florida's hospitals cannot be determined until further regulatory guidance becomes available, the combined impact of federal Medicare and Medicaid DSH cuts may reduce income from this source by about two-thirds – in the range of \$640 million annually.

Florida's hospitals face another unique challenge should the state not move forward with the Medicaid expansion.

Currently the state's Section 1115 Medicaid Research and Demonstration waiver, which is operating in five counties, contains a statewide fund of federal dollars known as the Low Income Pool (LIP). Many hospitals (and some other safety net providers) currently receive approximately \$2 billion from the LIP – these dollars are primarily intergovernmental transfers from local governments that are matched by federal dollars.

This waiver agreement is scheduled to expire on June 30, 2014. Since the intent of the LIP is to provide additional support to hospitals providing uncompensated care, whether the federal government would continue matching these funds for Florida should the state choose not to pick up the Medicaid expansion at 100 percent federal cost in 2014 is highly uncertain.

FIGURE 3: RATE OF UNINSURED IN FLORIDA COMPARED TO THE UNITED STATES
2011 American Community Survey



WHICH FLORIDIANS WILL BE COVERED IF THE STATE CHOOSES TO EXTEND MEDICAID?

Florida has much to gain from enacting the Medicaid expansion as the state's uninsurance rate is the fourth highest in the country and considerably higher than the national average for both children and adults. (Figure 3)

Nearly 4 million Floridians do not have health insurance today. It is estimated that 1,295,000 uninsured adult Floridians would become newly eligible for coverage if the state chooses to extend coverage. (Figure 4) Parents and children currently eligible also would be more likely to enroll.¹⁴

FIGURE 4: PROJECTED MEDICAID COVERAGE FOR FLORIDA'S ADULTS AND CHILDREN UNDER DIFFERENT ASSUMPTIONS

	ADULTS NEWLY ELIGIBLE FOR MEDICAID	ADULTS CURRENTLY ELIGIBLE FOR MEDICAID	CHILDREN CURRENTLY ELIGIBLE FOR MEDICAID	TOTAL
Total uninsured	1,295,000	257,000	500,000	2,052,000
Projected take-up rate (low assumption)	57%	10%	10%	
Number projected to gain Medicaid coverage (low assumption)	740,000	25,000	50,000	815,000
Projected take-up rate (high assumption)	75%	40%	40%	
Number projected to gain Medicaid coverage (high assumption)	970,000	100,000	200,000	1,270,000

THE NEWLY ELIGIBLE

Adults are more likely than children to lack insurance coverage today as a result of the decline in employer-sponsored insurance, the increasing costs of health insurance and, most importantly, lower levels of Medicaid eligibility.

Florida's Medicaid and CHIP eligibility level for children is 200 percent of the FPL. However, Florida's eligibility threshold for parents is just 20 percent of the FPL (less than \$4,000 annually for a family of three in 2012).

Some pregnant women and some adults with disabilities are eligible for Medicaid at higher income levels. But for the most part, Florida offers no coverage to non-disabled adults without dependent children.

Between 57 and 75 percent of newly eligible adults are expected to enroll in an expanded Medicaid program, based on estimates from the Urban Institute, relying in part on assumptions made by the Congressional Budget Office.

The higher participation rate generally assumes a more aggressive state effort to enroll the population.¹⁵ The lower rates could be more realistic for Florida, given that Florida's participation rate is low by national standards. (For example, enrollment of eligible children in Florida is 77 percent, well below the national average of 85 percent, in fact, the fourth lowest of all states.)¹⁶

Based on the Urban Institute participation rates, 740,000 to 970,000 newly eligible adults would gain coverage.¹⁷ (Figure 4)

THOSE CURRENTLY ELIGIBLE BUT NOT ENROLLED

Implementation of the Affordable Care Act is also expected to spur enrollment among those who currently are eligible for Medicaid, but have not yet enrolled.

This projection is driven by a new "culture of coverage" that is likely to develop as new tax penalties start creating a greater incentive for uninsured Americans to acquire insurance as of 2014, whether or not the state chooses to extend Medicaid benefits. The changing climate is expected to motivate some current non-participants to enroll themselves and their children – even though very low-income families are not subject to the tax penalty.¹⁸

Most of those who benefit from this culture change are expected to be children, since eligibility criteria for adults are limited under current law.

Because these eligible adults and children are not currently enrolled in Medicaid, they are assumed to sign up at a lower rate than those who are newly eligible.¹⁹ Based on participation rates in the Urban Institute analysis, about 25,000 to 100,000 currently eligible adults and 50,000 to 200,000 currently eligible children would be added to Medicaid. (Figure 4)

FAMILIES AND CHILDREN HAVE MUCH AT STAKE IN THE STATE'S MEDICAID CHOICE

There currently are 883,000 parents who are uninsured in Florida, and 223,000 of these uninsured parents – the most vulnerable among them – would become newly eligible for Medicaid should the state decide to extend coverage.²⁸

Florida also has a significant number of parents (approximately 145,000) who currently are eligible for Medicaid but not enrolled.²⁹

Covering parents clearly improves the lives of those parents, but there also are many tangible benefits for their children. Parents' health has a positive impact on a child's health and well-being, such as the child's ability to do better in school. Children are also more likely to be insured and have access to preventive care and receive other health care services when their parents are insured.³⁰ Fully insured families also gain financial stability as medical debt is a leading cause of bankruptcy.

Covering parents also would lead to more eligible children enrolling in Medicaid and CHIP and accessing coverage themselves.

An estimated 500,000 children in Florida are eligible for Medicaid/CHIP but not enrolled.³¹ The average Medicaid/CHIP participation rate in the United States for children is 85 percent and Florida's Medicaid/CHIP participation rate is well below that at 77 percent.

If Florida's participation rate increased to the national average, about 175,000 children would gain coverage.

THE COMBINED IMPACT

After calculating the impact of full implementation of the Affordable Care Act on both groups of beneficiaries (the newly eligible and the currently eligible but not enrolled), between 815,000 and 1,295,000 children and adults in Florida with no health insurance today are projected to gain coverage from Medicaid expansion and the Affordable Care Act. (Figure 4)

MEDICAID COVERAGE SAVES LIVES AND IMPROVES HEALTH

Numerous studies have shown the value of Medicaid coverage.

A 2012 study examined adults in three states that extended Medicaid to childless adults, five years before and after the change. The research found that mortality rates for these adults declined by more than 6 percent.³² The study also found that the number of people who delayed care due to costs declined after gaining Medicaid coverage and that individuals who self-reported their health as “very good” or “excellent” increased.

Similarly, a new and very comprehensive study looking at Oregon found that having Medicaid coverage for one year improved the lives of those enrolled.³³

Access to care was improved, as those with Medicaid were more likely than the uninsured to have a regular source of care and access to prescription drugs. Those with Medicaid coverage also reported more financial security and had fewer unpaid medical bills. Lastly, the individuals with Medicaid coverage, compared to the uninsured, were less likely to indicate that their health status had declined over the previous six months and were less likely to be depressed.

WHAT IS THE IMPACT OF FLORIDA'S MEDICAID CHOICE ON ITS BUDGET?

In an April 2011 policy brief, we presented information on the costs of broader Medicaid coverage required under the Affordable Care Act.²⁰ At that time, we concluded that the state's cost projection for implementing the Act's Medicaid provisions was based on unrealistic assumptions. We found that more realistic assumptions generated a much lower cost estimate and the possibility that offsetting savings might be greater than the new costs to the state.

In August, Florida's Social Services Estimating Conference released new figures on the projected cost of Medicaid expansions – figures that are much closer to those presented in our earlier brief.²¹

The estimates presented in this brief rely on the best available information on the impact on Florida's budget of the Medicaid expansion and other Medicaid changes resulting from the Affordable Care Act. Although we rely primarily on these new state cost estimates, we also look at some potential offsetting savings for state and local support of the health safety net and the changing landscape in 2014 – factors not considered by the Estimating Conference. A more comprehensive look is important for Florida policymakers to consider as implementation of many aspects of the Affordable Care Act begin in 2014

Should Florida choose to extend Medicaid coverage to adults with incomes up to 133 percent of FPL, federal funding will be available to cover a large share of costs for this new coverage. Florida would not need any state funds for newly eligible adults between 2014 and 2016 and no more than 10 percent of these costs into the future.

According to the state's Estimating Conference, over a 10-year period through state fiscal year 2022-2023, the total cost to the state if it chooses to extend coverage would fall below \$300 million per year from 2017 forward – about 3 percent more than the state currently spends each year on Medicaid.

These estimates may be high, however.

For example, the state assumes that about 80 percent of the newly eligible population would enroll in Medicaid – well above the current rate of enrollment for eligible adults and higher than the assumptions of between 57 percent and 75 percent made in the Urban Institute's analysis.²² Achieving 80 percent enrollment, as the state assumes, would be a significant increase when compared to Florida's past performance.

The state's Estimating Conference opted not to issue “official” enrollment projections or cost estimates for those already eligible but not enrolled in Medicaid – the increase in enrollment that would be a likely response to a new “culture of coverage.” While this new enrollment should be encouraged as increasing access to health care, it will come with some new costs to the state.

For this population, neither the full federal funding for 2014 through 2016 nor the high matching funds rate thereafter would apply. Normal federal matching funds, however, would be available for these new enrollees.

Even if all eligible children and adults were to enroll – a highly improbable outcome – new costs to the state would be in the range of \$325 million per year, according to numbers issued by the Estimating Conference. Based on the Urban Institute enrollment assumptions described above, it is probably realistic to expect no more than one-third of these new costs or about \$100 million per year.

Thus, total new costs to the state for all newly covered or enrolled likely represent no more than a 1 percent increase in the state share of Medicaid spending in 2014 to 2016, and no more than a 4 percent increase in later years.

There are several other factors that may lead to state costs being lower than the estimates made by the state's Estimating Conference.

The Estimating Conference assumes that the average newly eligible enrollee will cost Medicaid \$315 per person per month – about 8 percent below the current rate for adults enrolled based on receiving Temporary Assistance for Needy Families, a generally comparable population.

According to a 2010 study, adults who enroll in Medicaid under reform are likely to be less expensive than those already in Medicaid (although more expensive than those who remain uninsured).²³ This is because the sickest, most costly beneficiaries are likely already enrolled in Medicaid by virtue of a disability or because a health care provider has taken steps to make sure they are enrolled as a way to ensure payment. It remains unclear whether the 8 percent lower average spending assumed by the state fully reflects this group's better health – and thus whether an even lower per-person rate would be appropriate.

Although some adjustments might lower the Estimating Conference estimate, other sources of potential costs could increase the estimate modestly.

For example, state administrative expenses could rise as a result of having more people in the program, pushing total spending up somewhat. The impact of some other health reform provisions, such as changes to how prescription drugs are paid for, also have not been considered.

HOW WOULD MORE INSURANCE COVERAGE CREATE OFFSETTING SAVINGS?

Florida's Estimating Conference looks at new state costs for covering a larger Medicaid population, but it does not take into account any potential offsetting savings for the state.

More insurance coverage, through both Medicaid coverage and the health insurance exchanges, will change the nature of the health care safety net.

Today people without insurance typically receive at least some health services through clinics, safety-net hospitals and other community programs that make primary care and other health services available. Persons with mental health problems likely receive some services through state funded programs. When patients lack any means of payment, services are supported by payments from a variety of state and local programs.

IMPROVING ACCESS TO PRIMARY CARE

One additional possible source of new costs to the state comes from a provision in the Affordable Care Act that increases payments to physicians for primary care services.

These higher payments are intended to ensure that an adequate number of physicians will be available to treat both current and new Medicaid beneficiaries.

The most recent available data show that primary care rates paid by Florida Medicaid are only 55 percent of Medicare rates, compared to a national average of 66 percent (only six states rank lower).³⁴ The federal government has committed to paying the entire cost of higher payments at the full Medicare rate in 2013 and 2014.

Florida will face a decision on whether to continue these higher payment rates or to revert to the rates in place today – or somewhere in between.

If the state chooses to keep the higher rates, normal federal matching rates will apply. But new costs to the state could be as high as about \$375 million annually, using the most extreme assumptions about enrollment, but lower based on more realistic participation rate assumptions.

New sources of insurance coverage should reduce the burden on these programs.

Nationally, an analysis by the Lewin Group found that, collectively, state and local governments will save \$198 billion over the 10 years between 2014 and 2023 from a reduced need for safety-net programs.²⁴ If true, these savings would dwarf the \$21 billion to \$45 billion in new state costs throughout the country as identified by the Urban Institute study.

Some of these savings were presumably captured in the Affordable Care Act through the cuts to both Medicaid and Medicare DSH payments that are made to hospitals serving a low-income population. (As mentioned previously, these cuts will occur even if Florida opts not to extend Medicaid eligibility.)

In addition to DSH funds and payments from the LIP, Florida's safety net providers rely on other sources of state and local funding to pay a portion of the cost of care for those without health insurance.

For example, 12 Florida counties currently operate 16 independent hospital taxing districts with authority to levy taxes. In 2007 (the most recent available numbers), these districts collected about \$600 million in taxes, a 75 percent increase over 2002.²⁵ Typically, these districts support local hospitals that care for poor and uninsured county residents.

If coverage expansions substantially lower the number of uninsured patients, the hospitals, doctors and others who treat them may have less need for support from public dollars – even after taking into account cuts made to DSH and LIP payments. This in turn could allow Florida counties to lower these special taxes.

Although hospital care is probably the largest source of offsetting savings, state funds also support many mental health and substance abuse service programs aimed at people with no source of payment. It is likely that many who use these services today will gain coverage through Medicaid, federal premium tax credits used in the exchange, or through private insurance that no longer imposes pre-existing condition requirements.

It is reasonable to assume that new Medicaid coverage could allow the state to scale back state-funded mental health and substance abuse service programs considerably, thus freeing up a substantial share of the \$500 million to \$600 million of state appropriated funds currently spent by the state and substituting federal or private insurance dollars.

A similar (but smaller) source of savings might be the state's current \$10 million contribution to federal AIDS Drug Assistance Program (ADAP), a portion of which would become unnecessary if more people with HIV/AIDS gained private insurance, tax credits or Medicaid coverage.²⁶

The state of Florida has submitted a Section 1115 Medicaid Research and Demonstration waiver request to begin a premium-based system for its “medically needy” program, which includes people whose incomes are too high to qualify for regular Medicaid but who experience catastrophic medical expenses. Nearly 50,000 people qualify each month for the program; a total of 250,000 people use the program at least one month out of the year.

These people have the highest average per-person costs of any group in Medicaid and collectively cost more than \$1 billion in 2011-12,²⁷ using nearly \$500 million in state general revenues. Many in this group today lack other sources of insurance.

Once health insurance exchanges are created and subsidies go into effect in 2014, some of these individuals should be able to purchase private insurance using tax credits in the exchange, and some might become eligible at 100 percent federal cost if the state extends Medicaid coverage. The result could be considerable savings if the state alters or eliminates its Medically Needy program without any loss of access to health services.

In fact, a proposal in the state's budget submission for state FY 2013-14 would drop Medicaid coverage for some medically needy individuals, based on their ability to get coverage through the new insurance exchanges in 2014. The state has a similar proposal for some pregnant women now covered by Medicaid. Together, these proposals would reduce state spending by about \$60 million, a recognition on the state's part that the Act has the potential to save state funds.

WHAT IS THE BOTTOM LINE ON THE COSTS OF EXTENDING MEDICAID IN FLORIDA?

The financial impact for the state of the various changes under way in Medicaid will depend on a variety of factors. These include the decisions by the state on whether to exercise the option to extend Medicaid coverage to many people not currently eligible, as well as further decisions about the future role for various safety-net programs that could become less important as more people obtain coverage from private insurance or Medicaid.

FIGURE 5: IMPACT ON FLORIDA'S BUDGET	BEST ESTIMATE
NEW STATE COSTS PER YEAR	
Cost of Medicaid Coverage for Newly Eligible Population	\$300 million
Cost of Medicaid Coverage for New Enrollment by Currently Eligible Population	\$100 million
Cost of Continuing Higher Primary Care Payment Rates for Physicians	\$200 million
TOTAL NEW STATE COSTS PER YEAR	\$600 million
OFFSETTING STATE SAVINGS PER YEAR	
State Support for Safety Net Providers	\$200 million
State Mental Health, Substance Abuse Programs	\$250 million
Medicaid Eligibility Changes, for example, to the Medically Needy Program	\$250 million
TOTAL OFFSETTING STATE SAVINGS PER YEAR	\$700 million
NET STATE SAVINGS PER YEAR	\$100 million

NOTE: Estimates are based on a single year after 100 percent federal funding is phased out. New state costs will be lower in earlier years, especially from 2014 through 2016.

The financial impact on the state will also be affected by the decisions of individual Florida citizens in responding to new opportunities for health insurance.

Figure 5 represents our best estimate of this financial impact for the later years after full federal support for the new group phases down. Our estimate shown here illustrates possible costs and savings, but exact numbers will vary based on state, federal and individual decisions.

Our estimate relies on the newest estimates by the state Estimating Conference for the cost of coverage for the newly eligible Medicaid population, although we suspect that actual costs may be somewhat lower than the estimate. Although the Estimating Conference did not present a final estimate for the cost of new coverage for the currently eligible, but uninsured, population, we include what we think is a realistic estimate for those costs. We also include an estimate for higher payment rates to physicians for primary care services, even though the state could decide not to continue these higher payments after 2014 or the federal government could extend them. The estimate here is about half the maximum potential cost, reflecting a possible state decision to continue higher physician payment rates, but at a lower level than in 2013 and 2014 at full federal cost.

It is also important to recognize that improved insurance coverage, as of 2014, will result in offsetting savings in several of the ways that the state supports the health care safety net (some of which already are recognized in the state's latest budget documents). Because some Floridians will continue to require safety net services, even after the expansion of coverage, we generally assume no more than a 50-percent reduction in state support for these programs. But even with these conservative assumptions, the cost of new Medicaid coverage should be more than offset by these savings.

The bottom line for Florida is that the state should incur no net costs for taking up the optional extension of Medicaid coverage even after accounting for the state covering more people who are currently eligible but not enrolled.

In fact, overall state costs may well be reduced by an estimated \$100 million per year because some safety net programs will become less necessary.

Furthermore, extending Medicaid coverage to Florida citizens should have positive effects in terms of lower mortality, less illness, improved economic stability and a higher quality of life for those gaining coverage. In turn, improved health may well lead to lower overall health costs for both these individuals and the state.

ENDNOTES

- (1) The case in which the Court rendered its verdict is *National Federation of Independent Business v. Sebelius*.
- (2) In particular the Court ruled that HHS could not withhold all of a state's Medicaid funds for not extending coverage to the new mandatory adult coverage group.
- (3) The CBO is now estimating that the higher number of 25 million persons will be enrolled in exchanges as a consequence of the Supreme Court decision. The estimate also suggests that Medicaid coverage will drop to 11 million as a result of the decision although as the estimate points out there are many unknowns. Congressional Budget Office, July 24, 2012. Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision.
- (4) Estimates for adults are based on G. Kenney et al., *Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?* Urban Institute August, 2012. Estimates include both those eligible under expanded Medicaid coverage and those current eligible for Medicaid.
- (5) Estimates for eligible children are derived from G. Kenney et al., August 2012, and G. Kenney et al., *Making the Medicaid Expansion an ACA Option: How Many Low-Income Americans Could Remain Uninsured*, June 2012, Urban Institute.
- (6) For more on the matching rate and related issues see our previous brief in this series, J. Hoadley and J. Alker, *Understanding Florida Medicaid Today and the Impact of Federal Health Care Reform*, Georgetown University Health Policy Institute, April 2011.
- (7) Social Services Estimating Conference, *Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs*, August 14, 2012.
- (8) An effort to charge a \$10 monthly premium regardless of income or age was passed by the Legislature and included in the state's Section 1115 Medicaid Research and Demonstration request and was rejected by the federal Department of Health and Human Services because it violated the "MOE" provisions. See letter from CMS to AHCA, February 9, 2012. These premiums would have resulted in large numbers of children losing coverage. See J. Alker and J. Hoadley, *Proposed Medicaid Premiums Challenge Coverage for Florida's Children and Parents*, Georgetown University Health Policy Institute, December 2011.
- (9) There is currently much speculation about whether a state could do a partial expansion – for example to 100 percent of FPL - through use of Section 1115 waiver authority. As of this writing HHS has not opined on this matter, but there are reasons to believe this will not be a viable avenue – chief among them that permitting states to go this route would incur very substantial costs to the federal government.
- (10) If they are working, parents can disregard earned income bringing their eligibility level to 58 percent FPL. However this exclusion will disappear in 2014 regardless of whether or not the state expands coverage.
- (11) Kenney et al., August 2012.
- (12) CBO estimate, p. 10 footnote 17.
- (13) The ACA also provides for additional Medicare payments where evidence shows that hospitals continue to have an uncompensated care burden.
- (14) Kenney et al., August 2012.
- (15) J. Holahan and I. Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133 percent FPL*, Kaiser Commission on Medicaid and the Uninsured, May 2010.
- (16) G. Kenney et al., "Gains for Children: Increased Participation in Medicaid and CHIP in 2009," Urban Institute, August 2011.

- (17) These estimates (and those for the currently eligible) are based on the take-up rate proposed by Holahan and Headen, May 2010, and the number of uninsured from Kenney et al., August 2012.
- (18) The penalty will not apply to persons who do not have enough income to file taxes and there will be a "hardship exemption," which has not yet been defined in regulation.
- (19) Among those who are currently eligible for Medicaid, but have not enrolled, it is assumed that from 10 percent to 40 percent will choose to enroll during the period when other new coverage begins. Holahan and Headen, May 2010.
- (20) J. Hoadley and J. Alker, Understanding Florida Medicaid Today and the Impact of Federal Health Care Reform, Georgetown University Health Policy Institute, April 2011.
- (21) Social Services Estimating Conference, Estimates Related to Federal Affordable Care Act
- (22) Holahan and Headen, May 2010.
- (23) J. Holahan et al., The Health Status of New Medicaid Enrollees Under Health Reform, Urban Institute, August 2010.
- (24) Lewin Group, Patient Protection and Affordable Care Act (PPACA): Long Term Costs for Governments, Employers, Families and Providers, Staff Working Paper #11, June 8, 2010.
- (25) Florida Tax Watch, Florida's Fragmented Hospital Taxing District System in Need of Reexamination, February 2009.
- (26) National Alliance of State & Territorial AIDS Directors, National ADAP Monitoring Project Annual Report, August 2012.
- (27) "Florida Medically Needy Waiver Demonstration Amendment to the Florida MEDS AD section 1115 Demonstration," submitted by Florida to CMS, April 26, 2012.
- (28) Kenney et al, August 2012, p. 9.
- (29) Florida: Uninsured Parents Potentially Eligible for Medicaid under the ACA, Georgetown Center for Children and Families, June 2012.
- (30) Center on Budget and Policy Priorities and Georgetown University Health Policy Institute Center for Children and Families, Expanding Coverage for Parents Helps Children, 2012. M. Heberlein et al., Medicaid Coverage for Parents Under the Affordable Care Act, Georgetown University Health Policy Institute Center for Children and Families, June 2012.
- (31) Estimates for eligible children are derived from G. Kenney et al., August 2012, and G. Kenney et al., June 2012.
- (32) B. Sommers, K. Baicker, and A. Epstein, "Mortality and Access to Care among Adults after State Medicaid Expansions," New England Journal of Medicine 367:1025-1034, 2012.
- (33) A. Finkelstein et al., "The Oregon Health Insurance Experiment: Evidence from the First Year," The Quarterly Journal of Economics, 127(8): 1057-1106, August 2012
- (34) S. Zuckerman et al., "Trends In Medicaid Physician Fees, 2003-2008," Health Affairs 28(3): w511-w520, April 2009.

This educational brief is one of a series made possible through the generous support of the Jessie Ball duPont Fund and the Winter Park Health Foundation.

Copies may be found at www.dupontfund.org, www.wphf.org and at hpi.georgetown.edu/floridamedicaid.

AUTHORS

Joan Alker
 Jack Hoadley
 Wesley Prater

Health Policy Institute
 Georgetown University
 Box 571444
 3300 Whitehaven Street NW
 Washington, D.C. 20057
 202-687-0880

The authors would like to acknowledge the research assistance of Karina Wagnerman.



Sherry P. Magill
 PRESIDENT
 Jessie Ball duPont Fund
 One Independent Drive
 Suite 1400
 Jacksonville, Florida 32202
 904-353-0890
www.dupontfund.org



WINTER PARK
 HEALTH FOUNDATION

Patricia Maddox
 PRESIDENT
 Winter Park
 Health Foundation
 220 Edinburgh Drive
 Winter Park, Florida 32792
 407-644-2300
www.wphf.org

Greg Mellowe, Director of Health Research and Analysis, Florida Center for Fiscal and Economic Policy

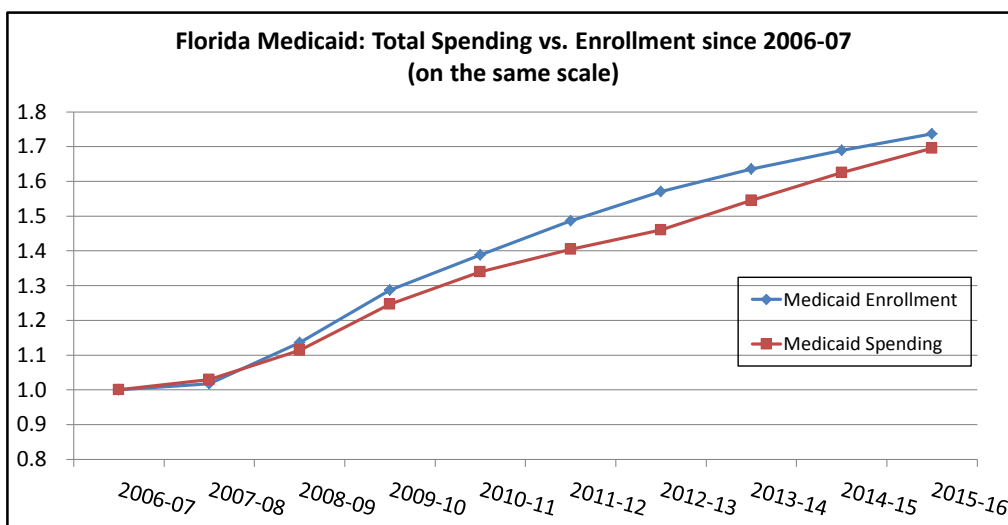
Greg has advocated with and for low-income Floridians in support of a strong safety net and the availability of other essential services and opportunities for almost 20 years. He has experience with a wide range of health, human services,, and housing-related programs and policy areas at the federal, state, and local levels. He has completed policy and budget analysis on behalf of a dozen different state and national advocacy organizations, drafted policy recommendations incorporated into numerous laws and ordinances, and is frequently cited as an expert on Medicaid and other public financed health coverage programs.

Greg also currently serves part-time as Policy Director for Florida CHAIN. He has previously coordinated statewide efforts to respond to homelessness and served as research director for a consumer watchdog group. His policy work is also informed by experience with direct service provision, agency administration, and community development. Greg holds graduate degrees in mathematics and social work from Florida State University.

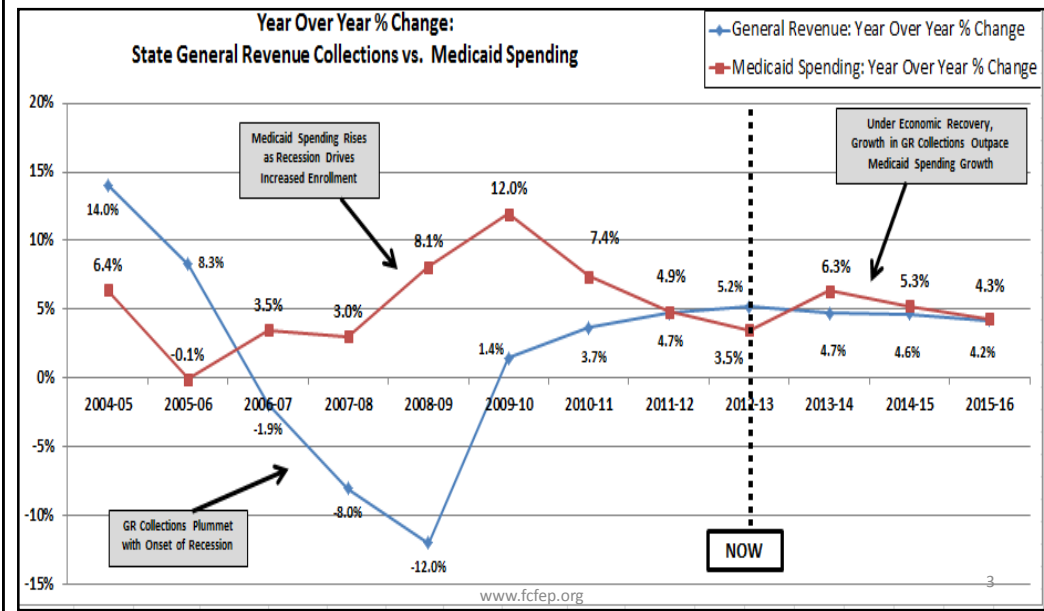
Florida's Medicaid Expansion Decision: Context, Costs, and Considerations

Greg Mellowe
Florida Center for Fiscal and Economic Policy
February 11, 2013

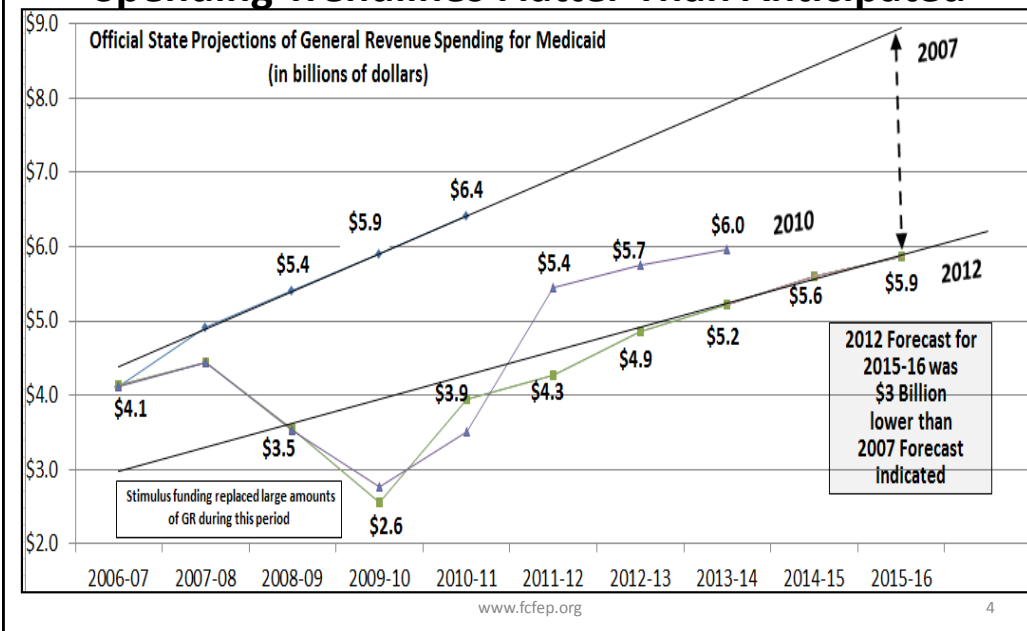
Medicaid Expansion in Context: Spending Increases Due to Enrollment Increases



Medicaid Expansion in Context: Medicaid Not Spiraling Out of Control

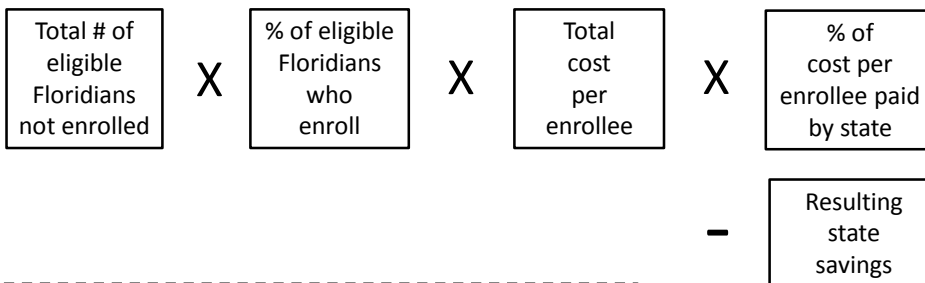


Medicaid Expansion in Context: Spending Trendlines Flatter Than Anticipated



Estimating the Cost of Medicaid Expansion

COST =



HOWEVER, Different Subgroups Require Different Assumptions:

- Already Eligible or Newly Eligible?
- Uninsured or “Crowd Out”?
- Adult or Child?
- Direct Purchase or Employer-Sponsored?

5

Medicaid Expansion Cost Estimates

Source of Cost Estimate	Estimated 10-Yr Cost to State (in billions)	Key Assumption
AHCA December 2012	\$21.1	Medicaid expansion in place, but state never receives federal match in law
AHCA January 2012	\$7.4	100% of uninsured and eligible sign up (and do so almost immediately)
Kaiser Commission/ Urban Institute November 2012	\$5.4	Cost per person estimate used is much higher than actual FL experience
Social Services Estimating Conference January 2013	Between \$1.7 and \$5.1	Two sets of estimates: One w. no currently eligible enrolling One w. 100% currently eligible enrolled
Georgetown University November 2012	Less than \$3.1	Estimates do not include state savings, which may exceed costs
FCFEP, January 2013	\$2.7	Estimate is sum of 16 sub-estimates

www.fcfe.org

6

Key Question Re: Expansion Cost #1

Already Eligible under current rules (“Woodwork”)
(state pays 40-45% of cost over 10 years)

vs.

Newly Eligible as a result of expansion
(state pays 6% of cost over 10 years)

So estimating Woodwork participation rate is critical because, all other things being equal, state will pay roughly **7 times more** for an Already Eligible than Newly Eligible over 10 years

**In fact, under most state-generated forecasts,
Woodwork constitutes the majority of expansion cost**

www.fcfe.org

7

Who Is Already Medicaid-Eligible in FL?

Broad Category	MAXIMUM Monthly Income	Current Enrollment (in thousands)
Low-Income children (under age 19)	\$2,115 (family of 3) <i>Infants higher</i>	1,780 (69%)
Adult SSI recipients (disabled and poor)	\$710 (single individual)	282 (11%)
Unemployed parents	\$303 (family of 3)	404 (16%)
Under-employed parents	\$806 (family of 3)	
Pregnant women	\$2,943 (family of 3)	82 (3%)
Other		34 (1%)
TOTAL Under 65 w. full Medicaid*		2,583 (100%)

* Total excludes 260,000 elderly + 500,000 others who do not receive full Medicaid. 8

Who Would Be Newly Eligible (Adults)?

Under age 65
Not on previous chart
Family income to \$15K for individual, \$26K for family of 3

- **Working** parents
 - Low-wage and/or underemployed
 - (Unemployed already qualify for Medicaid)
- Adults with no children
 - Never before eligible at any income level
 - Most are **employed**, disproportionately in service sector jobs
- Disabled **workers**
 - Social Sec Disability = Medically Needy now, Medicare after 29 mos.
 - (SSI recipients already qualify for Medicaid)

www.fcfe.org

9

Key Question Re: Expansion Cost #2

Program/Group (with Sources of Estimated Participation Rates)	Estimated Participation Rate
Existing Programs:	
Total FL Medicaid (AHCA)	80%
Medicaid Adults (Urban Institute)	67%
Medicare	96%
Other Means-Tested Programs	43-86%
Already Eligible but Not Enrolled:	
Current (per AHCA)	80%
AHCA*	100%
SSEC (Maximum Exposure)*	100%
Urban Institute	40%
Newly Eligible:	
AHCA*	100%
SSEC*	80%
Urban Institute	74%

* - Includes undocumented immigrants?

10

Woodwork Impact Likely Overstated

- Starting with stringent eligibility criteria
- Majority of Already Eligible but Not Enrolled are children.
- Almost no one who is Already Eligible (for full Medicaid) could be subject to a penalty under the ACA's personal responsibility provision.
 - For example, below tax filing threshold are exempt:

Head of Household	\$12,500
Married Filing Jointly	\$19,500
- "Crowd out" impact on Already Eligible very small
(Very poor, eligible for Medicaid under current rules, buys own coverage)

www.fcfe.org

11

Key Question Re: Expansion Cost #3

- SSEC estimate of weighted total cost per person per month:

Newly Eligible	\$306
Woodwork	\$254
- Largest component of that estimate is based on existing "TANF adults" category (\$333 per month).
 - However, that \$333 appears to apply to women only (*see next slide*)
 - True cost may be \$100 lower (which reduces total cost by billions)
- Cost for disabled and chronically ill is high, but:
 - 1) lower rate of these among Newly Eligible
 - 2) many of these are already served (inadequately) in Medically Needy:
 - Up to ¾ of disabled MN (non-dual) may be eligible under expansion, until Medicare kicks in
- SSEC estimate cost per child: \$141 (*see previous discussion*)

www.fcfe.org

12

September 1, 2012 - August 31, 2013 HMO RATES (90112)
(MEDICAID Non-Reform HMO CAPITATION RATES)
 By Area , Age and Eligibility Category

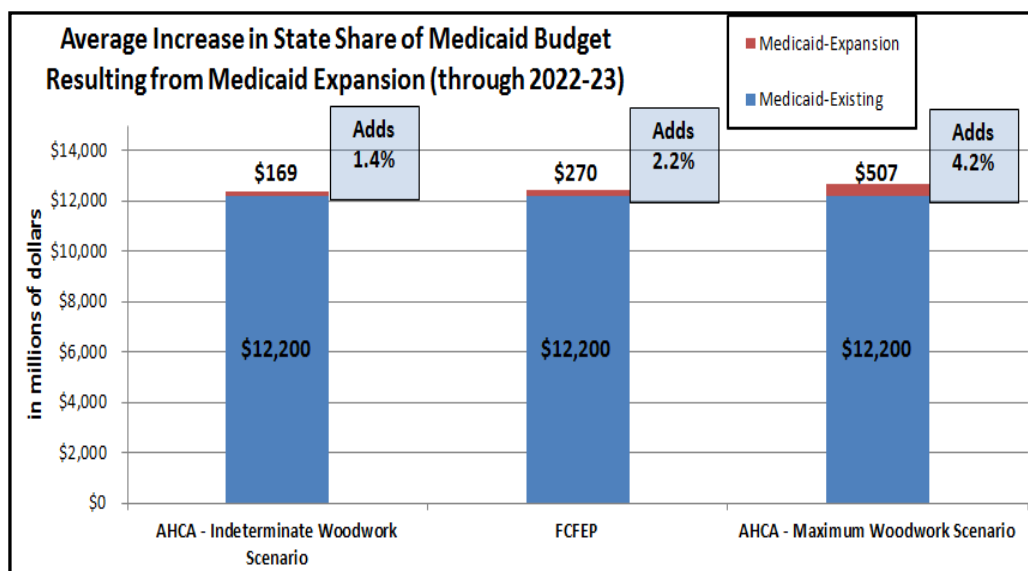
General Rates:

Area	AGE (21-54)	
	Female	Male
01	276.12	123.88
02	266.26	116.87
03	300.83	138.66
04	321.40	143.83
06	348.21	167.68
08	331.03	162.13
07	310.18	137.68
09	324.08	146.83
10	288.12	130.34
11	384.88	188.66
6B	331.08	162.23
8A	326.87	148.87
8B	286.33	134.06

www.fcfeep.org

13

Medicaid Expansion in Context: The Big Picture



Medicaid Expansion as Economic Development

- Pump \$2 Billion+ per year in federal funds into FL economy
- Create 55-65K new, good private sector jobs
- Provide fully funded benefit to low-wage employers that are backbone of FL's service-based economy (\$14B over 10 yrs)
- Provide low-wage employers with opportunity to avoid penalty for not satisfying ACA employer responsibility requirement
- Reduce cost-shifting of "uncompensated care" in private insurance

www.fcfe.org

15

Medicaid Expansion as Win-Win for Service Sector Employers & Workers

- Almost 500,000 uninsured workers would be Newly Eligible, almost all in service industry jobs
- Typical single parent in FL retail or hospitality job would be eligible, even at 40 hours per week
- Typical single parent in 6 of 10 largest occupations in Florida would be eligible, even at 40 hours per week
- Reduced absenteeism, increased productivity and retention

www.fcfe.org

16

Protecting the Existing Medicaid Safety Net During Transition

ACA's Maintenance of Effort

No tightening of eligibility standards for adults until 2014*
(children protected until 2019)

Likely need to carefully study impact of ACA implementation and decide how to best protect:

- 1) MEDS-AD Waiver for elderly & disabled (just above SSI line)
- 2) Medically Needy for elderly and for disabled with Medicare
- 3) Medically Needy for some catastrophically ill above Medicaid line
- 4) Pregnant women 150-185% of poverty level

www.fcfe.org

17

Additional Program and Policy Issues

- Conversion to MAGI – will happen regardless of expansion decision
- Alternative (different) benefit package for Newly Eligible
- Bridge plans
- Using Medicaid for premium assistance
- Other available federal flexibility

www.fcfe.org

18

Biography of G. Mark O'Bryant

Mark O'Bryant is President and Chief Executive Officer of Tallahassee Memorial HealthCare, Inc., the parent corporation of Tallahassee Memorial Hospital in the state's capital city. Mr. O'Bryant assumed the role as leader of the 773-bed regional tertiary facility in July, 2003.

Since arriving at Tallahassee Memorial, Mr. O'Bryant has focused on operational, financial and strategic improvements centered on evidence-based quality initiatives. Reorganizing around the service line concept, instituting clear measurement tools, and partnering with physicians through the use of detailed practice profiles, substantial gains in quality have been posted. Recent recognition includes the Thomson Reuters Overall Winner of the Healthcare Advantage Award for effective use of data analytics to increase the quality of care, which resulted in a 23 percent reduction in the hospital's mortality rate. During a nationally televised address to introduce his health reform initiatives, President Obama highlighted Tallahassee Memorial's success in reducing patient mortality rates, along with two other facilities stating, "... these (hospitals) are islands of excellence that we need to make the standard in our health care system." And, for the eighth year in a row, TMH is the recipient of the National Research Corporation's Consumer Choice Award.

Tallahassee Memorial continues to maintain its historical market dominance in its 22-county referral area in north Florida and south Georgia. The organization consists of three inpatient facilities focusing on acute care, behavioral health and rehabilitation care. The main hospital provides several centers of excellence in the areas of cardiac, neurological, orthopedic, cancer, medicine, diabetes, women and children services. TMH has been awarded accreditation in multiple areas of specialty including trauma, stroke, chest pain, and brain and spinal cord injury. It also provides the longest continually accredited cancer program in the southeast and is an affiliate of UF & Shands Academic Health Center in Gainesville. Tallahassee Memorial operates a fully accredited Family Practice Residency Program, started over 40 years ago. In addition, Tallahassee Memorial sponsors an Internal Medicine Residency Program, in association with the Florida State University College of Medicine.

Mr. O'Bryant has also coordinated the development and implementation of a metrics-driven strategic plan centered on the vision of becoming a recognized, world-class community health system. With a focus on operating efficiencies, revenue stream, supply chain management, and payer relationships, the organization achieved a reversal of several consecutive years of debilitating losses and realized significant improvement in days of cash while serving as a regional safety net, trauma center that does not receive on-going community tax support.

Under his direction, TMH has strengthened the organizational culture around a colleague defined set of core values using an expansive set of communication tools, leadership visibility & accessibility, performance transparency, and engagement programs. Demonstrated results are evidenced by significantly improved colleague satisfaction scores through Press Ganey surveys, receiving the Modern Healthcare 100 Best Places to Work Award in 2008, the 2009 Psychologically Healthy Workplace Award for Florida, and the 2010 National Winner of the Psychologically Healthy Workplace Award from the American Psychological Association.

Mr. O'Bryant has also led efforts to fortify TMH's position in the regional referral markets through a variety of methods to include: Cooperative coverage strategies with aligned physician groups; and, the enhancement of information connectivity with rural health facilities through federal grant funding. In addition, TMH entered into management agreements with Weems Memorial Hospital in Apalachicola, and with Doctors Memorial Hospital in Perry, Florida.

Prior to his recruitment to Tallahassee, Mr. O'Bryant came from Memorial Health Care System, Chattanooga, Tennessee, a 420-bed hospital organization affiliated with the Catholic Health Initiatives. As Sr. Vice President and Chief Operating Officer, he directed the strategic and operational activities of the organization. Under his leadership, Memorial and Memorial North Park hospitals were recognized for clinical excellence, strong operational performance, and high patient and employee satisfaction. In particular, the two facilities were ranked #1 and #3 respectively among the sixty-eight Catholic Health Initiatives hospitals in the area of Overall Quality. His organization also received recognition for having the highest employee satisfaction in the nation in the large hospital category.

Mr. O'Bryant is a Diplomat in the American College of Health Care Executives. His undergraduate degree is from Brigham Young University; his Master of Health Administration and Master of Business Administration degrees are from Georgia State University.

He and his wife Angela are the proud parents of three sons and one daughter.

Economic Impacts of the *Patient Protection and Affordable Care Act* in Florida

November 26, 2012

Sponsored Project Report to the Florida Hospital Association

By Alan W. Hodges and Mohammad Rahmani
University of Florida, Food & Resource Economics Department
PO Box 110240, Gainesville, FL
email awhodges@ufl.edu; telephone 352-294-7674

Introduction

Healthcare is a major driver of economic activity in the United States, valued at \$2.6 trillion in 2010, representing approximately 17.9 percent of Gross Domestic Product (CMS, 2011). Activity in the healthcare sector has grown dramatically compared to many other sectors of the economy, and serves as a source of economic development and job growth in many areas. Healthcare services are an important component of Florida's economy due to its rapidly growing and aging population.

The passage of the *Patient Protection and Affordable Care Act*, signed into law by President Obama on March 23, 2010 provided a new dimension in the healthcare services in the United States. This legislation constitutes the largest change to the American health care system and is estimated to expand coverage to 32 million individuals at a cost of \$940 billion over 10 years (federal fiscal years 2010 – 2019) based on a Congressional Budget Office projection.

The law focuses on expanding coverage, insurance market reforms, delivery system reforms, Medicare and Medicaid payment changes, wellness and prevention initiatives, quality and comparative effectiveness, workforce and graduate medical education and regulatory oversight and program integrity. Health care coverage will be expanded to more Americans through the following mechanisms:

1. Mandates that almost all Americans purchase health insurance coverage.
2. Subsidies through the form of tax credits and cost sharing assistance for those individuals between 100 and 400 percent of the Federal Poverty Level (FPL).
3. Subsidies for small businesses to offset the cost of providing employees health insurance coverage.
4. Penalties assessed on large employers if they do not provide coverage to their employees.
5. Coverage expansion of Medicaid to adults and children with incomes less than 138 percent.

Costs associated with expanding Medicaid coverage will be covered initially by the federal government with a portion being covered by the states starting in 2017. The federal dollars to fund the Medicaid expansion represent new resources (final demand) for health care services in the state. Each of the above mentioned features of the *Patient Protection and Affordable Care Act* will have economic impacts on Florida's economy.



Mission to Care. Vision to Lead.

This study evaluated the broad economic impacts of projected changes in federal spending for the *Patient Protection and Affordable Care Act* in Florida from state fiscal year (SFY) 2012-13 through 2022-23. The scope of the study was limited to the expansion and changes related to coverage and payments under Medicaid and the Children’s Health Improvement Program.

Methods and Data

Estimates of new enrollment, state costs and total costs for Medicaid and Children’s Health Improvement Program (CHIP) under the *Patient Protection and Affordable Care Act* were taken from projections made by the Florida Legislature--Office of Economic and Demographic Research, adopted in their Social Services Estimating Conference (August, 2012). Projections were made for the 11-year period of State fiscal years (July-June) 2012-13 through 2022-23. The projections accounted for the provisions of the federal legislation to support increased rates for primary care practitioners, provision of additional coverage, and expansion or “crowd out” of currently insured individuals. The Estimating Conference developed two sets of projections: the “Adopted Impact”, which represents consensus estimates of the most likely enrollment levels and costs based on current trends, and the “Maximum Exposure” scenario, which represents the largest potential coverage for absorbing the currently eligible but not enrolled population into the existing Medicaid program, expanding up to 100 percent of the newly eligible population, and providing a continuing rate increase for payments to primary care practitioners. Projections of patient enrollment, state cost, and total cost for Medicaid and CHIP programs in Florida under the Federal *Patient Protection and Affordable Care Act* during the period 2012-13 through 2022-23 are shown in Table 1.

The data includes four categories for the Adopted Impact forecast scenario:

- Enrollment and Federal Medical Assistance Percentage (FMAP) changes to Medicaid (Titles XIX, XXI) (Existing program). The Conference concluded that these additional expenditures to the existing program, based on the pace of the population’s presentation for services, could not be reasonably forecast, so these estimates were considered “indeterminate” and no forecast was made.
- Enrollment and FMAP Changes to Title XIX and Title XXI (Optional Program – expansion based on current enrollment trends of 79.7 percent).
- Increased rates for primary care practitioners (Existing Program – 100 percent federally funded for two years).
- Increased rates for primary care practitioners (Optional Program – state and federally funded).

For the Maximum Exposure scenario, four categories of changes were considered:

- Enrollment and FMAP Changes to Title XIX (Existing Program – currently eligible but not enrolled).
- Enrollment and FMAP Changes to Title XIX and Title XXI (Optional Program – based on 100 percent enrollment of eligible individuals).
- Increased rates for primary care practitioners (Existing Program – 100 percent federally funded for two years).
- Increased rates for primary care practitioners (Optional Program – state and federally funded).

The Maximum Exposure scenario represents 100 percent of the eligible population covered, who are currently eligible but not enrolled under existing program. The Estimating Conference assumed that 60 percent of likely new enrollees would enter in the first fiscal year (2013-14) if expansion is exercised beginning Jan. 1, 2014, then this percentage increases to 90 percent for the second year (2014-15) and to 100 percent for the third year (2015-16).

Federal government expenditures under the legislation, which represent new final demand to the healthcare industry in the state, were taken as the net difference between projected total costs and state costs. Total payments by the federal government for the Adopted and Maximum Exposure scenarios are shown in Table 1.

Table 1

Projected costs for the Patient Protection and Affordable Care Act in Florida, state fiscal years 2012-13 to 2022-23, Adopted and Maximum Exposure scenarios

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23
Values in Million Dollars											
Adopted (Consensus) Forecast Scenario											
Impact of Enrollment and FMAP Changes to Title XIX and Title XXI (Optional Program)											
Enrollment		463,280	735,756	845,312	854,939	864,534	873,952	883,230	892,390	901,422	910,324
State Cost	\$0.0	\$0.0	\$0.0	\$0.0	\$79.2	\$176.1	\$210.5	\$278.2	\$330.8	\$334.2	\$337.6
Total Cost	\$0.0	\$862.8	\$2,729.1	\$3,129.8	\$3,166.3	\$3,202.6	\$3,238.2	\$3,273.3	\$3,308.0	\$3,342.2	\$3,375.9
Impact of Increased Rates for Primary Care Practitioners (Existing Program)											
State Cost	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total Cost	\$424.8	\$849.7	\$424.8	\$424.8	\$424.8	\$424.8	\$424.8	\$424.8	\$424.8	\$424.8	\$424.8
Impact of Increased Rates for Primary Care Practitioners (Optional Program)											
State Cost	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0	\$0.0
Total Cost	\$0.0	\$38.2	\$54.4	\$54.4	\$54.4	\$54.4	\$54.4	\$54.4	\$54.4	\$54.4	\$54.4
Total Payments by the Federal Government (\$)	\$424.8	\$1,750.7	\$3,208.3	\$3,129.8	\$3,087.1	\$3,026.4	\$3,027.7	\$2,995.1	\$2,977.2	\$3,008.0	\$3,038.3
Maximum Exposure Scenario											
Impact of Enrollment and FMAP Changes to Title XIX (Existing Program)											
Enrollment		365,783	365,783	365,783	365,783	365,783	365,783	365,783	365,783	365,783	365,783
State Cost	\$0.0	\$195.3	\$386.5	\$291.7	\$260.8	\$260.8	\$260.8	\$260.8	\$260.8	\$260.8	\$260.8
Total Cost	\$0.0	\$512.0	\$1,024.0	\$1,024.0	\$1,024.0	\$1,024.0	\$1,024.0	\$1,024.0	\$1,024.0	\$1,024.0	\$1,024.0
Impact of Enrollment and FMAP Changes to Title XIX and Title XXI (Optional Program)											
Enrollment		564,405	889,407	1,018,430	1,030,510	1,042,548	1,054,365	1,066,005	1,077,499	1,088,831	1,100,000
State Cost	\$0.0	\$0.0	\$0.0	\$0.0	\$95.8	\$213.2	\$254.9	\$337.0	\$400.9	\$405.2	\$409.4
Total Cost	\$0.0	\$1,054.2	\$3,310.6	\$3,785.1	\$3,830.8	\$3,876.3	\$3,921.1	\$3,965.1	\$4,008.6	\$4,051.5	\$4,093.8
Impact of Increased Rates for Primary Care Practitioners (Existing Program)											
State Cost	\$0.0	\$0.0	\$179.9	\$357.4	\$357.4	\$357.4	\$357.4	\$357.4	\$357.4	\$357.4	\$357.4
Total Cost	\$424.8	\$864.7	\$879.7	\$879.7	\$879.7	\$879.7	\$879.7	\$879.7	\$879.7	\$879.7	\$879.7
Impact of Increased Rates for Primary Care Practitioners (Optional Program)											
State Cost	\$0.0	\$0.0	\$0.6	\$1.3	\$5.0	\$9.5	\$11.2	\$14.4	\$16.9	\$17.1	\$17.3
Total Cost	\$0.0	\$42.5	\$131.1	\$149.4	\$151.3	\$153.2	\$155.1	\$157.0	\$158.8	\$160.6	\$162.5
Total Payments by the Federal Government (\$)	\$424.8	\$2,278.1	\$4,778.4	\$5,187.7	\$5,166.8	\$5,092.3	\$5,095.6	\$5,056.1	\$5,035.2	\$5,075.4	\$5,115.0

Source: Florida Legislature, Office of Economic and Demographic Research, Social Service Estimating Conference, Aug 14, 2012.

Total federal payments reflect total cost less state cost.

* Federal Medical Assistance Percentages.



Mission to Care. Vision to Lead.

Economic impacts of the projected changes in federal spending under the *Patient Protection and Affordable Care Act* were estimated using a regional economic model for the state of Florida developed with the IMPLAN software (v.3) and associated Florida dataset for 2010 (MIG, Inc. 2011). This type of model for input-output analysis, augmented with social accounting matrices, enables estimation of the secondary impacts of industry activities in the local economy arising from new final demand (Miller and Blair, 2009). A glossary of economic impact analysis terminology is provided in the Appendix. The economic model for Florida was constructed using default parameters and trade flow assumptions, and all social accounts internalized. The multipliers capture effects of input purchases or supply chain activity generated by the healthcare industry, and expenditures by households, local, state and federal governments, and capital investment generated by new resources garnered through federal government expenditure in Florida. A summary of economic multipliers for twelve healthcare related sectors in Florida is provided in Table 2, along with their direct output values in 2010.

Table 2
Florida healthcare related economic sectors, economic values and final demand multipliers, 2010

Healthcare Industry Sector (number)	Industry Output (Mill. \$)	Percent	Total Final Demand Multipliers				
			Output	Employment	Value-added	Labor Income	Indirect Business Taxes
Offices of physicians, dentists, and other health practitioners (394)	37,191	35.87%	3.00	26.61	1.94	1.42	0.11
Private hospitals (397)	29,912	28.85%	2.93	25.28	1.80	1.25	0.11
Nursing and residential care facilities (398)	10,249	9.88%	2.97	36.13	1.97	1.38	0.14
Medical and diagnostic labs and outpatient and other ambulatory care services (396)	9,623	9.28%	2.97	26.26	1.81	1.22	0.10
Pharmaceutical preparation manufacturing (133)	5,167	4.98%	2.40	12.25	1.10	0.64	0.07
Home health care services (395)	4,607	4.44%	2.99	35.90	2.01	1.50	0.11
Surgical and medical instrument, laboratory and medical instrument manufacturing (305)	2,547	2.46%	2.72	17.68	1.59	0.95	0.09
Ophthalmic goods manufacturing (308)	1,431	1.38%	2.60	16.41	1.65	0.90	0.08
Surgical appliance and supplies manufacturing (306)	1,345	1.30%	2.63	18.05	1.63	0.90	0.08
Electro-medical and electrotherapeutic apparatus manufacturing (248)	1,142	1.10%	2.53	14.74	1.24	0.78	0.08
Dental laboratories manufacturing (309)	259	0.25%	2.91	29.10	1.87	1.36	0.10
Dental equipment and supplies manufacturing (307)	217	0.21%	2.55	17.07	1.54	0.88	0.08
Total All Sectors	<u>103,690</u>	<u>100%</u>					

Source: *IMPLAN* (MIG, Inc., 2011). Multipliers are denominated in dollars per dollar change in direct output, except employment is fulltime and part-time jobs per million dollars output.

The total projected federal expenditures for the Adopted and Maximum Exposure scenarios were allocated to healthcare related sectors based on their share of direct output in 2010, as shown in Table 3. The economic impacts of additional federal expenditures on health care sectors were estimated by applying the appropriate multipliers for each sector against these projected direct spending changes.

Table 3

Spending changes for the *Patient Protection and Affordable Care Act*, Adopted and Maximum Exposure scenarios, by healthcare industry sector, state fiscal years 2012-13 to 2022-23

Scenario / Healthcare Industry Sector	State Fiscal Year										
	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-2019	2019-2020	2020-2021	2021-2022	2022-2023
Adopted (Consensus) Forecast Scenario	million dollars										
Offices of physicians, dentists, and other health practitioners	152	628	1,151	1,123	1,107	1,086	1,086	1,074	1,068	1,079	1,090
Private hospitals	123	505	926	903	891	873	873	864	859	868	876
Nursing and residential care facilities	42	173	317	309	305	299	299	296	294	297	300
Medical and diagnostic labs and outpatient and other ambulatory care services	39	162	298	290	286	281	281	278	276	279	282
Pharmaceutical preparation manufacturing	21	87	160	156	154	151	151	149	148	150	151
Home health care services	19	78	143	139	137	134	135	133	132	134	135
Surgical and medical instrument, laboratory and medical instrument manufacturing	10	43	79	77	76	74	74	74	73	74	75
Ophthalmic goods manufacturing	6	24	44	43	43	42	42	41	41	42	42
Surgical appliance and supplies manufacturing	6	23	42	41	40	39	39	39	39	39	39
Electro-medical and electrotherapeutic apparatus manufacturing	5	19	35	34	34	33	33	33	33	33	33
Dental laboratories manufacturing	1	4	8	8	8	8	8	7	7	8	8
Dental equipment and supplies manufacturing	1	4	7	7	6	6	6	6	6	6	6
Total All Sectors	425	1,751	3,208	3,130	3,087	3,026	3,028	2,995	2,977	3,008	3,038
Maximum Exposure Scenario											
Offices of physicians, dentists, and other health practitioners	152	817	1,714	1,861	1,853	1,827	1,828	1,814	1,806	1,820	1,835
Private hospitals	123	657	1,378	1,497	1,490	1,469	1,470	1,459	1,453	1,464	1,476
Nursing and residential care facilities	42	225	472	513	511	503	504	500	498	502	506
Medical and diagnostic labs and outpatient and other ambulatory care services	39	211	443	481	479	473	473	469	467	471	475
Pharmaceutical preparation manufacturing	21	114	238	259	257	254	254	252	251	253	255
Home health care services	19	101	212	231	230	226	226	225	224	226	227
Surgical and medical instrument, laboratory and medical instrument manufacturing	10	56	117	127	127	125	125	124	124	125	126
Ophthalmic goods manufacturing	6	31	66	72	71	70	70	70	69	70	71
Surgical appliance and supplies manufacturing	6	30	62	67	67	66	66	66	65	66	66
Electro-medical and electrotherapeutic apparatus manufacturing	5	25	53	57	57	56	56	56	55	56	56
Dental laboratories manufacturing	1	6	12	13	13	13	13	13	13	13	13
Dental equipment and supplies manufacturing	1	5	10	11	11	11	11	11	11	11	11
Total All Sectors	425	2,278	4,778	5,188	5,167	5,092	5,096	5,056	5,035	5,075	5,115

Results

Economic impacts of projected federal expenditures under the *Patient Protection and Affordable Care Act* in Florida during state fiscal years 2012-13 to 2022-23 for the Adopted and Maximum Exposure scenarios are summarized in Tables 4 and 5, respectively. The tables present federal expenditures and economic impacts for output (industry revenues), value-added (GDP), labor income (employee wages, benefits, proprietor income), indirect business taxes paid to local, state and federal governments, and employment (fulltime and part-time jobs).

Under the Consensus scenario projection, total expenditures of \$24.44 billion by the federal government in Florida during 2012-13 to 2022-23 would generate \$71.32 billion in output, \$44.59 billion in value-added, \$31.19 billion in labor income, \$2.61 billion indirect business taxes, and employment impacts of 597,172 job-years or an average of 54,288 permanent jobs over the 11-year period (Table 4).

Under the Maximum Exposure projection, total expenditures of \$39.62 billion by the federal government in Florida during 2012-13 to 2022-23 would generate \$115.59 billion in output, \$72.26 billion in value-added, \$50.55 billion in labor income, \$4.22 billion indirect business taxes, and employment impacts of 967,766 job-years or 87,979 permanent jobs (Table 5). Note that all values are expressed in constant 2012 dollars.

Table 4

Summary of economic impacts of the *Patient Protection and Affordable Care Act* in Florida under the Adopted Forecast scenario

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	Cum. Total 2012-13 to 2022-23
Federal expenditures (Mill. \$)	411	1,639	2,907	2,744	2,620	2,486	2,438	2,363	2,302	2,279	2,257	24,445
Output (Mill. \$)	1,200	4,785	8,485	8,007	7,644	7,251	7,111	6,893	6,714	6,648	6,583	71,322
Value added-GDP (Mill. \$)	751	2,992	5,306	5,006	4,779	4,533	4,445	4,308	4,197	4,156	4,115	44,587
Labor Income (Mill. \$)	526	2,095	3,714	3,503	3,343	3,170	3,108	3,013	2,935	2,906	2,877	31,190
Indirect business taxes (Mill. \$)	44	175	310	293	279	265	260	252	245	243	240	2,606
Employment (Job-Years)	10,068	40,128	71,124	67,077	64,004	60,680	59,506	57,681	56,185	55,633	55,085	597,172

Values expressed in 2012 dollars. Estimates include regional multiplier effects.

Table 5

Summary of economic impacts of the *Patient Protection and Affordable Care Act* in Florida under the Maximum Exposure scenario

	2012-13	2013-14	2014-15	2015-16	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	2022-23	Cum. Total 2012-13 to 2022-23
Federal expenditures (M\$)	411	2,133	4,330	4,548	4,385	4,183	4,103	3,989	3,893	3,845	3,799	39,618
Output (M\$)	1,200	6,226	12,637	13,271	12,794	12,201	11,968	11,636	11,356	11,218	11,082	115,589
Value added-GDP (M\$)	751	3,894	7,903	8,298	7,998	7,626	7,480	7,273	7,098	7,012	6,927	72,260
Labor Income (M\$)	526	2,726	5,531	5,806	5,595	5,333	5,231	5,086	4,964	4,903	4,844	50,546
Indirect business taxes (M\$)	44	228	462	485	467	446	437	425	415	410	405	4,223
Employment (Job-Years)	10,068	52,216	105,930	111,181	107,122	102,101	100,147	97,373	95,023	93,870	92,736	967,766

Values expressed in 2012 dollars. Estimates include regional multiplier effects.

Figures 1-3 illustrate the trend in federal government expenditures, value added impacts, and employment impacts, respectively, of the *Patient Protection and Affordable Care Act* in Florida during the period 2012-13 to 2022-23. For both the Adopted forecast and Maximum Exposure scenarios, there is a rapid increase in expenditures during the first few years, until 2014-15 or 2015-16, then a slight decrease thereafter. Employment and value-added impacts followed this same pattern. Under the Adopted Forecast scenario, in the peak year of 2014-15, total value added impacts were \$5.31 billion and employment impacts were 71,124 jobs. In the peak year of 2015-16 under the Maximum Exposure scenario, total value added impacts were \$8.30 billion and employment impacts were 111,181 jobs.

Figure 1

Federal expenditures for the *Patient Protection and Affordable Care Act* in Florida, 2012-13 to 2022-23

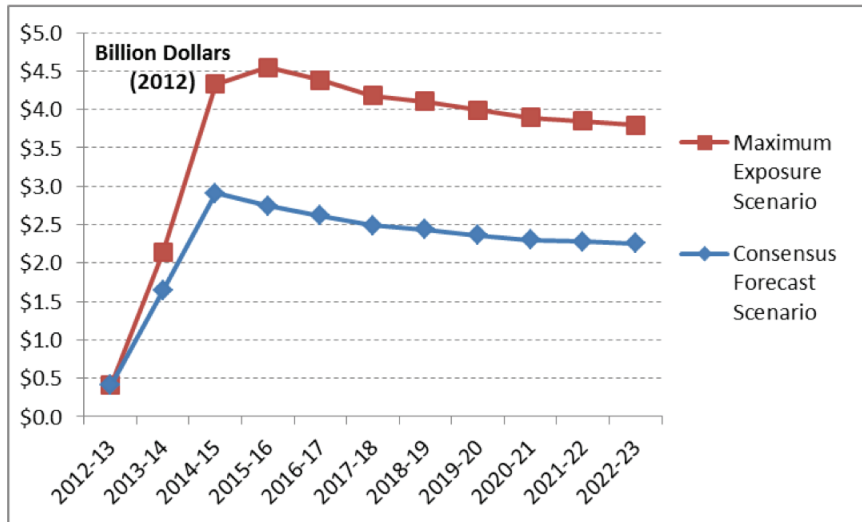
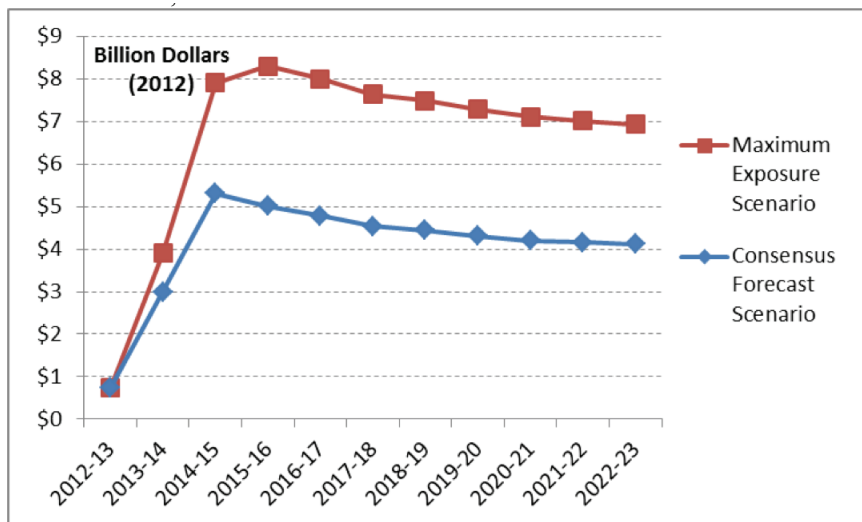


Figure 2

Value added impacts to Gross Domestic Product of the *Patient Protection and Affordable Care Act* in Florida, 2012-13 to 2022-23

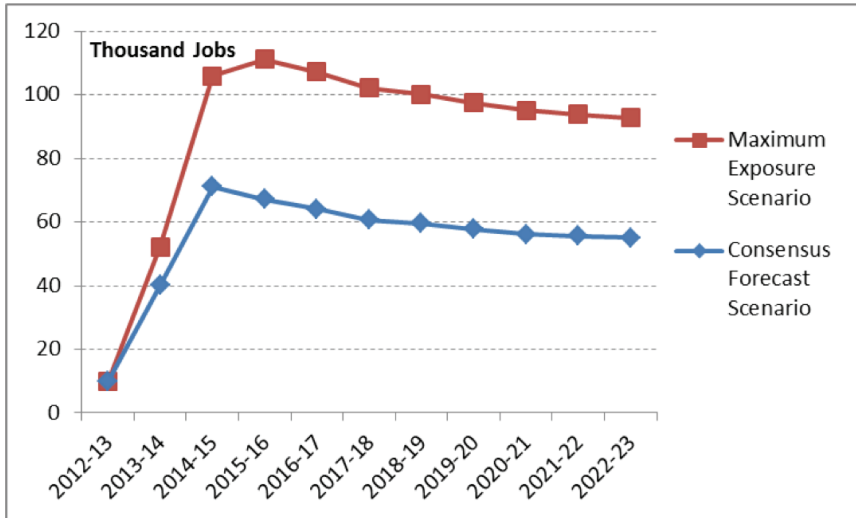


Estimates include regional multiplier effects.



Figure 3

Employment impacts of the *Patient Protection and Affordable Care Act* in Florida, 2012-13 to 2022-23



Employment includes fulltime and part-time jobs. Estimates include regional multiplier effects.

Literature and Information Sources Cited

Centers for Medicaid and Medicare Services (CMS), 2011. “National Health Expenditures, 2010 Highlights”, available at <http://www.cms.gov/Research-Statistics>.

HealthCare.gov, “Key Features of the Affordable Care Act, by Year”, October, 22, 2012, available at <http://www.healthcare.gov/law/timeline/full.html>,

Florida Legislature, Office of Economic and Demographic Research, Social Service Estimating Conference, “Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid & Title XXI (CHIP) Programs”, Adopted August 14, 2012, available at <http://edr.state.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf>

Miller, Roland E. and Peter D. Blair, *Input-Output Analysis: Foundations and Extensions*. Second edition Cambridge University Press, May 2009.

Minnesota IMPLAN Group, Inc. (MIG). *IMPLAN Professional*, economic impact analysis and social accounting software and county data for Florida. Stillwater, MN. Web resources available at www.implan.com.

Appendix: Glossary of Economic Impact Terms

Terms are presented in a logical order rather than alphabetically

Region defines the geographic area for which impacts are estimated. Regions are generally an aggregation of one or more counties. Economic regions identified in this paper were defined based on worker commuting patterns.

Sector is a grouping of industries that produce similar products or services, or production processes. Most economic reporting and models in the U.S. are based on the North American Industrial Classification System (NAICS).

Impact analysis estimates the impact of changes in a regional economy resulting from a change in final demand or direct employment to industries, and changes in household income.

Input-output (I-O) model. An input-output model is a representation of the flows of economic activity between industry sectors within a region. The model captures what each business or sector must purchase from every other sector in order to produce its output of goods or services. Using such a model, flows of economic activity associated with any change in spending may be traced backwards (e.g., purchases of plants that leads growers to purchase additional inputs -- fertilizers, containers, etc.). Multipliers for a region may be derived from an input-output model of the region's economy.

IMPLAN is a micro-computer-based input-output modeling system and Social Accounting Matrix (SAM). With IMPLAN, one can estimate models for any region consisting of one or more counties. IMPLAN includes procedures for generating multipliers and estimating impacts by applying final demand changes to the model. The current version of the software is *IMPLAN* version three.

Direct effects are the changes in economic activity during the first round of spending. **Secondary effects** are the changes in economic activity from subsequent rounds of re-spending. There are two types of secondary effects: **Indirect effects** are the changes in sales, income or employment within the region in backward-linked industries supplying goods and services to businesses. For example, the increased sales in input supply firms resulting from more nursery industry sales is an indirect effect. **Induced effects** are the increased sales within the region from household spending of the income earned in the direct and supporting industries. Employees in the direct and supporting industries spend the income they earn on housing, utilities, groceries, and other consumer goods and services. This generates sales, income and employment throughout the region's economy. **Total effects** are the sum of direct, indirect and induced effects.

Multipliers capture the total effects, both direct and secondary, in a given region, generally as a ratio of the total change in economic activity in the region relative to the direct change. Multipliers may be expressed as ratios of sales, income or employment, or as ratios of total income or employment changes relative to direct sales. Multipliers express the degree of interdependency between sectors in a region's economy and therefore vary considerably across regions and sectors. **Type I** multipliers include only direct and indirect effects. **Type II** multipliers also include induced effects. **Type SAM** multipliers used by IMPLAN additionally account for capital investments and transfer payments such as welfare and retirement income. A **sector-specific multiplier** gives the total changes to the economy associated with a unit change in output or employment in a given sector.

Purchaser prices are the prices paid by the final consumer of a good or service. **Producer prices** are the prices of goods at the factory or production point. For manufactured goods the purchaser price equals the producer price plus a retail margin, a wholesale margin, and a transportation margin. For services, the producer and purchaser prices are equivalent.

Margins. The retail, wholesale and transportation margins are the portions of the purchaser price accruing to the retailer, wholesaler, and grower, respectively. Only the retail margins of many goods purchased by consumers accrue to the local region, as the wholesaler, shipper, and manufacturer often lie outside the local area.

Measures of economic activity. **Sales or output** is the dollar volume of a good or service produced or sold. **Final Demand** is sales to final consumers, including households, governments, and exports. **Intermediate sales** are sales to other industrial sectors. **Income** is the money earned within the region from production and sales. Total income includes personal income (wage and salary income, including income of sole proprietor's profits and rents). **Jobs** or employment is a measure of the number of jobs required to produce a given volume of sales/production, usually expressed as full time equivalents, or as the total number including part time and seasonal positions. Value Added is the sum of total income and indirect business taxes. **Value added** is the most commonly used measure of the contribution of a region to the national economy, as it avoids double counting of intermediate sales and captures only the "value added" by the region to final products.



Gwen M. MacKenzie, President and Chief Executive Officer

Gwen M. MacKenzie is president and CEO of Sarasota Memorial Health Care System, a regional medical center consisting of an 806-bed hospital, physician practices and a network of specialized medical campuses and clinics that include a nursing and rehabilitation center, home health, psychiatric hospital, walk-in medical centers and outpatient centers that offer the latest diagnostic and treatment services.

The only public hospital in the four-county Southwest Florida region, Sarasota Memorial has nearly 4,000 staff members, 1,000 volunteers and 802 physicians. It is one of the largest acute-care public hospitals in the nation and is currently Sarasota County's second-largest employer.

Despite the challenges of being the county's only safety-net hospital for the uninsured and underinsured, Sarasota Memorial offers a breadth and depth of services usually found only in major academic medical centers. The organization is the only hospital in the region with "Magnet" status – the nation's highest honor for excellence in nursing. It also is the only hospital in southwest Florida named in the nation's top 1% of hospitals for consistent clinical excellence, earning a spot on HealthGrades' "America's 50 Best Hospitals" list for 2011. Sarasota Memorial also has received the independent health care ratings organization's highest honor for patient safety – the Patient Safety Excellence Award™.

Since joining Sarasota Memorial in 2005, MacKenzie has successfully opened five new outpatient centers, including a freestanding Emergency Room and Health Care Center in North Port. She shepherded the hospital through an ER initiative with a 30-minute door-to-doctor goal. Those kinds of operational and patient care improvements, coupled with a strong focus on growth opportunities and cost-saving measures, helped Sarasota Memorial turn around a longstanding operating loss. Indeed, the organization's positive financial performance has resulted in bond-rating agency upgrades and paved the way for the hospital's \$250 million campus improvement project.

Trained as an oncology nurse, Ms. MacKenzie worked for 25 years at the nine-hospital Detroit Medical Center. Starting as an advanced practice nurse practitioner, she worked her way from bedside care and clinical management to executive vice president and chief operating officer at DMC. She also was president of a number of the DMC hospitals and for a time served as interim CEO of the system. Ms. MacKenzie attended the University of Michigan, earning a Bachelor of Science and a Master's in health services administration. She also received a Master's degree in Nursing from the University of California, Los Angeles.



Steve Purves, FACHE, President & Chief Executive Officer

Steve Purves joined Munroe Regional Medical Center as President and Chief Executive Officer in September of 2006. He has held a number of executive positions throughout his 30-year career in healthcare administration. Prior to joining Munroe, he was President and CEO of 322-bed Sisters of Charity Providence Hospitals, a two hospital regional health system located in Columbia, South Carolina. In 2005, Mr. Purves served as Chairman of the South Carolina Hospital Association, and in 2001, he was honored to be appointed to the position of Civilian Aide to the Secretary of the Army for South Carolina and served in this role until 2006.

Since moving to Ocala, Florida, Mr. Purves has joined the boards of the United Way of Marion County, Marion County Public Policy Institute, Ocala/Marion County Chamber of Commerce, the Economic Development Council of Marion County, Marion County Children's Alliance, and Heart of Florida Regional Coalition. He has served in positions with both the American Hospital Association and Florida Hospital Association. He is current Chair of the Florida Hospital Association's Advocacy Committee. In August 2009, he was appointed by the Florida Speaker of the House, Larry Cretul, to serve on the Medicaid Low Income Pool (LIP) Council.

Mr. Purves received a BS degree in Health Education from Springfield College in Springfield, Massachusetts in 1978 and a Master of Science Degree in Healthcare Administration from Trinity University in San Antonio, Texas in 1981. He is a Fellow in the American College of Health Executives.

He and his wife, Mary Anne, have two grown children.



Quality Care. Done Right.

11750 Bird Road, Miami, Florida 33175-3530
Phone: (305) 223-3000

SCOTT A. CIHAK BIO

Scott Cihak, FACHE, is the Chief Executive Officer of Kendall Regional Medical Center, a 412 bed, full service medical center including a Level II Provisional Trauma Center. Mr. Cihak previously served as the Chief Executive Officer of Columbia Hospital in West Palm Beach, Florida from 2010 to 2011.

Prior to becoming a Chief Executive Officer, Mr. Cihak served as a Chief Operating Officer at Westside Regional Medical Center from 2004 to 2010 and at Palms West Hospital from 2000 to 2004. Prior to joining Senior Leadership, Mr. Cihak served as an Associate Administrator, Director, and Supervisor.

Mr. Cihak, a native of Florida, has worked for Hospital Corporation of America (HCA) in South Florida for the past twenty-two years. Mr. Cihak received his Masters in Business Administration and his Bachelors in Health Service Administration, both from Florida International University. Mr. Cihak is a Fellow with the American College of Healthcare Executives.

**Tarren Bragdon, President and Chief Executive Officer
The Foundation for Government Accountability**

Tarren Bragdon is president and chief executive officer of the Foundation for Government Accountability, founded in 2011.

Tarren is a nationally recognized expert on health reform issues with a specialty in Medicaid reform. He has testified before the U.S. Senate Small Business and Entrepreneurship Committee; state legislative committees in Alabama, Connecticut, Florida, Georgia, Illinois, Maine and New York; numerous national conferences; and the American Swiss Foundation in Switzerland. His work has been featured on Fox News' Sean Hannity show, National Public Television's NOW, in Wall Street Journal editorials and op-eds, and in the New York Post, Boston Globe, New York Times and on National Public Radio.

From 2008 to early 2011, Tarren was CEO of The Maine Heritage Policy Center, a free market think tank based in Portland, Maine. Under his leadership, the organization grew to become the largest state-based free market think tank per capita. In September 2010, he received the Thomas Roe Award, given annually by the State Policy Network to the individual with the greatest impact on the nation's free market movement.

From 1996 through 2000, Tarren served in the Maine House of Representatives. Elected at the age of 21, Tarren remains the youngest person ever elected to the Maine Legislature.

He received his Bachelor of Science degree in Computer Science from the University of Maine and his Masters of Science of Business degree from Husson University in Bangor, Maine.

Tarren and his wife Anna have four children; Wyatt, Waverly and the twins, Jude and Asher.

Promise vs. Truth: Lessons from Medicaid Expansion in Arizona & Maine

Tarren Bragdon, CEO
Foundation for Government Accountability
Naples, Florida
www.FloridaFGA.org
tbragdon@FloridaFGA.org or 239.244.8808

ARIZONA

Promises to Patients & Taxpayers:

- Reduce uninsured
- Reduce charity care
- Save general fund money
- Have low, predictable enrollment & costs

Truth:

- Every promise broken
- High costs
- Huge enrollment spikes
- Massive new GF costs to state
- Program capped and patients thrown off
- No reduction in charity care & “hidden tax” scheme

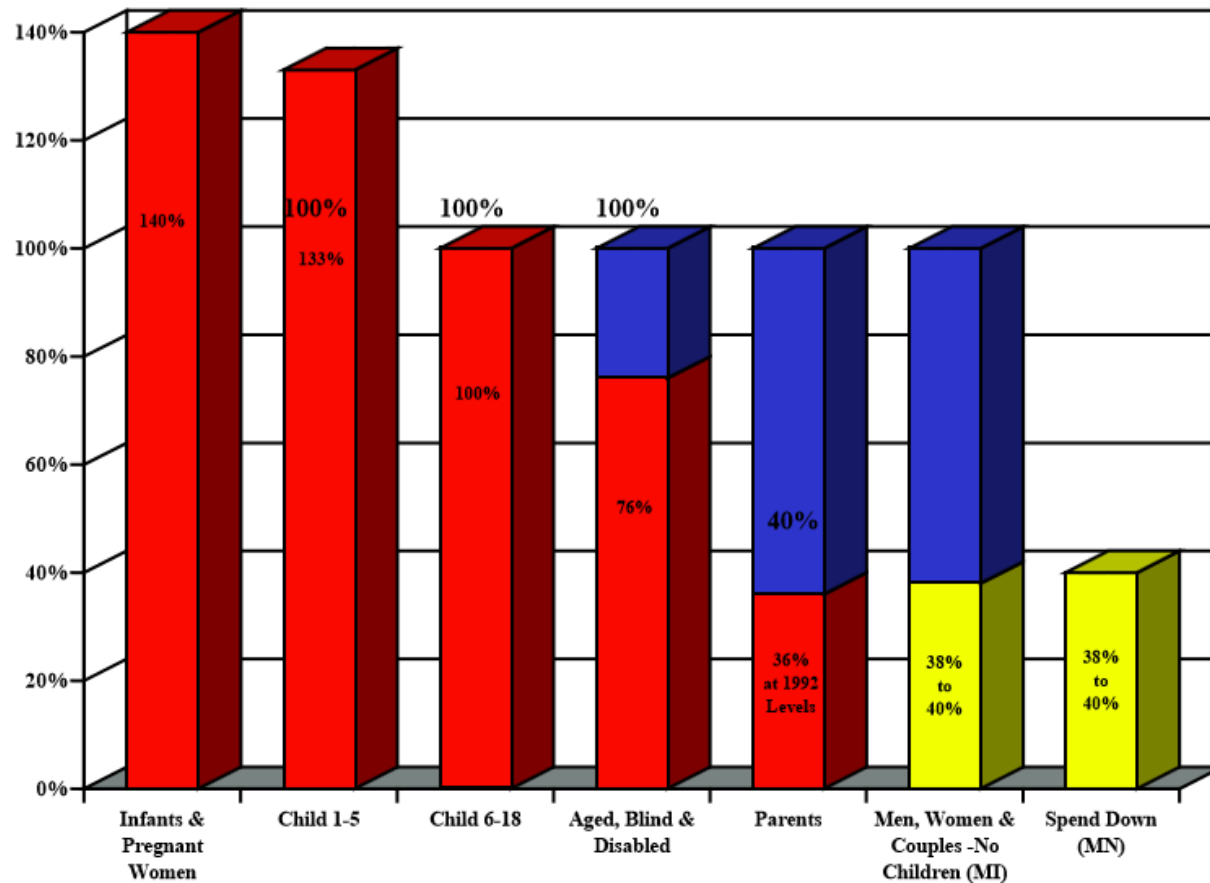
Arizona – Proposition 204 in 2000

Use “Free” Tobacco Settlement \$ for Medicaid Expansion

Proposition 204 - Changes in FPL Standards



Prop 204 expanded Medicaid for parents to 100% FPL (from 36%) and started covering childless adults up to 100% FPL, beginning July 2001.



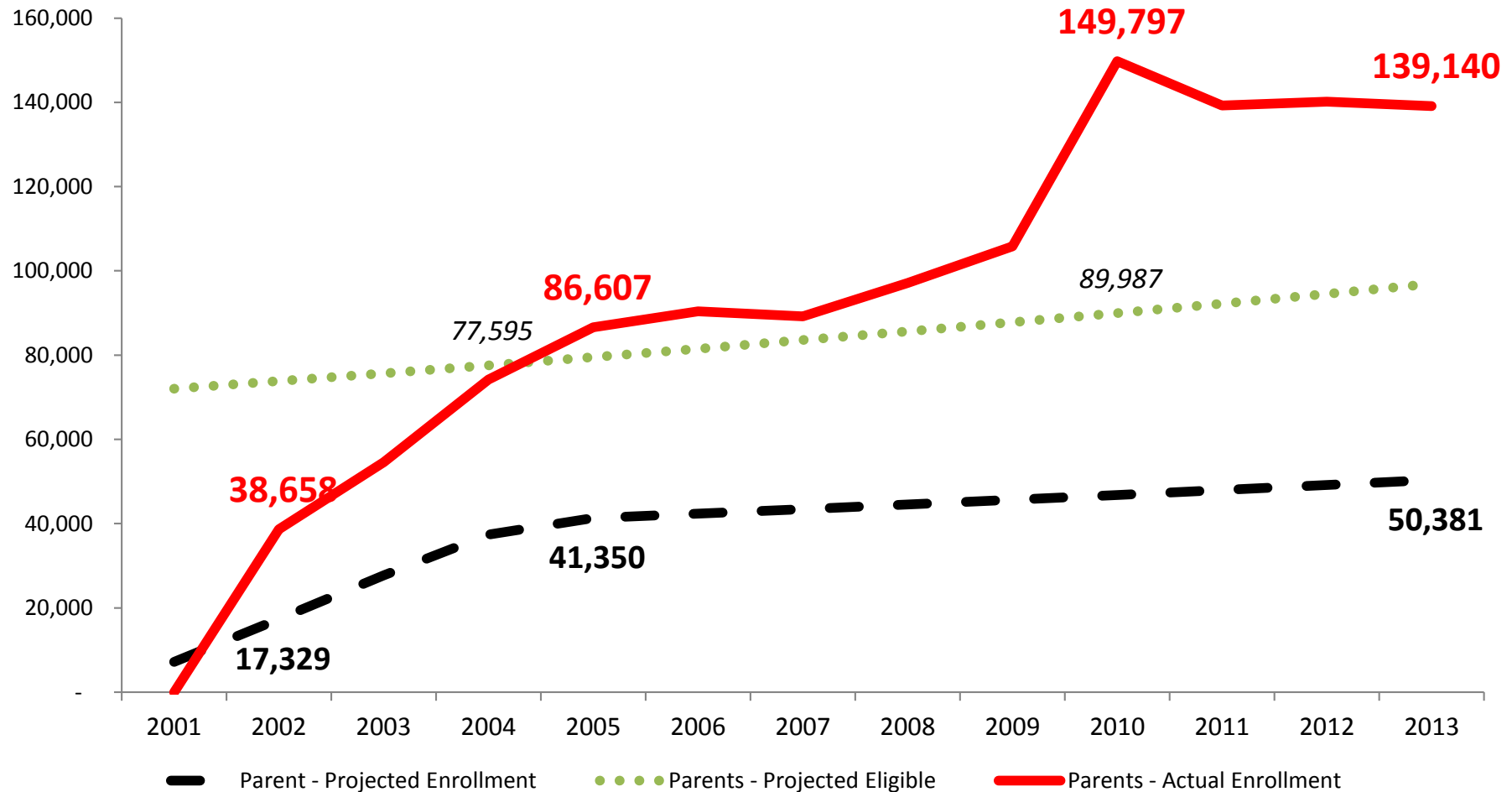
- Current FPL Standard for Medicaid
- New FPL Standard
- Current FPL for Medically Indigent/Medically Needy

[Childless Adults]

Arizona's Prop 204 Promises

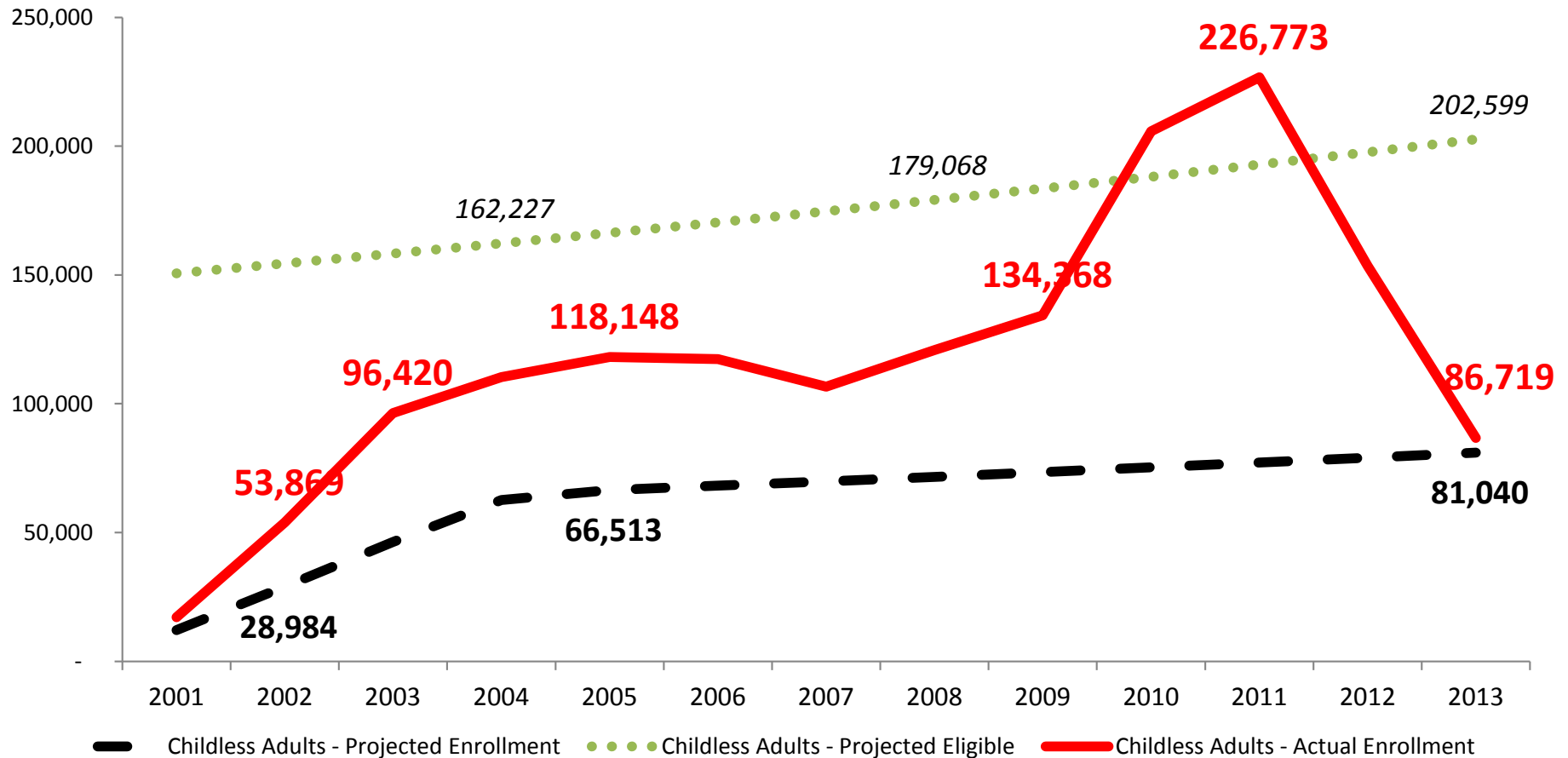
- “Save” General Fund about \$30 million a year
- Reduce the number of uninsured
- Reduce charity care
- Reduce “hidden tax” on private insurance from uninsured and uncompensated care

Arizona - Prop 204 Parents Expansion



Source: Arizona Legislature's Joint Legislative Budget Committee (2001 actual and 2001-2013 projected) & Arizona Health Care Cost Containment System (2001-2013 actual, based on January enrollment).

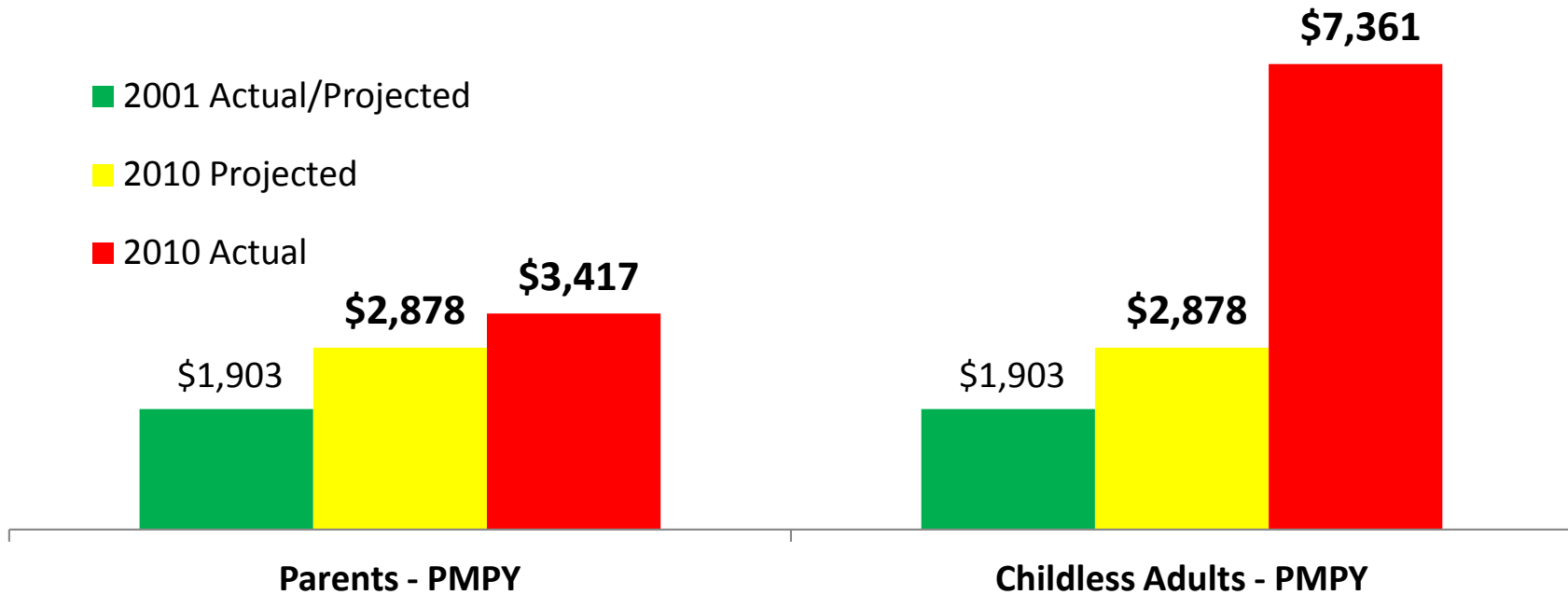
Arizona - Prop 204 Childless Adult Expansion



Source: Arizona Legislature's Joint Legislative Budget Committee (2001 actual and 2001-2013 projected) & Arizona Health Care Cost Containment System (2001-2013 actual, based on January enrollment).

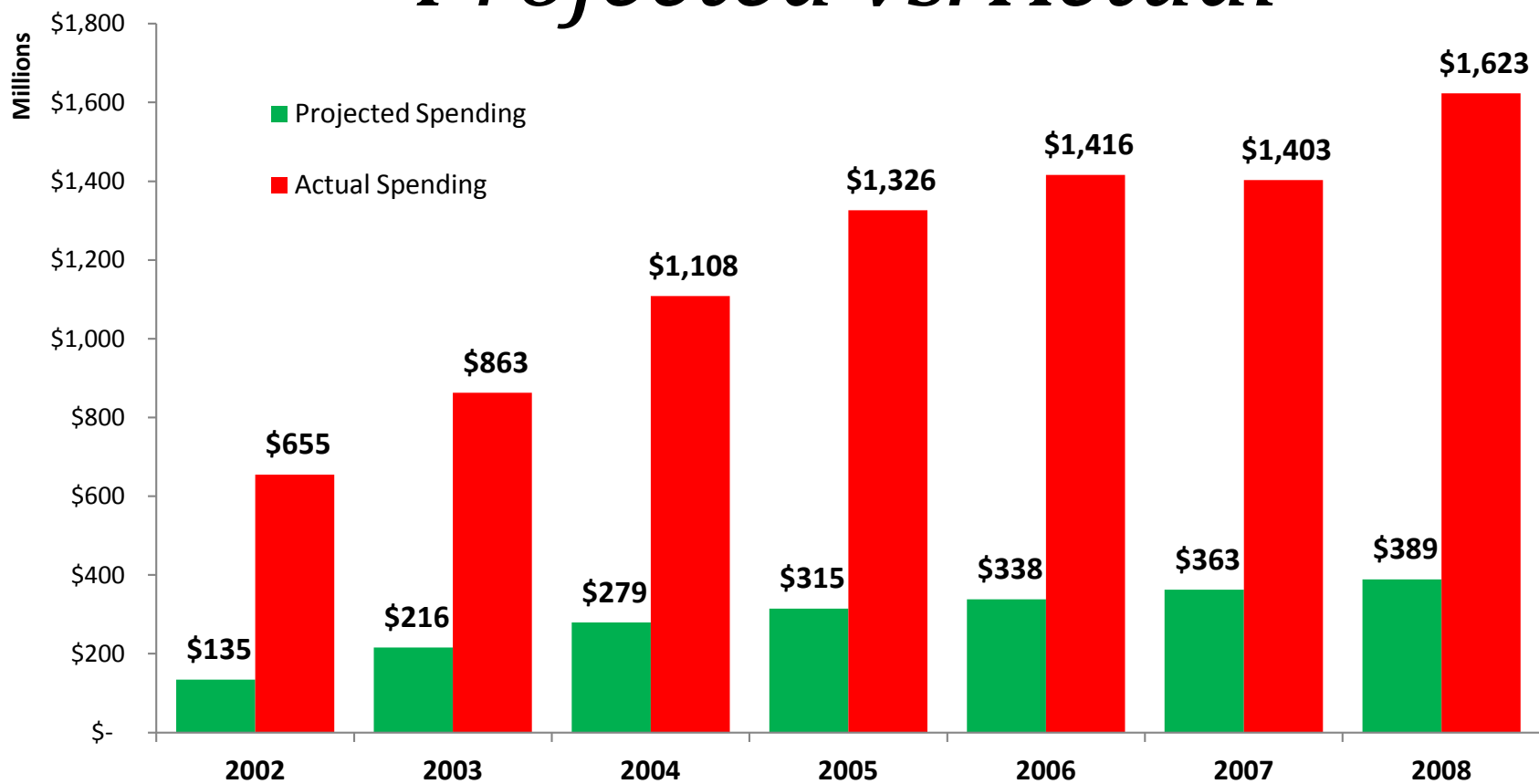
Arizona's Cost Increases from Medicaid Expansion – 2001-2010

**Per Member True Cost in 2010:
Childless Adults – 2.5x projection
Parents - 19% above projection**



Source: Arizona Legislature's Joint Legislative Budget Committee (2001 actual, 2010 projected) & Arizona Health Care Cost Containment System (2010 actual). Childless adults not covered until 2001.

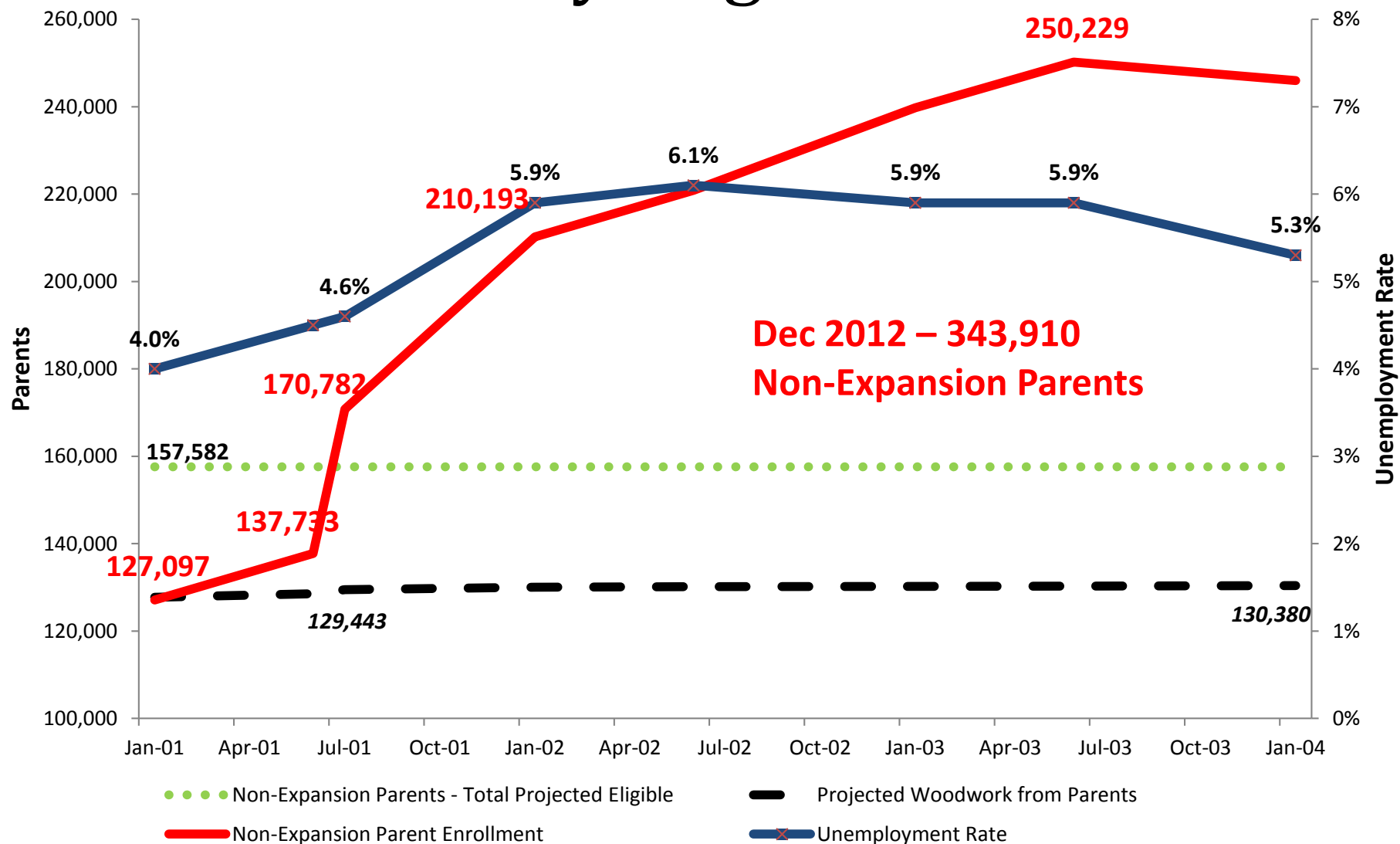
Arizona's Medicaid Expansion Spending (in millions) *Projected vs. Actual*



Source: Arizona Legislature's Joint Legislative Budget Committee (2002-2008 projected) & Arizona Health Care Cost Containment System (2002-2008 actual).

The Woodwork Effect

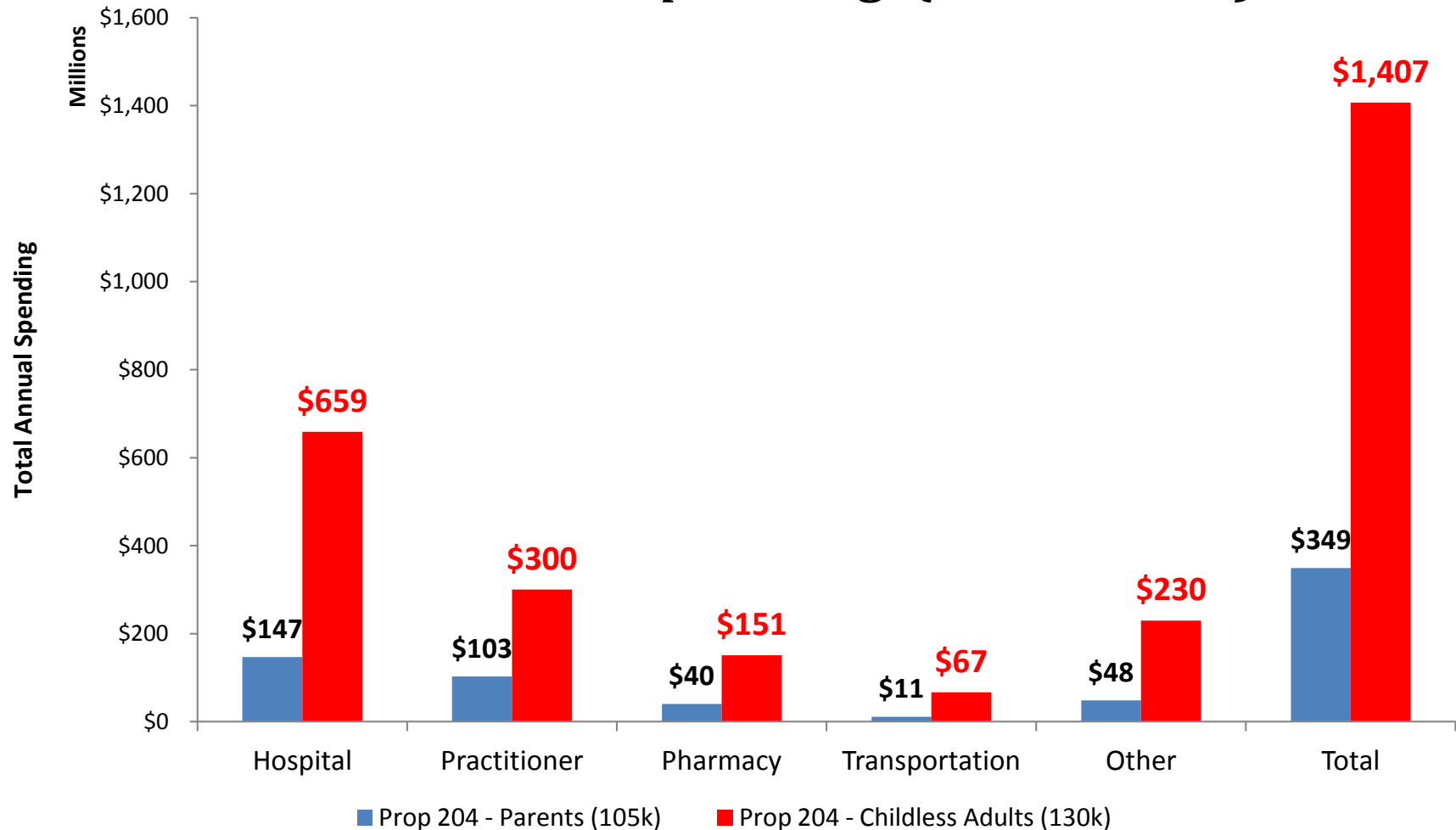
Parents Already Eligible – 2001-2003



Source: Arizona Legislature's Joint Legislative Budget Committee (2002-2004 projected) & Arizona Health Care Cost Containment System (2002-2004 actual). Bureau of Labor Statistics (unemployment rate in AZ).

What's Driving the High Costs?

2009 Actual Spending (in millions)



Source: Arizona Health Care Cost Containment System (2009 actual).

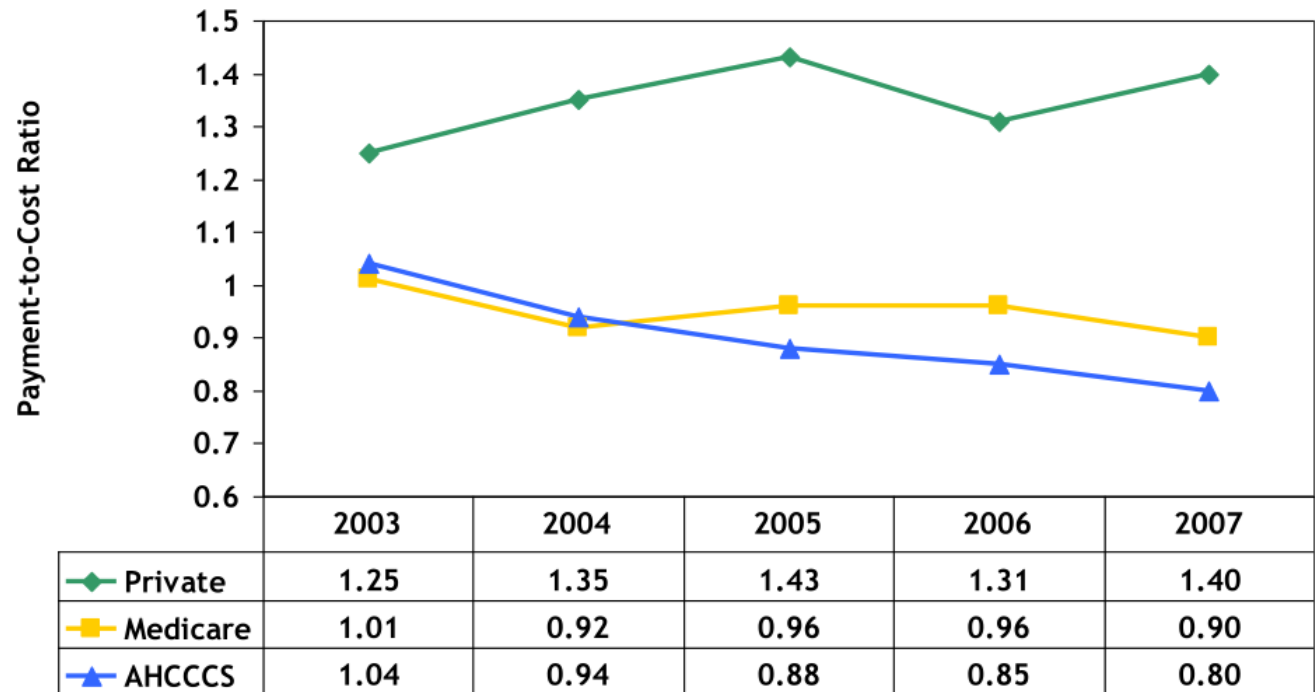
Impact on Arizona's Hospital Charity Care/Uncompensated Care

- Promise:
 - Prop 204 would dramatically reduce charity care
- Truth:
 - “The Arizona Hospital and Healthcare Association reports that **hospital uncompensated care has increased an average of about 9 percent per year since 2000 reaching \$364 million in 2007.**”
 - The Lewin Group, March 6, 2009

The Medicaid Expansion went into effect July 2001.

“Hidden Tax” to Private Insurance Worsened

Arizona Hospital Payment-to-Cost Ratios By Payer 2003-2007



In 2007 Arizona Hospitals had

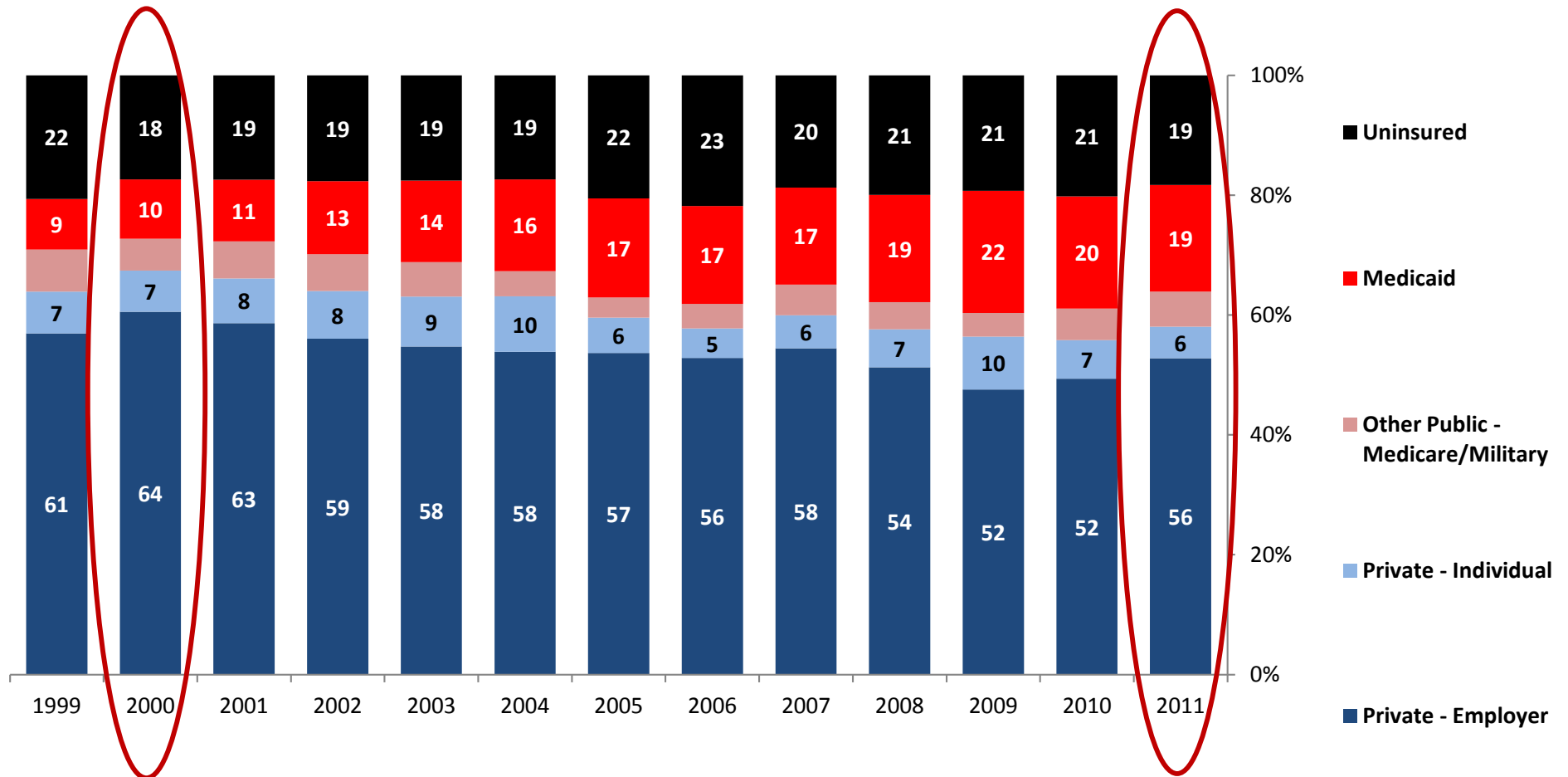
- Medicaid cost shift of \$407 M
- Uncompensated care cost shift of \$390 M

Note: Private payers include commercial managed care plan, other third party payers, Self-pay, and other non-government insurers. Includes a consistent panel of hospitals over the five year period.

Source: Lewin Group analysis American Hospital Association data for Arizona hospitals.

Effect of Prop 204 on Arizona's Uninsured Rate

Arizona Health Coverage - 1999-2011 - Non-Elderly



Source: U.S. Census Bureau

Why is Arizona Expanding Medicaid?

No Real Choice.

- Recent federal guidance provides that expansion states like Arizona that already provide Medicaid coverage for Childless Adults up to 100% FPL, are not eligible for enhanced federal funding unless the State expands Medicaid to cover individuals up to 133% FPL
- Arizona's two options:
 1. Do nothing, hope the feds extend the waiver, run the risk the feds don't extend the waiver letting it expire on January 1, 2014, leaving 86,000 Arizonans uninsured
 2. Restore coverage of Childless Adults up to 100% FPL, open enrollment, and expand Medicaid to cover all adults from 100% to 133% FPL to secure enhanced federal matching funds

MAINE

Promises to Patients & Taxpayers:

- Reduce uninsured
- Reduce charity care
- Have low, predictable enrollment & costs

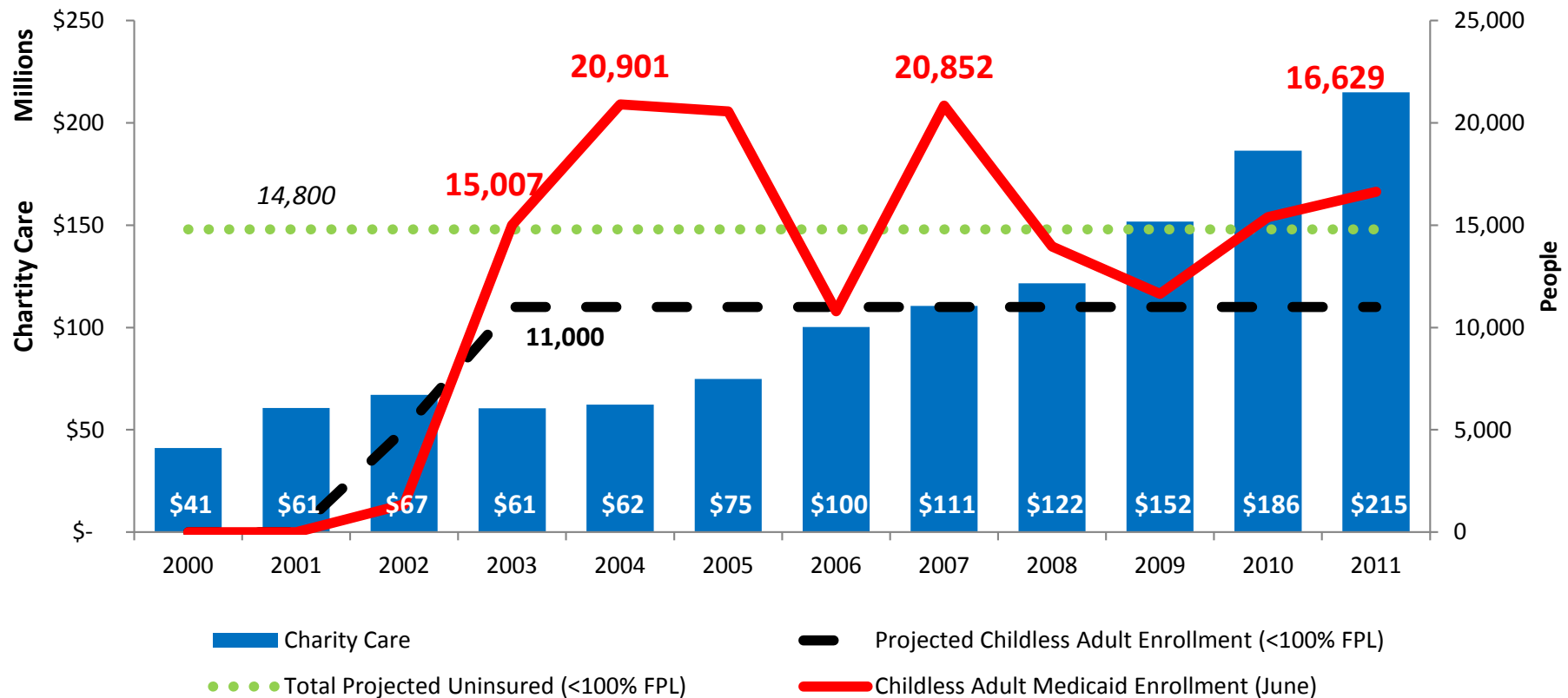
Truth:

- Every promise broken
- High costs
- Huge enrollment spikes
- Program capped and patients thrown off
- No reduction in charity care & “hidden tax” scheme

2002 Childless Adult Expansion

- Covered childless adults up to 100% of FPL
- Used 1115 Waiver and federal DSH funds with annual expenditure cap (state & federal)
- Same promises as Arizona: lower charity care, fewer uninsured, less “hidden tax” on private insurance, and low enrollment and per person costs

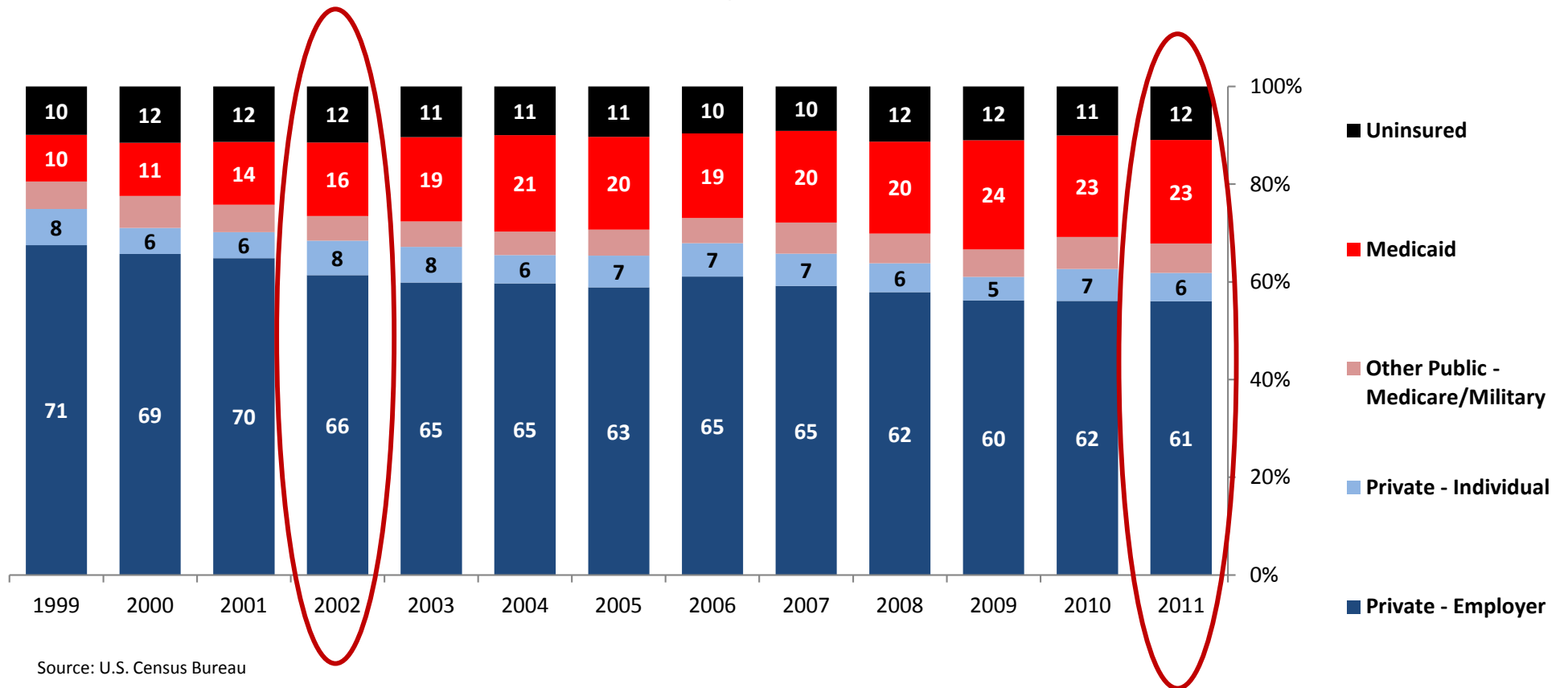
Maine's Childless Adult Expansion and the Impact on Charity Care (in millions)



Source: Maine Legislature's Fiscal Office (projections, enrollment), Maine Hospital Association (charity care)

Effect of Medicaid Expansion in Maine on Uninsured Rate

Maine Health Coverage - 1999-2011 - Non-Elderly



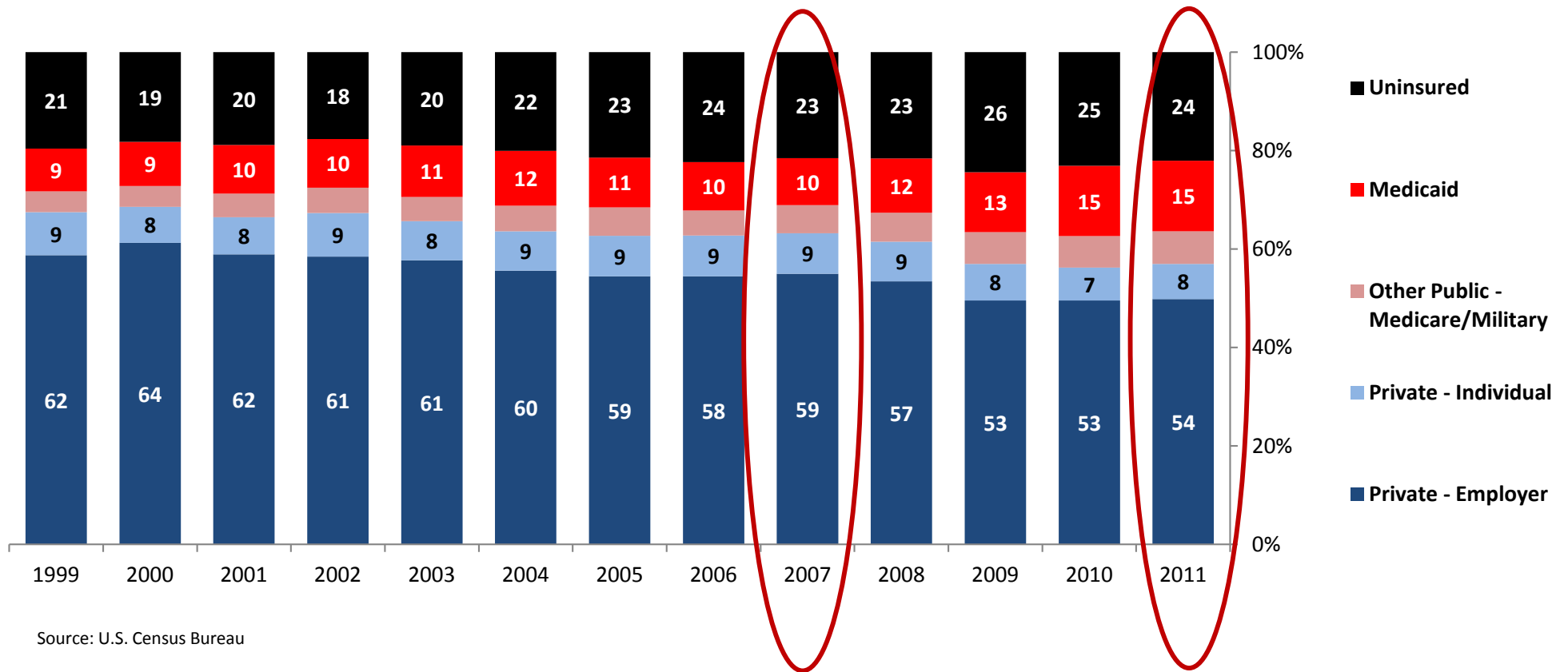
Source: U.S. Census Bureau

- Projections by advocates are historically way off
- Expect costs to dramatically increase
- Plan to throw patients off Medicaid within a few years

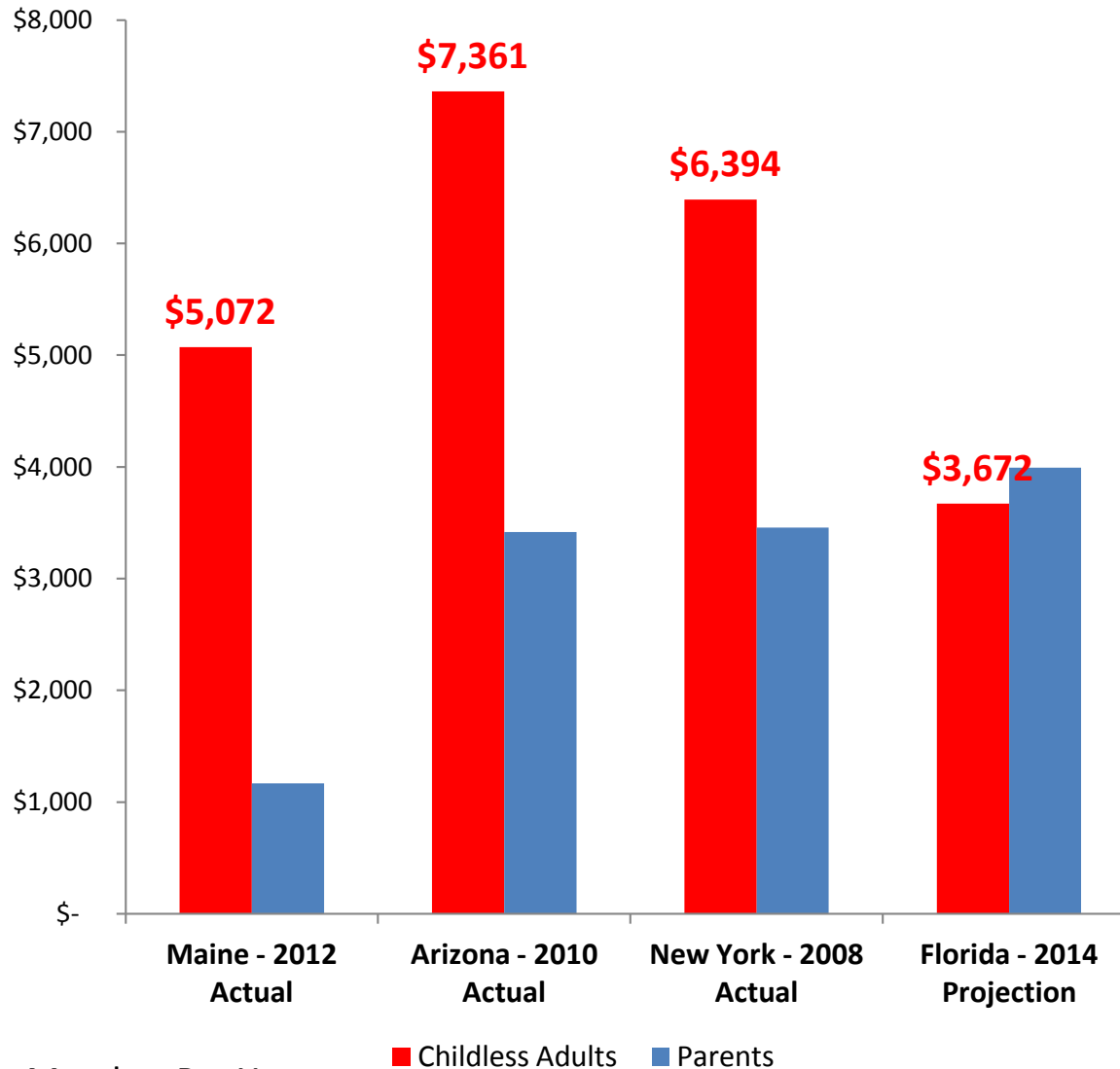
LESSONS FOR FLORIDA

Florida Health Coverage Over Time

Florida Health Coverage - 1999-2011 - Non-Elderly



Childless Adults Cost Much More



Per Member Per Year

CMS/Mathematica 2011 study found that childless adults were:

- “Older and included more men”
- “More likely to become Medicaid eligible due to disability”
- Cost “approximately 60 percent higher than expenditures for adults with dependent children”

Source: “Who Will Enroll in Medicaid in 2014? Lessons From Section 1115 Medicaid Waivers” May 2011

Projected vs. Actual Take-Up Rates Vary Dramatically

Childless Adults - Expansion

- Maine 74% projected v. 169% actual (within 3 years)
- Arizona 40% projected v. 111% actual (within 3 years)
- Florida 80% projected (Social Services Estimating Conference)
- Florida 57-75% projected (Georgetown)

Parents - Expansion

- Arizona 50% projected v. 71% actual (within 3 years) and 117% actual (within 10 years)
- Florida 80% projected (Social Services Estimating Conference)
- Florida 57-75% projected (Georgetown)

Parents – Woodwork for Currently Eligible

- Arizona 10% projected v. 135% actual (immediately) and 393% actual (within 2.5 years)
 - Florida Indeterminate projected (Social Services Estimating Conference)
 - Florida 10-40% projected (Georgetown)
- Massachusetts (only state with employer/individual mandate) – 96% actual (Kaiser Family Foundation)

Promise v. Truth

Key Lessons from Arizona & Maine

- Cost of childless adults dramatically **under-projected**
- Enrollment rates dramatically **under-projected**
- Many more people enroll, often **more than entire projected uninsured population**
- Costs and enrollments **skyrocket**
- Charity care continues to **grow**
- Uninsured rate virtually **unchanged**

**WHAT IF HISTORY REPEATS ITSELF
YET AGAIN...IN FLORIDA?**

Mary Mayhew, Commissioner, Maine Department of Health & Human Services



Mary Mayhew is Commissioner of the Department of Health and Human Services.

Prior to Mayhew's appointment she was Senior Health Policy Advisor for the LePage Administration. Mayhew advises on healthcare issues focused on MaineCare policy, Department of Health & Human Services policies and finance and state and federal health care issues. In addition, Mayhew has responsibility for Appropriations - DHHS, insurance, banking, and agriculture, forestry, and conservation.

Before joining the LePage Administration, Mayhew served as Vice President of the Maine Hospital Association for 11 years. As Vice President, Ms. Mayhew was responsible for state and federal government relations and development and advocacy of the association's health care policies. Prior to joining the hospital association, Mayhew was a partner in the public affairs firm of Hawkes & Mayhew based in Augusta providing association management, public relations, and advocacy services to a variety of clients. Mayhew also served as a manager of state government relations for the Equifax Corporation in Atlanta, Georgia. Mayhew began her professional career as a legislative assistant in Washington D.C. for Congressman William Alexander.

Mayhew holds a B.A. in Political Science.

Childless Adults Coverage in Maine 2001 – 2013

Mary Mayhew

Commissioner, Maine Department of
Health and Human Services

February 11, 2013

Maine – Snapshot View

- Maine's Total Population – **1,329,192**
- Total MaineCare population – **338,000**
- Uninsured – **10.1%**
- Hospitals/Non-profits – **37 total, 36 non-profits**
- Race – **95.4% white**
- Per Capita Income – **\$26,195**

Why Maine Expanded Coverage for Childless Adults Up to 100% FPL

- **To reduce the number of uninsured**
- **To reduce charity care and bad debt for hospitals**
 - 2001 report from the Maine Hospital Association in support of expansion:

Uninsured: “Our first priority would be to enroll all of those currently eligible for government assistance or employer-sponsored health insurance...Our second priority would be to provide coverage for the unemployed uninsured who are least able to afford it, and the most effective way to do that is to expand publicly provided insurance.”

Charity Care: “some of the hospitals’ cost of caring for the uninsured and underinsured must be shifted to others in the form of higher charges. For example, in Maine, the health care providers’ charity care and bad-debt write-offs amounted to approximately \$163 million in 1999 (\$41 million in charity care).”

What were the Expectations?

1) Reduce the uninsured by 20,000 – 40,000

- Speaker of the House initially said 40 – 50k
- Later in the process that number was changed to 20,000 by advocates and legislators [for expansion up to 125% of FPL for childless adults]

2) Charity care and bad debt to the hospitals would be reduced

3) 11,000 would “gradually” enroll in the program

- There were estimated to be 14,800 uninsured childless adults below 100% of FPL
- 74% enrollment rate projected (11,000/14,800)

Lessons Learned from Maine

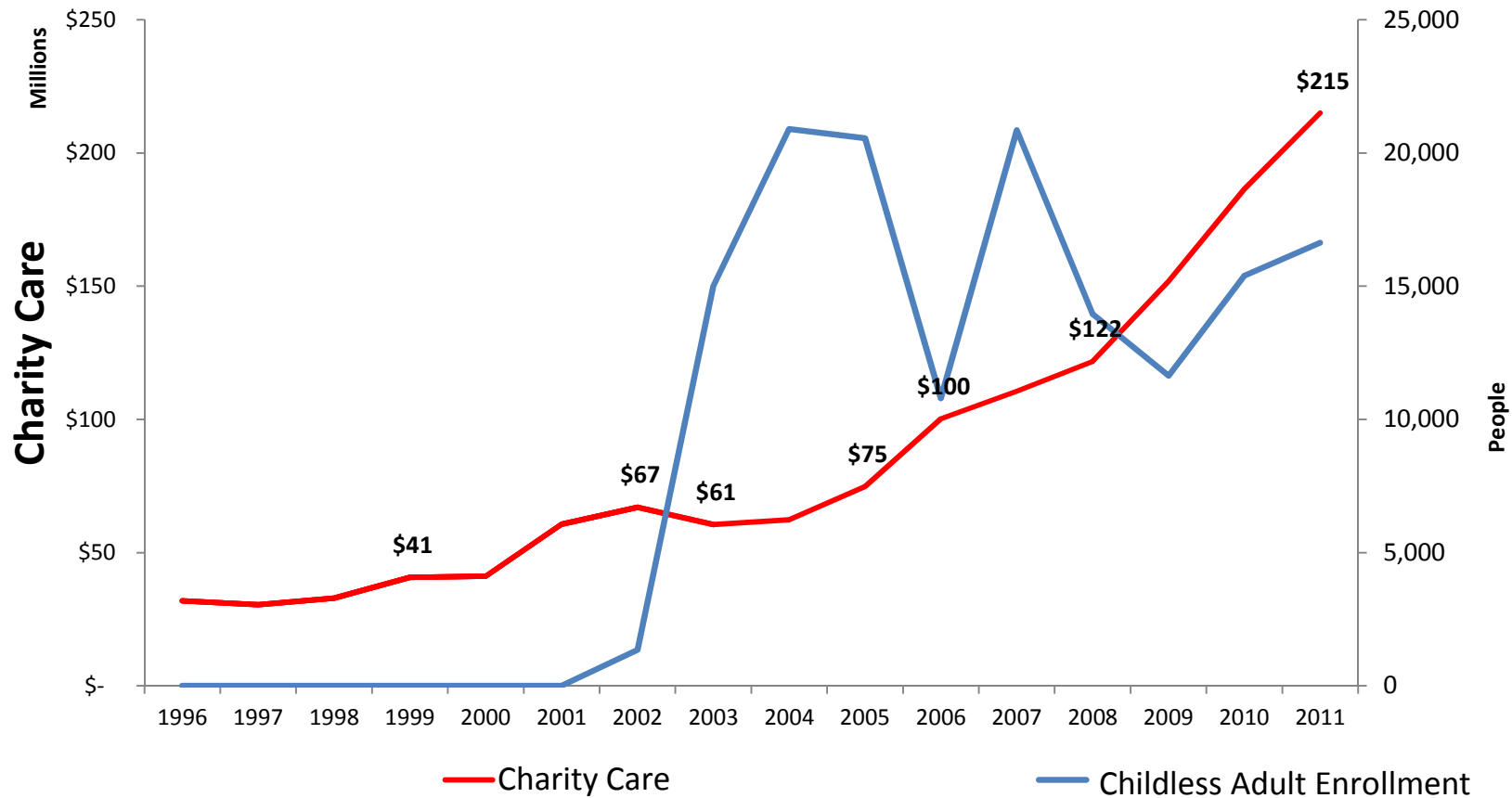
1) Limited change in number of uninsured, particularly for target population

- Maine’s uninsured numbers have been only marginally reduced in the decade since expansion.
- There were 136,000 uninsured (non-elderly) in 2001, and the uninsured population **decreased just 3,000 in a decade**, to 133,000 in 2011.

	Childless Adults (19-64) Uninsured <100% FPL	Total Childless Adults (19-64) <100% FPL	Uninsured Rate
2001	14,800		
2002	18,000	53,000	34%
2003	15,000	51,000	29%
2004	17,000	63,000	27%
2005	19,000	66,000	29%
2006	12,000	49,000	24%
2007	13,000	52,000	25%
2008	19,000	59,000	32%
2009	15,000	54,000	28%
2010	16,000	60,000	27%
2011	22,000	77,000	29%

Lessons Learned from Maine

2) Charity Care and Bad Debt at Hospitals Continued to Grow



Lessons Learned from Maine

3) Enrollment far exceeded expectations

- Within 14 months, enrollment reached nearly 17,000
- 5,000 individuals enrolled “overnight”
- **Enrollment reached a peak of 25,000 within the 2 years**
 - Far above entire childless adult uninsured population of 14,800 and 11,000 enrollment projection

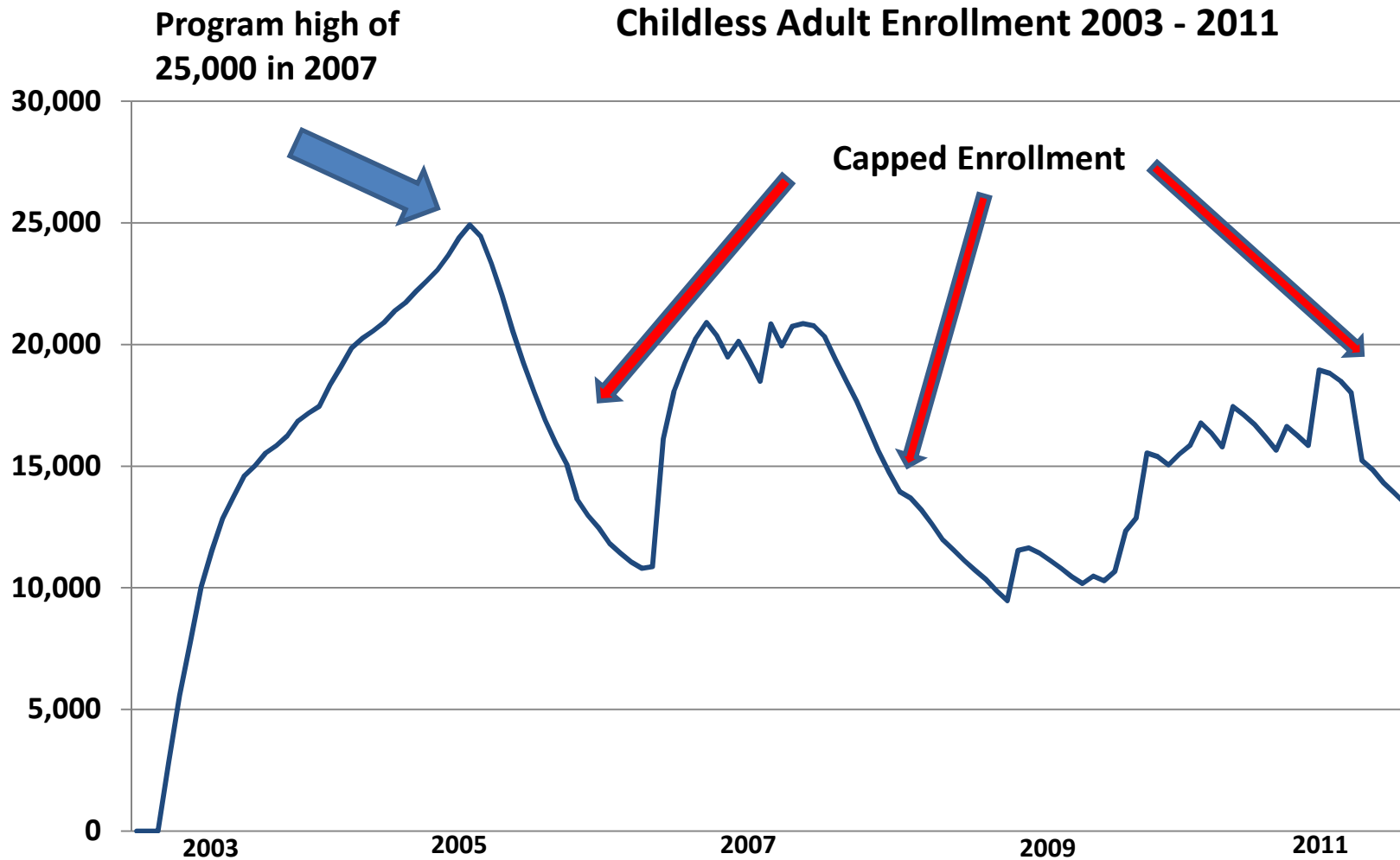
Financial challenges cause the program to be capped and opened at different times, creating sharp drops and spikes in enrollment

Current Enrollment and Waitlist

- There are currently 10,749 Childless Adults enrolled on MaineCare
- There are **24,331 currently on the Waitlist for services**
 - US Census Reports 22,000 uninsured childless adults in Maine <100% of FPL for 2011, the most recent year available

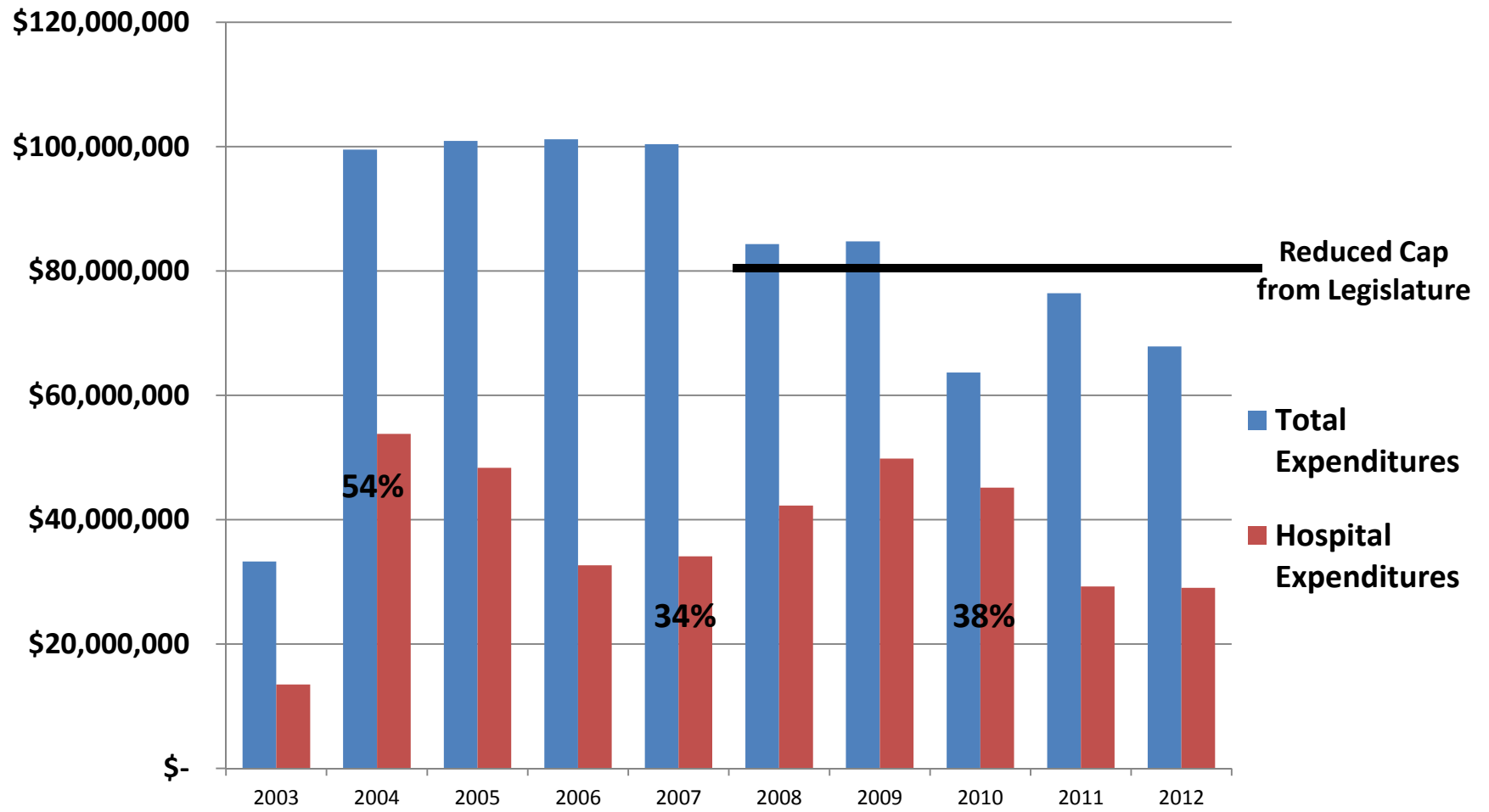
Lessons Learned from Maine

3) Enrollment far exceeded expectations



Lessons Learned from Maine

4) Costs have far exceeded expectations



Lessons Learned from Maine

4) Costs have far exceeded expectations

	Childless Adults < 100% FPL	Parents < 100% FPL
FY 2012 Annual Cost Per Member	\$5,072	\$1,168

Demographics – Childless Adults Enrolled on MaineCare

Gender	Number Enrolled	Percent of Total
<i>Male</i>	9,389	59%
Female	6,608	41%
Age	Number Enrolled	Percent of Total
21-24	2,287	15%
25-34	4,135	27%
35-44	2,738	18%
45-54	4,271	28%
55-64	2,550	17%
Marital Status	Number Enrolled	Percent of Total
<i>Single</i>	9,557	60%
Divorced	2,396	15%
Married	2,155	13%
Other	901	12%

Impact on Life

Higher enrollment and spending have created competing priorities to our core mission

- 3,100 Disabled and Elderly are on waiting lists while able-bodied adults have coverage

Health hasn't improved

- New England Journal of Medicine study shows expanding Medicaid did not “save lives.” Compared to New Hampshire, which did not expand Medicaid, Maine’s “all-cause mortality” among adults between 20-64 increased by 13.4 deaths per 100,000 post-expansion

Medical Access Issues

- Reimbursement rate reductions have caused access issues

Questions?

Mary C. Mayhew

Commissioner

Maine Department of Health & Human Services

Mary.Mayhew@maine.gov

207-287-4223

Comparison of Studies of Fiscal and Economic Impacts of Medicaid Expansion in Florida
February, 2013

Components of Analysis		Kaiser Commission on Medicaid and the Uninsured	Georgetown Health Policy Institute	Florida Hospital Association/ University of Florida	Social Services Estimating Conference	AHCA Estimates
Description	Publication date	November 2012	November 2012	November 26, 2012	August 14, 2012	December 20, 2012
	Focus and purpose	Estimates and compares costs under nationwide Medicaid expansion versus no Medicaid expansion in any state.	Predicts Florida's costs and savings under Medicaid expansion	Predicts potential impacts to Florida economy under Medicaid expansion	Consensus estimates related to the PPACA and expansion of Medicaid	Agency estimates related to the PPACA and expansion of Medicaid
	Timeframe for estimates / modeling	10-years in the aggregate, 2013-2022	Varies. Estimated savings pertain to a SFY after 100% FMAP expires. SFY 2017-18 is first such year.	SFYs 2012-13 through 2022-23	SFYs 2013-14 through 2022-23	SFYs 2013-14 through 2022-23
Data Sets Used	Income and eligibility	<ul style="list-style-type: none"> • Current Population Survey • Medical Expenditure Panel Survey • Congressional Budget Office estimates • Population demographics 	Refers to the Estimating Conference and to the Urban Institute's tabulations of the 2010 American Community Survey but precise data elements used cannot always be traced.		Three years of data from the American Community Survey, 2008-2010	Three years of data from the American Community Survey, 2008-2010
	Medicaid caseload and expenditures	National database.	Indeterminate	SSEC: July 17, 2012	SSEC: July 17, 2012	SSEC: November 29, 2012

Comparison of Studies of Fiscal and Economic Impacts of Medicaid Expansion in Florida
February, 2013

Components of Analysis	Kaiser Commission on Medicaid and the Uninsured	Georgetown Health Policy Institute	Florida Hospital Association/ University of Florida	Social Services Estimating Conference	AHCA Estimates	
Key Economic Inputs	<p>Supply Inputs:</p> <ul style="list-style-type: none"> • Capacity • Time to expand • Availability of substitute sources of service • Simultaneous expansion of privately insured • Changes in costs • Difference in payment levels between Medicaid versus private coverage 	None	None	None	None	
	<p>Demand Inputs:</p> <ul style="list-style-type: none"> • Number of eligible people • Take up rate • Changes in uptake over time • Changes in other types of coverage • Consumer behavior in response to incentives or penalties 	<ul style="list-style-type: none"> • Number of eligibles is <i>not specified</i>. • Take up rate: <ul style="list-style-type: none"> ○ For newly eligible = 60.5% ○ For currently eligible but not enrolled = 23.4% <i>nationally</i> • Expected additional enrollment in 10 years (2022) = 1,276,000ⁱ • Other demand inputs not considered. 	<ul style="list-style-type: none"> • Number of new eligibles = 1,295,000ⁱⁱ • Number of currently eligible but not enrolled = 250,000ⁱⁱⁱ • Take up rate: <ul style="list-style-type: none"> ○ For newly eligible = 57% to 75% ○ For currently eligible but not enrolled = 10% to 40%^y • Other demand inputs not considered 	<ul style="list-style-type: none"> • No unique demand inputs; • Uses SSEC results. • Other demand inputs not considered 	<ul style="list-style-type: none"> • Number of eligibles is 852,804. • Number of currently eligible but not enrolled = 253,941 • Take up rate: <ul style="list-style-type: none"> ○ For newly eligible = 79.7% ○ For currently eligible but not enrolled = <i>indeterminate</i> • Expected enrollment due to expansion in 10 years (2022) = 995,618 • Other demand inputs not considered 	<ul style="list-style-type: none"> • Number of new eligibles is 852,804. • Number of currently eligible but not enrolled = 253,941 • Take up rate: <ul style="list-style-type: none"> ○ For newly eligible = 79.7% ○ For currently eligible but not enrolled = <i>indeterminate</i> • Expected enrollment due to expansion in 10 years (2022) = 1,008,614 • Other demand inputs not considered

Comparison of Studies of Fiscal and Economic Impacts of Medicaid Expansion in Florida
February, 2013

Components of Analysis	Kaiser Commission on Medicaid and the Uninsured	Georgetown Health Policy Institute	Florida Hospital Association/ University of Florida	Social Services Estimating Conference	AHCA Estimates
Medicaid costs	<p>Uses an adjusted cost per enrollee that increases over time:</p> <ul style="list-style-type: none"> • Average cost = \$5,440 in 2016 • Average cost = \$7,399 in 2022 	None	Uses SSEC results as fiscal inputs.	Uses most recent Medicaid expenditure estimates; does not include a factor for medical inflation.	Uses most recent Medicaid expenditure estimates; does not include a factor for medical inflation.
Change in Local and state government funding for health care	Assumes \$1.25 billion reduction in uncompensated care spending over 10 years.	<p>Assumes \$700 million in reduced spending^{iv}:</p> <ul style="list-style-type: none"> • \$200 million less in public funding to safety net providers; • \$250 million less in mental health and substance abuse funding; • \$250 million less in state funding for Medically Needy. 	None	None	None
Federal funding	<p>Assumes current law:</p> <ul style="list-style-type: none"> • 100% federal for 3 years; • Declining to 90% by CY 2020; • 90% thereafter 	<p>Assumes current law:</p> <ul style="list-style-type: none"> • 100% federal for 3 years; • Declining to 90% by CY 2020; • 90% thereafter 	Uses SSEC results as fiscal inputs.	<p>Assumes current law:</p> <ul style="list-style-type: none"> • 100% federal for 3 years; • Declining to 90% by CY 2020; • 90% thereafter 	<p>Assumes current law:</p> <ul style="list-style-type: none"> • 100% federal for 3 years; • Declining to 90% by CY 2020; • 90% thereafter
Shift from taxable to non-taxable activity	None	None	None	None	None

Key Fiscal Inputs

Comparison of Studies of Fiscal and Economic Impacts of Medicaid Expansion in Florida
February, 2013

ⁱ Appears to make no exclusion of currently eligible but not enrolled.

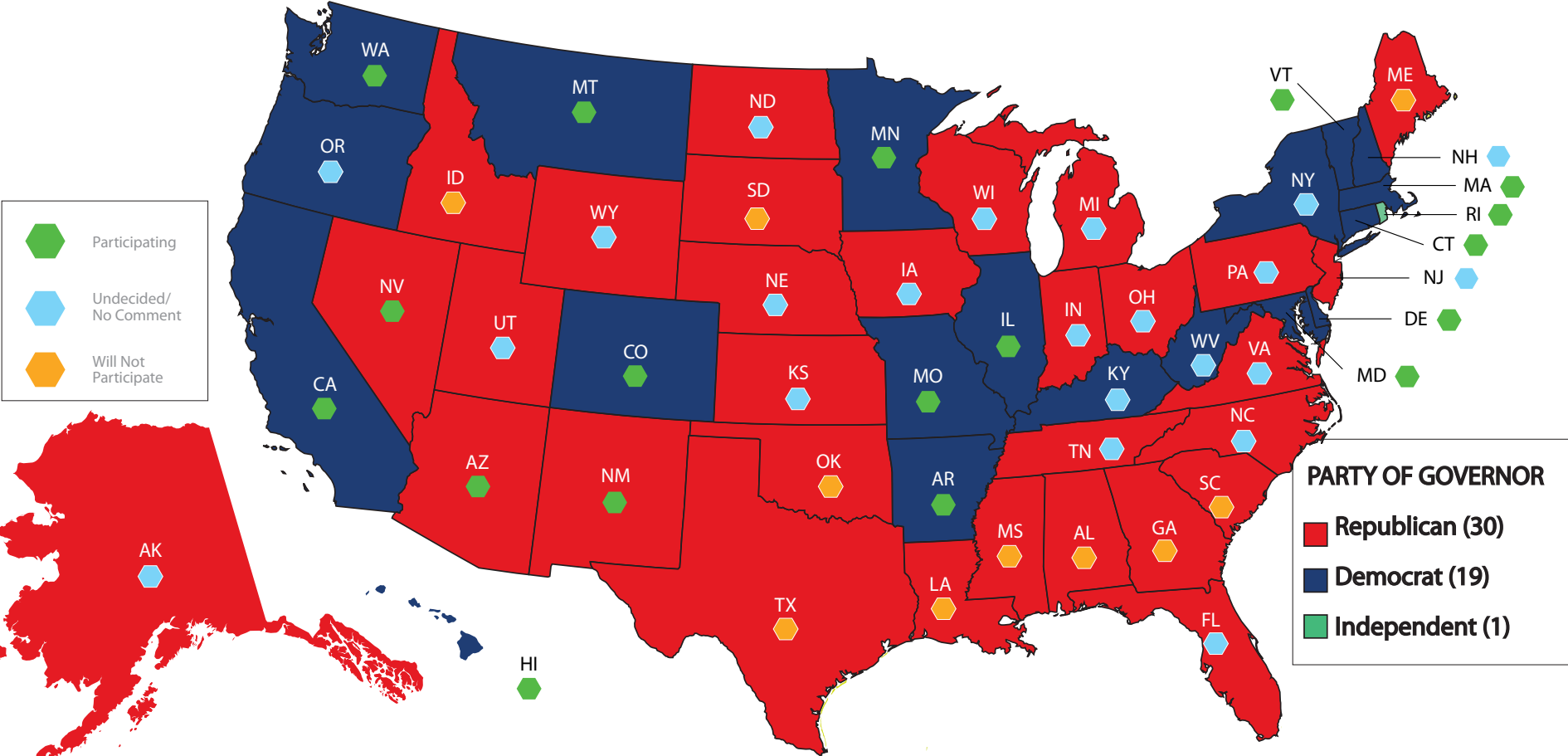
ⁱⁱ References the Urban Institute Tabulations of the 2010 American Community Survey (ACS). These Urban Institute estimates adjust for the underreporting of Medicaid and CHIP on the ACS. Modeling Medicaid eligibility for adults based on a household survey is subject to measurement error due to the complexity of the rules in place that govern Medicaid eligibility for adults, gaps in the information available on income, assets, household structure, immigration status etc., and difficulties measuring eligibility for certain pathways, such as pregnancy and disability.

ⁱⁱⁱ *Ibid*

^{iv} This amount is based on an assumed reduction of 50% in state and local spending.

^v Due to the proprietary nature of the HPSM methodology used by Kaiser, it is impossible to know specifically how this number was generated and whether it includes the HIT.

State Positions on Medicaid Expansion



Information based on best available data as of 1/31/13. State policies are subject to change.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Feb 11, 2013

Meeting Date

Topic PPACA - Medicaid Expansion

Bill Number _____
(if applicable)

Name Richard Polangin

Amendment Barcode _____
(if applicable)

Job Title Govt Affairs Director

Address 1300 N Duval St

Phone (850) 224-4206

Tallahassee, FL 32303
City State Zip

E-mail richardpolangin@
hotmail.com

Speaking: For Against Information

Representing Florida Alliance for Retired Americans

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13
Meeting Date

Topic Medicaid Expansion

Bill Number PPACA-Medicaid
(if applicable)

Name SAM BELL

Amendment Barcode _____
(if applicable)

Job Title _____

Address 1298 MILLSTREAM
Street

Phone 222-3533

TALLAHASSEE FL 32312
City State Zip

E-mail sbellepennington@law.com

Speaking: For Against Information

Representing FLORIDA PEDIATRIC SOCIETY

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-11-13

Meeting Date

Topic MEDICAID EXPANSION

Bill Number _____
(if applicable)

Name MARTHA BAKER, RN

Amendment Barcode _____
(if applicable)

Job Title PRESIDENT SEIU L-1991 & JHS NURSE

Address 1685 CLEVELAND RD
Street

Phone 305-620-6555

MIAMI BEACH FL 33141
City State Zip

E-mail Martha@SEIU1991.ORG

Speaking: For Against Information

Representing SEIU L 1991 - NURSES & DOCTORS & HC PROF. @ JACKSON

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13
Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name Magalie VANCOL PENA

Amendment Barcode _____
(if applicable)

Job Title Social Worker

Address 9893 NW 14th Ct

Phone (954) 383-3123

PEM Brook Pines FL 33024
Street City State Zip

E-mail magalie.vancol@yaho.com

Speaking: For Against Information

Representing Nurses and Healthcare Prof and doc at JMH

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Feb 11, 2013

Meeting/Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name Debbie King

Amendment Barcode _____
(if applicable)

Job Title Student

Address 8416 N. Jones Ave

Phone (813) 500-1763

Tampa FL 33604
Street City State Zip

E-mail debbie.king1979@gmail.com

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11 FEB 2013
Meeting Date

Topic MEDICAID EXPANSION

Bill Number _____
(if applicable)

Name MARK MORRIS MD

Amendment Barcode _____
(if applicable)

Job Title PEDIATRICIAN

Address 2533 W MARYLAND AVE

Phone 727-480-5130

TAMPA FL 33629
City State Zip

E-mail MMORRIS2264@GMAIL.COM

Speaking: For Against Information

Representing FLORIDA PEDIATRIC ASSOCIATES

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Feb. 11, 2013

Meeting Date

Topic PPACA

Bill Number _____
(if applicable)

Name Jeanie Vincent

Amendment Barcode _____
(if applicable)

Job Title Adjunct Professor

Address 20623 Northeast 22nd Lane

Phone 352-468-1242

Street

Hawthorne

FL

32640

City

State

Zip

E-mail _____

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

(20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13

Meeting Date

Topic Medicaid Expansion

Bill Number (if applicable)

Name Paula Witthaus

Amendment Barcode (if applicable)

Job Title Executive Director Living Insurance For Every one

Address 7 Rhoda Ct. S.

Phone 727-550-7175

Street St. Petersburg FL 33701 City State Zip

E-mail hurricane3159@yahoo.com

Speaking: [X] For [] Against [] Information

Representing Self

Appearing at request of Chair: [] Yes [X] No

Lobbyist registered with Legislature: [] Yes [X] No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/2013

Meeting Date

Topic MEDICAID EXPANSION

Bill Number _____
(if applicable)

Name GARY STEIN, M.D.

Amendment Barcode _____
(if applicable)

Job Title _____

Address 7035 BELT LINE LOOP

Phone (813) 973-3835

Street

WESLEY CUNARD FL 33545

City

State

Zip

E-mail gstein@jhsph.edu

Speaking: For Against Information

Representing MY FAMILY, MYSELF & MY STATE

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13
Meeting Date

Topic _____ Bill Number _____
Name Judi Evans _____ (if applicable)
Job Title Exec. Director _____ Amendment Barcode _____ (if applicable)
Address 1030 E Lafayette St #10 _____ Phone 671-4445 _____
Sal. Fl 32301 _____ E-mail _____
City State Zip

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13

Meeting Date

Topic PPAC - Acupuncture as EHB

Bill Number _____
(if applicable)

Name Ellen Teeter

Amendment Barcode _____
(if applicable)

Job Title President

Address 6320 Georgia Ave

Phone 941-780-6019

Bradenton, FL 34207
City State Zip

E-mail ellen@fsoma.com

Speaking: For Against Information

Representing Florida State Oriental Medical Association

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13
Meeting Date

Topic MEDICAID EXPANSION

Bill Number _____
(if applicable)

Name JACK MÉRAY

Amendment Barcode _____
(if applicable)

Job Title _____

Address 200 W. COLLEGE ST., # 304
Street

Phone 250-228-7295
(cell)

TLH FL 32301
City State Zip

E-mail jmcroy@aarp.org

Speaking: For Against Information

Representing AARP **OUT OF TIME**

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13

Meeting Date

Topic PPACA

Bill Number _____
(if applicable)

Name STEVE PURVES

Amendment Barcode _____
(if applicable)

Job Title PRESIDENT / CEO

Address 4911 SE 7th Ave

Phone 352-351-7393

Ocala FLA
City State Zip

E-mail stewpurses@mrhs.org

Speaking: For Against Information

Representing FLORIDA HOSPITAL ASSOC. - MUNROE REGIONAL MEDICAL CENTER

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13

Meeting Date

Topic PPACA

Bill Number _____
(if applicable)

Name GWEN MACKENZIE

Amendment Barcode _____
(if applicable)

Job Title PRESIDENT/CEO

Address 1700 S. TAMiami Trail

Phone 941-917-2498

Street

SARASOTA, FLORIDA

City

State

Zip

E-mail Gwen-Mackenzie@SMH.com

Speaking: For Against Information

Representing FLORIDA HOSPITAL ASSOC. - SARASOTA MEMORIAL HEALTH Sys.

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13

Meeting Date

Topic PPACA Bill Number _____ (if applicable)

Name MARK O'BRYAN Amendment Barcode _____ (if applicable)

Job Title PRES/CEO

Address 9616 DEER VALLEY DRIVE TALLAHASSEE FL 32312 Phone (850) 431-5380

Street TALLAHASSEE City FLORIDA State _____ Zip _____ E-mail MARK.OBRYAN@TMD.ORG

Speaking: For Against Information

Representing FLORIDA HOSPITAL ASSOC. - TALLAHASSEE MEMORIAL

Appearing at request of Chair: Yes No Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/2013

Meeting Date

Topic Affordable Care Act - Medicaid Expansion

Bill Number _____
(if applicable)

Name Heather Wildermuth

Amendment Barcode _____
(if applicable)

Job Title Director of Government Relations

Address 2619 Centennial Blvd., Suite 101
Street

Phone 850-329-4557

Tallahassee FL 32308
City *State* *Zip*

E-mail heather.wildermuth@cancer.org

Speaking: For Against Information

Representing American Cancer Society Cancer Action Network (ACS CAN)

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13

Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name David Francis

Amendment Barcode _____
(if applicable)

Job Title Director of Government Relations

Address 2851 Remington Green Circle, Suite 201

Phone 850-567-0598

Street

Tallahassee

FL

32308

E-mail david.francis@heart.org

City

State

Zip

Speaking: For Against Information

Representing American Heart Association

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-11-13
Meeting Date

Topic Medicaid Expansion

Bill Number Medicaid Expansion
(if applicable)

Name Barbara DeVane

Amendment Barcode _____
(if applicable)

Job Title Independent Contractor

Address 625 E. Broadway ST

Phone 857-222-3969

Tallahassee FL 32308

E-mail barbaradevane1@

Speaking: Waste my time in support of medicare expansion
 For Against Information

yahoo.com

Representing FL NOW (National Organization for Women)

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-11-13

Meeting Date

Topic MEDICAID EXPANSION Bill Number _____ (if applicable)
Name DR. DAVID SMITH Amendment Barcode _____ (if applicable)
Job Title STATE RETIREE

Address 1225 WINDFRED DR Phone 850-877-1864
Street
TALLAHASSEE FL 32308 E-mail SMITH/827@COMCAST.NET
City

Speaking: For Against Information
WAIVE MY TIME IN SUPPORT OF MEDICAID EXPANSION

Representing AFSCME RETIREES

Appearing at request of Chair: Yes No
Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting. S-001 (10/20/11)



44629175



COMMITTEE/SUBCOMMITTEE APPEARANCE RECORD

Please fill out the entire form, then click the "Submit and Print" button. Two copies of the printed form should be submitted to the Committee Administrative Assistant at the meeting. If you are unable to submit and/or print this interactive form, you may contact the Committee for a .pdf copy of the form or fill out a paper copy at the meeting.

Bill Number (If Applicable): N/A

Meeting Date: Feb 11 2013 1:00PM

PCB/PCS/Amendment # or N/A

Presentation/Workshop

Topic:

Committee/Subcommittee: Select Committee on PPACA (Patient Protection and Affordable Care Act)

Name: Clay, Karen

Title: Ms.

Address: 3417 W. Alline Avenue

Address (cont):

City: Tam

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-11-13

Meeting Date

Topic Medicaid Expansion

Bill Number Medicaid Expansion
(if applicable)

Name Wilson Barnes

Amendment Barcode _____
(if applicable)

Job Title NAACP Health Committee Member

Address 1949 Setting Sun Trail
Tallahassee FL 32303

Phone 850-562-1025

E-mail _____

Waive my time in support of Medicaid Expansion
Speaking: For Against Information

Representing NAACP

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/2013
Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name Alisa Snow

Amendment Barcode _____
(if applicable)

Job Title _____

Address P.O. Box 1344
Street

Phone 850-443-1319

Tallahassee, FL 32302
City State Zip

E-mail ALISASNOW
@yahoo.com

Speaking: For Against Information

Representing Florida Nurses Association

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

5/11/13

Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name Missy Wesolowski

Amendment Barcode _____
(if applicable)

Job Title Legislative Coordinator

Address 2300 N. Florida Mango
Street

Phone 561-291-9236

West Palm Beach FL 33409
City State Zip

E-mail missy.wesolowski
@ppsofla.org

Speaking: For Against Information

Representing Planned Parenthood

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

wave in support of Medicaid expansion

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13
Meeting Date

Topic MEDICAIDE EXPANSION

Bill Number N/A
(if applicable)

Name DARRELL CONDRY

Amendment Barcode _____
(if applicable)

Job Title CNA

Address 2450 E HILLSBOROUGH 1111 APT

Phone 813-409-9203

Street

Tampa

City

FL

State

33612

Zip

E-mail CONDY4@HOTMAIL.COM

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13
Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name Verna Pearson

Amendment Barcode _____
(if applicable)

Job Title CPA

Address 4448 Crabapple Dr #308
Street

Phone (813) 484-0779

Wesley Chapel, FL 33545
City State Zip

E-mail _____

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13
Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name William "Wayne" McDermid

Amendment Barcode _____
(if applicable)

Job Title Lobbyist/Consultant

Address 2010 Dorman Dr
Street

Phone 850 251-9389

Tall Fla 32308
City State Zip

E-mail McDermid@ADJ.com

Speaking: For Against Information

Representing NATIONAL ASSOCIATION OF SOCIAL WORKERS FLA Chapter

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

THE FLORIDA SENATE

COMMITTEE APPEARANCE RECORD

(Submit to Committee Chair or Administrative Assistant)

2/14/2013
Date

Workshop
Bill Number

Barcode

Name BRIAN PITTS

Phone 727/897-9291

Address 8119 Newton Ave So

E-mail justicedjesos@yahoo.com

Street

St Petersburg
City

FL
State

33705
Zip

Job Title Trustee

Speaking: For Against Information

Appearing at request of Chair

Subject Medicaid reform

Representing Justice-2-Jesus

Lobbyist registered with Legislature: Yes No

Pursuant to s. 11.061, Florida Statutes, state, state university, or community college employees are required to file the first copy of this form with the Committee, unless appearance has been requested by the Chair as a witness or for informational purposes.

If designated employee: Time: from _____ .m. to _____ .m.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

11 Feb 2013

Meeting Date

Topic Patient Protection and Affordable Care Act

Bill Number _____
(if applicable)

Name Joseph Cain

Amendment Barcode _____
(if applicable)

Job Title _____

Address 2807 Sterling Dr
Street

Phone 850-385-0227

Tallahassee FL 32312
City *State* *Zip*

E-mail joecain3@comcast.net

Speaking: For Against Information

Representing self

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/13

Meeting Date

Topic Medicaid expansion

Bill Number _____
(if applicable)

Name Jordan A. Allen

Amendment Barcode _____
(if applicable)

Job Title STUDENT

Address 12100 Knights Crossing Circle
Street

Phone 813-347-8042

Orlando FL 32817
City State Zip

E-mail ja92013@gmail.com

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2/11/2013
Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name Charles Richardson

Amendment Barcode _____
(if applicable)

Job Title _____

Address 310 East Palmer Ave.

Phone 863-207-7455

Tallahassee, FL 32301
City State Zip

E-mail erich2984@gmail.com

Speaking: For Against Information

Representing Self / Life Without Limits International Church

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

2-11-13

Meeting Date

Topic MEDICAID EXPANSION

Bill Number _____
(if applicable)

Name REV. JIMMIE L. BAKER

Amendment Barcode _____
(if applicable)

Job Title _____

Address 1533 S. MOORE ST.

Phone (800) 264-7930

Street

TLH

City

FL

State

32301

Zip

E-mail jimmiebaker17@me.com

Speaking: For Against Information

Representing LIFE WITHOUT LIMITS INTERNATIONAL CHURCH

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic Florida's Medicaid expansion under ACA

Bill Number _____
(if applicable)

Name Joan Alker

Amendment Barcode _____
(if applicable)

Job Title Research Associate Professor

Address 3300 Whiteaven St
Street
WDC 20057
City State Zip

Phone _____

E-mail _____

Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

While it is a Senate tradition to encourage public testimony, time may not permit all persons wishing to speak to be heard at this meeting. Those who do speak may be asked to limit their remarks so that as many persons as possible can be heard.

This form is part of the public record for this meeting.

CourtSmart Tag Report

Room: KN 412

Case:

Type:

Caption: Senate Select Committee on Patient Protection and Affordable Care Act

Judge:

Started: 2/11/2013 2:02:12 PM

Ends: 2/11/2013 4:59:07 PM

Length: 02:56:56

2:02:18 PM Call to order
2:02:37 PM Roll call
2:02:49 PM Senator Negron w opening remarks and introductions
2:06:51 PM Joan Alker, M. Phil Research Associate Professor, Health Policy Institute
2:18:49 PM Senator Negron w comments
2:19:01 PM Greg Mellowe, Director of Health Research and Analysis, Florida Center for Fiscal and Economic Policy
2:29:13 PM Senator Negron w question
2:29:46 PM Joan Alker to answer
2:31:02 PM Senator Smith w question
2:31:35 PM Joan Alker to answer
2:32:23 PM Senator Soto w question
2:32:46 PM Joan Alker to answer
2:34:11 PM Senator Soto w follow-up
2:34:30 PM Joan Alker to answer
2:35:14 PM Senator Bean w question
2:36:13 PM Joan Alker to answer
2:37:07 PM Senator Sobel w question
2:37:58 PM Joan Alker to answer
2:39:10 PM Senator Sobel w follow-up
2:39:39 PM Greg Mellowe to answer
2:40:26 PM Senator Negron w comments
2:40:35 PM Senator Gibson w question
2:41:24 PM Joan Alker to answer
2:41:48 PM Senator Gibson w follow-up
2:42:05 PM Joan Alker to answer
2:42:28 PM Senator Flores w question
2:43:30 PM Joan Alker to answer
2:45:32 PM Senator Negron w comments
2:46:10 PM Mark O'Bryant, Pres/CEO, Tallahassee Memorial Hospital
2:55:29 PM Senator Simmons w questions
2:56:00 PM Senator Gibson w questions
2:56:43 PM Mark O'Bryant to answer
2:57:25 PM Senator Gibson w follow-up
2:57:55 PM Mark O'Bryant to answer
2:58:32 PM Senator Simmons w question
2:58:51 PM Mark O'Bryant to answer
2:59:16 PM Senator Simmons w follow-up
2:59:32 PM Mark O'Bryant to answer
2:59:39 PM Senator Flores w questions
3:00:24 PM Mark O'Bryant to answer
3:00:45 PM Senator Flores w follow-up
3:01:05 PM Mark O'Bryant to answer
3:01:23 PM Senator Sobel w questions
3:02:25 PM Mark O'Bryant to answer
3:02:42 PM Senator Negron w comment
3:02:59 PM Senator Sobel w follow-up
3:03:23 PM Senator Negron w comments
3:03:47 PM Gwen MacKenzie, President and CEO, Sarasota Memorial Health Care System
3:12:58 PM Senator Negron w comments
3:13:05 PM Steve Purves, President and CEO, Munroe Regional Medical Center
3:20:43 PM Senator Negron w comments
3:20:50 PM Scott Cihak, CEO, Kendall Regional Medical Center

3:22:59 PM Senator Negron w question
3:23:06 PM Scott Cihak to answer
3:25:49 PM Senator Grimsley w questions
3:26:00 PM Gwen MacKenzie to answer
3:26:38 PM Senator Grimsley w follow-up
3:26:51 PM Gwen MacKenzie to answer
3:26:56 PM Senator Soto w question
3:27:36 PM Gwen MacKenzie to answer
3:28:30 PM Senator Flores w question
3:30:11 PM Steve Purves to answer
3:32:05 PM Senator Bean w questions
3:32:49 PM Senator Bean w follow-up
3:32:59 PM Gwen MacKenzie to answer
3:34:07 PM Senator Brandes w comments and questions
3:35:33 PM Steve Purves to answer
3:36:40 PM Senator Negron w comments
3:37:18 PM Senator Sobel w question
3:37:48 PM Steve Purves to answer
3:39:30 PM Senator Negron w comments
3:40:16 PM Senator Gibson w questions
3:40:42 PM Richard Polangin, Florida Alliance for Retired Americans
3:43:49 PM Sam Bell, Florida Pediatric Society -waive in support
3:44:05 PM Karen Clay, Tampa, Florida
3:47:01 PM Martha Baker, RN, Jackson Memorial Hospital, Miami, Florida
3:49:36 PM Maglie Pena, Social Worker, Jackson Memorial Hospital, Miami, Florida
3:50:30 PM Debbie King, Student, Tampa, Florida
3:52:01 PM Mark Morris, M.D., Florida Pediatric Associates, St. Petersburg, Florida
3:54:45 PM Jeanie Vincent, Adjunct Professor, Hawthorne, Florida
3:57:17 PM Paula Witthaus, Executive Director, Living Insurance for Everyone, St. Petersburg, Florida
4:01:58 PM Gary Stein, MPH, Wesley Chapel, Florida
4:06:11 PM Judi Evans -waive in support
4:06:33 PM Ellen Teeter, President, Florida States Oriental Medical Association, Bradenton, Florida
4:07:59 PM Jack McRay, AARP
4:11:34 PM Tarren Bragdon, President and CEO, Foundation for Government Accountability, Naples, Florida
4:20:03 PM Senator Negron w question
4:21:04 PM Tarren Bragdon w answer
4:21:33 PM Senator Negron w follow-up
4:22:15 PM Tarren Bragdon to answer
4:22:41 PM Senator Negron w follow-up
4:22:46 PM Tarren Bragdon to answer
4:23:44 PM Senator Soto w question
4:24:01 PM Tarren Bragdon to answer
4:24:29 PM Senator Flores w question
4:25:11 PM Tarren Bragdon to answer
4:25:57 PM Senator Gibson w questions
4:26:10 PM Tarren Bragdon to answer
4:26:40 PM Senator Gibson w follow-up
4:27:07 PM Tarren Bragdon to answer
4:28:06 PM Senator Gibson w follow-up
4:28:28 PM Tarren Bragdon to answer
4:28:33 PM Senator Gibson w follow-up
4:29:25 PM Tarren Bragdon to answer
4:29:57 PM Senator Simmons w questions
4:32:53 PM Gwen MacKenzie to answer
4:33:28 PM Scott Cihak to answer
4:33:57 PM Senator Bean w question
4:34:40 PM Tarren Bragdon to answer
4:35:10 PM Mary Mayhew, Commissioner, Maine Department of Health and Human Services -via skype
4:45:32 PM Senator Negron w comments
4:45:59 PM Mary Mayhew to answer
4:46:07 PM Senator Negron w follow-up
4:46:21 PM Mary Mayhew to answer

4:47:00 PM Senator Simmons w questions
4:48:19 PM Mary Mayhew to answer
4:49:18 PM Senator Simmons w follow-up
4:49:46 PM Mary Mayhew to answer
4:49:59 PM Senator Simmons w comments & questions
4:52:19 PM Mary Mayhew to answer
4:53:10 PM Senator Gibson w questions
4:53:57 PM Mary Mayhew to answer
4:54:32 PM Senator Gibson w follow-up
4:54:58 PM Mary Mayhew to answer
4:55:54 PM Senator Soto w questions
4:56:20 PM Mary Mayhew to answer
4:57:15 PM Senator Negron w comments
4:57:23 PM Tarren Bragdon w final comments
4:58:01 PM Senator Brandes w questions
4:58:14 PM Tarren Bragdon to answer
4:58:42 PM Senator Negron w final comments
4:58:49 PM Meeting adjourned