The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

SELECT COMMITTEE ON PATIENT PROTECTION AND AFFORDABLE CARE ACT
Senator Negron, Chair
Senator Sobel, Vice Chair

MEETING DATE: Monday, February 18, 2013
TIME: 2:00 —5:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

MEMBERS: Senator Negron, 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	PPACA Impacts on State Group Health Insurance Barbara Crosier, Director of State Group Health Insurance, Department of Management Services Amy Baker, Coordinator, Office of Economic and Demographic Research		
2	Presentation by the Office of Insurance Regulation Wenceslao Troncoso, Life and Health Deputy Commissioner, Office of Insurance Regulation		
3	Other Related Meeting Documents		

Barbara Crosier

As Director of State Group Insurance since November 2011, Barbara Crosier directs and oversees the procurement, provision, and fiscal management of pre-tax insurance benefits for the State of Florida's 375,000+ employees, retirees, and their dependents.

With a staff of 20 employees, the Division of State Group Insurance is responsible for the contract management and oversight of five self-insured health plans, two fully-insured health plans, the self-insured pharmacy benefits management contract, and contracts for life insurance and variety of supplemental insurance plans. Additional responsibilities include fiscal and budget oversight and determination of eligibility, enrollment and financial requirements for participation in the benefits offered. For the 2012-13 fiscal year, the state employees' health insurance program is estimated to spend approximately $1.9 billion.

From 2003 until 2007, Barbara served as General Counsel for the Department of Elder Affairs. In 2007, she joined the Department of Management Services' (DMS) Office of the General Counsel as Assistant General Counsel where she focused on contracts and procurements for DMS and served as the informal hearing officer for the Division of State Group Insurance.

In 2005, Barbara attended leadership training – *Mastering Negotiations: Building Dynamic Agreements* – at the John F. Kennedy School of Government, Harvard University, Cambridge, Massachusetts.

Barbara has been a member of the Florida Bar since 1997 and was selected by her peers for inclusion in *Florida Trend* magazine's Elite Lawyers, Governmental Lawyers Section, 2009 Edition.

DEPARTMENT OF MANAGEMENT
SERVICES

State Group Insurance

Program Overview and Impacts of the Patient Protection and Affordable Care Act

Barbara Crosier, Director

Senate Select Committee on PPACA

Monday, February 18, 2013

412 Knott Building

Agenda

- Current Program
- Impact of PPACA to the Program
  - Mandates currently in effect
  - Mandates effective in 2014 and beyond
  - Trust Fund Impact

DEPARTMENT OF MANAGEMENT
SERVICES

Program Overview: Budget

The State Employees' Health Insurance Program:

- Estimated to spend $1.9 billion in FY 2012-13
- Expense trend is 9.2% per year
- Funded primarily by the state through each agency's "Salaries & Benefits" appropriations category
  - Actual employer spend: $1.45 billion in FY 2011-12

Program Overview: Plan Design Options

	HMO Standard	PPO Standard		PPO and HMO HIHP	
	Network Only	**Network**	**Out-of-Network**	**Network**	**Out-of-Network (PPO Only)**
Deductible	None	$250 | $500 Single | Family	$750 | $1,500 Single | Family	$1,250 | $2,500 Single | Family	$2,500 | $5,000 Single | Family
Annual State Health Savings Account Deposit	N/A	N/A		$500 for Single $1,000 for Family	
Primary Care	$20 copayment	$15 copayment	40% after deductible	20% after deductible	40% after deductible
Specialist	$40 copayment	$25 copayment			
Hospital	$250 copayment	20% after $250 copayment	20% after $500 copayment		
Generic | Preferred | Non-Preferred Prescriptions	$7 | $30 | $50 Retail	$7 | $30 | $50 Retail		30% after deductible 30% after deductible 50% after deductible	
	$14 | $60 | $100 Mail Order	$14 | $60 | $100 Mail Order			
Out-of-Pocket Maximum	$1,500 | $3,000 Single | Family	$2,500 | $5,000 plus deductible Single | Family		$3,000 | $6,000 (plus deductible) (PPO only) Single | Family	

Program Overview: Health Plan Enrollment

Plan/Category	Actual	Estimated	
	FY 2011-12	FY 2012-13	FY 2013-14
Total PPO Standard	**87,535**	**86,200**	**84,642**
Active	58,738	57,309	55,643
COBRA	474	477	477
Early Retirees	4,593	4,508	4,438
Medicare Retirees	23,730	23,906	24,084
Total PPO HIHP	**1,162**	**1,200**	**1,207**
Active	1,085	1,118	1,125
COBRA	3	3	3
Early Retirees	42	44	44
Medicare Retirees	32	35	35
TOTAL PPO	**88,697**	**87,400**	**85,849**
Total HMO Standard	**82,309**	**82,241**	**83,556**
Active	74,232	73,939	75,128
COBRA	195	213	213
Early Retirees	2,830	2,849	2,860
Medicare Retirees	5,052	5,240	5,355
Total HMO HIHP	**441**	**459**	**464**
Active	432	452	457
COBRA	3	2	2
Early Retirees	4	3	3
Medicare Retirees	2	2	2
Total HMO	**82,750**	**82,700**	**84,020**
Total All	**171,447**	**170,100**	**169,869**

Program Overview: Health Plan Contributions

		PPO and HMO Plans					
		Standard			Health Investor (HIHP)		
Category	Coverage	Employer	Enrollee	Total	Employer *	Enrollee	Total
Career Service	Single	499.80	50.00	549.80	499.80	15.00	514.80
	Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
	Spouse	1,213.36	30.00	1,243.36	1,097.64	30.00	1,127.64
SES/SMS	Single	541.46	8.34	549.80	506.46	8.34	514.80
	Family	1,213.34	30.00	1,243.34	1,097.64	30.00	1,127.64
COBRA	Single		560.80	560.80		482.60	482.60
	Family		1,268.21	1,268.21		1,065.20	1,065.20
Early Retirees	Single		549.80	549.80		473.14	473.14
	Family		1,243.34	1,243.34		1,044.31	1,044.31
Medicare Retirees	One Eligible		305.82	305.82		230.52	230.52
	Family		881.80	881.80		722.16	722.16
	Two Eligible		611.61	611.61		461.04	461.04

*Includes employer tax-free Health Savings Account (HSA) contribution - $41.66 and $83.33 per month for single and family coverage, respectively.

DEPARTMENT OF MANAGEMENT
SERVICES

PPACA Overview

- Signed into law on March 23, 2010
- Components include:
  - New reporting requirements
  - Taxes and fees
  - Major changes, such as insurance reforms and employer and individual mandates
- Impacts most health insurance plans, including the State Employees' Group Insurance Program

Provisions in Effect and Impact on the Program

- Effective October 1, 2012
  - Patient-centered outcome research institute fees – $1 per participant for the first year and $2 per participant each year thereafter through 2019
    - **$375,000 for plan year 2012 – payable July 2013**
    - **$750,000 for each plan year through 2019 – payable in July of the following year**

Preventive Health Services – No Member Cost

<table>
<tr><th>Effective January 1, 2011</th><th>Effective January 1, 2013</th></tr>
<tr><td>1. Services that have a rating of “A” or “B” from the United State Preventive Services Task Force
• Includes screenings for cancer, cholesterol, depression, diabetes, osteoporosis, and blood pressure for adults
2. Immunizations that have been recommended by the Advisory Committee on Immunization Practices (children and adults)
3. Care and screenings provided in guidelines supported by the Health Resources and Services Administration for infants, children and adolescents
• Includes measurements, developmental assessment, and sensory (i.e. vision and hearing) and other screenings</td><td>1. Additional services required by the U.S. Health and Human Services guidelines for women:
• Select contraceptive methods and counseling, HPV testing, breastfeeding counseling and gestational diabetes screenings in pregnant women
• Available contraceptive methods include diaphragms, Intra-Uterine Devices (IUDs), surgical tubal ligations and generic oral contraceptives</td></tr>
</table>

Changes Effective January 1, 2014

- Reinsurance
  - **FY 13-14 $9.9 million ($5.25 PMPM)**
  - **FY 14-15 $16.4 million ($3.50 PMPM)**
  - **FY 15-16 $10.7 million ($2.19 PMPM)**
- Eliminate all preexisting condition limitations
  - **Annual estimated fiscal impact – $4.3 million**
  - Preexisting condition limitation exclusion applies to all plan participants regardless of age

DEPARTMENT OF MANAGEMENT
SERVICES

Changes Effective January 1, 2014

- "Shared responsibility" provisions require employers to offer affordable coverage that meets minimum standards to full-time employees (average 30 or more hours per week) or face potential penalties
- Offer coverage to "full-time" employees or pay $2,000 per year for *all* employees if any employee enrolls in an exchange plan and receives a subsidy
  - Estimated cost to cover OPS employees that qualify:
    - **FY 2013-14: $23.5 million**
    - **FY 2014-15: $44.3 million**
    - **FY 2015-16: $48.7 million**
  - Estimated annual penalty to *not* offer coverage to OPS employees: **$318 million**

Changes Effective January 1, 2014

- Shared responsibility (continued)
  - Offer affordable coverage or pay $3,000 per year for each employee who enrolls in the exchange and receives a subsidy; capped at $2,000 per FTE

DEPARTMENT OF MANAGEMENT
SERVICES

Changes Effective January 1, 2014

Decisions for coverage of OPS employees that qualify:

- Initial measurement period (begins in 2013) to determine on-going employees – no less than 6 months and start before 7/1/13
- Measurement period (2014 and thereafter) – 3, 6, 9 or 12 months
- Stability period – employers must offer coverage to qualified employees; must be at least equal to measurement period or 6 months, whichever is longer
- Administrative period – must offer qualified employees coverage within 90 days of eligibility; applies to new hires and those determined eligible during the measurement period

Changes Effective January 1, 2014

Options to consider to avoid the shared responsibility penalty:

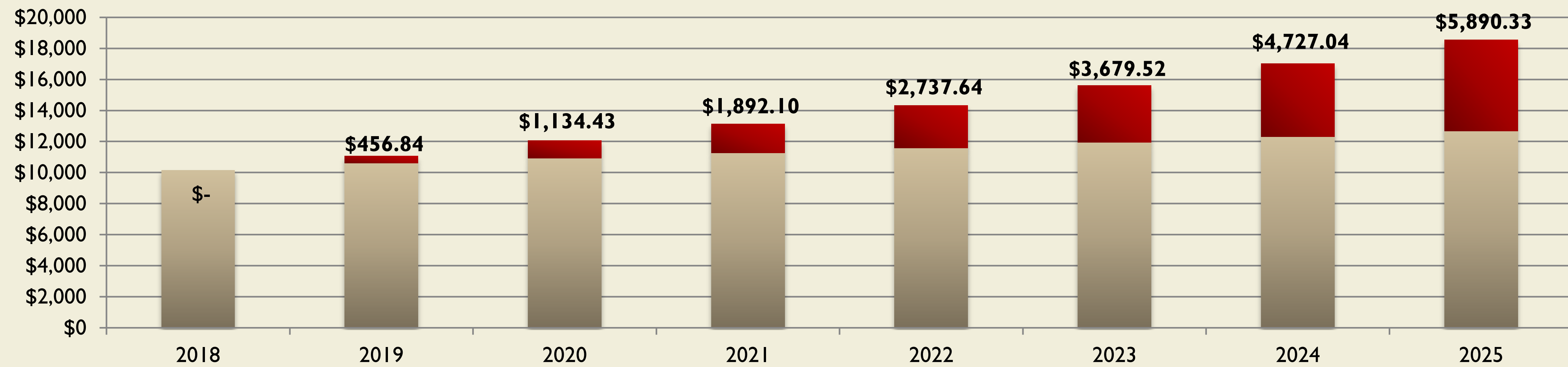
- Eliminate OPS positions
- Implement a cap of 29 hours per week for OPS employees
- Provide a plan that meets the affordability requirements – the employer covering 60% of the cost and the employee's portion not exceeding 9.5% of income
  - Allow qualified OPS employees to enroll in single coverage in the HIHP PPO plan
  - Procure a new plan

DEPARTMENT OF MANAGEMENT
SERVICES

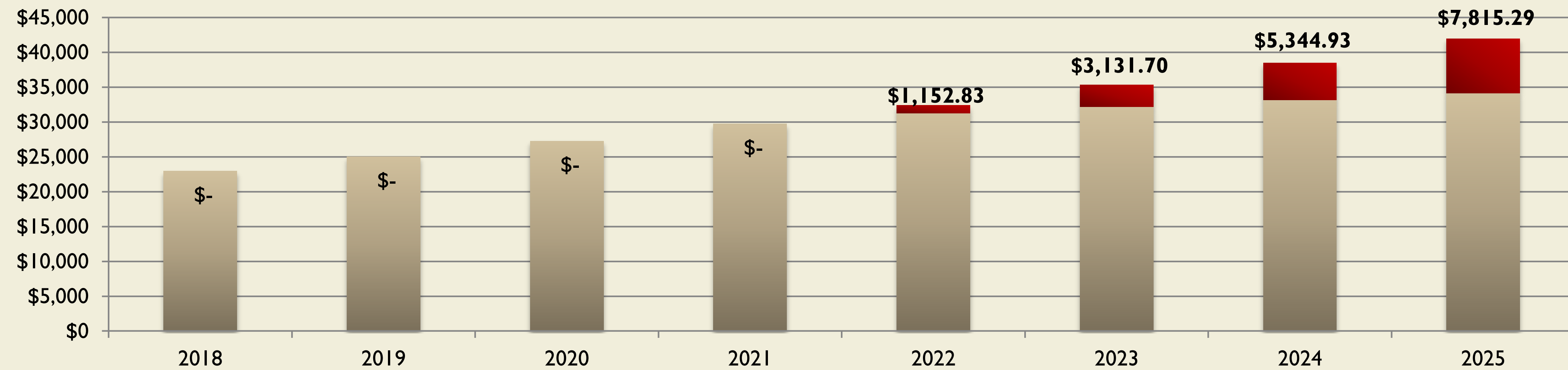
Excise Tax on High Cost Coverage – 2018

- Starting in 2018, plans with total, annual premium cost in excess of specified thresholds ($10,200/single and $28,600/family) are subject to an excise tax of 40% on the amount of premium exceeding the threshold
- Threshold levels are adjusted annually for inflation after 2018:
  - 2019: CPI-U + 1%
  - 2020 and beyond: CPI-U
- Assuming an annual premium growth rate of 9%, CPI growth of 3%, and no change to the health plans, the state will be subject to the tax for single coverage contracts in 2019 and family coverage contracts in 2022

Single Coverage



Family Coverage

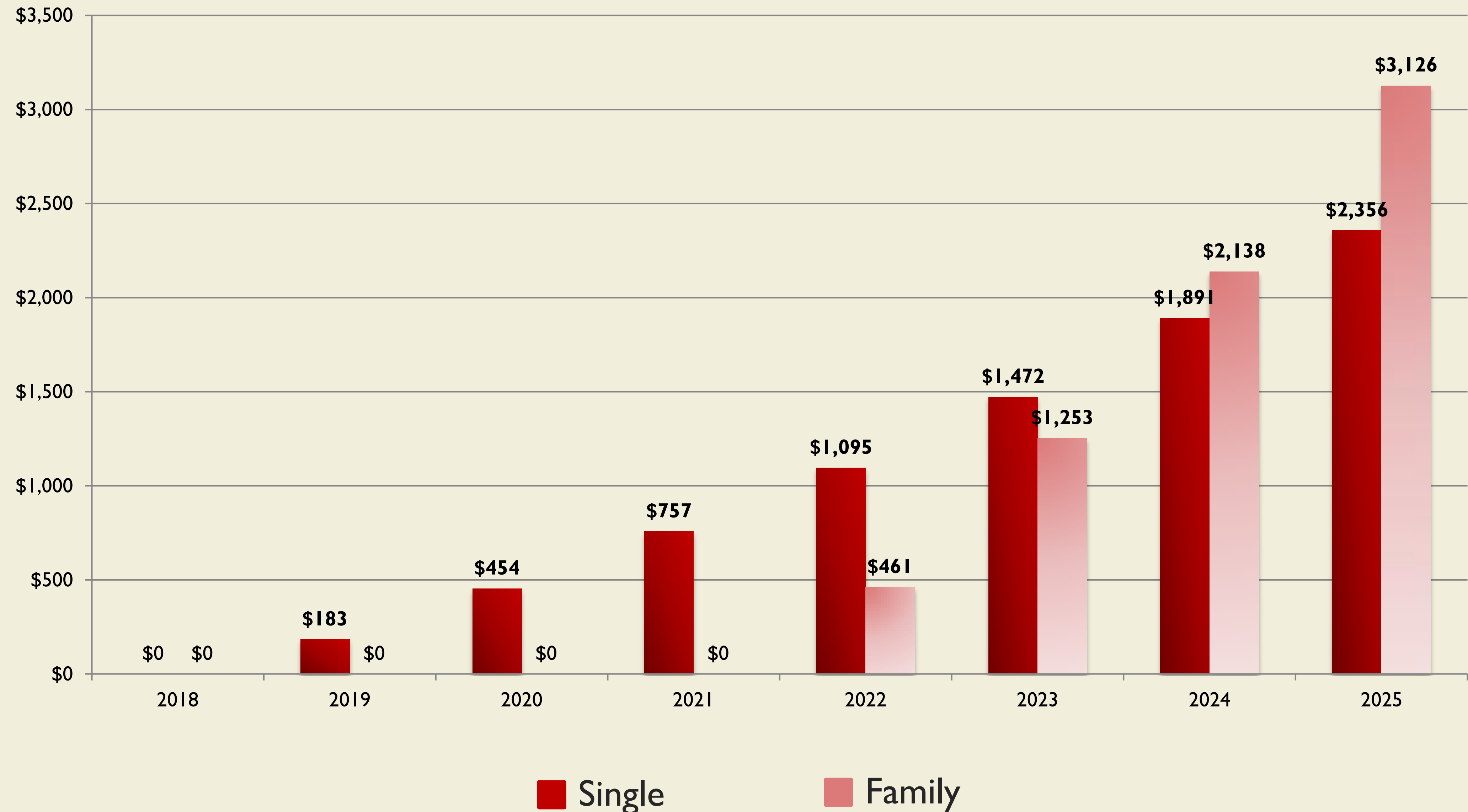


Premium Subject to Excise Tax

Premium Not Subject to Excise Tax

Excise Tax Per Contract

(40% of the Premium Subject to Excise Tax)



Estimating Conference Links

- State Employees' Group Health Insurance Trust Fund Report on the Financial Outlook
  - http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceOutlook.pdf
- Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act (PPACA)
  - http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceImpact.pdf

DEPARTMENT OF MANAGEMENT
SERVICES

Definitions

- Administrative Period (14) – the period of time between Measurement and Stability periods to make determinations, offer coverage and administer enrollments to employees who meet the hours of service threshold.
- Coinsurance (4) – a percentage of costs, based on the allowed amount, paid after meeting the annual deductible.
- Copayment (4) – a set dollar amount payment for medical services and prescription drugs.
- CPI-U (16) - Consumer Price Index for all urban consumers
- Deductible (4) – dollar amount that must be paid out of pocket before the insurance plan pays for services.
- HIHP (4, 5, 6, 15) – Health Investor Health Plan, a low premium, high-deductible plan that currently offers a health savings account.
- Measurement Period (14) – a prior period of three to twelve months employers choose and then analyze to determine whether employees meet the hours of service thresholds for employer-sponsored coverage.
- Reinsurance (11) – in this context, the fees insurers pay to the federal government to protect other insurers from losses as a result of unanticipated claims experience.
- Stability Period (14) – the future period of time during which the employer must offer coverage to employees who meet the hours of service threshold. It must be at least six months and not shorter than the Measurement Period for employees determined to be full time. For those determined not to be full time, it cannot be longer than the Measurement Period.

Amy Baker, Coordinator, Office of Economic and Demographic Research

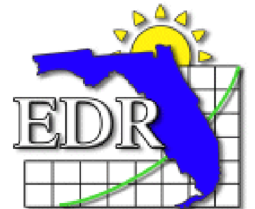
After spending two years in the Florida House Appropriations Committee as both the deputy and actual staff director, Ms. Baker became the Coordinator of the Florida Legislature's Office of Economic & Demographic Research in 2004. In this role, she serves as the Legislature's Chief Economist.

She has worked in or for state government since 1986, serving in both the executive and legislative branches of government. Some of her past jobs include Legislative Affairs Director for Governor Bob Martinez, Chief of Staff for former Senator Ander Crenshaw when he was President of the Florida Senate, and Chief Financial Officer for the Department of Children and Families. Living in Florida since 1980, she did her graduate work in Economics at Florida State University.

State Employees Health Insurance:
Impact of Patient Protection and Affordable Care Act

February 18, 2013

Presented by:



The Florida Legislature
Office of Economic and
Demographic Research
850.487.1402
http://edr.state.fl.us

Underlying Program

Financial Outlook	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
(Dollars in Millions)	Actual	Estimate	Estimate	Estimate	Estimate
Beginning Cash Balance	$ 197.8	$ 313.9	$ 256.7	$ 171.9	$ 0.0
Revenues	$ 1,903.4	$ 1,885.2	$ 1,972.6	$ 1,969.5	$ 1,975.3
Expenses	$ 1,787.3	$ 1,942.4	$ 2,057.4	$ 2,232.2	$ 2,443.3
Operatir Gain/(Loss)	$ 116.1	$ (57.2)	$ (84.8)	$ (262.7)	$ (468.0)
Ending Cash Balance	$ 313.9	$ 256.7	$ 171.9	$ (90.8)	$ (468.0)

Note: Assumes no carry forward of negative cash balance from prior year beginning FY 2015-16.

- Total expenditure growth averages just over 8.1% per year during the forecast.
- The Trust Fund is expected to remain solvent through FY 2013-14; however, projected revenue ($1.89 billion) will first fall short of meeting the anticipated growth in health plan expenses in FY 2012-13 ($1.94 billion in total).
  - There is a projected cash surplus of $256.7 million in FY 2012-13.
  - There is a smaller surplus in 2013-14 as the operating loss begins to erode the available balance.
  - There is a projected ending cash deficit of $90.8 million in FY 2014-15.

What's Included in the Estimate...

- The impacts associated with the **Patient Protection and Affordable Care Act (PPACA)** that have already been implemented by the Division of State Group Insurance are included in the affected revenue and expense line items for each year of the outlook. The impacts to the Program that will occur in the future and have yet to start are excluded.

- The major health care reform provisions with potential employer impact that have been implemented, or are in the process of being implemented, for the Program, include:
  - Elimination of overall lifetime plan maximums;
  - Removal of annual limits for essential health benefits;
  - Elimination of pre-existing condition exclusions for children under age 19;
  - Patient-centered outcome research institute fees ($1 per participant for the 1st year and $2 per participant for subsequent years through 2019);
  - Extended coverage for employees' adult children to age 26 without regard to dependency; and
  - Imposition of pass-through fees relating to the pharmaceutical industry.

Costs of Previously Implemented Provisions...

Effective January 1, 2011, the adopted outlook began to reflect the following:

- No lifetime dollar maximum...**$3.06 million in FY 11-12**
- Restricted annual dollar limits...no estimated impact
- Elimination of preexisting conditions for subscribers and dependents under age 19...**$1.7 million in FY 11-12**
- Extension of coverage for all adult children until age 26...**$10.21 million in FY 11-12**

What's Excluded from the Estimate, but Addressed Separately...

- Major changes, effective January 1, 2014, which include:
  - Reinsurance, risk corridors, and risk adjustment;
  - Elimination of all remaining pre-existing condition limitations;
  - "Shared responsibility" provisions requiring employers to offer affordable coverage meeting minimum standards to full-time workers (30 or more hours per week) or face potential penalties; and
  - Individual mandate to maintain health coverage or face a penalty.

- In some instances, implementation of reforms may require changes to state law for compliance or to avoid significant penalties. For example, current law prohibits employees in the Other Personal Services (OPS) category from being covered by the State Group Insurance Program.

Opt-Outs and OPS

- Single largest cost piece of the remaining issues to be implemented.
- Over 20,000 State and State University System employees will potentially be affected.
- Employer penalty for failing to offer health coverage for all “full-time” employees = $2,000 per year, per employee as to all employees, if one or more the affected employees enroll in an exchange and receives a premium credit. The penalty would potentially exceed $318 million annually.
- Since the cost of this provision is far less than the penalty (about one-third of the penalty in FY 2015-16), the Self-Insurance Estimating Conference assumes the Legislature will change the current law and offer the coverage to the employees meeting the hours of work requirement.
  - Assume 6,291 qualifying OPS workers ($28.67 million in FY 2013-14, and grows to $67.62 million in FY 2015-16).
  - Assumes the return of 13,723 qualifying Opt Outs ($8.31 million in FY 2013-14, and grows to $39.22 million in FY 2015-16).

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	FY 2012-13 Total	FY 2013-14 Total	FY 2014-15 Total	FY 2015-16 Total [2]
1. Early retiree medical reinsurance		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
2. No lifetime dollar maximum	Jan 2011	**Net**	*ALREADY EMBEDDED*			
3. Restricted annual dollar limits		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	**Net**	*ALREADY EMBEDDED*			
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-
		E	0.38	0.75	0.75	0.75
		Net	**(0.38)**	**(0.75)**	**(0.75)**	**(0.75)**
6. Other pass-through fees include:						
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	E	-	20.41	42.82	42.82
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	**Net**	**-**	**(20.41)**	**(42.82)**	**(42.82)**
7. Extension of coverage for all adult children until age 26	Jan 2011	**Net**	*ALREADY EMBEDDED*			
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-
		E	-	2.03	4.30	4.30
		Net	**-**	**(2.03)**	**(4.30)**	**(4.30)**
9. Free choice vouchers		**Net**	*REPEALED BY CONGRESS*			
10. Shared responsibility "free rider surcharge"		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
11. Medicaid Expansion and migration into Exchange		**Net**	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*			
12. Individual Mandate with federal subsidies	Jan 2014					
Opt-Outs [3]		R	-	10.01	27.16	34.30
Agency and Universities OPS [4][5][6]		R	-	27.01	46.30	46.30
Opt-Outs [3]		E	-	8.31	26.98	39.22
Agency and Universities OPS [4][5][6]		E	-	28.67	62.04	67.62
		Net	**-**	**0.04**	**(15.56)**	**(26.24)**
TOTAL REVENUES [7]			0.00	37.02	73.46	80.60
TOTAL EXPENSES			0.38	59.79	137.27	155.09
NET TOTAL [8]			**(0.38)**	**(22.77)**	**(63.81)**	**(74.49)**

Conference Expenditure Summary

(millions)	2012-13	2013-14	2014-15	2015-16
Expenses Related to Previously Implemented Provisions (Embedded)	16.2	17.5	18.9	20.5
Expenses Related to New Provisions (Required Future Additions)	0.4	59.8	137.3	155.1
	16.6	**77.2**	**156.1**	**175.6**
Enrollees	170,100	169,869	170,325	171,018
Per Member Per Year Impact	$97.30	$454.70	$916.60	$1,027.00

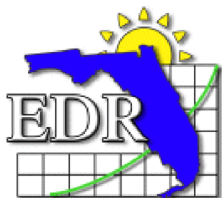
- The revenues to meet these expenses are derived largely from state-paid premiums. However, the final funding methodology will be set by the Legislature.
- The Conference results showed that the existing revenue structure would be insufficient to meet the expenses related to the new provisions in their entirety.

Next Conference

- Scheduled for February 28th.

- Continuing to refine the OPS numbers; however recent guidance has added even more complications and decision points. The “seasonality” associated with university employment is particularly challenging.

- Updated information relating to the cost projections associated with the mandated pharmaceutical industry (Pharma) fee, medical device fee, and transitional reinsurance program fee has just been received and is being evaluated.



State Employees' Group Health Self-Insurance Trust Fund

Report on the Financial Outlook

For the Fiscal Years Ending June 30, 2012 through June 30, 2016

Adopted December 12, 2012 by the

Self-Insurance Estimating Conference

Prepared by: Florida Department of Management Services
Division of State Group Insurance

EXECUTIVE SUMMARY

The Florida Division of State Group Insurance (the Division) prepared a financial Outlook for the State Employees' Group Health Self-Insurance Trust Fund (the Trust Fund) for the fiscal years ending June 30, 2012, through June 30, 2016 to assist in the State's planning and budgeting in accordance with Section 216.136(9), *Florida Statutes.* The Division prepared the Outlook using cash basis methods and modeling based on the healthcare benefit and funding design currently in place.

The August 2012 Outlook reported and recognized the fiscal impact of the activities listed below:

1. Monthly enrollment from January 2012 through June 2012.
2. Actual enrollment as of June 30, 2012.
3. FY 2011-12 actual revenue and expense results.
4. FY 2011-12 cash flow activity through June 2012.

This Outlook used the August 2012 financial outlook as its base and reports and recognizes the fiscal impact of the following activities to Trust Fund:

1. Actual enrollment through November 2012.
2. Actual cash flow through September 2012.
3. Open Enrollment results for Plan Year 2013.
4. Enrollment model revisions.

This Outlook is improved from the prior Outlook presented in August 2012, with increases in ending cash balances for FY 2012-13 and FY 2013-14, as well as reductions in previously projected deficits for FY 2014-15 and FY 2015-16. The increases are due to recognition of monthly enrollment activity through November 2012 and Open Enrollment results for plan year 2013; refined enrollment projection methods; updated revenue and expenditure activity through September 2012; and allocation of the net increase of HMO medical and RX expenses to the Risk Reserve. The Trust Fund is expected to remain solvent through FY 2013-14. The projected ending cash balance for FY 2012-13 increased from $241.6 million to $256.7 million; the estimated operating loss decreased from $72.3 million to $57.2 million. For FY 2013-14 the ending cash balance increased from $148 million to $171.9 million; the estimated operating loss decreased from $93.6 million to $84.8 million. The projected ending cash balance for FY 2014-15 decreased from a projected deficit of $128.6 million to a deficit of $90.8 million.

If there are no changes to benefit attributes, covered services, premium rates, or other plan factors, the Trust Fund is projected to have a cash surplus of $256.7 million in FY 2012-13 and a projected ending cash deficit of $90.8 million in FY 2014-15. Projected revenue will fall short in meeting growth in health plan expenses by $262.7 million in FY 2014-15.

Following is a summary of the Outlook from FY 2011-12 through FY 2015-16.

Financial Outlook	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
(Dollars in Millions)	Actual	Estimate	Estimate	Estimate	Estimate
Beginning Cash Balance	$ 197.8	$ 313.9	$ 256.7	$ 171.9	$ 0.0
Revenues	$ 1,903.4	$ 1,885.2	$ 1,972.6	$ 1,969.5	$ 1,975.3
Expenses	$ 1,787.3	$ 1,942.4	$ 2,057.4	$ 2,232.2	$ 2,443.3
Operating Gan/(Loss)	$ 116.1	$ (57.2)	$ (84.8)	$ (262.7)	$ (468.0)
Ending Cash Balance	$ 313.9	$ 256.7	$ 171.9	$ (90.8)	$ (468.0)

Note: Assumes no carry forward of negative cash balance from prior year beginning FY 2015-16.

Enrollment

Open Enrollment (OE) results for 2013 show a decreased trend in movement from the PPO plans to the HMO plans within the active employee population. PPO plans enrollment decreased by an annual average over the past five years of 1,065 contracts. HMO plans enrollment increased by an annual average of 2,525 contracts over the same period. For 2013, OE reflects a decrease of enrollment in the PPO plan of 779 active contracts and an increase of 2,096 active HMO contracts. The change in new contracts decreased from a five year annual average of 1,460 to 1,317 in 2013.

Lower than previously projected new OE subscribers and a decrease in the employee population from July through November 2012 resulted in adjustments to enrollment projections for the forecast period. Total subscriber enrollment is projected to decrease at an annual average of 0.3 percent through the forecast period. The affected revenue and expense components of the Outlook have been adjusted accordingly to consider the decrease in enrollment provided in previous projections.

Fiscal Year 2012-13 total enrollment distribution is projected at 51.4 percent in the PPO plans and 48.6 percent in the HMO plans. However, active employee enrollment is projected at 44 percent in the PPO plans and 56 percent in the HMO plans, during the same period.

As of November 2012, approximately 1,671 subscribers (1,582 active employees) were currently enrolled in a High Deductible Health Plan (0.986 percent of total enrollment). Approximately 1,049 of those active employees, or 66.3 percent, were participating in the integrated state-sponsored Health Savings Account offering.

In January 2013, approximately 1,678 subscribers (1,586 active employees) will be enrolled in a High Deductible Health Plan (0.983 percent of total enrollment). Approximately 1,085 of those active employees, or 68.4 percent, will be participating in the integrated state-sponsored Health Savings Account offering

Growth Trends

This forecast reflects a moderate reduction in PPO medical expenses over the forecasted period, and an increase in HMO medical claims is forecasted. Additionally, pharmacy costs for both the PPO and HMO have been marginally reduced. These changes are primarily due to updated claims experience through September 2012, as well as changes to updated enrollment projections and enrollment shifts from the PPO to HMO plans.

The declining employee membership trend and other economic influences continue to impact utilization patterns and costs for the state. The medical growth rate for the forecasted period is held consistent with the previous forecast at 9.0% for both PPO and HMO. The assumed growth rate falls within the expected industry range of 5.4% to 10.0%.

The forecasted trend rate for prescription drug costs has been reduced from 8.3% to 8.1% for the PPO plan and from 10.3% to 10% for the HMO. The assumed growth rates are within the industry range of 5.3% to 10.5%. The primary drivers impacting the differences in the forecasted trend rates are due to (1) member demographics, (2) utilization and (3) drug mix. Generic dispensing rates are higher among the PPO population, whereas more costly specialty drugs account for a higher percentage of overall drug spend in the HMO population

The increase in premium rates for the two fully-insured HMO vendors continues at 9.0 percent. The assumed growth rate is slightly lower than the expected industry range of 3.5 to 9.2 percent for traditional HMO offerings. For plan year 2013, all counties in Florida will have at least one HMO plan offering. The PPO standard and high deductible health plans remain available worldwide.

Increases in forecasted third party administrator refunds reflected in this Outlook are due primarily to the updates of actuals through September 2012, including the realization of refunds being received under the new self-insured HMO contracts.

Following is a summary of the trends used in the previous projections and those used for the development of this Outlook.

	August 2012		December 2012 *	
	Trend	Industry Range	Trend	Industry Range
PPO Medical Claims	9.0%	5.4% - 10.0%	9.0%	4.0% - 11.0%
HMO Medical Claims	9.0%		9.0%	
PPO Prescription Drug Claims	8.3%	6.9% - 9.6%	8.1%	5.3% - 10.5%
HMO Prescription Drug Claims	10.3%		10.0%	
HMO Premium Payments	9.0%	7.8% - 9.9%	9.0%	3.5% - 9.2%

* Survey data for Calendar Years 2012 and 2013.

Federal Patient Protection and Affordable Care Act (PPACA)

Reports on the Financial Outlook prepared from December 2010 through June 2012 included estimates of the impact of PPACA on the Program. In the August 2012 Financial Outlook, the impact of PPACA was treated differently with the new approach conforming the treatment of the impacts of PPACA on the Program to the treatment used by the Social Services Estimating Conference for Medicaid and KidCare.

Those impacts that have already been implemented by the Program are included in the affected revenue and expense line items of each year's outlook. The impacts to the Program that will occur in the future were removed from the Outlook and are now described in a separate report titled the Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act.

Exhibits

The exhibits that follow provide more in-depth information about the projections, estimated cash positions and comparisons to the previous Outlook.

STATE EMPLOYEES' GROUP HEALTH SELF-INSURANCE TRUST FUND

Exhibit I

Financial Outlook by Fiscal Year

Highlights of Changes to Forecast - Conference December 2012 Compared to August 2012

(In Millions)

	FY 2011-12			FY 2012-13			FY 2013-14			FY 2014-15			FY 2015-16		
	Aug '12	Dec '12	Diff.	Aug '12	Dec '12	Diff.	Aug '12	Dec '12	Diff.	Aug '12	Dec '12	Diff.	Aug '12	Dec '12	Diff.
BEGINNING CASH BALANCE	$ 197.8	$ 197.8	$ -	$ 313.9	$ 313.9	$ -	$ 241.6	$ 256.7	$ 15.1	$ 148.0	$ 171.9	$ 23.9	$ 0.0	$ 0.0	$ -
REVENUES:															
Insurance Premiums	$ 1,825.1	$ 1,825.1	$ -	$ 1,809.2	$ 1,791.7	$ (17.5)	$ 1,902.5	$ 1,887.7	$ (14.8)	$ 1,895.0	$ 1,891.6	$ (3.4)	$ 1,887.8	$ 1,898.7	$ 10.9
Investment Interest	4.7	4.7	-	5.5	5.6	0.1	3.9	4.2	0.3	-	-	-	-	-	-
PPO-TPA Refunds	11.9	11.9	-	9.3	10.9	1.6	9.3	9.3	-	9.3	9.3	-	9.3	9.3	-
PPO-PBM Rebates	24.2	24.2	-	23.4	23.4	-	17.6	17.5	(0.1)	14.8	14.7	(0.1)	13.2	13.1	(0.1)
HMO-TPA Refunds	-	-	-	-	2.9	2.9	-	2.9	2.9	-	2.9	2.9	-	2.9	2.9
PPO-Medicare Part D Subsidy	15.7	15.7	-	19.6	20.9	1.3	21.5	21.8	0.3	22.2	22.7	0.5	21.8	23.6	1.8
TOTAL REVENUES	$ 1,903.4	$ 1,903.4	$ -	$ 1,896.8	$ 1,885.2	$ (11.6)	$ 1,984.0	$ 1,972.6	$ (11.4)	$ 1,969.6	$ 1,969.5	$ (0.1)	$ 1,959.8	$ 1,975.3	$ 15.5
TOTAL CASH AVAILABLE	$ 2,101.2	$ 2,101.2	$ -	$ 2,210.7	$ 2,199.1	$ (11.6)	$ 2,225.6	$ 2,229.3	$ 3.7	$ 2,117.6	$ 2,141.4	$ 23.8	$ 1,959.8	$ 1,975.3	$ 15.5
EXPENSES:															
PPO Plan	$ 881.0	$ 881.0	$ -	$ 943.0	$ 927.3	$ (15.7)	$ 1,006.0	$ 984.3	$ (21.7)	$ 1,069.1	$ 1,044.8	$ (24.3)	$ 1,147.9	$ 1,122.3	$ (25.6)
HMO Plan	897.9	897.9	-	1,016.4	1,005.4	(11.0)	1062.5	1064.0	1.5	1168.0	1178.3	10.3	1,286.9	1,311.9	25.0
TOTAL EXPENSES	$ 1,787.3	$ 1,787.3	$ -	$ 1,969.1	$ 1,942.4	$ (26.7)	$ 2,077.6	$ 2,057.4	$ (20.2)	$ 2,246.2	$ 2,232.2	$ (14.0)	$ 2,443.9	$ 2,443.3	$ (0.6)
EXCESS OF REV. OVER EXP.	$ 116.1	$ 116.1	$ -	$ (72.3)	$ (57.2)	$ 15.1	$ (93.6)	$ (84.8)	$ 8.8	$ (276.6)	$ (262.7)	$ 13.9	$ (484.1)	$ (468.0)	$ 16.1
ENDING CASH BALANCE	**$ 313.9**	**$ 313.9**	**$ -**	**$ 241.6**	**$ 256.7**	**$ 15.1**	**$ 148.0**	**$ 171.9**	**$ 23.9**	**$ (128.6)**	**$ (90.8)**	**$ 37.8**	**$ (484.1)**	**$ (468.0)**	**$ 16.1**
ADDITONAL INFORMATION															
Total Unreported Claims Liability	**$ 123.9**	**$ 123.9**	**$ -**	**$ 139.3**	**$ 131.0**	**$ (8.3)**	**$ 142.2**	**$ 133.3**	**$ (8.9)**	**$ 150.6**	**$ 141.2**	**$ (9.4)**	**$ 166.4**	**$ 156.4**	**$ (10.0)**

Revenue and Expense categories have been collapsed to present the highlights of changes to forecast.
Exhibits II through XII present detail forecast information per fiscal year.

Highlights of Changes to Forecast

1) Inclusion of actual enrollment through November 2012
2) Inclusion of Open Enrollment results for Plan Year 2013
3) Inclusion of actual cash flow activity through September 2012
4) Update to Medicare rates for Self-Insured HMOs
5) Update to calculation of Risk reserve for HMO Medical and Rx claims

Exhibit II

Financial Outlook by Fiscal Year [1] (In Millions)

	FY 2011-12 Actual	FY 2012-13 Estimate	FY 2013-14 Estimate	FY 2014-15 Estimate	FY 2015-16 Estimate
BEGINNING CASH BALANCE	$ 197.8	$ 313.9	$ 256.7	$ 171.9	$ 0.0 [2]
REVENUES:					
Insurance Premiums:					
Employer	$ 1,446.0	$ 1,414.0	$ 1,496.5	$ 1,497.0	$ 1,500.3
Employee	165.3	161.6	161.5	161.9	162.6
HSA Contributions [3]	1.7	1.6	1.6	1.6	1.6
COBRA	6.0	6.3	6.7	6.7	6.7
Early Retiree	63.0	61.3	64.3	63.6	62.8
Medicare	143.1	146.9	157.1	160.8	164.7
Investment Interest	4.7	5.6	4.2	0.0	0.0
PPO-TPA Refunds	11.9	10.9	9.3	9.3	9.3
PPO-PBM Rebates	24.2	23.4	17.5	14.7	13.1
HMO-TPA Refunds	0.0	2.9	2.9	2.9	2.9
HMO-PBM Rebates	0.0	9.8	9.2	8.3	7.7
Pretax Trust Fund Transfer	19.0	19.0	19.0	19.0	19.0
PPO-Medicare Part D Subsidy	15.7	20.9	21.8	22.7	23.6
HMO-Medicare Part D Subsidy	0.3	1.0	1.0	1.0	1.0
Other Revenues	2.5	0.0	0.0	0.0	0.0
TOTAL REVENUES	$ 1,903.4	$ 1,885.2	$ 1,972.6	$ 1,969.5	$ 1,975.3
TOTAL CASH AVAILABLE	$ 2,101.2	$ 2,199.1	$ 2,229.3	$ 2,141.4	$ 1,975.3
EXPENSES:					
State PPO Plan: [4]					
Medical Claims	$ 600.7	$ 631.7	$ 676.3	$ 726.8	$ 782.0
ASO Fee	19.4	19.1	18.8	18.5	18.2
Prescription Drug Claims	260.7	276.3	289.0	299.3	321.9
PBM Claims Administration	0.2	0.2	0.2	0.2	0.2
HMO Plan: [5]					
Premium Payments	626.3	260.9	282.9	314.4	349.8
Medical Claims	190.4	525.3	581.8	646.7	719.7
Risk Reserve [6]	0.0	35.9	N/A	N/A	N/A
ASO Fee	11.2	29.4	31.8	34.1	36.7
Prescription Drug Claims	70.0	153.9	167.5	183.1	205.7
HSA Deposits [3]	1.7	1.6	1.6	1.6	1.6
Operating Costs & Admin Assessment	2.2	3.6	3.0	3.0	3.0
Premium Refunds	4.4	4.4	4.4	4.4	4.4
Other Expenses	0.1	0.1	0.1	0.1	0.1
TOTAL EXPENSES	$ 1,787.3	$ 1,942.4	$ 2,057.4	$ 2,232.2	$ 2,443.3
EXCESS OF REVENUES OVER EXPENSES	$ 116.1	$ (57.2)	$ (84.8)	$ (262.7)	$ (468.0)
ENDING CASH BALANCE [7]	**$ 313.9**	**$ 256.7**	**$ 171.9**	**$ (90.8)**	**$ (468.0)**

ADDITONAL INFORMATION

		FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
Total Unreported Claims Liability [8]		$ 123.9	$ 131.0	$ 133.3	$ 141.2	$ 156.4
Average Enrollment by Plan	PPO Standard	88,470	86,200	84,642	83,435	82,347
	PPO HIHP	1,083	1,200	1,207	1,207	1,207
	HMO Standard	83,005	82,241	83,556	85,219	87,000
	HMO HIHP	452	459	464	464	464
	Total	173,010	170,100	169,869	170,325	171,018
Average Enrollment by Coverage Type	Active Standard	134,609	131,248	130,771	131,110	131,736
	Active HIHP	1,452	1,570	1,582	1,582	1,582
	COBRA	674	695	695	695	695
	Early Retiree	7,671	7,404	7,345	7,278	7,189
	Medicare	28,604	29,183	29,476	29,660	29,816
	Total	173,010	170,100	169,869	170,325	171,018

1) Actual results may differ from projected values with increasing likelihood of variance in future periods.
2) Assumes no carry forward of negative ending cash balance from prior year.
3) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
4) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.00M.
5) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
6) Established by Principals of the Revenue Estimating Conference for HMO medical and prescription drug claims. Calculated for Fiscal Year 2012-13 at 6.5% of total estimated HMO claim costs. Per approval of Principals for December 12, 2012 Conference, the calculated amount of the Risk Reserve is reduced by the net increase in HMO Medical and Rx claims from the previous Estimating Conference.
7) Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.
8) Includes estimated PPO Plan and Self-Insured HMO Plans Incurred but not Reported (IBNR) claims and outstanding drafts.

Exhibit III
Financial Outlook - Fiscal Year 2011-12 (In Millions)

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE	$ 197.8	$ 197.8	$ 0.0
REVENUES:			
Insurance Premiums:			
Employer	$ 1,446.0	$ 1,446.0	$ 0.0
Employee	165.3	165.3	0.0
HSA Contributions (1)	1.7	1.7	0.0
COBRA	6.0	6.0	0.0
Early Retiree	63.0	63.0	0.0
Medicare	143.1	143.1	0.0
Investment Interest	4.7	4.7	0.0
PPO-TPA Refunds	11.9	11.9	0.0
PPO-PBM Rebates	24.2	24.2	0.0
HMO-PBM Rebates	0.0	0.0	0.0
Pretax Trust Fund Transfer	19.0	19.0	0.0
PPO Medicare Part D Subsidy	15.7	15.7	0.0
HMO Medicare Part D Subsidy	0.3	0.3	0.0
Other Revenues	2.5	2.5	0.0
TOTAL REVENUES	$ 1,903.4	$ 1,903.4	$ 0.0
TOTAL CASH AVAILABLE	$ 2,101.2	$ 2,101.2	$ 0.0
EXPENSES:			
State PPO Plan: (2)			
Medical Claims	$ 600.7	$ 600.7	$ 0.0
ASO Fee	19.4	19.4	0.0
Prescription Drug Claims	260.7	260.7	0.0
PBM Claims Administration	0.2	0.2	0.0
HMO Plan: (3)			
Premium Payments	626.3	626.3	0.0
Medical Claims	190.4	190.4	0.0
Risk Reserve (4)	0.0	0.0	0.0
ASO Fee	11.2	11.2	0.0
Prescription Drug Claims	70.0	70.0	0.0
HSA Deposits (1)	1.7	1.7	0.0
Operating Costs & Admin Assessment	2.2	2.2	0.0
Premium Refunds	4.4	4.4	0.0
Other Expenses	0.1	0.1	0.0
TOTAL EXPENSES	$ 1,787.3	$ 1,787.3	$ 0.0
EXCESS OF REVENUES OVER EXPENSES	$ 116.1	$ 116.1	$ 0.0
ENDING CASH BALANCE (5)	**$ 313.9**	**$ 313.9**	**$ 0.0**

ADDITONAL INFORMATION

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Total Unreported PPO Plan Claims Liability (6)	$ 62.6	$ 62.6	$ 0.0
Total Unreported HMO Plan Claims Liability (7)	57.5	57.5	0.0
Total Unreported PBM Claims Liability (8)	3.8	3.8	0.0
Total Unreported Claims Liability	$ 123.9	$ 123.9	$ 0.0

		(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Average Enrollment by Plan	PPO Standard	88,470	88,470	0
	PPO HIHP	1,083	1,083	0
	HMO Standard	83,005	83,005	0
	HMO HIHP	452	452	0
	Total	173,010	173,010	0
Average Enrollment by Coverage Type	Active Standard	134,609	134,609	0
	Active HIHP	1,452	1,452	0
	COBRA	674	674	0
	Early Retiree	7,671	7,671	0
	Medicare	28,604	28,604	0
	Total	173,010	173,010	0

1) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
2) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
3) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
4) Actual expenses recognized in medical claims, pharmacy claims, and ASO fees.
5) Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.
6) Includes estimated PPO Incurred but not Reported (IBNR) claims of $55.6M and outstanding drafts of $7.0M.
7) Includes estimated HMO IBNR medical claims and outstanding drafts.
8) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit IV

Financial Outlook - Fiscal Year 2012-13 (In Millions)

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE	$ 313.9	$ 313.9	$ 0.0
REVENUES:			
Insurance Premiums:			
Employer	$ 1,430.6	$ 1,414.0	$ (16.6)
Employee	163.4	161.6	(1.8)
HSA Contributions (1)	1.6	1.6	0.0
COBRA	6.1	6.3	0.2
Early Retiree	61.6	61.3	(0.3)
Medicare	145.9	146.9	1.0
Investment Interest	5.5	5.6	0.1
PPO-TPA Refunds	9.3	10.9	1.6
PPO-PBM Rebates	23.4	23.4	0.0
HMO-TPA Refunds	0.0	2.9	2.9
HMO-PBM Rebates	9.8	9.8	0.0
Pretax Trust Fund Transfer	19.0	19.0	0.0
PPO Medicare Part D Subsidy	19.6	20.9	1.3
HMO Medicare Part D Subsidy	1.0	1.0	0.0
Other Revenues	0.0	0.0	0.0
TOTAL REVENUES	$ 1,896.8	$ 1,885.2	$ (11.6)
TOTAL CASH AVAILABLE	$ 2,210.7	$ 2,199.1	$ (11.6)
EXPENSES:			
State PPO Plan: (2)			
Medical Claims	$ 643.9	$ 631.7	$ (12.2)
ASO Fee	19.2	19.1	(0.1)
Prescription Drug Claims	279.7	276.3	(3.4)
PBM Claims Administration	0.2	0.2	0.0
HMO Plan: (3)			
Premium Payments	264.5	260.9	(3.6)
Medical Claims	520.6	525.3	4.7
Risk Reserve (4)	44.8	35.9	(8.9)
ASO Fee	29.7	29.4	(0.3)
Prescription Drug Claims	156.8	153.9	(2.9)
HSA Deposits (1)	1.6	1.6	0.0
Operating Costs & Admin Assessment	3.6	3.6	0.0
Premium Refunds	4.4	4.4	0.0
Other Expenses	0.1	0.1	0.0
TOTAL EXPENSES	$ 1,969.1	$ 1,942.4	$ (26.7)
EXCESS OF REVENUES OVER EXPENSES	$ (72.3)	$ (57.2)	$ 15.1
ENDING CASH BALANCE (5)	**$ 241.6**	**$ 256.7**	**$ 15.1**

ADDITONAL INFORMATION

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Total Unreported PPO Plan Claims Liability (6)	$ 62.6	$ 57.3	$ (5.3)
Total Unreported HMO Plan Claims Liability (7)	68.0	65.1	(2.9)
Total Unreported PBM Claims Liability (8)	8.7	8.6	(0.1)
Total Unreported Claims Liability	$ 139.3	$ 131.0	$ (8.3)

		(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Average Enrollment by Plan	PPO Standard	86,912	86,200	(712)
	PPO HIHP	1,162	1,200	38
	HMO Standard	82,863	82,241	(622)
	HMO HIHP	441	459	18
	Total	171,378	170,100	(1,278)
Average Enrollment by Coverage Type	Active Standard	132,612	131,248	(1,364)
	Active HIHP	1,517	1,570	53
	COBRA	675	695	20
	Early Retiree	7,477	7,404	(73)
	Medicare	29,097	29,183	86
	Total	171,378	170,100	(1,278)

1) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
2) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
3) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
4) Established by Principals of the Revenue Estimating Conference for Fiscal Years 2011-12 and 2012-13 for HMO medical and prescription drug claims. Calculated at 6.5% of total estimated HMO claim costs. Per approval of Principals for December 12, 2012 Conference, the calculated amount of the Risk Reserve is reduced by the net increase of $8.9M in HMO Medical and Rx claims from the previous Estimating Conference. See Page 12 for details on the increase in HMO Medical and Rx claims.
5) Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.
6) Includes estimated PPO Incurred but not Reported (IBNR) claims of $50.3M and outstanding drafts of $7.0M.
7) Includes estimated HMO IBNR medical claims and outstanding drafts.
8) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit V

Financial Outlook - Fiscal Year 2013-14 (In Millions)

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE	$ 241.6	$ 256.7	$ 15.1
REVENUES:			
Insurance Premiums:			
Employer	$ 1,511.7	$ 1,496.5	$ (15.2)
Employee	162.5	161.5	(1.0)
HSA Contributions [1]	1.6	1.6	0.0
COBRA	6.4	6.7	0.3
Early Retiree	64.9	64.3	(0.6)
Medicare	155.4	157.1	1.7
Investment Interest	3.9	4.2	0.3
PPO-TPA Refunds	9.3	9.3	0.0
PPO-PBM Rebates	17.6	17.5	(0.1)
HMO-TPA Refunds	0.0	2.9	2.9
HMO-PBM Rebates	9.2	9.2	0.0
Pretax Trust Fund Transfer	19.0	19.0	0.0
PPO Medicare Part D Subsidy	21.5	21.8	0.3
HMO Medicare Part D Subsidy	1.0	1.0	0.0
Other Revenues	0.0	0.0	0.0
TOTAL REVENUES	$ 1,984.0	$ 1,972.6	$ (11.4)
TOTAL CASH AVAILABLE	$ 2,225.6	$ 2,229.3	$ 3.7
EXPENSES:			
State PPO Plan: [2]			
Medical Claims	$ 692.8	$ 676.3	$ (16.5)
ASO Fee	19.0	18.8	(0.2)
Prescription Drug Claims	294.0	289.0	(5.0)
PBM Claims Administration	0.2	0.2	0.0
HMO Plan: [3]			
Premium Payments	285.7	282.9	(2.8)
Medical Claims	574.5	581.8	7.3
ASO Fee	32.1	31.8	(0.3)
Prescription Drug Claims	170.2	167.5	(2.7)
HSA Deposits [1]	1.6	1.6	0.0
Operating Costs & Admin Assessment	3.0	3.0	0.0
Premium Refunds	4.4	4.4	0.0
Other Expenses	0.1	0.1	0.0
TOTAL EXPENSES	$ 2,077.6	$ 2,057.4	$ (20.2)
EXCESS OF REVENUES OVER EXPENSES	$ (93.6)	$ (84.8)	$ 8.8
ENDING CASH BALANCE [4]	**$ 148.0**	**$ 171.9**	**$ 23.9**

ADDITONAL INFORMATION

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Total Unreported PPO Plan Claims Liability [5]	$ 62.6	$ 57.3	$ (5.3)
Total Unreported HMO Plan Claims Liability [6]	70.3	66.9	(3.4)
Total Unreported PBM Claims Liability [7]	9.3	9.1	(0.2)
Total Unreported Claims Liability	$ 142.2	$ 133.3	$ (8.9)

		(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Average Enrollment by Plan	PPO Standard	85,769	84,642	(1,127)
	PPO HIHP	1,162	1,207	45
	HMO Standard	83,906	83,556	(350)
	HMO HIHP	441	464	23
	Total	171,278	169,869	(1,409)
Average Enrollment by Coverage Type	Active Standard	131,993	130,771	(1,222)
	Active HIHP	1,517	1,582	65
	COBRA	675	695	20
	Early Retiree	7,490	7,345	(145)
	Medicare	29,603	29,476	(127)
	Total	171,278	169,869	(1,409)

1) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
2) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
3) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
4) Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.
5) Includes estimated PPO Incurred but not Reported (IBNR) claims of $50.3M and outstanding drafts of $7.0M.
6) Includes estimated HMO IBNR medical claims and outstanding drafts.
7) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VI
Financial Outlook - Fiscal Year 2014-15 (In Millions)

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE	$ 148.0	$ 171.9	$ 23.9
REVENUES:			
Insurance Premiums:			
Employer	$ 1,502.0	$ 1,497.0	$ (5.0)
Employee	161.5	161.9	0.4
HSA Contributions (1)	1.6	1.6	0.0
COBRA	6.4	6.7	0.3
Early Retiree	64.8	63.6	(1.2)
Medicare	158.7	160.8	2.1
Investment Interest	0.0	0.0	0.0
PPO-TPA Refunds	9.3	9.3	0.0
PPO-PBM Rebates	14.8	14.7	(0.1)
HMO-TPA Refunds	0.0	2.9	2.9
HMO-PBM Rebates	8.3	8.3	0.0
Pretax Trust Fund Transfer	19.0	19.0	0.0
PPO Medicare Part D Subsidy	22.2	22.7	0.5
HMO Medicare Part D Subsidy	1.0	1.0	0.0
Other Revenues	0.0	0.0	0.0
TOTAL REVENUES	$ 1,969.6	$ 1,969.5	$ (0.1)
TOTAL CASH AVAILABLE	$ 2,117.6	$ 2,141.4	$ 23.8
EXPENSES:			
State PPO Plan: (2)			
Medical Claims	$ 745.2	$ 726.8	$ (18.4)
ASO Fee	18.7	18.5	(0.2)
Prescription Drug Claims	305.0	299.3	(5.7)
PBM Claims Administration	0.2	0.2	0.0
HMO Plan: (3)			
Premium Payments	315.1	314.4	(0.7)
Medical Claims	634.0	646.7	12.7
ASO Fee	34.1	34.1	0.0
Prescription Drug Claims	184.8	183.1	(1.7)
HSA Deposits (1)	1.6	1.6	0.0
Operating Costs & Admin Assessment	3.0	3.0	0.0
Premium Refunds	4.4	4.4	0.0
Other Expenses	0.1	0.1	0.0
TOTAL EXPENSES	$ 2,246.2	$ 2,232.2	$ (14.0)
EXCESS OF REVENUES OVER EXPENSES	$ (276.6)	$ (262.7)	$ 13.9
ENDING CASH BALANCE (4)	**$ (128.6)**	**$ (90.8)**	**$ 37.8**

ADDITONAL INFORMATION

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Total Unreported PPO Plan Claims Liability (5)	$ 62.6	$ 57.3	$ (5.3)
Total Unreported HMO Plan Claims Liability (6)	78.2	74.3	(3.9)
Total Unreported PBM Claims Liability (7)	9.8	9.6	(0.2)
Total Unreported Claims Liability	$ 150.6	$ 141.2	$ (9.4)

		(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Average Enrollment by Plan	PPO Standard	84,626	83,435	(1,191)
	PPO HIHP	1,162	1,207	45
	HMO Standard	84,959	85,219	260
	HMO HIHP	441	464	23
	Total	171,188	170,325	(863)
Average Enrollment by Coverage Type	Active Standard	131,374	131,110	(264)
	Active HIHP	1,517	1,582	65
	COBRA	675	695	20
	Early Retiree	7,513	7,278	(235)
	Medicare	30,109	29,660	(449)
	Total	171,188	170,325	(863)

1) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
2) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
3) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
4) Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.
5) Includes estimated PPO Incurred but not Reported (IBNR) claims of $50.3M and outstanding drafts of $7.0M.
6) Includes estimated HMO IBNR medical claims and outstanding drafts.
7) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VII
Financial Outlook - Fiscal Year 2015-16 (In Millions)

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE	$ 0.0 [1]	$ 0.0 [1]	$ 0.0
REVENUES:			
Insurance Premiums:			
Employer	$ 1,492.3	$ 1,500.3	$ 8.0
Employee	160.6	162.6	2.0
HSA Contributions [2]	1.6	1.6	0.0
COBRA	6.4	6.7	0.3
Early Retiree	64.7	62.8	(1.9)
Medicare	162.2	164.7	2.5
Investment Interest	0.0	0.0	0.0
PPO-TPA Refunds	9.3	9.3	0.0
PPO-PBM Rebates	13.2	13.1	(0.1)
HMO-TPA Refunds	0.0	2.9	2.9
HMO-PBM Rebates	7.7	7.7	0.0
Pretax Trust Fund Transfer	19.0	19.0	0.0
PPO Medicare Part D Subsidy	21.8	23.6	1.8
HMO Medicare Part D Subsidy	1.0	1.0	0.0
Other Revenues	0.0	0.0	0.0
TOTAL REVENUES	$ 1,959.8	$ 1,975.3	$ 15.5
TOTAL CASH AVAILABLE	$ 1,959.8	$ 1,975.3	$ 15.5
EXPENSES:			
State PPO Plan: [3]			
Medical Claims	$ 801.5	$ 782.0	$ (19.5)
ASO Fee	18.5	18.2	(0.3)
Prescription Drug Claims	327.7	321.9	(5.8)
PBM Claims Administration	0.2	0.2	0.0
HMO Plan: [4]			
Premium Payments	347.5	349.8	2.3
Medical Claims	699.6	719.7	20.1
ASO Fee	36.4	36.7	0.3
Prescription Drug Claims	203.4	205.7	2.3
HSA Deposits [2]	1.6	1.6	0.0
Operating Costs & Admin Assessment	3.0	3.0	0.0
Premium Refunds	4.4	4.4	0.0
Other Expenses	0.1	0.1	0.0
TOTAL EXPENSES	$ 2,443.9	$ 2,443.3	$ (0.6)
EXCESS OF REVENUES OVER EXPENSES	$ (484.1)	$ (468.0)	$ 16.1
ENDING CASH BALANCE [5]	**$ (484.1)**	**$ (468.0)**	**$ 16.1**

ADDITONAL INFORMATION

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Total Unreported PPO Plan Claims Liability [6]	$ 62.6	$ 57.3	$ (5.3)
Total Unreported HMO Plan Claims Liability [7]	93.1	88.5	(4.6)
Total Unreported PBM Claims Liability [8]	10.7	10.6	(0.1)
Total Unreported Claims Liability	$ 166.4	$ 156.4	$ (10.0)

		(A) Aug '12	(B) Dec '12	(B) - (A) Difference
Average Enrollment by Plan	PPO Standard	83,493	82,347	(1,146)
	PPO HIHP	1,162	1,207	45
	HMO Standard	86,014	87,000	986
	HMO HIHP	441	464	23
	Total	171,110	171,018	(92)
Average Enrollment by Coverage Type	Active Standard	130,755	131,736	981
	Active HIHP	1,517	1,582	65
	COBRA	675	695	20
	Early Retiree	7,548	7,189	(359)
	Medicare	30,615	29,816	(799)
	Total	171,110	171,018	(92)

1) Assumes no carry forward of negative ending cash balance from prior year.
2) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
3) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
4) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
5) Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.
6) Includes estimated PPO Incurred but not Reported (IBNR) claims of $50.3M and outstanding drafts of $7.0M.
7) Includes estimated HMO IBNR medical claims and outstanding drafts.
8) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VIII

Comparison of Financial Outlooks

Fiscal Year 2011-12

(In Millions)

$	**313.9**	**Previous Ending Cash Balance Forecast [1]**
	-	Increase in Revenue Forecast
	-	Decrease in Expense Forecast
$	**313.9**	**Ending Cash Balance**

[1] Self Insurance Estimating Conference held in August 2012.

Exhibit IX
Comparison of Financial Outlooks
Fiscal Year 2012-13
(In Millions)

$ 241.6 Previous Ending Cash Balance Forecast [1]

- \- Increase in Beginning Cash Balance Forecast
- (11.6) Decrease in Revenue Forecast
  - (17.5) - Net decrease in Insurance Premiums
    - (1.9) - Decrease due to premium rates effective May 2013 for June 2013 coverage
    - (15.6) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 171,378 to 170,100 and category shifts
  - 0.1 - Increase in Investment Interest due to an increase in projected cash balance
  - 1.6 - Increase in PPO-TPA Refunds due to higher projected activity
  - 2.9 - Increase in HMO-TPA Refunds due to higher projected activity
  - 1.3 - Increase in PPO-Medicare Part D Subsidy due to higher projected activity
- (26.7) Decrease in Expense Forecast
  - (15.7) Decrease in State PPO Plan
    - (12.2) - Decrease in Medical Claims
      - (4.9) - Decrease due to a decrease in projected enrollment from 88,074 to 87,400 and category shifts
      - (7.3) - Decrease due to lower projected claims experience
    - (0.1) - Decrease in ASO Fee due to a decrease in projected enrollment
    - (3.4) - Decrease in Prescription Drug Claims
      - (2.1) - Decrease due to lower projected enrollment and category shifts
      - (1.3) - Decrease due to lower projected claims experience and trend
  - (11.0) Decrease in HMO Plan
    - (3.6) - Decrease in Premium Payments due to a decrease in projected enrollment from 30,616 to 30,299 and category shifts
    - 4.7 - Increase in Medical Claims
      - (5.9) - Decrease due to a decrease in projected enrollment from 53,002 to 52,400
      - 10.6 - Increase due to higher projected claims experience
    - (8.9) - Decrease in Risk Reserve due to an increase in projected Medical and Rx claims
    - (0.3) - Decrease in ASO Fees due to a decrease in projected enrollment from 53,002 to 52,400
    - (2.9) - Decrease in Prescription Drug Claims
      - (1.2) - Decrease due to a decrease in projected enrollment from 83,304 to 82,699
      - (1.7) - Decrease due to lower projected claims experience and trend

$ 256.7 Ending Cash Balance

[1] Self Insurance Estimating Conference held in August 2012.

Exhibit X

Comparison of Financial Outlooks

Fiscal Year 2013-14

(In Millions)

$ 148.0 Previous Ending Cash Balance Forecast [1]

- 15.1 Increase in Beginning Cash Balance Forecast
- (11.4) Decrease in Revenue Forecast
  - (14.8) - Net decrease in Insurance Premiums
    - 1.5 - Increase due to premium rates effective May 2013 for June 2013 coverage
    - (16.3) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 171,278 to 169,869 and category shifts
  - 0.3 - Increase in Investment Interest due to an increase in projected cash balance
  - (0.1) - Decrease in PPO-PBM Rebates due to a decrease in projected claims experience
  - 2.9 - Increase in HMO-TPA Refunds due to higher projected activity
  - 0.3 - Increase in PPO-Medicare Part D Subsidy due to higher projected activity
- (20.2) Decrease in Expense Forecast
  - (21.7) Decrease in State PPO Plan
    - (16.5) - Decrease in Medical Claims
      - (8.8) - Decrease due to a decrease in projected enrollment from 86,931 to 85,849 and category shifts
      - (7.7) - Decrease due to lower projected claims experience
    - (0.2) - Decrease in ASO Fee due to a decrease in projected enrollment
    - (5.0) - Decrease in Prescription Drug Claims
      - (3.7) - Decrease due to lower projected enrollment
      - (1.3) - Decrease due to lower projected claims experience
  - 1.5 Increase in HMO Plan
    - (2.8) - Decrease in Premium Payments due to a decrease in projected enrollment from 30,989 to 30,784 and category shifts
    - 7.3 - Increase in Medical Claims
      - (4.7) - Decrease due to a decrease in projected enrollment from 53,675 to 53,239
      - 12.0 - Increase due to higher projected claims experience
    - (0.3) - Decrease in ASO Fees due to a decrease in projected enrollment from 53,675 to 53,239
    - (2.7) - Decrease in Prescription Drug Claims
      - (0.7) - Decrease due to a decrease in projected enrollment from 84,347 to 84,023
      - (2.0) - Decrease due to lower projected claims experience and trend

171.9 Ending Cash Balance

---

[1] Self Insurance Estimating Conference held in August 2012.

Exhibit XI

Comparison of Financial Outlooks

Fiscal Year 2014-15

(In Millions)

$ (128.6) Previous Ending Cash Balance Forecast [1]

- 23.9 Increase in Beginning Cash Balance Forecast
- (0.1) Decrease in Revenue Forecast
  - (3.4) - Net decrease in Insurance Premiums
    - 3.2 - Increase due to premium rates effective May 2013 for June 2013 coverage
    - (6.6) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 171,188 to 170,325 and category shifts
  - (0.1) - Decrease in PPO-PBM Rebates due to a decrease in projected claims experience
  - 2.9 - Increase in HMO-TPA Refunds due to higher projected activity
  - 0.5 - Increase in PPO-Medicare Part D Subsidy due to higher projected activity
- (14.0) Decrease in Expense Forecast
  - (24.3) Decrease in State PPO Plan
    - (18.4) - Decrease in Medical Claims
      - (10.0) - Decrease due to a decrease in projected enrollment from 85,788 to 84,642 and category shifts
      - (8.4) - Decrease due to lower projected claims experience
    - (0.2) - Decrease in ASO Fee due to a decrease in projected enrollment
    - (5.7) - Decrease in Prescription Drug Claims
      - (4.1) - Decrease due to lower projected enrollment
      - (1.6) - Decrease due to lower projected claims experience
  - 10.3 Increase in HMO Plan
    - (0.7) - Decrease in Premium Payments due to an increase in projected enrollment from 31,366 to 31,393 and category shifts
    - 12.7 - Increase in Medical Claims due to higher projected claims experience
    - (1.7) - Decrease in HMO Plan Prescription Drug Claims
      - 0.6 - Increase due to an increase in projected enrollment from 85,400 to 85,686
      - (2.3) - Decrease due to lower projected claims experience and trend

(90.8) Ending Cash Balance

---

[1] Self Insurance Estimating Conference held in August 2012.

Exhibit XII

Comparison of Financial Outlooks

Fiscal Year 2015-16

(In Millions)

$ (484.1) Previous Ending Cash Balance Forecast [1]

15.5 Increase in Revenue Forecast
- 10.9 - Net increase in Insurance Premiums
  - 5.1 - Increase due to premium rates effective May 2013 for June 2013 coverage
  - (0.2) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 171,110 to 171,018
  - 6.0 Increase in employer and enrollee Insurance Premiums due to category shifts
- (0.1) - Decrease in PPO-PBM Rebates due to a decrease in projected claims experience
- 2.9 - Increase in HMO-TPA Refunds due to higher projected activity
- 1.8 - Increase in PPO-Medicare Part D Subsidy
  - (0.2) - Decrease due to a decrease in projected enrollment from 84,655 to 83,554 and category shifts
  - 2.0 - Increase due to higher projected activity

(0.6) Decrease in Expense Forecast
- (25.6) Decrease in State PPO Plan
  - (19.5) - Decrease in Medical Claims
    - (10.4) - Decrease due to a decrease in projected enrollment from 84,655 to 83,554 and category shifts
    - (9.1) - Decrease due to lower projected claims experience
  - (0.3) - Decrease in ASO Fee due to a decrease in projected enrollment
  - (5.8) - Decrease in Prescription Drug Claims
    - (4.3) - Decrease due to lower projected enrollment
    - (1.5) - Decrease due to lower projected claims experience
- 25.0 Increase in HMO Plan
  - 2.3 - Increase in Premium Payments
    - 3.2 - Increase due to an increase in projected enrollment from 31,743 to 32,038 and category shifts
    - (0.9) - Decrease due to category shifts
  - 20.1 - Increase in Medical Claims
    - 5.1 - Increase due to an increase in projected enrollment from 55,029 to 55,429
    - 15.0 - Increase due to higher projected claims experience
  - 0.3 - Increase in ASO Fee due to an increase in projected enrollment from 55,029 to 55,429
  - 2.3 - Increase in Prescription Drug Claims
    - 2.3 - Increase in Prescription Drug Claims due to an increase in projected enrollment from 86,455 to 87,467
    - (1.6) - Decrease due to changes in projected claims experience and trend
    - 1.6 - Increase due to correction in projected claims from August 2012 estimating conference

(468.0) Ending Cash Balance

---

[1] Self Insurance Estimating Conference held in August 2012.

Premium Rate Table

Effective December 2011 for January 2012 Coverage

(Premium rate change ONLY for CHP and FHCP Medicare Participants)

Subscriber Category / Contribution Cycle		Coverage Type	PPO/HMO Standard			PPO/HMO HIHP		
			Employer	Enrollee	Total	Employer [7]	Enrollee	Total
Career Service	Monthly Full -Time Employees [1]	Single	499.80	50.00	549.80	499.80	15.00	514.80
		Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
		Spouse	1,213.36	30.00	1,243.36	1,097.64	30.00	1,127.64
	Bi-Weekly Full -Time Employees [1]	Single	249.90	25.00	274.90	249.90	7.50	257.40
		Family	531.67	90.00	621.67	531.67	32.15	563.82
		Spouse	606.68	15.00	621.68	548.82	15.00	563.82
"Payalls"	Monthly Full -Time Employees [1,2]	Single	541.46	8.34	549.80	506.46	8.34	514.80
		Family	1,213.34	30.00	1,243.34	1,097.64	30.00	1,127.64
	Bi-Weekly Full -Time Employees [1,2]	Single	270.73	4.17	274.90	253.23	4.17	257.40
		Family	606.67	15.00	621.67	548.82	15.00	563.82
COBRA	Monthly [3]	Single	0.00	560.80	560.80	0.00	482.60	482.60
		Family	0.00	1,268.21	1,268.21	0.00	1,065.20	1,065.20
Early Retirees	Monthly	Single	0.00	549.80	549.80	0.00	473.14	473.14
		Family	0.00	1,243.34	1,243.34	0.00	1,044.31	1,044.31
Overage Dependents		Single	0.00	549.80	549.80	0.00	473.14	473.14

Medicare Monthly Premium Rates (Effective January 1, 2012)

Plan Name	Plan Type	Medicare I One Eligible [4]	Medicare II One Under/Over [5]	Medicare III Both Eligible [6]
Self-Insured PPO/HMO Plans	Standard	305.82	881.80	611.64
	HIHP	230.52	722.16	461.04
Capital Health Plan [8]	Standard	266.00	895.49	532.00
	HIHP	244.69	810.36	489.38
Florida Health Care Plan [8]	Standard	45.50	644.84	91.00
	HIHP	45.50	534.54	91.00

Notes:

(1) Premium contribution for Part-Time Employees is to be calculated as follows:
  Step 1. State Contribution x FTE% = Calculated State Contribution
  Step 2. Total Contribution - Calculated State Contribution = Employee Contribution
(2) "Payalls" - Includes executive, legislative and judicial branch agencies for employees with enhanced benefits, excluding Spouse Program participants.
(3) Includes an additional 2% for administrative costs as permitted by federal regulations.
(4) Single coverage for participant eligible for Medicare Parts A and B.
(5) Family coverage for two or more participants, if at least one participant is eligible for Medicare Parts A and B.
(6) Family coverage for two participants and both are eligible for Medicare Parts A and B.
(7) The employer monthly HSA contribution of $41.66/single ($500 annually) and $83.33/family ($1,000 annually) is included in the listed employer rates.
(8) Medicare eligible members who enroll with either CHP or FHCP must also enroll in a Medicare Advantage Prescription Drug ("MAPD") plan with CHP or FHCP for an additional premium.

Premium Rate Table

Effective December 2012 for January 2013 Coverage

(Premium rate change ONLY for CHP and FHCP Medicare Participants)

Subscriber Category / Contribution Cycle		Coverage Type	PPO/HMO Standard			PPO/HMO HIHP		
			Employer	Enrollee	Total	Employer [4]	Enrollee	Total
Career Service	Monthly Full -Time Employees [1]	Single	499.80	50.00	549.80	499.80	15.00	514.80
		Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
		Spouse	1,213.36	30.00	1,243.36	1,097.64	30.00	1,127.64
	Bi-Weekly Full -Time Employees [1]	Single	249.90	25.00	274.90	249.90	7.50	257.40
		Family	531.67	90.00	621.67	531.67	32.15	563.82
		Spouse	606.68	15.00	621.68	548.82	15.00	563.82
"Payalls"	Monthly Full -Time Employees [1,2]	Single	541.46	8.34	549.80	506.46	8.34	514.80
		Family	1,213.34	30.00	1,243.34	1,097.64	30.00	1,127.64
	Bi-Weekly Full -Time Employees [1,2]	Single	270.73	4.17	274.90	253.23	4.17	257.40
		Family	606.67	15.00	621.67	548.82	15.00	563.82
COBRA	Monthly [3]	Single	0.00	560.80	560.80	0.00	482.60	482.60
		Family	0.00	1,268.21	1,268.21	0.00	1,065.20	1,065.20
Early Retirees	Monthly	Single	0.00	549.80	549.80	0.00	473.12	473.12
		Family	0.00	1,243.34	1,243.34	0.00	1,044.32	1,044.32
Overage Dependents		Single	0.00	549.80	549.80	0.00	473.14	473.14

Medicare Monthly Premium Rates (Premium rate change effective December 1, 2012 for CHP and FHCP only)

Plan Name	Plan Type	Medicare I One Eligible [5]	Medicare II One Under/Over [6]	Medicare III Both Eligible [7]
Self-Insured PPO / HMO [8]	Standard	305.82	881.80	611.64
	HIHP	230.52	722.16	461.04
Capital Health Plan [9]	Standard	268.00	921.83	536.00
	HIHP	259.98	853.57	519.96
Florida Health Care Plan [9]	Standard	48.00	698.89	96.00
	HIHP	48.00	579.10	96.00

Notes:

(1) Premium contribution for Part-Time Employees is to be calculated as follows:
  Step 1. State Contribution x FTE% = Calculated State Contribution
  Step 2. Total Contribution - Calculated State Contribution = Employee Contribution
(2) "Payalls" - Includes executive, legislative and judicial branch agencies for employees with enhanced benefits, excluding Spouse Program participants.
(3) Includes an additional 2% for administrative costs as permitted by federal regulations.
(4) The employer monthly HSA contribution of $41.66/single ($500 annually) and $83.33/family ($1,000 annually) is included in the listed employer rates.
(5) Single coverage for participant eligible for Medicare Parts A and B.
(6) Family coverage for two or more participants, if at least one participant is eligible for Medicare Parts A and B.
(7) Family coverage for two participants and both are eligible for Medicare Parts A and B.
(8) Premium rates for Medicare participants enrolled in a Self-Insured HMO plan may differ from what is presented.
(9) Medicare eligible members who enroll with either CHP or FHCP must also enroll in a Medicare Advantage Prescription Drug ("MAPD") plan with CHP or FHCP.

Premium Rate Table

Effective May 2013 for June 2013 Coverage

(Premium rate change for all participants EXCEPT CHP and FHCP Medicare)

Subscriber Category / Contribution Cycle		Coverage Type	PPO/HMO Standard Employer	PPO/HMO Standard Enrollee	PPO/HMO Standard Total	PPO/HMO HIHP Employer [4]	PPO/HMO HIHP Enrollee	PPO/HMO HIHP Total
Career Service	Monthly Full -Time Employees [1]	Single	537.74	50.00	587.74	537.74	15.00	552.74
		Family	1,149.14	180.00	1,329.14	1,149.14	64.30	1,213.44
		Spouse	1,299.16	30.00	1,329.16	1,183.44	30.00	1,213.44
	Bi-Weekly Full -Time Employees [1]	Single	268.87	25.00	293.87	268.87	7.50	276.37
		Family	574.57	90.00	664.57	574.57	32.15	606.72
		Spouse	649.58	15.00	664.58	591.72	15.00	606.72
"Payalls"	Monthly Full -Time Employees [1,2]	Single	579.40	8.34	587.74	544.40	8.34	552.74
		Family	1,299.14	30.00	1,329.14	1,183.44	30.00	1,213.44
	Bi-Weekly Full -Time Employees [1,2]	Single	289.70	4.17	293.87	272.20	4.17	276.37
		Family	649.58	15.00	664.58	591.72	15.00	606.72
COBRA	Monthly [3]	Single	0.00	599.49	599.49	0.00	521.30	521.30
		Family	0.00	1,355.72	1,355.72	0.00	1,152.71	1,152.71
Early Retirees	Monthly	Single	0.00	587.74	587.74	0.00	511.08	511.08
		Family	0.00	1,329.14	1,329.14	0.00	1,130.11	1,130.11
Overage Dependents		Single	0.00	587.74	587.74	0.00	511.08	511.08

Medicare Monthly Premium Rates (Premium rate change effective May 1, 2013 for PPO only)

Plan Name	Plan Type	Medicare I One Eligible [5]	Medicare II One Under/Over [6]	Medicare III Both Eligible [7]
Self-Insured PPO / HMO	Standard	326.92	942.64	653.84
	HIHP	246.43	771.99	492.85
Capital Health Plan [8]	Standard	268.00	921.83	536.00
	HIHP	259.98	853.57	519.96
Florida Health Care Plan [8]	Standard	48.00	698.89	96.00
	HIHP	48.00	579.10	96.00

Notes:

(1) Premium contribution for Part-Time Employees is to be calculated as follows:
   Step 1. State Contribution x FTE% = Calculated State Contribution
   Step 2. Total Contribution - Calculated State Contribution = Employee Contribution
(2) "Payalls" - Includes executive, legislative and judicial branch agencies for employees with enhanced benefits, excluding Spouse Program participants.
(3) Includes an additional 2% for administrative costs as permitted by federal regulations.
(4) The employer monthly HSA contribution of $41.66/single ($500 annually) and $83.33/family ($1,000 annually) is included in the listed employer rates.
(5) Single coverage for participant eligible for Medicare Parts A and B.
(6) Family coverage for two or more participants, if at least one participant is eligible for Medicare Parts A and B.
(7) Family coverage for two participants and both are eligible for Medicare Parts A and B.
(8) Medicare eligible members who enroll with either CHP or FHCP must also enroll in a Medicare Advantage Prescription Drug ("MAPD") plan with CHP or FHCP.

Exhibit XIII

Abbreviations / Description of Terms

Term	Description
Accrual Basis	Accounting method in which transactions are recorded when the order is made, the item is delivered, or the services occur, regardless of when the money is actually received or paid. Income is recorded when the sale occurs, and expenses are recorded when goods or services are received.
ASO	Administrative Services Only
Cash Basis	Accounting method in which income is not recorded until cash, check or electronic payment is actually received, and expenses are not recorded until they are actually paid.
Carve-Out	Health insurance benefits that are separated from a contract and paid and administered under a different vendor/arrangement.
COBRA	Consolidated Omnibus Budget Reconciliation Act
DSGI	Division of State Group Insurance
FTE	Full Time Equivalency
FY	Fiscal Year (July 1 through June 30)
HIHP	Health Investor Health Plan (i.e., High Deductible Health Plan)
HMO	Health Maintenance Organization
HSA	Health Savings Account
IBNR	Incurred but not Reported Claims – The IBNR claims liability reflect the estimated total amount owed by the trust fund for valid medical claims incurred by self-insured plan members but not yet reported/submitted by providers to the state's TPA.
Fully-Insured Plan	A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.
Medicare Advantage Prescription Drug (MAPD) Plan	A type of Medicare health plan offered by a private company that contracts with Medicare to provide beneficiaries with all Medicare Part A (hospital coverage), Part B (doctors' services, outpatient care, home health services, some preventive services, and other medical services) and Part D (prescription drugs) benefits. MAPDs include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans.
Medicare Part D Subsidy	A federal program passed as part of the Medicare Modernization Act (MMA) in 2003 to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. By being the primary payer for Medicare eligible subscribers drug claims, the state receives 28 percent of covered charges (net of rebates) between $310 and $6,300 for each Medicare-eligible participant.
Outstanding Drafts	Represent drafts (checks) that have been issued by the PPO plan TPA but have not been presented to the bank account for payment.
N/A	Not applicable.
PBM	Pharmacy Benefits Manager
PPACA	Patient Protection and Affordable Care Act signed into law on March 23, 2010, known as the Federal Health Care Reform
PPO	Preferred Provider Organization
Self-Insured Plan	A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered. All types of plans (Conventional Indemnity, Preferred Provider Organizations, Exclusive Provider Organizations, Health Maintenance Organizations, Point of Service, and Physician Hospital Organizations) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.
TPA	Third Party Administrator

Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act

Adopted December 12, 2012 by the Self-Insurance Estimating Conference

Prepared by: Florida Department of Management Services
Division of State Group Insurance

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. PPACA has many components, including new reporting mandates, taxes and fees, and major structural changes such as insurance reforms, employer and individual mandates, and insurance exchanges phasing in over many years. Every employer-sponsored health plan, including the State Group Insurance Program, will be affected.

The Division of State Group Insurance contracted with a consultant (Mercer) in 2010 to estimate the annual financial impact of PPACA. The results of the consultant's analysis, published on September 1, 2010, were included as an appendix to subsequent State Employee's Group Health Insurance Trust Fund estimating conference documents, adjusted as necessary, and rolled up into single lines in the revenues and expense categories for reporting purposes. The original estimates have been revised over time by subsequent conferences based on revised assumptions and information. In the August 2012 conference, the impacts of PPACA began being reported separately from the Report on the Financial Outlook of the State Employees' Group Health Self-Insurance Trust Fund.

The major health care reform provisions with potential employer impact that have been implemented, or are in the process of being implemented, for the Program, include:

- Elimination of overall lifetime plan maximums;
- Removal of annual limits for essential health benefits;
- Elimination of pre-existing condition exclusions for children under age 19;
- Patient-centered outcome research institute fees (phased in at $1 to $2 per participant); and
- Extended coverage for employees' adult children to age 26 without regard to dependency.

Major changes, effective January 1, 2014, include:

- Imposition of pass-through fees relating to the pharmaceutical industry; 2.3% excise tax on medical devices; and reinsurance, risk corridors, and risk adjustment;
- Elimination of all pre-existing condition limitations;
- "Shared responsibility" provisions requiring employers to offer affordable coverage meeting minimum standards to full-time workers (30 or more hours per week) or face potential penalties; and
- Individual mandate to maintain health coverage or face a penalty.

It is important to note that federal regulations implementing PPACA have not been finalized. For example, the Mercer report referenced Health Insurance Industry Fees effective 2014, now identified by The Centers for Medicare and Medicaid Services, Department of Health and Human Services (HHS) as Transitional Reinsurance, Risk Corridors, and Risk Adjustment Programs. The Transitional Reinsurance Program is applicable to the State Group Insurance Program, however the others are not. This is a temporary program, in place from 2014 to 2016, and the primary purpose of the program is to help stabilize premiums in the individual health insurance marketplace. The total amount to be collected under the program is projected to be $25 billion over three years. HHS has recently released proposed preliminary guidance for determining enrollment and associated costs, however final guidance is slated for release in 2013. Impacts to the State Employees' Group Health Program will need to be determined at that time.

In some instances, implementation of reforms may require changes to state law for compliance or to avoid significant penalties. For example, current law prohibits employees in the Other Personal Services (OPS) category from being covered by the State Group Insurance Program. However, this prohibition subjects the State to significant penalties (potentially exceeding $318 million annually). This analysis assumes that such employees, meeting hours of work requirements, would be covered. This report reflects the changes to the financial impact forecasted in the August 2012, due to increased OPS enrollment.

This report has been revised to reflect updated OPS and Opt Out data and projected costs associated with implementation of the Individual Mandates with federal subsidies for these two groups. There is a substantial increase in reported OPS enrollment, up from 3,864 OPS workers forecasted in August 2012, to 6,291 OPS workers reported for this analysis. The number of Opt Outs has decreased from 14,897 to 13,723.

These enrollment changes have had the following impacts to previously forecasted revenues: Fiscal Year 2013-14 revenues increased from $27.04M to $37.02, up $9.98M; FY 2014-15 revenues increased from $57.24M to $73.46, up $16.22M; and for FY 2015-16 revenues increase from $65M to $80.6M, up $15.6M, for a total revenue increase of $41.8M for the FY 2013-14 through FY 2015-16 periods.

The fiscal impacts to previously forecasted expenses due to the changes in OPS and Opt Outs are: Fiscal Year 2013-14 expenses increased from $48.82M to $59.79M, up $10.97M; FY 2014-15 expenses of $117.55M increased to $137.27M, up $19.72M; and, for FY 2015-16 expenses of $127.55M increased to $155.09M, up $27.54M, for a total expense increase of $58.23M for FY 2013-15 through FY 2015-16 periods.

SUMMARY OF PPACA REFORMS WITH A FISCAL IMPACT ON THE STATE EMPLOYEES' HEALTH INSURANCE PROGRAM (PROGRAM)

1. Early Retiree Reinsurance Program (ERRP) – Interim Final Regulations Effective on June 1, 2010

- **Effective June 2010**
- **No** estimated fiscal impact to Trust Fund (Estimated fiscal impact modified by Division of State Group Insurance to reflect that federal money provided for this purpose has been depleted prior to the state receiving any requested reimbursements.)

Provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents.

- 80% Reimbursement for certain claims between $15,000 and $90,000 (with those amounts being indexed for plan years starting on or after October 1, 2011).
- Claims must be for participants ages 55-64 who are not Medicare eligible.
- Payments must be used to lower plan costs (i.e. offsetting future premium increases for all members).

2. No lifetime dollar maximum

- **Effective January 1, 2011**
- Actual costs are embedded in medical and pharmacy claims reported in FY 2011-12 and subsequent years. As a result, specific costs cannot be separately identified for this estimate and are not included.

Plans cannot impose any lifetime dollar limits on benefits.

- Plans may place lifetime limits per beneficiary on specific covered benefits other than "essential health benefits," if the limits are otherwise permitted by federal or state law.
- **Essential health benefits** include items and services in the below listed categories:
  - ambulatory patient services; emergency services; hospital, maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care.

3. Restricted annual dollar limits

- **Effective January 1, 2011**
- **No** estimated fiscal impact as minimum requirements are already met by the Program.

All insured and self-insured group health plans will face new rules on annual dollar limits. For plan years subsequent to 2011, "restricted" or no annual dollar limits may apply to "essential health benefits" (discussed below).

- The maximum annual dollar limit that may be imposed on essential health benefits are:
  - $750,000 for the plan year beginning on or after September 23, 2010 but before September 23, 2011.

  - $1,250,000 for the plan year beginning on or after September 23, 2011 but before September 23, 2012.
  - $2,000,000 for the plan year beginning on or after September 23, 2012 but before January 1, 2014.
  - No annual dollar limits permitted for plan years on or after January 1, 2014.
- Plans may impose annual per-beneficiary limits on non-essential benefits.

4. Elimination of preexisting condition for subscribers or dependents under 19 – Interim Final Regulations Issued on June 28, 2010

- **Effective January 1, 2011**
- Actual costs were incurred as part of medical and pharmacy claims in FY 2011-12 and are indeterminable as pertains to PPACA. Costs for FY 2012-13 through FY 2014-15 are based on the FY 2011-12 actual and are also indeterminable.

Before 2014, insured and self-insured plans cannot impose preexisting condition exclusions for subscribers and dependents under age 19.

- Until 2014, employers may continue to adopt or retain preexisting condition exclusions for participants ages 19 and older.
- A general ban is effective for all members for plan years starting in 2014. See #8 below.

5. Patient-centered outcome research institute fees

- **Effective October 1, 2012 for the next plan year.**
- Annual estimated fiscal impact for the Program – **$750 thousand**.

- State of Florida Employees' Group Health Insurance Program - Beginning January 1, 2012, $1 per participant in 1st year.
- $2 in subsequent years, from 2013 thru 2019 (sunset after 2019).

6. Other pass-through fees included

- **Effective January 1, 2014**
- Annual estimated fiscal impact for the Program – **$42.82 million**.

Fees include pharmaceutical industry fees; 2.3% excise tax on medical devices, and reinsurance, risk corridors, and risk adjustment.

7. Extension of coverage for all adult children until age 26 – Interim Final Regulations Issued on July 12, 2010

- **Effective January 1, 2011**
- Actual costs were embedded in medical and pharmacy claims in FY 2011-12 and subsequent years. As a result, specific costs cannot be separately identified for this estimate and are not included.

Applies to fully-insured and self-insured group health plans providing dependent coverage.

- Coverage available until the child's 26th birthday.
- The mandate applies regardless of the typical criteria for dependent status under the tax law, such as whether the adult child resides with the covered employee or is the employee's tax dependent, a full- or part-time student, or married or unmarried.
- Plans may extend coverage beyond the child's 26th birthday – for example, until the end of the plan year in which the child turns 26. However, plans will not have to extend coverage to an adult child's dependents.
- No special-enrollment period required; eligible dependents need not be enrolled until the plan's next open enrollment.

8. Eliminate all preexisting condition limitations – Interim Final Regulations Issued on July 30, 2010

- **Effective January 1, 2014**
- Annual estimated fiscal impact for the Program –**$4.3 million**.

Preexisting condition limitation exclusion applies to all plan participants regardless of age as of January 1, 2014. See #4 above.

9. Free-choice vouchers (FCVs) – Repealed by Congress

- **Effective January 1, 2014**
- **No** estimated fiscal impact to the Program.

10. Shared responsibility "free rider surcharge'

- **Effective January 1, 2014**
- **No** estimated direct fiscal impact to the Program. .

Individuals who fail to maintain coverage will face a penalty (lesser of these amounts):

- National average premium for the year, or the greater of
- 1% AGI or $95 in 2014; 2% AGI or $325 in 2015; 2.5% AGI or $695 in 2016; indexed thereafter.

11. Medicaid expansion and migration to Exchange

- **Effective January 1, 2014**
- There will be no direct fiscal impact to the Program unless the state elects to expand the current Medicaid Program to include the optional enhancements. The optional enhancements would expand the current Medicaid Program to cover persons up to 138% of the Federal Poverty Level (FPL) beginning in 2014.

Medicaid expanded to up to 133% of Federal Poverty Level (FPL), effective 2014 when the State-exchanges come online.

12. Individual mandate with federal subsidies

- **Effective January 1, 2014**
- Total estimated fiscal impact for the Program – See item #12 on the Summary of Fiscal Impacts to the State Group Insurance Program for details.

  - Large employers (those employing 50 or more) are required to offer health coverage to all "full-time" employees (i.e., persons who annually work an average of 30 hours or more per week).
  - Employer penalty for failing to offer health coverage for all such "full-time" employees = $2,000 per year, per employee as to all employees, if one or more employees enroll in an exchange and receives a premium credit.
  - Subsidies available to anyone on an exchange plan with household income 133-400% FPL (person cannot be Medicaid eligible).
  - Income level must be verifiable for the two years prior to the current calendar year of coverage (example, eligibility for affordability assistance for 2016 is based on household income for 2014).
  - Assistance in the form of premium credits will be provided for exchange-participants on a sliding scale based on household income. Premium credits will be paid directly to the insurer; individuals will be required to pay insurers any remaining premium amount.
  - Employer penalties = $3,000 per year for each employee enrolled in the exchange and receiving a subsidy, if employee is offered coverage which is unaffordable (i.e., cost exceeds 9.5% of the employee's household income) or if the offered coverage fails to cover a minimum of 60% of covered health care expenses. Capped at $2,000 per FTE.
  - Employers with more than 200 full-time employees must automatically enroll new full-time employees in a plan (and continue enrollment of current employees). (The implementation date is subject to the adoption of required federal regulations.)

In most instances, these impacts will be borne by the State Employee Health Insurance Trust Fund. In some instances, the fiscal impacts may be borne by other funding sources or participating employers, as determined by the Legislature.

State Health Insurance Program | **State of Florida DSGI**

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	FY 2012-13			FY 2013-14			FY 2014-15			FY 2015-16 [2]		
			Aug '12	Dec '12	Diff	Aug '12	Dec '12	Diff	Aug '12	Dec '12	Diff	Aug '12	Dec '12	Diff
1. Early retiree medical reinsurance		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*											
2. No lifetime dollar maximum	Jan 2011	Net	*ALREADY EMBEDDED*											
3. Restricted annual dollar limits		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*											
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	Net	*ALREADY EMBEDDED*											
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	-	-	-	-
		E	0.38	0.38	-	0.75	0.75	-	0.75	0.75	-	0.75	0.75	-
		Net	**(0.38)**	**(0.38)**	**-**	**(0.75)**	**(0.75)**	**-**	**(0.75)**	**(0.75)**	**-**	**(0.75)**	**(0.75)**	**-**
6. Other pass-through fees include:														
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-	-	-	-	-	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	E	-	-	-	20.41	20.41	-	42.82	42.82	-	42.82	42.82	-
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	Net	**-**	**-**	**-**	**(20.41)**	**(20.41)**	**-**	**(42.82)**	**(42.82)**	**-**	**(42.82)**	**(42.82)**	**-**
7. Extension of coverage for all adult children until age 26	Jan 2011	Net	*ALREADY EMBEDDED*											
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	-	-	-	-
		E	-	-	-	2.03	2.03	-	4.30	4.30	-	4.30	4.30	-
		Net	**-**	**-**	**-**	**(2.03)**	**(2.03)**	**-**	**(4.30)**	**(4.30)**	**-**	**(4.30)**	**(4.30)**	**-**
9. Free choice vouchers		Net	*REPEALED BY CONGRESS*											
10. Shared responsibility "free rider surcharge"		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*											
11. Medicaid Expansion and migration into Exchange		Net	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*											
12. Individual Mandate with federal subsidies	Jan 2014													
Opt-Outs [3]		R	-	-	-	10.88	10.01	(0.87)	29.54	27.16	(2.38)	37.30	34.30	(3.00)
Agency and Universities OPS [4][5][6]		R	-	-	-	16.16	27.01	10.85	27.70	46.30	18.60	27.70	46.30	18.60
Opt-Outs [3]		E	-	-	-	9.04	8.31	(0.73)	29.32	26.98	(2.34)	42.60	39.22	(3.38)
Agency and Universities OPS [4][5][6]		E	-	-	-	16.97	28.67	11.70	39.98	62.04	22.06	36.70	67.62	30.92
		Net	**-**	**-**	**-**	**1.03**	**0.04**	**(0.99)**	**(12.06)**	**(15.56)**	**(3.50)**	**(14.30)**	**(26.24)**	**(11.94)**
TOTAL REVENUES [7]			-	-	-	27.04	37.02	9.98	57.24	73.46	16.22	65.00	80.60	15.60
TOTAL EXPENSES			0.38	0.38	-	48.82	59.79	10.97	117.55	137.27	19.72	127.55	155.09	27.54
NET TOTAL [8]			**(0.38)**	**(0.38)**	**-**	**(21.78)**	**(22.77)**	**(0.99)**	**(60.31)**	**(63.81)**	**(3.50)**	**(62.55)**	**(74.49)**	**(11.94)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program			State of Florida DSGI			

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	FY 2012-13 Total	FY 2013-14 Total	FY 2014-15 Total	FY 2015-16 Total [2]
1. Early retiree medical reinsurance		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
2. No lifetime dollar maximum	Jan 2011	Net	*ALREADY EMBEDDED*			
3. Restricted annual dollar limits		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	Net	*ALREADY EMBEDDED*			
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-
		E	0.38	0.75	0.75	0.75
		Net	**(0.38)**	**(0.75)**	**(0.75)**	**(0.75)**
6. Other pass-through fees include:						
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	E	-	20.41	42.82	42.82
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	Net	**-**	**(20.41)**	**(42.82)**	**(42.82)**
7. Extension of coverage for all adult children until age 26	Jan 2011	Net	*ALREADY EMBEDDED*			
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-
		E	-	2.03	4.30	4.30
		Net	**-**	**(2.03)**	**(4.30)**	**(4.30)**
9. Free choice vouchers		Net	*REPEALED BY CONGRESS*			
10. Shared responsibility "free rider surcharge"		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
11. Medicaid Expansion and migration into Exchange		Net	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*			
12. Individual Mandate with federal subsidies	Jan 2014					
Opt-Outs [3]		R	-	10.01	27.16	34.30
Agency and Universities OPS [4][5][6]		R	-	27.01	46.30	46.30
Opt-Outs [3]		E	-	8.31	26.98	39.22
Agency and Universities OPS [4][5][6]		E	-	28.67	62.04	67.62
		Net	**-**	**0.04**	**(15.56)**	**(26.24)**
TOTAL REVENUES [7]			0.00	37.02	73.46	80.60
TOTAL EXPENSES			0.38	59.79	137.27	155.09
NET TOTAL [8]			**(0.38)**	**(22.77)**	**(63.81)**	**(74.49)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)
(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	Estimated Annual Fiscal Impact FY 2012-13 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2012-13 Total
1. Early retiree medical reinsurance		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
2. No lifetime dollar maximum	Jan 2011	Net	*ALREADY EMBEDDED*								
3. Restricted annual dollar limits		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	Net	*ALREADY EMBEDDED*								
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	0.18	-	0.20	0.38	0.38
		Net	-	-	-	-	(0.18)	-	(0.20)	(0.38)	(0.38)
6. Other pass-through fees include:											
Pharmaceutical industry fees	Jan 2011	R	*IMPACT WILL NOT OCCUR UNTIL 2013-14*								
2.3% excise tax on medical devices	Jan 2013	E									
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	Net									
7. Extension of coverage for all adult children until age 26	Jan 2011	Net	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	*IMPACT WILL NOT OCCUR UNTIL 2013-14*								
		E									
		Net									
9. Free choice vouchers		Net	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		Net	PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR								
12. Individual Mandate with federal subsidies	Jan 2014		*IMPACT WILL NOT OCCUR UNTIL 2013-14*								
Opt-Outs [3]		R									
Agency and Universities OPS [4][5][6]		R									
Opt-Outs [3]		E									
Agency and Universities OPS [4][5][6]		E									
		Net									
TOTAL REVENUES [7]			-	-	-	-	-	-	-	-	-
TOTAL EXPENSES			-	-	-	-	0.18	-	0.20	0.38	0.38
NET TOTAL [8]			-	-	-	-	(0.18)	-	(0.20)	(0.38)	(0.38)

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program											State of Florida DSGI

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	Estimated Annual Fiscal Impact FY 2013-14 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2013-14 Total
1. Early retiree medical reinsurance		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
2. No lifetime dollar maximum	Jan 2011	Net	*ALREADY EMBEDDED*								
3. Restricted annual dollar limits		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	Net	*ALREADY EMBEDDED*								
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	0.34	-	0.41	0.75	**0.75**
		Net	-	-	-	-	(0.34)	-	(0.41)	(0.75)	**(0.75)**
6. Other pass-through fees include:											
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-	-	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	E	-	-	-	-	7.25	1.87	11.29	20.41	**20.41**
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	Net	-	-	-	-	(7.25)	(1.87)	(11.29)	(20.41)	**(20.41)**
7. Extension of coverage for all adult children until age 26	Jan 2011	Net	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	0.69	0.21	1.13	2.03	**2.03**
		Net	-	-	-	-	(0.69)	(0.21)	(1.13)	(2.03)	**(2.03)**
9. Free choice vouchers		Net	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		Net	PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR								
12. Individual Mandate with federal subsidies	Jan 2014										
Opt-Outs [3]		R	-	-	-	-	-	-	-	10.01	**10.01**
Agency and Universities OPS [4][5][6]		R	-	-	-	-	-	-	-	27.01	**27.01**
Opt-Outs [3]		E	-	-	-	-	-	-	-	8.31	**8.31**
Agency and Universities OPS [4][5][6]		E	-	-	-	-	-	-	-	28.67	**28.67**
		Net	-	-	-	-	-	-	-	0.04	**0.04**
TOTAL REVENUES [7]			**-**	**-**	**-**	**-**	**-**	**-**	**-**	**37.02**	**37.02**
TOTAL EXPENSES			**-**	**-**	**-**	**-**	**8.10**	**2.08**	**12.63**	**59.79**	**59.79**
NET TOTAL [8]			**-**	**-**	**-**	**-**	**(8.10)**	**(2.08)**	**(12.63)**	**(22.77)**	**(22.77)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family covera ge if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Re venues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respectiv e fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other part icipating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insu rance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Sin gle OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the Decemb er 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimat ed 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and a re therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have covera ge from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenue s and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program | **State of Florida DSGI**

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	Estimated Annual Fiscal Impact FY 2014-15 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2014-15 Total
1. Early retiree medical reinsurance		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
2. No lifetime dollar maximum	Jan 2011	Net	*ALREADY EMBEDDED*								
3. Restricted annual dollar limits		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	Net	*ALREADY EMBEDDED*								
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	**-**
		E	-	-	-	-	0.33	-	0.42	0.75	**0.75**
		Net	-	-	-	-	(0.33)	-	(0.42)	(0.75)	**(0.75)**
6. Other pass-through fees include:											
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-	-	-	-	-	**-**
2.3% excise tax on medical devices	Jan 2013	E	7.38	1.90	11.49	20.77	7.83	2.02	12.20	22.05	**42.82**
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	Net	(7.38)	(1.90)	(11.49)	(20.77)	(7.83)	(2.02)	(12.20)	(22.05)	**(42.82)**
7. Extension of coverage for all adult children until age 26	Jan 2011	Net	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	**-**
		E	0.71	0.22	1.16	2.09	0.75	0.23	1.23	2.21	**4.30**
		Net	(0.71)	(0.22)	(1.16)	(2.09)	(0.75)	(0.23)	(1.23)	(2.21)	**(4.30)**
9. Free choice vouchers		Net	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		Net	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*								
12. Individual Mandate with federal subsidies	Jan 2014										
Opt-Outs [3]		R	-	-	-	13.58	-	-	-	13.58	**27.16**
Agency and Universities OPS [4][5][6]		R	-	-	-	23.15	-	-	-	23.15	**46.30**
Opt-Outs [3]		E	-	-	-	13.49	-	-	-	13.49	**26.98**
Agency and Universities OPS [4][5][6]		E	-	-	-	31.02	-	-	-	31.02	**62.04**
		Net	-	-	-	(7.78)	-	-	-	(7.78)	**(15.56)**
TOTAL REVENUES [7]			**-**	**-**	**-**	**36.73**	**-**	**-**	**-**	**36.73**	**73.46**
TOTAL EXPENSES			**8.09**	**2.12**	**12.65**	**67.37**	**9.09**	**2.25**	**14.05**	**69.90**	**137.27**
NET TOTAL [8]			**(8.09)**	**(2.12)**	**(12.65)**	**(30.64)**	**(9.09)**	**(2.25)**	**(14.05)**	**(33.17)**	**(63.81)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program							**State of Florida DSGI**				

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

			Estimated Annual Fiscal Impact FY 2015-16								
Reform	**Effective Date**	**Revenue(R) Expense (E) Net [1]**	**July-December**				**January-June**				**FY 2015-16**
			Medical	**Drugs**	**HMO**	**Total**	**Medical**	**Drugs**	**HMO**	**Total**	**Total**
1. Early retiree medical reinsurance		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
2. No lifetime dollar maximum	Jan 2011	**Net**	*ALREADY EMBEDDED*								
3. Restricted annual dollar limits		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	**Net**	*ALREADY EMBEDDED*								
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	**-**
		E	-	-	-	-	0.33	-	0.42	0.75	**0.75**
		Net	-	-	-	-	(0.33)	-	(0.42)	(0.75)	**(0.75)**
6. Other pass-through fees include:											
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-	-	-	-	-	**-**
2.3% excise tax on medical devices	Jan 2013	E	7.38	1.90	11.49	20.77	7.83	2.02	12.20	22.05	**42.82**
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	**Net**	(7.38)	(1.90)	(11.49)	(20.77)	(7.83)	(2.02)	(12.20)	(22.05)	**(42.82)**
7. Extension of coverage for all adult children until age 26	Jan 2011	**Net**	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	**-**
		E	0.71	0.22	1.16	2.09	0.75	0.23	1.23	2.21	**4.30**
		Net	(0.71)	(0.22)	(1.16)	(2.09)	(0.75)	(0.23)	(1.23)	(2.21)	**(4.30)**
9. Free choice vouchers		**Net**	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		**Net**	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*								
12. Individual Mandate with federal subsidies	Jan 2014										
Opt-Outs [3]		R	-	-	-	17.15	-	-	-	17.15	**34.30**
Agency and Universities OPS [4][5][6]		R	-	-	-	23.15	-	-	-	23.15	**46.30**
Opt-Outs [3]		E	-	-	-	19.61	-	-	-	19.61	**39.22**
Agency and Universities OPS [4][5][6]		E	-	-	-	33.81	-	-	-	33.81	**67.62**
		Net	-	-	-	(13.12)	-	-	-	(13.12)	**(26.24)**
TOTAL REVENUES [7]			**-**	**-**	**-**	**40.30**	**-**	**-**	**-**	**40.30**	**80.60**
TOTAL EXPENSES			**8.09**	**2.12**	**12.65**	**76.28**	**9.09**	**2.25**	**14.05**	**78.81**	**155.09**
NET TOTAL [8]			**(8.09)**	**(2.12)**	**(12.65)**	**(35.98)**	**(9.09)**	**(2.25)**	**(14.05)**	**(38.51)**	**(74.49)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

University OPS

University	Total Number of OPS employees averaging more than 30 hours per week	Number that are students with teaching or research assistantships	Number that currently have university-required health care	Number in faculty or teaching positions	Typical Administrative / Other	OPS Contractors	Other student assistants
FAMU	198	0	0	22	176		
FAU	426	0	0	154	272		
FGCU	17	2	0	0	15		
FIU	264	0	Unknown	24	123		
FSU	1400	44	47	54	1119		
NCF	19	0	0	0	19		
UCF	381	47	Unknown	53	263	18	
UF	2948	note below	note below	138	1026		
UNF	168	0	0	19	127		22
USF	1515	67	38	761	687		
UWF	129	5	0	53	71		
Total SUS	7,465	165	85	1,278	3,898	18	22

Informtion updated 12/7/2012 via SUS data request.

UF knows the number of students w/ teaching or reseasrch assistantships, but cannot provide GA's that meet the 30 hour rule, as they are appointed .25 FTE.
UF can provide total GA numbers: 4,459 GA appointments. Of this number, 3,913 are enrolled in the Gator Grad Care, which is the health plan offered to this group.
There are also 1,759 Clinical Post Docs, Postdoctoral Associates, and Residents appointed greater than 30 hours and enrolled in health insurance. They are included in the 2,948 reported above.

- Clinical post docs: 76
- Postdoctoral Associates: 578
- Residents/Housestaff : 1,105

NOTE: For purposes of projecting financial impacts of extending health coverage to State University OPS , the 1,759 University of Florida Clinical Post Docs, Postdoctoral Associates, and Residents noted above, and the 85 identified as having university-required health coverage, are not included in the projections. Additionally, 25% (320) of Faculty OPS and 15% (585) of Administrative OPS are assumed to have coverage from other sources and are also not included in the projections.

WENCESLAO TRONCOSO, JD

DEPUTY COMMISSIONER – LIFE & HEALTH
FLORIDA OFFICE OF INSURANCE REGULATION

Wences Troncoso is the Florida Office of Insurance Regulation's Deputy Commissioner for Life & Health. As the Deputy Insurance Commissioner for Life & Health, Wences oversees the daily activities of the Life & Health Product Review and Life & Health Financial Oversight Units. These units provide oversight and services to insurers operating in Florida including life and health form and rate filings, licensure, and financial solvency.

Prior to being appointed Deputy Commissioner, Wences served as a supervising attorney in the Legal Division of the Florida Office of Insurance Regulation. He oversaw the transfer of responsibility for public records dissemination (Chapter 119) to the Legal Division and remained in charge of those matters. He was also responsible for training Office staff to ensure timely and accurate responses to public records requests. In addition, he was involved with company licensing, product review, and health care reform issues, including supervision and oversight of insurer solvency.

Before joining the Office of Insurance Regulation, Wences served as a Public Defender with the 2nd Judicial Circuit for two years.

Wences received his Bachelor of Science degree in Political Science from Florida State University and his Juris Doctor degree from Barry University.

(850) 413-5104 Work
(850) 212-3178 Mobile
Wenceslao.Troncoso@floir.com

200 E. Gaines Street, Suite 121
Tallahassee, FL 32399-0326
www.floir.com

Patient Protection & Affordable Care Act (PPACA) Overview

Senate Select Committee on PPACA

February 18, 2013

Wences Troncoso
Life & Health Deputy Commissioner

FLORIDA OFFICE OF INSURANCE REGULATION

Office of Insurance Regulation (Office) Objectives - PPACA

- Reduce uncertainty to help maintain a stable market
- Allow companies to expedite product approval
- Promote off-exchange competition
- Maintain consumer protection / transparency

Life & Health Product Review

<u>Form Review - Florida is a Prior Approval State:</u>
For all policy forms (large group, small group and individual)

➢Determine compliance with Florida Statutes and Rules (e.g., policy contracts, enrollment forms, schedule of benefits)

<u>Rate Review - Florida is a Prior Approval State:</u>
For small group and individual policies

➢Actuarial reviews of rate filings to ensure compliance with Florida Statutes and Rules

<u>Examples of Rating Factors</u>:
Age
Gender
Smoking status
Geographic location

<u>Examples of Analysis Factors:</u>
Historical loss experience
Medical trend
Insurance trend
Risk changes

Florida Office of Insurance Regulation

Conflicts of Law

Issue	Florida	PPACA
Rating*		
Age Rating	Actuarially supportable --- ratio is typically 7:1	Limited to 3:1
Gender Rating	Actuarially supportable – male/female rates different	Unisex rating
Forms		
Rescission Language	Rescissions 2 years unless fraud	No Rescissions unless fraud or misrepresentation
Dependents to Age 30	Must be offered to age 30 with restrictions	Up to age 26 – no restrictions

Relevant Statutes and Rules: Section 627.410(6)(a)&(b); Rule 69O-149.005

Supplemental: Office of Insurance Regulation Review PPACA January 2013

Florida Office of Insurance Regulation

Forms – Decision Matrix

Approve

Form complies with all PPACA laws <u>and</u> Florida laws

Form complies with <u>only</u> Florida laws

Disapprove

Form complies with all PPACA laws, but <u>not</u> Florida laws

Rate Review

- The Office may be preempted on the 3:1 compression ratio
- Statutory Basis for Review
  - Premiums are reasonable in relation to benefits
  - Rates cannot be excessive, inadequate or unfairly discriminatory

**Relevant Statutes and Rules: Section 627.410(6)(a)&(b); Rule 69O-149.005*

FLORIDA OFFICE OF INSURANCE REGULATION

Long-Term Options:

1. Expand Florida law to incorporate PPACA

   - Revise current statutes and rules
   - Resolve resource issues for current filings, reinstate review
   - Potential to better reflect new federal rulemaking
   - Future funding for technology enhancements and staff

2. Retain Florida law / Memorandum of understanding w/ federal government

   - Greater certainty in market for insurers and consumers
   - Still some potential litigation issues
   - OIR resource issues

3. Retain Florida law / Rely on federal preemption

4. Permanent exemption of form and rate review

Florida Office of Insurance Regulation

Form Review Logistical Issues

Short timeline for exchange products

- March 28, 2013 – Companies may file products with Health & Human Services (HHS)
- May 1, 2013 – Companies submission deadline for products to be filed with HHS
- July 31, 2013 – HHS deadline for products to be approved

Filings Expected (March - July 2013)

Rate Review Logistical Issues

- New products without historical experience
  - New risk population
  - Uninsured
  - Pre-existing conditions
- Pent-up demand
- Federal risk redistribution programs

Short-Term Options:

1. Retain Florida law / Rely on federal preemption
   - Potential litigation issues
   - OIR resource issues

2. Short-term informational rate & form filing

3. Conforming legislation to retain form and rate review authority

Other Challenges: Filing Requirements

- Unique form & rate filing situation
  - 49 states use the System for Electronic Rate & Form Filing (SERFF) via the National Association of Insurance Commissioners (NAIC)
  - Florida uses the I-File System
- Public records issues
- State filing and Health Information Oversight System (HIOS) filings – Health and Human Services (HHS)
- Potential duplicate filing issue

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
1. *"Grandfathered" Insurance Products –* **Effective: Date of enactment -- (March 23, 2010)**	All coverage in place on the date of enactment. PPACA Sec. 1251	Updated by Health and Human Services (HHS): The update allows fully-insured group health plans to retain their grandfathered status if they replace existing coverage with a new policy, so long as the terms of the new policy do not violate any of the tests which would cause an existing plan to lose grandfathered status.	**FL Insurance Code** • Does not recognize "grandfathered" insurance plans for purposes of review or regulation	
2. Web portal to identify affordable coverage options **Effective: July 1, 2010**	Individual Small Group Plans PPACA Sec. 1103	**Note/NAIC** Carriers and state regulators required to file information with HHS to facilitate consumer shopping for health insurance products by state of residence	**FL Insurance Code** • No FL Insurance Code requirement to provide OIR with information filed by carriers for healthcare.gov website display.	***Health Insurance Oversight System (HIOS):*** • Generally, it is unclear if FL OIR has unrestricted access to all information filed through the HIOS system by carriers authorized to transact insurance in FL – which includes plan details, rates, etc. • Confidentiality is preserved at federal level. A Memorandum of Understanding (MOU) between the National Association of Insurance Commissioners (NAIC) and HHS for data access from the HIOS site, does not extend to the States. • In Florida, should an MOU be proposed, there may be additional consideration needed with respect to the application of the State's open records laws and resulting public records requests.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
3. **Temporary high risk pool program** **Effective: 90 days after enactment** ***Floridians eligible for PCIP effective August 1, 2010***	PPACA Sec. 1101	HHS has established a temporary high risk health insurance pool program. $5 billion allocated to fund pools through 2013. The Federal Pre-Existing Condition Insurance Plan (PCIP) program is designed to sunset by 2015 10,109 Floridians are enrolled in PCIP as of January 2013. In 2014, Floridians enrolled in the Federal PCIP program will be eligible for individual policies offered through a Florida Exchange or for an individual qualified health plan (QHP) offered in the individual market	**FL Insurance Code** In 1982, at s. 627.648 - s.627-6498, Florida created a high risk pool – the Florida Comprehensive Health Association (FCHA). The Association has been closed to new entrants since 1992.	• FL current high risk pool closed since 1992 (FCHA –s. 627.648-s. 627.6498) Note: 1. In 2006, legislation created the Florida Health Insurance Plan (FHP) in s.627.64872, et.seq. designed to redesign a high risk pool for Floridians. However that plan was not made operational. 2. At present, there are still policyholders covered under the terms and conditions of the original high risk pool – the FCHA. It is unclear if the FCHA would be considered a "grandfathered" plan for purposes of PPACA compliance.

Effective for Plan Years beginning on or after September 23, 2010

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
4. Preexisting condition exclusions (Children)	All plans except grandfathered individual market plans PPACA Sec. 1201 & 10103(e) /PHSA 2704	A plan may not impose any preexisting condition exclusions for **children under age 1**9.	**FL Insurance Code** s. 627.6045, 627.6561, and 641.31(16)	Carriers offering “child only” health policies ceased new writing in 2010;
5. Rescissions	All plans PPACA Sec. 1001 /PHSA 2712	Coverage may be rescinded only for fraud or intentional misrepresentation of material fact as prohibited by the terms of the coverage. Notification must be made to policyholders prior to cancellation (30 days).	**FL Insurance Code** Generally, s. 626.9541(1)(g)3. -- unfair discrimination s.627.607 allows rescission up to 2 years. After 2 years only for fraud	In addition – HHS Regulation calls for 30 day notice for cancellation – FL requires 45/10 day notice periods for non-payment of premium cancellation at s. 627.6043
6. Annual Limits	Annual limits: All plans except grandfathered individual market plans PPACA Sec. 1001/ PHSA 2711	No annual limits for essential health benefits. • Annual limits on essential benefits are limited to $2 million for plan years beginning 9/23/2012-12/31/2013	**FL Insurance Code** No FL law specifies annual policy limits for a comprehensive health insurance policy or regulated health plan.	In FL law, there are annual limits set for some mandated benefits and/or mandated offers of coverage: Examples include: • **Autism** -- $36,000 per year (s. 627.6686 and s.641.31098) • **Home health services**, no less than $1,000 per year (s. 627.6617): • **Substance abuse** – maximum of 44 outpatient visits at a max of $35/per outpatient visit (s.627.669)

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
7. Lifetime Limits	Lifetime limits: All plans PPACA Sec. 1001/ PHSA 2711	• Plans may not establish lifetime limits *on the dollar value of essential benefits.* • Plans may only establish restricted limits prior to January 1, 2014 on essential benefits as determined by the Secretary of HHS (Waiver program for carriers, employers to seek waivers for "mini-med" plans was made operational in 2010)	**FL Insurance Code** Current law/rules are silent regarding allowable annual or lifetime dollar limits.	Florida law on autism benefit does establish annual and lifetime limits: -- annual dollar limit in current FL law for autism benefits ($200,000 lifetime) may be pre-empted if autism treatments are considered an essential medical/mental health benefit o This $200,000 limit is indexed to the medical component of the consumer price index • Current law does not define essential benefits
8. Coverage of preventive health services As of August 1, 2012 – List of Preventive Services exempt from cost-sharing requirements http://www.healthcare.gov/news/factsheets/2010/07/preventive-services-list.html	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2713	Plans must provide coverage without cost-sharing for specified preventive services, screenings, and immunizations. Plans that have a network of providers may impose cost-sharing for preventive items and services delivered by out-of-network providers. • Using reasonable medical management, plans may determine frequency, timing, method, treatment or setting of services to the extent not specified by HHS. • A plan may impose cost-sharing for a treatment not described in the regulations, even if that treatment results from an item or service that is a covered preventive service.	**FL Insurance Code** Current law/rules are generally silent regarding what constitutes a "preventive" service or limits/prohibitions on cost-sharing for such benefits	There are certain provisions within the Insurance Code that would need to be amended to align with HHS Rules. Some examples: **Autism** -- behavior assessments (627.6686 and /641.31098) Child has to be diagnosed as having a developmental disability at 8 years of age or younger (HHS Regulation: up to age 17) **Child Health Supervision** s. 627.6416, 627.6579; 641.31(30). -- (Immunizations, hearing, vision testing, etc.) in compliance with standards of *American Academy of Pediatrics* – (HHS: Preventive care and services ...supported by the *Health Resources and Services Administration (HERSA*) **Mammograms** –baseline, frequency by age groups (s.627.6418, 627.6613, 641.31095) ***Well-woman"*** care– s.627.6472(18), 627.662(9), 641.51(11), et.al. **Osteoporosis** Diagnosis—627.6409, 627.6691, 641.31(27)

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
9. Extension of adult dependent coverage	All plans PPACA Sec. 1001 HR 4872 §2301 /PHSA 2714	Plans that provide dependent coverage must make coverage available to adult children up to age 26. • Carriers are not required to cover children of adult dependents. • For plan years beginning before 2014, group health plans will be required to cover adult children only if the adult child is not eligible for employer-sponsored coverage.	**FL Insurance Code** At s.627.6562(1) the statute defining dependent coverage, FL law requires coverage up to the end of the calendar year in which the child reaches age 25 but with restrictions (must be unmarried without dependents of his/her own and must be resident or full-or part-time student, and is not eligible for other coverage;	• For up to age 26, federal law is less restrictive than FL law and thus may preempt FL law restrictions applicable to dependents under age 26. • At ss.627.602(c), 627.6562, 641.31(41): Under these same restrictions, coverage must be *offered* up to age 30. o Thus, FL would appear able to enforce its restrictions on the offer of coverage from age 26-30.
10. Provision of additional information	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2715A	All plans must submit to the Secretary and State insurance commissioner and make available to the public the following information in plain language: • Claims payment policies and practices • Periodic financial disclosures • Data on enrollment • Data on disenrollment • Data on the number of claims that are denied • Data on rating practices • Information on cost-sharing and payments with respect to out-of-network coverage Other information as determined appropriate by the Secretary	**FL Insurance Code** There is no provision in FL Insurance Code to require disclosure of all of these items in a “single location” posting and/or disclosure document.	

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
11. Appeals process – Internal and External Review Standards	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2719	**Internal claims appeal process:** • Group plans must incorporate the US Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. • Individual plans must incorporate applicable law requirements and update them to reflect standards established by the Secretary of HHS. **External review**: • All plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Model Act	**FL Insurance Code**	In 2012, in SB 730, by amendment to s. 627.602 and by creation of s. 627.6513, required FL policies to comply with 29 CFR s. 2560.503-1 relating to internal grievances. • However, 29 CFR 2560. 503-1 governs only claims handling of adverse result claims. This specific Federal Regulation does NOT contain the requirements or standards for internal (or external) claims review. It is 29 CFR 2590.715-2719 that actually sets forth the standards for internal (and external) review programs. • Further, the SB 730 amendments did not speak to incorporation of external review requirements for health insurance plans governed under Ch. 627 (indemnity plans). SB 730 did permit the OIR to promulgate rules to adopt the NAIC Model regulation OIR is currently drafting the HMO rule to adopt NAIC Model Act and Regulations for External Review to be made applicable to HMOs governed under the provisions of Ch. 641
12. Patient Protections Emergency Services	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2719A	Emergency services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing.	**FL Insurance Code** FL law makes HMO emergency services coverage subject to similar standards at s. 641.513(3) and 641.31(2) governing HMOs.	FL law does not contain standards of emergency care coverage for health insurance plans governed by Ch. 627. Florida law governing emergency service coverage for HMOs would need to be aligned with HHS Rules and similar requirements would need to be amended into Ch. 627, to govern health insurance plans.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
13. Patient Protections **Primary Care Provider** **Access to OB-GYN services**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2719A	**Primary Care Provider** A plan that provides for designation of a primary care provider must allow the choice of any participating primary care provider who is available to accept them, including pediatricians. **Access to OB-GYN services** A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.	**FL Insurance Code** *Primary Care Providers* FL law makes a requirement for primary care physicians for HMOs at 641.19(13)(e). *Access to OB-GYN Services* s. 641.19(13)(e): Requires HMOs, small group HMOs to permit a female subscriber to select an OB-GYN as her primary care provider – thus no referral authorization would be required.	**Primary Care Provider** -- FL law does make the primary care physician requirement applicable to individual, large group, or small group indemnity plans governed under Ch. 627 **Access to OB-GYN Services** -- FL law does not make the access to OB-GYN services requirement applicable to individual, large group, or small group indemnity plans governed under Ch. 627

Effective January 1, 2011

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
14. Medical Loss Ratios (MLR)	All fully insured plans, including grandfathered plans PPACA Sec. 1001 /PHSA 2718	Carriers must report to HHS the ratio of incurred losses (incurred claims) plus loss adjustment expense (change in contract reserves) to earned premiums.	**FL Insurance Code** There is no current statutory authority to implement new MLR requirements or to govern insurer compliance with required notices related to rebate determinations.	**MLR** Insurers must provide a rebate to consumers if the percentage of premiums expended for clinical services and activities that improve health care quality is less than 85% in the large group market and 80% in the small group and individual markets.

Rate increase in excess of 10% filed on or after July 1, 2010

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
15. Rate Review **A rate increase in excess of 10% for increases filed on or after July 1, 2011**	All non-grandfathered fully-insured plans PPACA Sec. 1003 /PHSA 2794	Rates subject to review. A rate increase in excess of 10% for increases filed on or after July 1, 2011. If a state reviews the increase, HHS will adopt the state's determination and will post the state's final determination on its website. If the issuer implements an unreasonable increase, it must submit a final justification to HHS and prominently post the information on the company web site for at least 3 years.	**FL Insurance Code** • FL has been determined by HHS to have an effective rate review program for individual and small group policies. • HHS has determined FL does NOT have an effective rate review program for association policies (rates for out of state associations are not subject to OIR rate approval (s. 627.410(1));	FL does NOT approve rates for large group policies with 51 or more persons per s. 627.410(6)(a). In making a determination that a state has an effective rate review system, HHS requires a state to maintain on its website a user-friendly program to permit consumer review of proposed rate changes and to file comments prior to final state action. The OIR has implemented access to rate filings, and continues to make information more complete and more user friendly – although additional resources for technology upgrades would facilitate making additional changes.

Effective January 1, 2012

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes	
16. Accountable Care Organizations (ACOs)	**(Effective January 1, 2012 for Medicare only contracts only)**	ACOs are authorized to participate as health plans offering coverage through an Insurance Exchange.	**FL Insurance Code** Currently, there are no FL insurance solvency or benefit laws that would apply to this new risk-bearing entity.	ACOs are authorized for participation in the State's Medicaid Managed Care legislation enacted in 2011.

Effective Within two (2) years – September 23, 2012

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code Status/ Florida Notes	
17. Uniform explanation of coverage documents and standardized definitions	All plans PPACA Sec. 1001 /PHSA 2715	The Secretary must develop standards for a summary of benefits and coverage (SBC) explanation to be provided to all potential policyholders and enrollees. The SBC must be made available in a culturally and linguistically appropriate manner. HHS issued its Final Regulation in February 2012 (45 CFR Part 147).	**FL Insurance Code** At s. 641.31(1) and (4) HMOs are required to provide disclosures including a member handbook. At s. 624.308, 627.642, 627.643 and 69O-154.107 FAC (Individual) there are some standards for outlines of coverage.	FL laws governing disclosures, a summary of benefits and coverage (SBC) and illustrative materials would need to be amended/created to align with the HHS Final Rule.
18. Ensuring quality of care **Effective: 2 years after enactment**	All non-grandfathered plans PPACA Sec. 1001 /PHSA 2717	Plans must submit annual reports to the Secretary of HHS on whether the benefits under the plan improve health outcomes.	**FL Insurance Code** Current annual reporting requirements for health and accident insurance are at s. 627.9175.	Current FL law does not require regulated health plans to provide a report on health outcomes,

Effective in 2013

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
19. Administrative simplification requirements **Rules adopted by July 1, 2011 to become effective by January 1, 2013.**	PPACA Sec. 1104 /SSA 1171	The new law will institute a series of changes to standardize billing and requires health plans to begin adopting and implementing rules for the secure, confidential, electronic exchange of health information HHS Interim Final Rule issued January 10, 2012.	**FL Insurance Code** At s. 627.611, s. 627.647, s. 627.6132 – FL law governs claim forms. At s.627.6132 -- payment of claims, the law requires use of specific Health Care Financing Administration (HCFA) claim form (or its successor form).	It is unknown if requirements regarding the standards of claims information and/or standardized billing requirements would require amendments to the Florida Insurance Code.
20. Co-Op Plans – Consumer Owned and Operated (Health Plans)	PPACA Sec. 1322	**UPDATE: 01/2013:** HHS has discontinued the Co-Op funding program. No Co-Op proposals were received by the FL OIR.	**FL Insurance Code**	As outlined in PPACA , a Co-Op entity in this State, as a risk-bearing entity, would be regulated by the OIR – and preliminary review suggested a Co-Op would be determined to be a form "mutual insurance company" for purposes of solvency regulation.

Effective Plan Year January 1, 2014

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
21. Pre-existing condition exclusions	All plans except grandfathered individual market plans PPACA Sec. 1201 /PHSA 2704	A plan may not impose any pre-existing condition exclusions.	**FL Insurance Code** There are a number of FL statutes (and rules) related to coverage of pre-existing conditions: 627.6045; 627.6561; and 641.3107 -- Preexisting condition; Related statutes: 627.64871; 641.31 (16) Health Maintenance contracts;641.185(h);	FL law currently permits waiting periods before pre-existing conditions are covered. Federal law would appear to prevent the imposition of such waiting periods. Rules (partial list) adopted pursuant to current statutes governing pre-existing condition coverage requirements**:** 69O-154.105(5) Standards for Policy Provisions- Pre-existing conditions; 69O-154.110. Certificate of Creditable Coverage.; 69O-154.111. Demonstration of Creditable Coverage
22. Fair health insurance premiums	Non-grandfathered fully-insured small group and individual plans. Fully insured large group plans in states that allow them to purchase through the Exchange. /PHSA 2701	Premiums may only vary by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family November 26, 2012 HHS Published Proposed Rule 45 CFR Parts 144, 147, 150, 154, and 156 – governing fair health insurance premiums, guaranteed availability and renewability; risk pools and catastrophic plans.	**FL Insurance Code** s. 627.411 --- Grounds for policy form and rate disapproval ... At (f)(1) a health insurance policy form (and rate) may be disapproved if the policy ... “Provides benefits that are unreasonable in relation to the premium charged”	The statutory standard – that the policy provides benefits that are [not] unreasonable in relation to premium charge – is supported by a set of OIR rules governing rate filings. Certain of these rules now conflict with the PPACA requirement that rate factors may only be developed using the four factors – age, tobacco, geographic rating area, and individual vs. family composition. In addition, under PPACA, rates may not vary by gender – a change from current FL regulatory standard that permits gender rating. Principal FL rules containing references to rate filing requirements are 69O-149.0025; 149.003; 149.005; 149.006; 149.007

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
23. Guaranteed availability of coverage	Non-grandfathered fully-insured plans. /PHSA 2702	Insurers must accept every employer and every individual that applies for coverage except : an insurer may restrict enrollment based upon open or special enrollment periods. November 26, 2012 HHS Published Proposed Rule 45 CFR Parts 144, 147, 150, 154, and 156 – governing fair health insurance premiums, guaranteed availability and renewability; risk pools and catastrophic plans	**FL Insurance Code** At s. 627.6699(5), current FL law requires guarantee issue products in the small group market (including groups of one).	FL does not require guarantee issue in the individual market unless the individual is Health Insurance Portability and Accountability Act (HIPAA) eligible – i.e., has exhausted the 18 month policy term of a Consolidated Ominbus Budget Reconciliation Act (COBRA) or (state COBRA) policy. See s.627.6425 Renewability of individual coverage
24. Guaranteed renewability of coverage	All non-grandfathered fully-insured plans. /PHSA 2703	Insurers must renew coverage or continue it in force at the option of the plan sponsor or the individual. November 26, 2012 HHS Published Proposed Rule 45 CFR Parts 144, 147, 150, 154, and 156 – governing fair health insurance premiums, guaranteed availability and renewability; risk pools and catastrophic plans	**FL Insurance Code** FL Insurance Code currently provides for guarantee renewable health insurance policies and HMO contracts. • See Statutes: s.627.6425 Individual; s. 627.6571 Group; s.641.31074 Group HMOs	

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
25. Prohibiting discrimination against individual participants and beneficiaries based on health status	All non-grandfathered plans /PHSA 2705	A plan may not establish rules for eligibility based on any of the following health status-related factors: Health status; Medical condition; Claims experience; Receipt of health care; Medical history; Generic information; Evidence of insurability (including conditions arising out of domestic violence); Disability; Any other health-status related factor deemed appropriate by the Secretary .	**FL Insurance Code** Current FL law prohibits unfair discrimination – see s. 626.9541 (1)(g)3.	November 26, 2012 HHS Published Proposed Rule 45 CFR Parts 144, 147, 150, 154, and 156 – governing fair health insurance premiums, guaranteed availability and renewability; risk pools and catastrophic plans Florida law and rules would need to be amended to align with HHS Rule.
26. Non-discrimination in health care	All non-grandfathered plans /PHSA 2706	Plans may not discriminate against any provider operating within their scope of practice. Does NOT require that a plan contract with any willing provider or prevent tiered networks. Plans may not discriminate against individuals or employers based upon whether they receive subsidies, provide information to state or federal investigators, etc.	**FL Insurance Code** At s. 627.419 and s. 641.19(12) and related statutes, FL law provides for provider participation based on scope of license related to benefits provided in the health plan.	The FL Insurance Code does not currently contain anti-discrimination provisions related to receipt of subsidies (available only through an exchange) or whether a person has provided information to a federal investigator
27. Prohibition on Excessive Waiting Periods	All group plans /PHSA 2708	Group health plans and group health insurance may not impose waiting periods that exceed 90 days.	**FL Insurance Code** At s. 627.6561(1)(c) waiting period is defined, but does not specify a time period restriction.	Current statutes do not contain waiting period restrictions applicable to group insurance policies

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
28. Wellness Programs	Non-grandfathered individual market plans /PHSA 2705	Health promotion and disease prevention programs that base the conditions for obtaining a premium discount or any other reward upon a health status-related factor *must limit such rewards to 30% of the cost of coverage.* The Secretaries of HHS, Labor and Treasury may increase the cap on rewards up to 50% if deemed appropriate. *Existing wellness programs established before March 23, 2010, may continue to be carried out.*	**FL Insurance Code** At s.627.6402, FL authorizes insurance rebates for healthy lifestyles *and places a 10% cap of paid premium*. At s. 626.9541(4) – under the Unfair Trade Practice Act – there are additional standards for wellness incentive program participation.	
29. Coverage for individuals participating in approved clinical trials	All non-grandfathered plans /PHSA 2709	A plan may not deny an individual participation in an approved clinical trial for cancer or a life-threatening disease or condition, may not deny or limit the coverage of routine patient costs for items and services provided in connection with the trial, and may not discriminate against participants in a clinical trial.	**FL Insurance Code** Does not currently contain provisions governing participation in clinical trials.	
30. Rating reforms must apply uniformly	PPACA Sec. 1252	Any standard or requirement adopted by a State pursuant to, or related to, Title I must be applied uniformly to all health plans in each market to which the standards or requirements apply.	**FL Insurance Code** There are no FL statutes that would require uniform application of standards or requirements of Title I of PPACA legislation.	

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
31. (*Essential Health Benefits)* Comprehensive health insurance coverage	All non-grandfathered plans /PHSA 2707	All plans must include the essential benefits package required of plans sold in the Exchanges. All plans must comply with limitations on annual cost-sharing for plans sold in the Exchanges. (See §§ 1302(a) and (c).) If a carrier offers coverage in one of the tiers of coverage specified for the Exchanges, they must also offer that coverage as a plan open only to children under age 21.	**FL Insurance Code** At s. 641.19(4) there is a definition of “comprehensive medical services” for purposes of defining a “comprehensive” medical services HMO contract. There is no corresponding definition in Ch. 627 to define a “comprehensive” or “major medical” health insurance (indemnity) policy. At OIR Rule O69-154.106(5) there are a set of requirements governing the review/approval of a “major medical” plan.	HHS has published a series of guidance documents related to essential health benefits. The set of essential health benefits will vary from state to state depending on that state’s choice or (by default) HHS determination.
32. Insurance Exchanges	PPACA Sections 1301-1321	States or Federal Government required to establish Insurance Exchanges in every state – to become operational for plan years beginning January 1, 2014.	**FL Insurance Code** Florida Insurance Code would need amendment to clarify the OIR’s regulatory role for contracts and rates associated with a Federally Facilitated or Federal Partnership Exchange model.	
33. Level Playing Field/Multi-State Plans	PPACA Sec. 1324	Health insurance plans shall not be subject to a set of requirements unless Co-Op plans and multi-state plans are also subject to them.	**FL Insurance Code** There are no current statutory standards for review of a multi-state plan.	The Federal Office of Personnel Management (OPM) HHS published a proposed Rule, 45 CFR Part 800 on November 30, 2012 to establish the Multi-State Plan Program for Insurance Exchanges.

Item/Effective Date	Applicability PPACA /US Code Sec	Brief Explanatory Notes	FL Insurance Code	Florida Notes
34. Transitional reinsurance program for individual market in each state	**Effective: Plan years beginning in 2014 through 2016** PPACA Sec. 1341	All plans must pay assessments. Non-grandfathered individual plans may receive payments. States shall enact a model regulation established by the Secretary, in consultation with the NAIC that will enable them to establish a temporary reinsurance program for plan years beginning in 2014-2016.	**FL Insurance Code** If a state does not elect to establish a reinsurance program, the program will be administered by the HHS.	The reinsurance standards applicable to this program will govern the re-integration of the PCIP population back into the regulated health plan market – inside and outside an exchange program HHS published its proposed regulation 45 CFR Parts 153,155, 2156, 157 and 158 on December 12, 2012.
35. Risk adjustment	Non-grandfathered individual and small group plans PPACA Sec. 1343	Each state shall assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees have an actuarial risk that is greater than the average arial risk in that state.	**FL Insurance Code** There is no statutory authority for the OIR to administer a risk adjustment program for issuers with a Certificate of Authority (COA) in FL.	The risk adjustment program will be applicable to the regulated health plan market – inside and outside an exchange program. HHS published its proposed regulation 45 CFR Parts 153,155, 2156, 157 and 158 on December 12, 2012
36. Establishment of risk corridors for plans in individual and small group markets	Qualified health plans; Non-grandfathered individual and small group plans PPACA Sec. 1342 1343	**Effective: for Calendar years 2014-2016** Plans will receive payments if the ratio of non-administrative costs, less risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.	**FL Insurance Code** To be administered by HHS for products offered through Insurance Exchanges.	HHS published its proposed regulation 45 CFR Parts 153,155, 2156, 157 and 158 on December 12, 2012

Summary of Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act (PPACA)

Adopted December 12, 2012

- Signed into law on March 23, 2010
- Effective January 1, 2011 - no separate impact – already embedded in expenses to trust fund
    - No lifetime maximums
    - Restricted annual dollar limits
    - Elimination of preexisting conditions for under age 19
    - Extension of coverage to all adult children until age 26
- Effective October 1, 2012
    - Patient centered outcome research fees – $1 per participant for first year and $2 per participant for each year thereafter until 2019 – will be adjusted for variations in enrollment
    - Plan year 2012 - $375,000 – payable July 2013
    - Plan years 2013-2019 – $750,000
- Effective January 1, 2013
    - Women's Preventive Health Services – additional services required to be provided with no copay
        - Select contraceptive methods and counseling, HPV testing, breastfeeding counseling and gestational screenings in pregnant women – indeterminate cost
        - Available contraceptive methods – indeterminate cost
- Effective January 1, 2014
    - Offer affordable coverage to employees who work an average of 30 hours per week or more or face potential penalties (estimated penalty if coverage is not offered is $318M).
        - Total state costs are comprised of the employer premiums and claims expense projections.
        - Opt-out projections based on current opt-out population and assumptions of new enrollees to the program.

(in millions)

Individual Mandate with Federal Subsidies	2013-14	2014-15	2015-16
Opt-Outs Employer Premiums	8.76	23.78	30.04
Opt-Outs Employee Premiums	1.24	3.38	4.27
Opt-Outs Claims Expense Projections	8.31	26.98	39.22
OPS Employer Premiums	24.03	41.19	41.19
OPS Employee Premiums	2.98	5.11	5.11
OPS Claims Expense Projections	28.67	62.04	67.63
Total Revenues to Trust Fund	**37.02**	**73.46**	**80.61**
Total Claims Expense to Trust Fund	**36.99**	**89.02**	**106.84**
Net Gain/Loss to Trust Fund	**0.04**	**(15.56)**	**(26.24)**

-
    - Eliminate preexisting condition limitation for all plan participants
        - $2.03M for FY 2013-14
        - $4.3M for FY 2014-15 and FY 2015-16
    - Brand name pharmacy fees,[1] excise tax on durable medical devices, and reinsurance fees (based on a per member per month (PMPM) calculation to be adjusted for variations in enrollment)[2]
        - $20.41M for FY 2013-14
        - $42.82M for FY 2014-15 and FY 2015-16
- **Total PPACA impacts from December 2012 Estimating Conference:**

(in millions)

Total Trust Fund Impacts	2012-13	2013-14	2014-15	2015-16
Revenues		37.02	73.46	80.60
Expenses	0.38	59.79	137.27	155.09
Net Impact	**(0.38)**	**(22.77)**	**(63.81)**	**(74.49)**

[1] Effective January 2011.

[2] Projections adopted in the December 2012 Estimating Conference combined pharmacy fees, durable medical device excise taxes, and reinsurances fees. **The -projections for the February 28, 2013 Estimating Conference are $5.1M for FY 2012-13, $15.6M for FY 2013-14, $22.4M for FY 2014-15, and $16.8M for FY 2015-16.**

State Employees' Group Health Self-Insurance Trust Fund
Summary of December 12, 2012 Report on the Financial Outlook

The following estimates were adopted by the Self-Insurance Estimating Conference on December 12, 2012. The financial estimates are in millions.

CASH POSITION OF THE TRUST FUND

	Beginning cash balance:	**Ending cash balance:**
FY 2012-13	$313.9	$256.7
FY 2013-14	$256.7	$171.9
FY 2014-15	$171.9	($90.8)
FY 2015-16	$0.0*	($468.0)

*negative ending balance from prior year not carried forward.

EXPENSE INFORMATION**

	Medical claims premium expense:	**Pharmacy claims payments expense:**	**Fully-Insured expense:**
FY 2012-13	$1,157.0	$430.2	$260.9
FY 2013-14	$1,258.1	$456.5	$282.9
FY 2014-15	$1,373.5	$482.4	$314.4
FY 2015-16	$1,501.7	$527.6	$349.8

** Actual costs of Federal Patient Protection and Affordable Care Act (PPACA) mandates implemented in 2011 and 2012 are embedded in medical and pharmacy expenses; as a result, specific costs cannot be separately identified.

	Annual Operating Loss Projection:
FY 2012-13	($57.2)
FY 2013-14	($84.8)
FY 2014-15	($262.7)
FY 2015-16	($468.0)

	Projected Enrollment:
FY 2012-13	170,100
FY 2013-14	169,869
FY 2014-15	170,325
FY 2015-16	171,018

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR CHRISTOPHER L. SMITH
Democratic Leader
31st District

COMMITTEES:
Criminal Justice, *Vice Chair*
Rules, *Vice Chair*
Appropriations
Appropriations Subcommittee on Criminal and Civil Justice
Appropriations Subcommittee on Health and Human Services
Communications, Energy, and Public Utilities
Community Affairs
Governmental Oversight and Accountability

SELECT COMMITTEE:
Select Committee on Patient Protection and Affordable Care Act

JOINT COMMITTEE:
Joint Legislative Budget Commission

February 13, 2013

The Honorable Joe Negron, Chair
Select Committee on Patient Protection Affordable Care Act
320 Knott Building
404 S Monroe Street
Tallahassee, FL 32399

Dear Chair Negron:

Please excuse me from the Select Committee on Patient Protection Affordable Care Act meeting on February 18, 2013. Due to the fact that I must attend a previously scheduled legislative update meeting with a group of constituents in the district. I have unfortunately had to reschedule this meeting previously on more than one occasion and their meeting calendar will not all me to do so again prior to the start of regular session. Because of limited flight availability, I will not be able to attend.

Thank you in advance for your consideration.

Sincerely,

Senator Christopher L. Smith
Senate Democratic Leader, District 30

Cc: Steve Burgess, Committee Staff Director
Theresa Frederick, Democratic Office Staff Director

REPLY TO:
☐ 1101 N.E. 40th Court, Suite 1, Oakland Park, Florida 33334 (954) 267-2114 FAX: (954) 267-2116
☐ 200 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5031

Senate's Website: *www.flsenate.gov*

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

THE FLORIDA SENATE

APPEARANCE RECORD

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

02/18/13
Meeting Date

Topic: PPACA / OIR regulatory authority

Bill Number: ______ *(if applicable)*

Name: Michael Garner

Amendment Barcode: ______ *(if applicable)*

Job Title: Pres + CEO

Address: 200 W. College Ave, Suite 104
Street

Tallahassee, FL 32301
City *State* *Zip*

Phone: 850-386-2904

E-mail: michael@fahp.net

Speaking: ☐ For ☐ Against ☑ Information

Representing: Florida Association of Health Plans

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)

2/18/13
Meeting Date

Topic PPACA

Bill Number ________ *(if applicable)*

Name Celeste Pullen

Amendment Barcode ________ *(if applicable)*

Job Title Chief of Finance, DSGI

Address 4050 Esplanade Way
Street

City *State* *Zip*

Phone 850-921-4530

E-mail Celeste.pullen@dms.myflorida.com

Speaking: ☐ For ☐ Against ☐ Information

Representing State Group Insurance

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)

2/18/13
Meeting Date

Topic: Federal Healthcare Reform

Bill Number: ______ *(if applicable)*

Name: Barbara Crosier

Amendment Barcode: ______ *(if applicable)*

Job Title: Director, Div. of State Group Ins

Address: 4050 Esplanade Way
Street

Tallahassee, FL 32399
City *State* *Zip*

Phone: 921-4658

E-mail: barbara.crosier@dms.myflorida.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)

2/18/13
Meeting Date

Topic OIR - PPACA - Regulator Bill Number ____________ *(if applicable)*

Name Wences Troncoso Amendment Barcode ____________ *(if applicable)*

Job Title Deputy Comm of Life & Health

Address 200 E Gaines Street Phone 850-413-5086
Street

Tallahassee, FL 32311 E-mail ____________
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing FL Office of Insurance Regulation

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)

CourtSmart Tag Report

Room: KN 412 **Case:** **Type:**
Caption: Senate Select Committee on Patient Protection and Affordable Care Act **Judge:**

Started: 2/18/2013 2:07:22 PM
Ends: 2/18/2013 3:39:06 PM **Length: 01:31:45**

2:07:35 PM	Opening Remarks
2:08:05 PM	Roll Call
2:09:13 PM	Amy Baker, Office of Economic and Demographic Research
2:17:58 PM	Senator Simmons w question
2:18:36 PM	Amy Baker to answer
2:18:41 PM	Senator Simmons w follow-up
2:19:34 PM	Amy Baker to answer
2:19:47 PM	Senator Simmons
2:22:03 PM	Amy Baker to answer
2:22:18 PM	Senator Sobel w question
2:22:33 PM	Amy Baker to answer
2:24:27 PM	Senator Sobel w follow-up
2:24:44 PM	Amy Baker to answer
2:25:51 PM	Senator Gibson w question
2:26:27 PM	Amy Baker to answer
2:27:07 PM	Senator Gibson w follow-up
2:27:27 PM	Amy Baker to answer
2:31:15 PM	Senator Soto w question
2:31:45 PM	Amy Baker to answer
2:32:21 PM	Senator Gibson w question
2:33:20 PM	Amy Baker to answer
2:34:56 PM	Senator Gibson w comment
2:35:05 PM	Amy Baker to continue
2:37:21 PM	Senator Gibson
2:37:51 PM	Amy Baker to answer
2:38:22 PM	Senator Gibson w follow-up
2:38:29 PM	Amy Baker to answer
2:38:53 PM	Senator Gibson w question
2:39:06 PM	Amy Baker to answer
2:39:38 PM	Senator Sobel w question
2:40:16 PM	Amy Baker to answer
2:40:37 PM	Senator Sobel w follow-up
2:40:48 PM	Amy Baker to answer
2:40:51 PM	Senator Sobel
2:40:54 PM	Amy Baker
2:41:00 PM	Senator Soto w question
2:41:42 PM	Senator Negron w comments
2:42:35 PM	Barbara Crosier, Director of State Group Health Insurance, Department of Management Services
2:50:16 PM	Senator Negron w introduction
2:50:32 PM	Senator Soto w question
2:51:09 PM	Barbara Crosier to answer
2:51:13 PM	Senator Negron w questions
2:51:21 PM	Barbara Crosier to answer
2:52:10 PM	Senator Negron w comments
2:52:49 PM	Senator Sobel w comments
2:53:34 PM	Senator Bean w comments
2:54:09 PM	Senator Simmons w comments
2:56:41 PM	Senator Soto w comments
2:57:43 PM	Senator Brandes w comments
2:58:13 PM	Senator Grimsley w comments
2:58:42 PM	Senator Gibson w comments and questions
3:00:19 PM	Senator Negron to answer

3:01:10 PM	Senator Sobel w comments
3:01:25 PM	Senator Negron w comments
3:02:33 PM	Senator ~~Legg w comments~~
3:03:22 PM	Senator Soto w comments
3:04:39 PM	Senator Negron
3:05:24 PM	Michael Garner, Pres & CEO, Florida Association of Health Plans
3:08:56 PM	Senator Simmons w question
3:09:45 PM	Michael Garner to answer
3:10:19 PM	Senator Simmons w follow-up
3:11:07 PM	Senator Negron to answer
3:11:29 PM	Senator Sobel w questions
3:11:54 PM	Michael Garner to answer
3:12:51 PM	Senator Sobel w follow-up
3:13:03 PM	Michael Garner to answer
3:13:08 PM	Senator Sobel w question
3:13:25 PM	Michael Garner to answer
3:14:31 PM	Senator Negron w comments
3:14:46 PM	Michael Garner to answer
3:14:59 PM	Senator Negron w questions
3:15:08 PM	Michael Garner to answer
3:15:12 PM	Senator Simmons w questions
3:16:17 PM	Michael Garner to answer
3:17:19 PM	Senator Simmons w follow-up
3:17:42 PM	Michael Garner to answer
3:17:47 PM	Senator Negron w comments
3:18:49 PM	Senator Gibson w question
3:19:00 PM	Senator Negron w answer and comments
3:19:50 PM	Wences Troncoso, Deputy Commissioner Life and Health, Office of Insurance Regulation
3:24:01 PM	Senator Sobel w comments
3:24:13 PM	Mr. Troncoso to continue
3:32:37 PM	Senator Soto w question
3:33:02 PM	Mr. Troncoso to answer
3:33:51 PM	Senator Soto w follow-up
3:34:08 PM	Mr. Troncoso to answer
3:34:18 PM	Senator Soto
3:34:39 PM	Mr. Troncoso to answer
3:34:57 PM	Senator Sobel w question
3:35:04 PM	Mr. Troncoso to answer
3:35:44 PM	Senator Sobel w follow-up
3:35:56 PM	Mr. Troncoso to answer
3:36:25 PM	Senator Sobel
3:36:28 PM	Mr. Troncoso
3:38:33 PM	Senator Negron w comments
3:38:44 PM	Meeting adjourned