

COMMITTEE MEETING EXPANDED AGENDA

**SELECT COMMITTEE ON PATIENT PROTECTION AND
AFFORDABLE CARE ACT**

**Senator Negron, Chair
Senator Sobel, Vice Chair**

MEETING DATE: Monday, March 4, 2013
TIME: 1:00 —3:00 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
	Public Testimony		
1	Discussion of Committee Recommendations		
	Other Related Meeting Documents		

Tab 1

INSURANCE REGULATION

Insurance Regulation

Key Components of Federal Law	<p>As of January, 2014, insurers are required to comply with new federal regulations on the scope of coverage and the methods used to set rates (premiums).</p> <ul style="list-style-type: none"> • Insurers are required to cover federally-defined essential health benefits: <ul style="list-style-type: none"> ○ <i>Ambulatory patient services, such as doctor's visits and outpatient services</i> ○ <i>Emergency services</i> ○ <i>Hospitalization</i> ○ <i>Maternity and newborn care</i> ○ <i>Mental health and substance use disorder services, including behavioral health treatment</i> ○ <i>Prescription drugs</i> ○ <i>Rehabilitative and habilitative services and devices</i> ○ <i>Laboratory services</i> ○ <i>Preventive and wellness services and chronic disease management</i> ○ <i>Pediatric services, including oral and vision care</i> • Insurers must limit age rating bands for adults to 3:1 meaning that older persons (who typically use more health services) can be charged no more than three times the rates charged to younger adults. Insurers may not use gender as a rating factor. • Insurers are required to offer coverage to all who apply (guaranteed issue) regardless of health status and may not exclude coverage for pre-existing conditions. <p>Other federal requirements impact the way insurers pool risks, the way premiums are set for small groups, and the geographic areas within which rates are evaluated. Final regulations are expected to be released by the end of February. States will have 30 days to provide additional information in support of any modifications in the federal standards.</p>
Background	<p><u>Short Term Issues</u></p> <p>Companies are expected to file PPACA-compliant products during March-July, 2013, leading to a substantial increase in the number of filings and policy questions for the Office of Insurance Regulation (OIR).</p> <p>Currently, Florida maintains a prior approval process for health insurance. Two types of review are required by state law and administrative rules.</p> <ul style="list-style-type: none"> • Forms are reviewed for products sold in the large and small group markets, and the individual market. • Rates are reviewed in the small group and individual markets. <p>Some state regulations are inconsistent with new federal requirements. Conflicts are found in the following areas:</p> <ul style="list-style-type: none"> • Mandated benefits; • Certain market behaviors (guaranteed issue); • Reporting requirements; and, • Certain rating practices (age and gender rating). <p>The conflicts related to rating practices are significant because OIR would normally not approve rates set in the manner required by PPACA. Florida requires that rates are “reasonable in relation to benefits”. This principle compels rates to be higher for subscribers who use more services (i.e., older persons and women), but such practices are limited or prohibited by PPACA.</p>

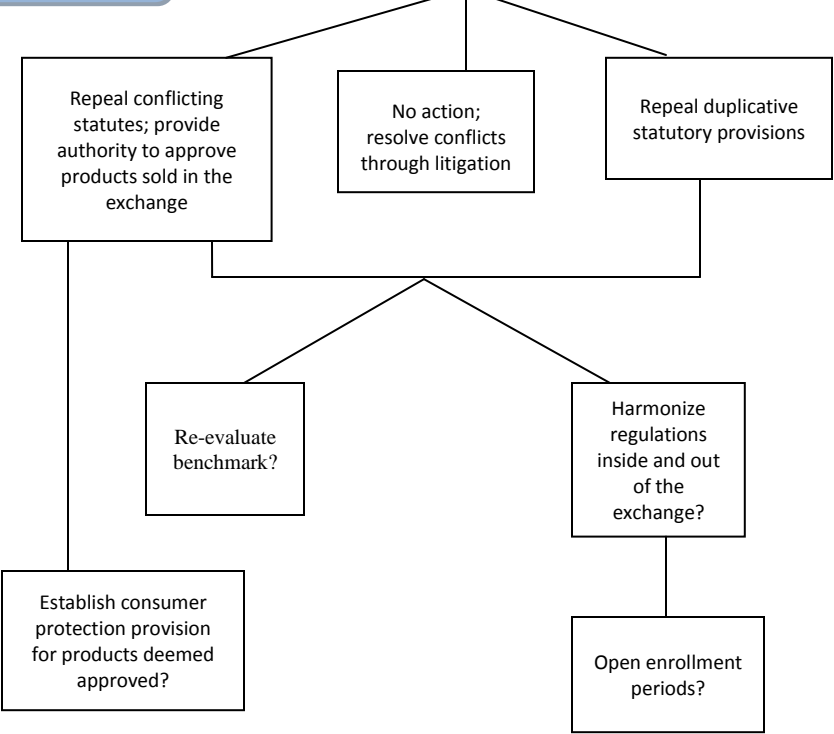
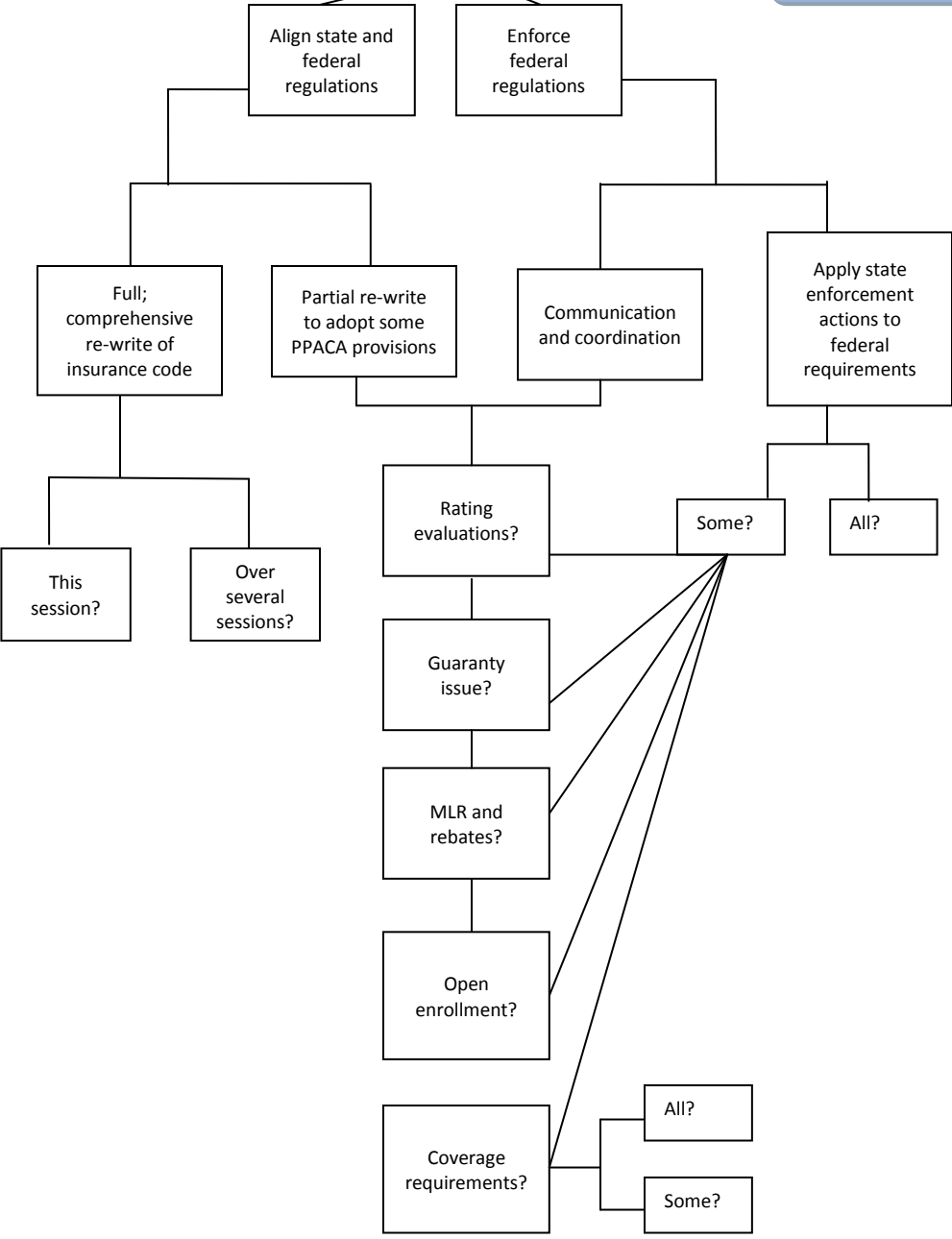
Insurance Regulation

<p>Background (continued)</p>	<p>New PPACA requirements also affect the historic basis that OIR relies upon to evaluate rates. For example, some services are not typically covered by individual and small group plans and little data is available to evaluate utilization trends. More debate surrounds the impact of <i>guaranty issue</i> on rates. Estimated increases range from 25-75%. Such uncertainty makes it more difficult for OIR to protect consumers from unreasonable rate increases, although the minimum loss ratios and rebate provisions of PPACA provide a remedy for overpricing. Consumers may also be at risk from companies that under-price these effects of the federal requirements.</p> <p><u>Long Term Issues</u></p> <p>A number of conforming changes—either general or specific—are needed to state laws. At present, OIR lacks direction regarding PPACA requirements. The federal government wants state assistance, but that assistance can vary from minimal involvement, to coordination and communication, or active enforcement. The federal government is allowed to enforce PPACA requirements on insurers if it determines that a state has failed to enforce a requirement.</p>
<p>State Options</p>	<ol style="list-style-type: none"> 1. Facilitate products moving to market in 2014 through OIR action: either emergency rulemaking or determination of preemption for certain statutes and regulations. 2. Maintain current review process by continuing OIR enforcement of Florida statutes and regulations until judicial determination of preemption. 3. Quick legislative action to resolve workload issues and regulatory conflicts during the next few months: <ol style="list-style-type: none"> a. Use either a narrow correction for specific conflicts or a general clarification of the state’s expectation that insurers comply with PPACA; b. Require insurers to certify compliance with state and federal law; c. Provide for new consumer protections to mitigate barriers to effective review. 4. Provide legislative direction for OIR’s role and responsibilities in relation to federal insurance regulation: <ol style="list-style-type: none"> a. Direct OIR to seek federal approval on specific issues such as rating areas; b. Permit OIR to assist HHS monitor compliance; c. Authorize OIR to enforce all or only some PPACA requirements. 5. Take legislative action to avoid market disruptions: <ol style="list-style-type: none"> a. Require the same open enrollment periods inside and outside the exchange; b. Conform the state’s definition of employee.
<p>Estimated Fiscal/ Economic Impact</p>	<ul style="list-style-type: none"> • Short-term fiscal impacts of increased workload may require additional trust fund spending authority for OIR. • Long-term fiscal impacts of giving OIR an active role in PPACA monitoring or enforcement indeterminate, but may qualify OIR to seek federal financial assistance; the amount and longevity of such assistance is unknown. • Economic impacts of no action to resolve conflicts between state and federal law could include significant disruption of the health insurance markets for individuals and small groups.
<p>Legislation Required</p>	<p>Options 3-5 require legislation; option 3 would require final action on a bill early in session.</p>

Insurance Regulation

Yes

No



DRAFT

February 25, 2013

The Florida Office of Insurance Regulation (the Office) has authority to enforce Florida law and rules, but does not have direct enforcement authority for federal law and regulations implementing the Affordable Care Act (ACA) and other federal laws. While the Department of Health and Human Services (HHS) is responsible for assuming direct enforcement in these circumstances, this letter serves as a means to accomplish our direct enforcement through a collaborative arrangement with the State of Florida.

It is important to both the Office and HHS that the elements of this collaborative arrangement be clearly described and delineated. Under this arrangement, the Office will perform the insurance compliance functions as specified below:

The Office will review insurance policy forms for compliance with Florida laws and rules. Further, during that review, the Office will review applicable policy forms for compliance with all federal laws and regulations. If the Office determines that an insurer's form filing is not in compliance with federal laws and regulations and is unable to obtain voluntary compliance, the Office will report potential violations of federal laws and regulations to HHS for appropriate formal enforcement action;

The Office will review insurance policy rates for compliance with all Florida laws and rules and review for compliance with all federal laws and regulations. If the Office determines that an insurer's rate filing is not in compliance with federal laws and regulations and is unable to obtain voluntary compliance, the Office will report potential violations of federal laws and regulations to HHS for appropriate formal enforcement action; and

The Office will perform market conduct examinations and investigations as warranted for compliance with all Florida laws and rules. During the examinations or investigations, the Office will review for compliance with federal laws and regulations. If the Office determines that an insurer's operations are not in compliance with federal laws and regulations, and is unable to obtain voluntary compliance, the Office will report potential violations to HHS for appropriate formal enforcement action.

This collaborative arrangement does not address, nor does it obligate the Office to perform consumer assistance functions on behalf of HHS. A separate agreement between HHS and the appropriate Florida consumer services agency will be necessary to address consumer assistance issues.

The collaborative arrangement outlined above will become effective March 1, 2013.

If the Florida Legislature adopts legislation giving the state direct enforcement authority for provisions consistent with the ACA and other federal laws, the Office will notify HHS of this development. Until then, this letter will document our collaborative arrangement.

Thank you for your cooperation.

Sincerely,

DRAFT

Provisions of PPACA Relating to Insurance Regulation/Current Florida Law

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
Guaranteed Availability of Coverage (1201)	Requires health insurers and HMOs to accept every individual and every employer that applies for coverage. However, plans may limit enrollment to specified open or special enrollment periods. Regulations allow plans to limit enrollment based on network adequacy or insufficient financial reserves, under certain conditions.	All plans, except grandfathered plans. (See last page for description of grandfathered plans.)	Plan years beginning on or after 01/01/14	<u>Individual</u> : Individuals who lose group coverage (“HIPPA eligible”) have guaranteed availability of coverage from the prior group insurer (conversion policy) or, if conversion not available, from an individual carrier (two most popular policies). <u>Small Employers</u> : Small group carriers must offer to all small employers, on a guaranteed-issue basis, the standard and basic policies. Sole proprietors are limited to a one month (Aug.) open enrollment period.
Non-Discrimination Based On Health Status (1201)	Prohibits a plan from establishing rules for eligibility based on any of the following health status-related factors: <ul style="list-style-type: none"> • Health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or • Any other health-status related factor deemed appropriate by HHS 	All plans, except grandfathered plans	Plan years beginning on or after 01/01/14	<u>Individual</u> : Other than HIPPA-eligible persons who lose group coverage, insurers may medically underwrite and deny coverage based on health-related factors. <u>Group</u> : Insurers and HMOs offering small group coverage are prohibited from establishing rules for eligibility based on same specified health-status related factors. For both small and large group policies, rules for eligibility of employees may not be based on these same health-status related factors.
Preexisting Condition Exclusions (1201)	Prohibits a plan from imposing any preexisting condition exclusions.	All plans, except grandfathered individual market plans	Plan years beginning on or after 9/23/2010 for children age 19 and	Individual policies/contracts may not exclude preexisting conditions for more than 24 months and may relate to conditions that manifested themselves during the 24-month period. Policy may exclude coverage for named or

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
			under. Plan years beginning on or after 01/01/2014 for all other individuals.	specific conditions without any time limit. Group policies/contracts may not exclude preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee and may only relate to conditions that manifested themselves during the 6-month period prior to coverage. Prior creditable coverage reduces the exclusion period.
Essential Health Benefits, Benchmark Plan, and Levels of Coverage (1302)	<p>Coverage offered in the individual and small group markets must provide the following categories of services (essential health benefits package):</p> <ul style="list-style-type: none"> • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care <p>States were provided the opportunity to select a benchmark plan among various options that reflected the scope of services offered by a “typical employer plan.” Florida did not make a selection, resulting in the default benchmark plan being selected, which is the small group plan with the largest enrollment in the state. A benchmark plan must be supplemented, if necessary, to cover all categories of essential benefits. States may mandate additional benefits but must defray the expenses of enrollees for the additional cost of these</p>	All individual and small group plans, except grandfathered plans.	Plan years beginning on or after 01/01/2014	Current Florida law mandates coverage of numerous benefits, services, and providers of services. However, there is no mandated essential health benefit plan.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	<p>benefits.</p> <p>Individual and small group markets must offer the following levels of coverage:</p> <ul style="list-style-type: none"> • Bronze level-provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan. • Silver level- provides benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan. • Gold level- provides benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan. • Platinum level-provides benefits that are actuarially equivalent to 90% of the full actuarial value of benefits under the plan. • Catastrophic coverage – Limited to adults under age 30 who are exempt from the individual mandate because affordable coverage is not available or they have a hardship exemption. 			
<p>Rating and Underwriting Standards (1201)</p>	<p>Premiums for individual and small group policies may vary only by:</p> <ul style="list-style-type: none"> • Age (3:1 maximum for adults) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family <p>The claims experience of all individual policies and all small group policies, respectively, must be pooled together for rating purposes. States may require that individual and small group policies be pooled together.</p>	<p>All fully insured individual and small group plans, except grandfathered plans. Also fully insured large group plans in states that allow them to purchase through the Exchange.</p>	<p>Plan years beginning on or after 01/01/2014</p>	<p><u>Individual market</u>: Factors used for rating include age, gender, family composition, area by county, tobacco usage. Carriers may also surcharge or “rate up” based on health status. The claims experience of all policies providing similar benefits must be pooled together for rating purposes.</p> <p><u>Small group</u>: Premiums may vary by gender, age, family composition, tobacco usage, and geographic area and premium adjustments of +/- 15% of the approved rate are allowed for claims experience, health status, and duration of coverage. The claims experience of</p>

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
				all policies providing similar benefits must be pooled together, except that policies covering fewer than 2 employees may be separately pooled.
State Review of Insurers Premium Increases (1003)	Requires HHS, in conjunction with the states, to develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the state and HHS a justification for an unreasonable premium increase and post it online. Insurers that have a pattern of unreasonable increases may be prohibited from participation in an exchange.	All fully insured plans, except grandfathered plans	Plan years beginning on or after 1/1/2010	Individual and small group rates filings are subject to prior approval by the OIR. Rate filings are available on the OIR website.
Insurer Reporting of Medical Loss Ratios (MLR) and Payment of Rebates (1001)	Requires plans to report to HHS information concerning the percent of premium revenue spent on claims for clinical services and activities (medical loss ratio). Requires insurers to provide a rebate to consumers if the percentage of premiums expended for clinical services and activities is less than 85% in the large group market and 80% in the small group and individual markets.	All fully insured plans.	Plan years beginning on or after 1/1/2011	As a condition of prior approval of rates by OIR, the projected MLR for small group and guaranteed renewable individual policies is generally 65 percent. Rebates are not required if MLR is not met. Calculation of MLR is not consistent with federal regulations. Rates for large group policies are not subject to approval by OIR.
Annual and Lifetime Limits (1001)	Prohibits lifetime and annual limits on the dollar value of essential health benefits.	Lifetime limits: all plans. Annual limits: all plans except grandfathered individual plans.	Plan years beginning on or after 9/23/2010	No prohibition on lifetime or annual limits. Some mandated benefits have limits, such as autism (\$35,000 annual/\$200,000 lifetime).
Coverage of Preventive Health Services (1001)	Requires coverage without cost-sharing (with exceptions) for: <ul style="list-style-type: none"> • Services recommended by the US Preventive Services Task Force (except for current breast cancer screening recommendation); • Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC; • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration; and • Preventive care and screenings for women supported 	All plans, except grandfathered plans	Plan years beginning on or after 9/23/2010	<u>Mammograms</u> : Plans must include coverage for a baseline mammogram for a woman age 40-49, every year for a woman age 50 or older, and one or more per year based on a physician's recommendation for a woman who is at risk based on specified criteria. <u>Well-child coverage</u> : Plans must cover child wellness benefits for children from birth to age 16 and is exempt

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	by the Health Resources and Services Administration.			from deductible. Requires newborn coverage and newborn hearing screening. <u>OB-GYN</u> : Must allow one annual OB-GYN visit. Cost sharing generally allowed.
Extension of Adult Dependent Coverage (1001)	Requires plans that provide dependent coverage to extend coverage to adult children until age 26. Dependents can be married. A plan or issuer may not define dependent for purposes of eligibility for dependent coverage other than in terms of the relationship between the child and the participant. Carriers are not required to cover children of adult dependents (grandchildren).	All plans (except for plans years beginning before 1/1/14, a grandfathered group health plan may exclude coverage for an adult child under age 26 who is eligible for other employer-sponsored coverage).	Plan years beginning on or after 9/23/2010	Group policies that insure dependent children of the policyholder must continue coverage at least until the end of the calendar year, in which the child reaches age 25, if the child is dependent on policyholder for support and the child is either living in the household of the policyholder or is a full-time or part-time student. Policies that insure dependent children must offer the option to insure a child until age 30 if the child is unmarried and does not have a dependent, is either a Florida resident or a student, and is not provided other coverage.
Internal Appeals and External Review (1001)	Requires plans to implement an internal appeals and independent external review process. For the internal appeals process, group plans must incorporate the U.S. 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 HHS. For the external review process, all plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform Health Carrier External Review Model Act (April, 2010) or with minimum standards established by HHS that are similar to the NAIC model.	All plans, except grandfathered plans	Plan years beginning on or after 9/23/2010	In 2012, legislation was enacted which required individual and group insurance policies to comply with internal grievance procedures of the U.S. Dept. of Labor (but cited regulations are not the updated version). The 2012 act also authorized OIR to adopt rules to administer the NAIC Uniform Health Carrier External Review Model Act (April, 2010), which rules have not yet been adopted.

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Emergency Room Coverage (1001)	If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a network provider. Services provided by non-network providers must be provided with cost-sharing that is no greater than that which would apply for a network provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. Regulations specify minimum reimbursement that plan must pay a non-network provider for emergency services.	All plans, except grandfathered plans	Plan years beginning on or after 9/23/2010	Insurers/HMOs may require higher copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments. HMOs must provide coverage without prior authorization for emergency care, based on determination by hospital physician or other personnel, provided by either a contract or non-contract provider. Specifies minimum reimbursement that HMO must pay a non-contract provider for emergency services. Insurers issuing EPO contracts must cover non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible.
Rescissions (1001)	Authorizes plan to rescind coverage only for fraud or intentional misrepresentation of material fact, as prohibited by the terms of the policy. Must provide 30 days advance notification to policyholder.	All plans	Plan years beginning on or after 9/23/2010	After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim starting. As an alternative insurer can have incontestability provisions that provide that after policy has been in force for 2 years, insurer cannot contest statements in the application or deny claims for preexisting conditions. Requires insurer/HMO to provide 45 days prior notice of cancellation.
Primary Care Physicians and OB-GYN Coverage (1001)	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. A plan may not require authorization or referral for a female	All plans, except grandfathered plans	Plan years beginning on or after 9/23/2010	Insurers issuing EPO contracts and HMOs must allow, without prior authorization, subscriber to visit contracted OB/GYN for one annual visit and for medically necessary

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.			follow-up care.
Prohibition on Waiting Periods (1201)	Prohibits group plans from imposing waiting periods that exceed 90 days (the time period that must pass before an individual is eligible to be covered).	All group plans	Plan years beginning on or after 01/01/14	No limit on waiting periods. Generally this is a contractual issue.
Coverage for Clinical Trial Participants (1201)	Prohibits an individual or small group plan from denying a qualified individual from participating in an approved clinical trial; denying or limiting conditions on the coverage of routine patient costs for items and services provided in connection with the trial; and discriminating against qualified individuals on the basis of such participation.	All plans, except grandfathered plans	Plan years beginning on or after 01/01/14	No similar requirement. (Several insurers and self-insured governmental entities entered into a voluntary agreement to provide routine patient care costs related to clinical trials for insureds diagnosed with cancer and accepted into a Phase II, Phase III, or Phase IV clinical trial for cancer.)
Temporary reinsurance program for individual market (1341)	<p>Requires each state or HHS to establish a temporary reinsurance program for plan years beginning in 2014-2016. The goal of the program is to stabilize premiums by partially offsetting claims for high-cost individuals in nongrandfathered plans for the first three years of the exchange operations.</p> <p>Insurers and TPAs, on behalf of self-insured plans, must make payments to the reinsurance entity. Nongrandfathered, individual market insurers that cover high-risk individuals will receive payments from the entity if they cover high-risk enrollees in the individual market.</p> <p>State may: 1) operate own program and collect from the fully insured market and allow HHS to collect contributions from the self-insured market; or 2) operate own program including the payment function, and defer all collection duties to HHS. If the HHS operates a state's reinsurance program, HHS will collect all contributions and perform payment functions.</p>	All plans must pay assessments. Nongrandfathered individual plans may receive payments.	<p>Plan years beginning in 2014 through 2016.</p> <p>HHS collection of reinsurance contributions begins 1/15/2014.</p>	N/A. No statutory authority to operate reinsurance program.
Temporary Risk Corridors for	Requires HHS to establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program	Qualified individual and small group	Calendar years 2014-	N/A. HHS administers.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
Plans in Individual and Small Group Markets (1342, 1343)	for Medicare Prescription Drug Plans. Plans will receive payments if their ratio of nonadministrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.	health plans. Nongrandfathered individual and small group plans.	2016	
Risk Adjustment (1343)	<p>Requires each state to 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 are have an actuarial risk that is below the average actuarial risk in that state.</p> <p>HHS, in consultation with the states, shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans.</p>	Nongrandfathered individual and small group plans	01/01/14	N/A. No statutory authority to administer program.
Insurer Reporting of Claims and Enrollment Data (1001)	<p>Requires plans to submit to HHS and state insurance regulators and make available to the public the following information in plain language:</p> <ul style="list-style-type: none"> • Claims payment policies and practices, • Periodic financial disclosures, • Data on enrollment and 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, and • Other information as determined by HHS. 	All plans, except grandfathered plans	Plan years beginning on or after 9/23/2010	Insurers/HMOs are required to submit financial audits and statements as well as enrollment, claims, and rating information to the Office of Insurance Regulation (OIR).
Insurer Reporting of Quality of Care (1001)	<p>Requires plans to submit annual reports to HHS on whether the benefits under the plan:</p> <ul style="list-style-type: none"> • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management; • Implement activities to prevent hospital readmission; • Implement activities to improve patient safety and reduce medical errors; and Implement wellness and health promotion activities. 	All plans, except grandfathered plans	Plans years beginning on or after 9/23/2012	N/A.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
Grandfathered Plans	Certain provisions of PPACA do not apply to individual or group coverage in which an individual was enrolled on March 23, 2010, for as long as the coverage maintains grandfathered status under federal regulations. Plans lose grandfathered status if they make certain significant changes that reduce benefits or increase cost sharing.			

Tab 2

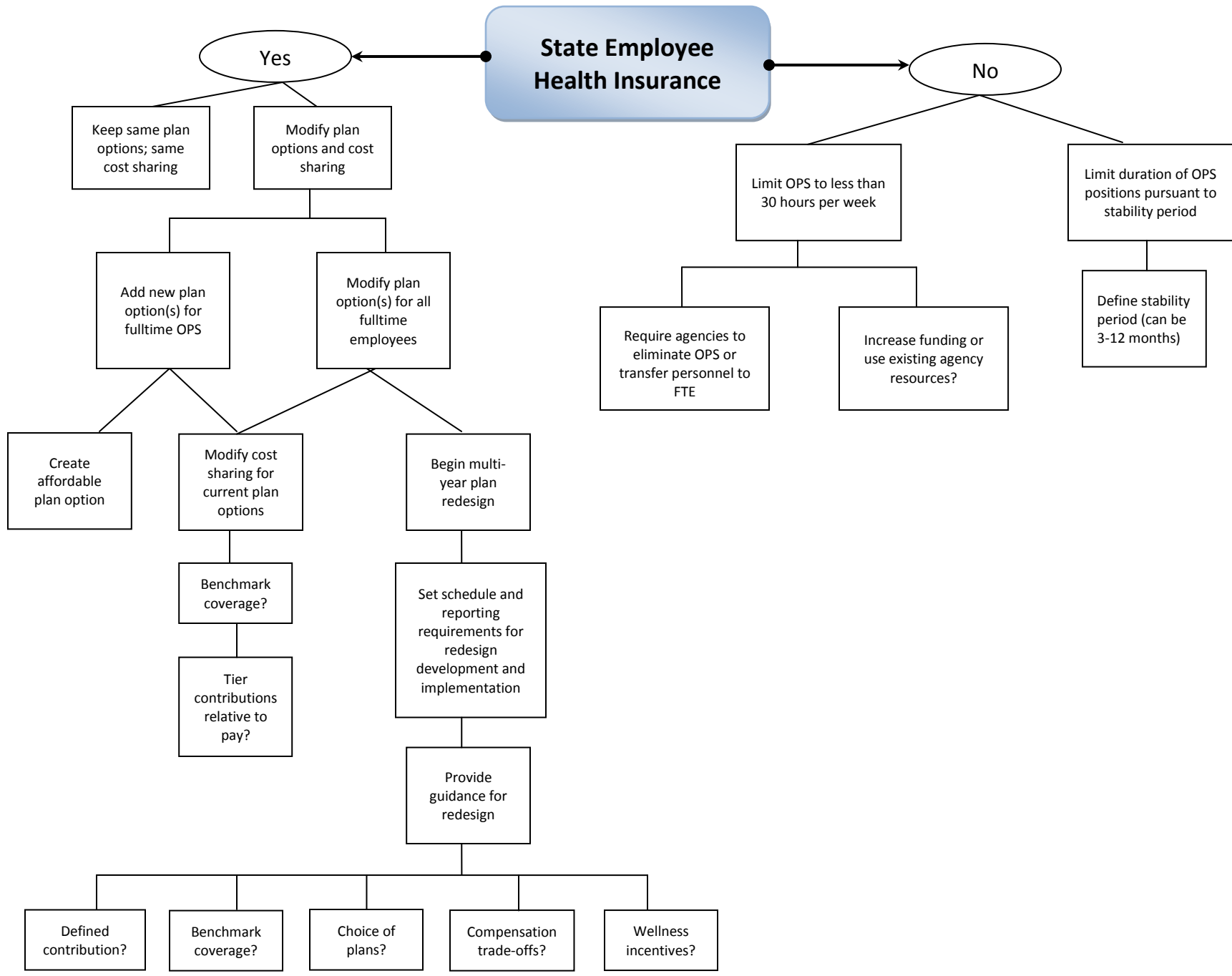
**STATE GROUP
HEALTH
INSURANCE**

State Group Health Insurance

<p>Key Components of Federal Law</p>	<p>As of January 2014, PPACA requires employers with more than 50 fulltime workers to offer <i>affordable</i> and <i>adequate</i> health insurance or pay a penalty. <i>Affordable</i> means that the cost to the employee should not exceed 9.5% of his/her individual income. <i>Adequate</i> means the benefits must include federally-defined essential services.</p> <p>Florida is a large employer under PPACA and subject to its penalties for failing to offer affordable and adequate health insurance.</p> <ul style="list-style-type: none"> • The following PPACA provisions are in effect and have resulted in changes to the state employee plan: <ul style="list-style-type: none"> ○ <i>No overall lifetime plan maximums;</i> ○ <i>No annual limits for essential health benefits;</i> ○ <i>No pre-existing condition exclusions for children under age 19;</i> ○ <i>Required fees for patient-centered outcome research (phased in at \$1 to \$2 per participant); and</i> ○ <i>Extended coverage for employees' adult children to age 26 without regard to dependency.</i> • The following PPACA requirements become effective January, 2014: <ul style="list-style-type: none"> ○ <i>No pre-existing condition limitations;</i> ○ <i>Required fees for pharmaceutical industry; excise tax of 2.3% on medical devices; and re-insurance, risk corridors and risk adjustments.</i>
<p>Background</p>	<p>The State of Florida employs more than 183,000 employees in state agencies and the state university system who are eligible to participate in the State Employee's Group Health Insurance (SGHI) program. Approximately 170,000 of those employees were enrolled in the plan as of September 2012.</p> <p>Under current state law, Other Personal Services (OPS) employees may not participate in SGHI. There are approximately 9,800 OPS employees employed by state agencies and the state university system, according to the December 2012 Self-Insurance Estimating Conference (SIEC). Starting in 2014, the state will be subject to penalties if it fails to offer affordable health coverage to each "full-time" employee working an average of 30 hours or more per week, including OPS employees. Penalties under PPACA are calculated as follows:</p> <ul style="list-style-type: none"> • \$2,000 for each full-time employee (excluding the first 30) for failure to offer insurance; • If the insurance offered does not cover at least 60% of the cost of the plan, the penalty is the lesser of: <ul style="list-style-type: none"> ○ \$3,000 per employee who enrolls in the exchange; or ○ \$2,000 for every FTE, minus the first 30 <p>Because PPACA requires individuals to purchase health insurance or pay a tax penalty, future participation in the state plan may increase. Some employees, who previously did not participate, may enroll to avoid the tax penalty.</p>
<p>Estimated Fiscal/Economic Impact</p>	<ul style="list-style-type: none"> • The latest SIEC report estimates a penalty of \$318 million annually for failure to comply with PPACA. • SIEC estimated cost to the State Employee's Group Health Insurance Trust Fund of complying with PPACA: <ul style="list-style-type: none"> ○ SFY 2013-'14 - \$59.8 million ○ SFY 2014-'15 - \$137.3 million ○ SFY 2015-'16 - \$155.1 million.

State Group Health Insurance

State Options	<ol style="list-style-type: none">1. Limit OPS employees to working less than 30 hours of work per week to avoid penalties2. Extend current state group health insurance plan options to OPS employees with similar cost sharing as full-time employees3. Extend modified group health insurance plan options with varying cost sharing levels to OPS employees4. Begin a multi-year plan redesign of state group health insurance
Legislation Required	All options require legislation.



**OPS Employees Working an Average of 30 or More Hours a Week
Estimated Annual Salary Based on 30-Hour Work Week**

	< \$20,000	\$20,000 - \$39,999	\$40,000 - \$49,999	\$50,000 - \$79,999	\$80,000 - \$99,999	\$100,000+	Grand Total
AHCA - Agency for Hlth Care Ad	9	28	4	5		1	47
APD - Persons w/Disabilities	28	82	4	2			116
CIT - Citrus	2						2
DACS - Agriculture & Csmr Svc	166	19					185
DBPR - Business & Prof. Reg.	21	4	1				26
DC - Corrections	158	88	12	1			259
DCF - Children and Families	27	31	6		1		65
DEO - Economic Opportunity	96	38	1				135
DEP - Environmental Protection	115	124	3	9		1	252
DFS - Financial Services	6	1		2			9
DJJ - Juvenile Justice	24	11	1				36
DLA - Legal Affairs	14	2					16
DMS - Management Svcs	1	1		2	2		6
DOE - Education	6	2					8
DOEA - Elder Affairs	9	17	1	2			29
DOH - Health	141	190	19	13	11	9	383
DOS - State	17	8	3				28
DOT - Transportation	1						1
EOG - Office of the Governor	3	38					41
FDLE - Law Enforcement	2	8		2	1		13
FPC - Parole Commission	1						1
FWC - Fish&Wildlife Cons Comm	51	153	9	3			216
HSMV - Hway Safety & Mtr Vhcle	2						2
JAC - Justice Admin Comm	12	6			1		19
PSC - Public Service Comm	2						2
REV - Revenue	14	3					17
SCS - State Courts System		7					7
Grand Total	928	861	64	41	16	11	1,921

Note: Counts reflect OPS reported in the December 12, 2012 Report on the Financial Outlook to the Self-Insurance Estimating Conference that are still active as of February 27, 2013

Tab 3

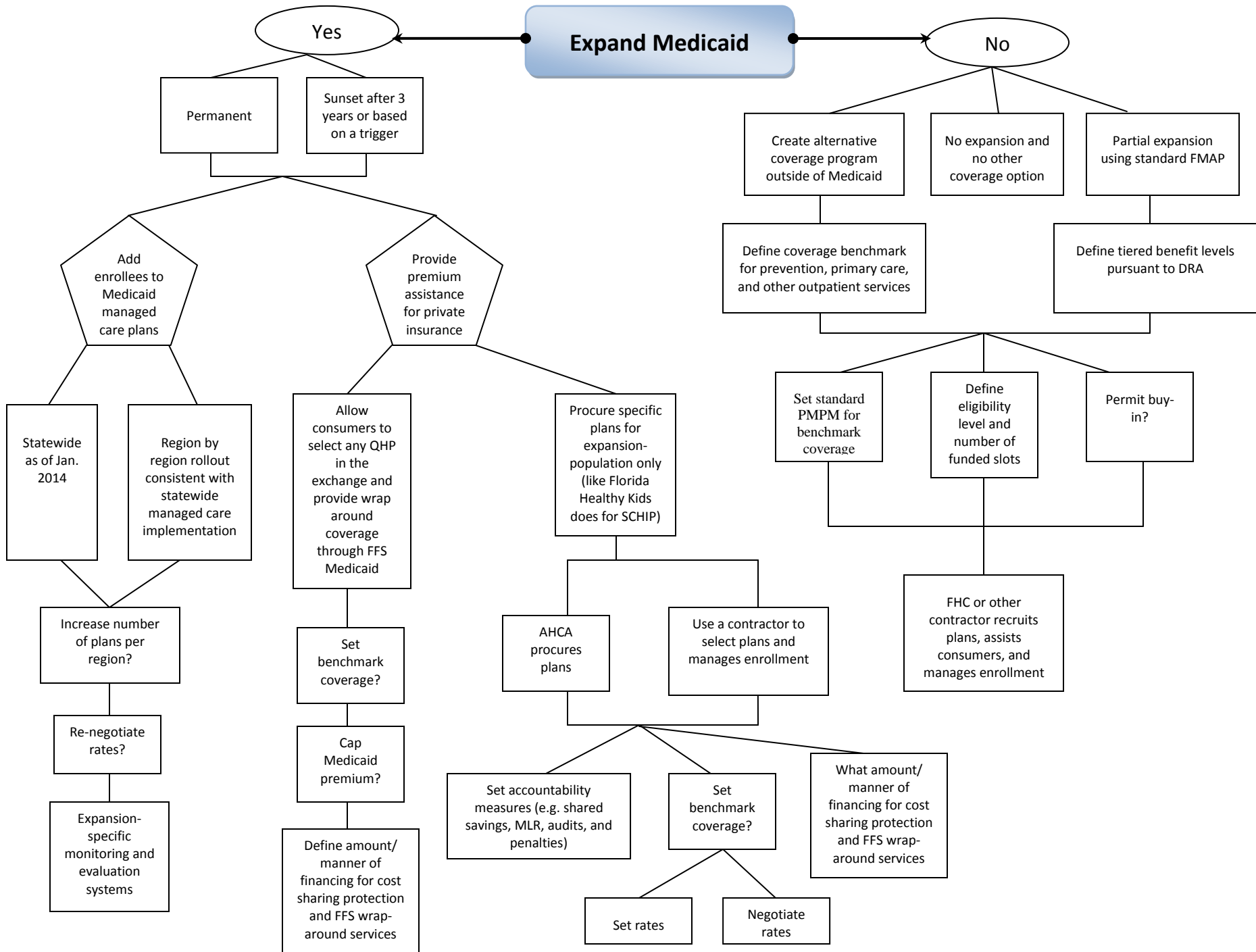
MEDICAID EXPANSION

Medicaid Expansion

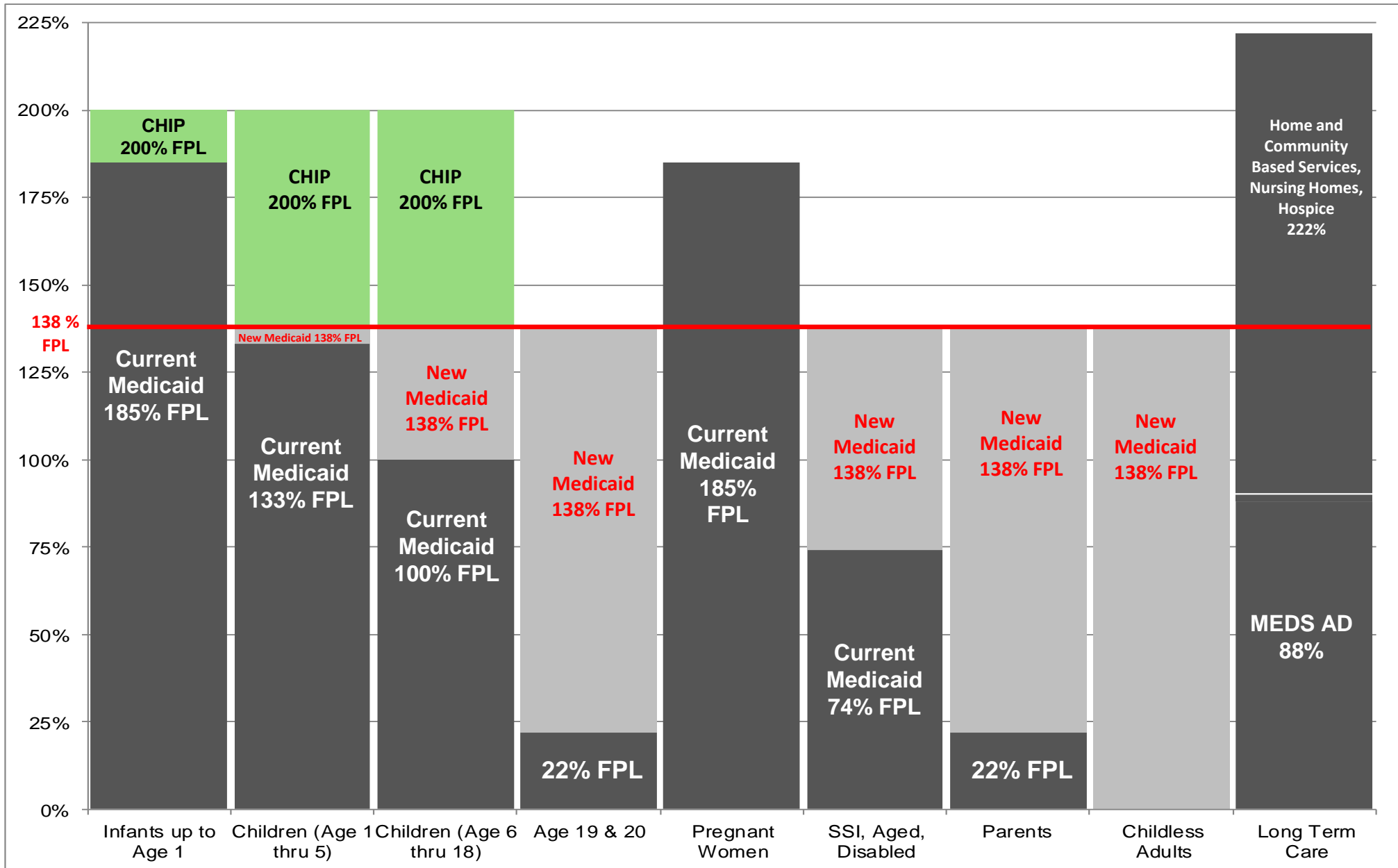
<p>Key Components of Federal Law</p>	<p>PPACA required states to expand Medicaid eligibility to at least 138% of poverty and authorized increased federal matching funds for the expansion. The Supreme Court ruled that expansion is optional for states. States may choose to expand or withdraw from expansion at any time. Other significant provisions of the federal law related to Medicaid include:</p> <ul style="list-style-type: none"> • <u>Enhanced match</u>: federal funds will cover 100% of the expansion costs during calendar years 2014 through 2016; the match rate declines beginning in 2017 until it reaches 90% in 2020. • <u>New eligibility method</u>: states must use modified adjusted gross income (MAGI)—a number derived from tax filings—to determine financial eligibility beginning in January 2014; • <u>Maintenance of effort</u>: states must maintain eligibility standards in effect as of March 23, 2010, until the HHS Secretary determines that an exchange is fully operational in the state for adults and through September 30, 2019 for children under age 19; • <u>Increased primary care provider payments</u>: rates must equal the Medicare rate and the costs of increased rate will be eligible for 100% federal funding during calendar years 2013 and 2014; • <u>Changes in children’s eligibility</u>: <ul style="list-style-type: none"> ○ Children ages 6 through 18 between 100% to 138% FPL currently enrolled in the Children’s Health Insurance Program (CHIP) known as Florida KidCare are required to transition to Medicaid on January 1, 2014; ○ Effective January 1, 2014, PPACA requires states to provide coverage to former foster care children until age 26. 	
<p>Background</p>	<p>Florida currently determines Medicaid eligibility based on a combination of financial and other characteristics:</p> <ul style="list-style-type: none"> • Children with family incomes up to 200% of poverty are eligible for Florida Kidcare; • Pregnant women are eligible with incomes up to 185% of poverty; • Aged and disabled persons are eligible with incomes up to 74% of poverty; • Persons assessed as needing long term care are eligible with incomes up to 88% of poverty for medical coverage and up to 222% of poverty for home and community based services; • Young adults (ages 19 and 20) and parents are eligible with incomes up to 22% of poverty. <p>As of February, 2013, Florida Medicaid covers 3,233,144 persons and more than half of these are children. Nearly 1 million additional people may be eligible under the expansion; however, the Social Services Estimating Conference (SSEC) determined that 463,280 persons are likely to enroll during 2014 with that number rising to 892,390 by 2020.</p> <p>More than 85% of the expansion population consists of childless adults and parents age 21 and over.</p>	
<p>Summary of Testimony to Select Committee</p>	<p style="text-align: center;"><u>Proponents</u></p> <ul style="list-style-type: none"> • Everyone needs health insurance, but many people can’t afford private coverage. • Without expansion, people with incomes below poverty will remain uninsured. • Uncompensated care costs are shifted to other payers and result in a “hidden tax” that is paid for through higher premiums and other government funding. 	<p style="text-align: center;"><u>Opponents</u></p> <ul style="list-style-type: none"> • Everyone needs access to health services; but Medicaid coverage doesn’t guarantee access. Limited provider participation is a significant barrier to accessing services. • Studies of the effect of Medicaid coverage on health status provide mixed results. • Low Medicaid payments discourage provider participation and causes cost shifts to private payers.

Medicaid Expansion

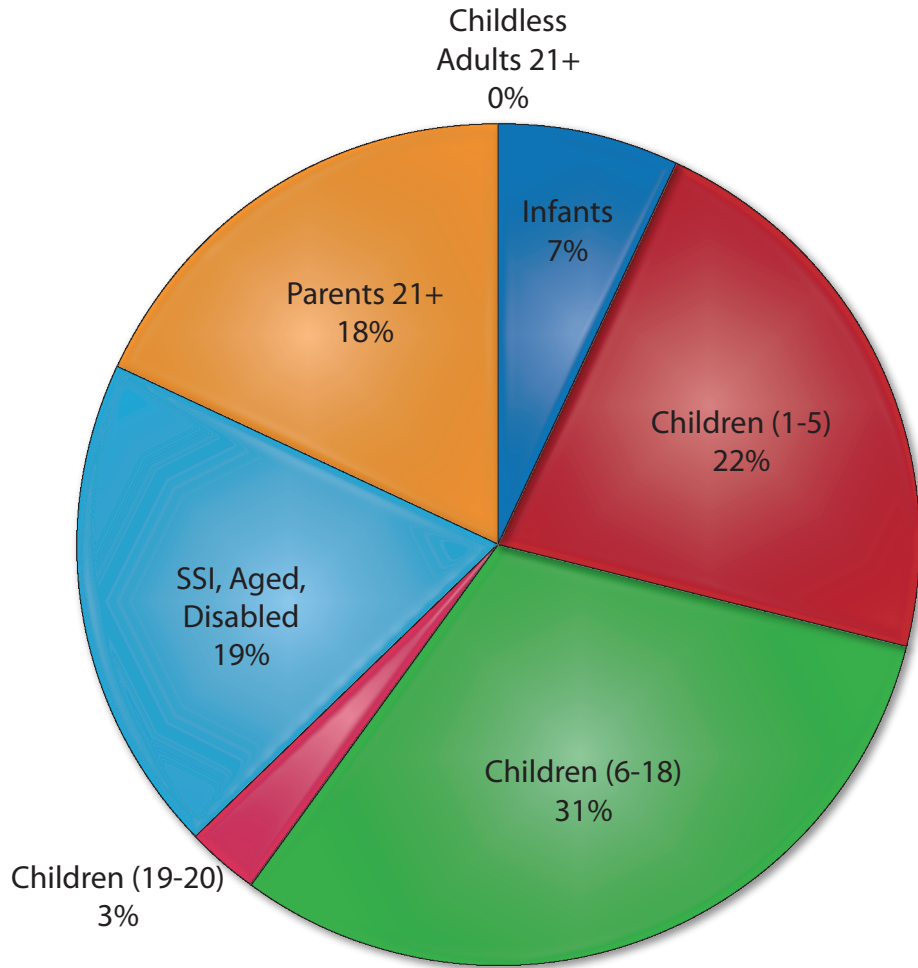
	<ul style="list-style-type: none"> • Medicaid expansion will save the state money by allowing reduced funding for other health programs. • Increased federal spending as part of Medicaid expansion will create new jobs and generate a positive economic impact for Florida. • The Medicaid expansion is 100% federally funded for the first three years and will never dip below 90% federal match. 	<ul style="list-style-type: none"> • Uncompensated care has not decreased in states that expanded Medicaid and other public funding for health care has not been reduced. • PPACA will cause economic impacts through numerous taxes and shifting economic activity to the health care sector. Medicaid expansion will add to these impacts, but predicting the nature and scale of those impacts is complex and uncertain. • Whether funded by the state or the federal government, all dollars are taxpayer dollars. • Federal funds for this program can be changed by Congress at anytime and the state will be required to pay a larger share of the costs. • Once an entitlement program has been implemented, it is extremely difficult to take it away.
<p>Estimated Fiscal/Economic Impact</p>	<ul style="list-style-type: none"> • The expansion is fully funded by the federal government for calendar years 2014, 2015 and 2016. • States must begin covering a portion of the adult expansion costs in 2017. • States are required to contribute 10% of the adult expansion costs beginning in 2020. • The latest SSEC estimates of the state's future costs for the adult expansion population are as follows: <ul style="list-style-type: none"> ○ \$79 million in SFY 2016-17; ○ \$176 million in SFY 2017-18; ○ \$330 million in SFY 2020-21. • Continuation of the primary care rate increases after calendar year 2014 is expected to cost at least \$174 million in SFY 2014-15 and \$345 million in 2015-16. • Costs may increase for the current Medicaid program due to higher enrollments related to outreach and other features of PPACA; the SSEC concludes that the amount of such increases is indeterminate. The Governor's budget expects those costs to reach \$116 million in SFY 2013-14. 	
<p>State Options</p>	<ol style="list-style-type: none"> 1. Expand Medicaid eligibility for children to 138% FPL and foster care children to age 26 only (both mandatory), but do not expand eligibility for adults; 2. Permit a choice between Florida Healthy Kids or Medicaid enrollment for children in families up to 138% of poverty. 3. Expand Medicaid eligibility for children in Option 1 and also adults to 138% FPL; 4. Expand Medicaid eligibility for children in Option 1, expand Medicaid eligibility for adults to 100% FPL under current Medicaid match rate, and direct adults over 100% FPL to seek federal subsidies for coverage through an exchange. 	
<p>Legislation Required</p>	<p>All Options will require legislation.</p>	



Existing and Optional Medicaid / CHIP Eligibility Levels



Current Medicaid Population



Newly Eligible Uninsured Expansion Population

