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, December 3, 2012
TIME: 3:00 —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

<table>
<thead>
<tr>
<th>TAB</th>
<th>BILL NO. and INTRODUCER</th>
<th>BILL DESCRIPTION and SENATE COMMITTEE ACTIONS</th>
<th>COMMITTEE ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Introduction of Committee Members and Staff</td>
<td></td>
<td>Discussed</td>
</tr>
<tr>
<td>2</td>
<td>Discussion of the Committee's Charge</td>
<td></td>
<td>Discussed</td>
</tr>
<tr>
<td>3</td>
<td>Overview of the Patient Protection and Affordable Care Act</td>
<td>Insurance Regulation</td>
<td>Presented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Purchasing and Financing</td>
<td>Presented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Medicaid and State Children’s Health Insurance Program (SCHIP)</td>
<td>Presented</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Employer Impact - Private and Public</td>
<td>Presented</td>
</tr>
<tr>
<td>4</td>
<td>Other Related Meeting Documents</td>
<td></td>
<td>Discussed</td>
</tr>
</tbody>
</table>
SELECT COMMITTEE ON PATIENT PROTECTION 
AND AFFORDABLE CARE ACT

December 3, 2012
INSURANCE REGULATION
Regulation of Insurance in Florida

Office of Insurance Regulation (OIR)

• Regulates and licenses insurers and other risk-bearing entities
  • Regulatory oversight includes:
    • Licensure
    • Approval of rates and policy forms
    • Market conduct and financial exams
    • Solvency oversight
    • Administrative supervision

Agency for Health Care Administration (AHCA)

• Responsible for ensuring HMO’s meet quality of care standards
  • Networks are adequate to serve members
  • Internal and external dispute processes are adequate
Early Reforms

Reforms Effective for Plan Years Beginning on or after 9/23/2010

- Lifetime Limits
- Annual Limits
- Rescissions
- Preventive Health Services
- Adult Dependent Coverage
- Pre-Existing Condition Exclusion for Under 19
- Internal and External Review Process
- Patient Protections
- Medical Loss Ratios
- Rate Review and Disclosure
2014 Market Reforms

• Guaranteed Issue
• No Pre-Existing Condition Exclusions for Adults
• Rating Rules
  ▪ No health status
  ▪ 3:1 maximum variation for age
  ▪ 1.5:1 maximum variation for tobacco use
• Essential Health Benefits Package
• Individual Mandate
• Employer Mandate
Decision Points

Market Regulation: Who Does What?
- Federal role
- State flexibility (OIR / AHCA authority)
- Comparability of regulations e.g. open enrollment
- Exchange functions

Consumer Protections: Who Enforces?
- Minimum essential health benefits
- Complaints
- Grievance resolution

Rate Review: Who Evaluates?
- Adequacy of rates
- Mitigation of market disruptions and insolvencies
- Compliance with medical loss ratio and rebate requirements
- Methodology e.g. regional vs. statewide
Decision Points

Coverage Requirements: What Benchmarks?
• The current benchmark is the default plan
• States can modify in the future
PURCHASING AND FINANCING
EXCHANGES

• Provide seamless consumer experience to obtain affordable health care coverage

• Eligibility screening and enrollment in insurance affordability programs:
  – Assess or determine eligibility for Medicaid and SCHIP
  – Facilitate purchase of insurance coverage by qualified individuals through qualified health plans (QHPs) - Individual market
  – Assist qualified employers enroll employees in QHPs—SHOP (Small Business Health Options Program)
Minimum Functions of an Exchange

• Consumer Assistance
• Plan Management
• Eligibility
• Enrollment
• Financial Management & Security
• SHOP – specific functions to assist small employers
• Provide for appeal of determinations
Minimum Functions of an Exchange

• Consumer assistance
  – Outreach and education
  – Call center
  – In person
  – Navigator program
  – Internet web site
  – Correspondence and notifications
Minimum Functions of an Exchange

• Plan Management
  – Certification/recertification of QHPs
  – Data collection and quality reporting
  – Plan monitoring and oversight
  – Risk adjustment and reinsurance
  – Assess rate increases
Minimum Functions of an Exchange

• Eligibility
  – Accept applications
  – Verify information (Federal data hub)
  – Assess or determine eligibility (redetermination) for Medicaid and SCHIP (MAGI)
  – Determine / redetermine eligibility for enrollment in QHPs, advance payment of premium assistance tax credits, and cost-sharing reductions (calculator)
  – Issue certificates of exemption
Minimum Functions of an Exchange

• Enrollment
  – Facilitate enrollment in Medicaid and SCHIP
  – Enroll applicant in chosen QHP (reenrollment)
  – Transmit information to the QHP / HHS
  – Provide open enrollment periods and enrollment per triggering events
  – Continuously monitor plan enrollment
Minimum Functions of an Exchange

• Financial Management & Security
  – Maintain operational budget, track costs and revenue
  – Aggregate and pay premiums to QHPs (optional)
  – Reconcile advance payments for tax credits and cost-sharing reductions according to terminations or changes in enrollee status
  – Maintain sustainability
  – Comply with standards for protecting confidential information (federal and state data sharing)
Minimum Functions of an Exchange

• SHOP (Small Business Health Options Program) – specific functions
  – Determine employer eligibility
  – Verify employee eligibility
  – Premium aggregation
EXCHANGE OPTIONS

• State Based Exchange (SBE)
• Federal/State Partnership Exchange (F/SP)
• Federally-Facilitated Exchange (FFE)

SBE may use Federal government services to perform advance premium tax credit, cost-sharing reduction, and exempt status eligibility determinations and administer reinsurance program.

State may participate in FFE but operate its own reinsurance program.
State Based Exchange

• Governmental agency or non-profit entity established by the state (one or more exchanges)
• State may authorize the Exchange to contract with an eligible entity to carry out responsibilities
• State may operate individual market Exchange and SHOP under separate governance or administrative structures
• Grant funding available through 2014 for planning, establishment, and operations (operations must be self-sufficient beginning January 1, 2015)
Approval Process for State Based Exchange (SBE)

- State submits Exchange Blueprint to HHS (Declaration Letter of Intent / Application by December 14, 2012 for operation in 2014)
- Demonstrates operational readiness through readiness assessment
- May elect to operate Exchange after 2014
  - Must have approved or conditionally approved plan by at least January 1 of prior year
  - Must work with HHS to develop plan to transition from FFE or F/SP
State Based Exchange (SBE) – Potential Participants

• Existing State Agencies / Entities performing some or similar activities
  – Agency for Health Care Administration
  – Office of Insurance Regulation
  – Department of Financial Services
  – Department of Children and Families
  – Florida Healthy Kids Corporation
  – Florida Health Choices

• New Entity(ies)
Federal / State Partnership
Exchange (F/SP)

- HHS has ultimate responsibility for and authority over partnership exchange
- Declaration Letter of Intent / Application by February 15, 2013
- State can assist in operating all plan management functions, some consumer assistance functions (in-person assistance to applicants and consumers, the Navigator program), or both
• State must agree to ensure cooperation from the State’s insurance, Medicaid, and SCHIP agencies to coordinate business processes, systems, data/information, and enforcement.

• State can use Exchange grant funding for these functions.
Federally-Facilitated Exchange (FFE)

- HHS will carry out all Exchange functions, including consulting with stakeholders
- HHS intends to work with State to preserve traditional responsibilities of State insurance departments (leverage State policies, capabilities, and infrastructure)
- HHS will seek to harmonize FFE policies with existing State programs and laws wherever possible
Decision Points

Exchange: What Type?
- Federally Facilitated Exchange
- Partnership
- State Based Exchange

Exchange Functions: Who Does What?
- Consumer Assistance
- Plan Management
- Eligibility
- Enrollment
- Financial Management & Security
Decision Points

If Florida Operates an Exchange: Who Does What?

- State agency (existing or new)
- Private not-for-profit (existing or new)

Market Participation: Who Decides?

- Selective vs. open
- Integration of Medicaid and private markets
Medicaid &
State Children’s Health Insurance Plan (SCHIP)
Optional Medicaid Expansion

• Supreme Court Ruling – State Option to Expand
  – 133% FPL with 5% disregard = 138% FPL

• Expansion remains in the law, the penalty is unenforceable

• No deadline to notify federal CMS of expansion
Optional Medicaid Expansion

• Initial guidance indicates states may be allowed to expand partially

• States may retract the expansion at any time

• Expansion\Retractions through Medicaid state plan amendments
Medicaid & SCHIP Overview

Existing and Optional Medicaid and SCHIP Eligibility

- Medicaid Option – 138% FPL Threshold

- Current Medicaid
- CHIP
- Optional Medicaid

<table>
<thead>
<tr>
<th>Category</th>
<th>Current Medicaid</th>
<th>CHIP</th>
<th>Optional Medicaid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn</td>
<td>185</td>
<td>133</td>
<td>100</td>
</tr>
<tr>
<td>Age 1 thru 5</td>
<td>175</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age 6 thru 18</td>
<td>150</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ages 19 &amp; 20</td>
<td>125</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pregnant Women</td>
<td>100</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SSI, Aged, Disabled</td>
<td>74</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parents/Caregivers</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childless Adults</td>
<td>22</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC - Meds AD</td>
<td>88</td>
<td></td>
<td></td>
</tr>
<tr>
<td>LTC - HCBS, Nursing Home</td>
<td>222</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Medicaid & SCHIP Provisions

• Maintenance of Effort Provisions
  – Through December 31, 2013 for Adults
  – Through September 30, 2019 for Children

• What does that mean?
  – Maintain eligibility standards as of March 23, 2010
  – Maintain income standards, methodologies and procedures for children in Medicaid and SCHIP
Changes in Eligibility Determination
Effective January 1, 2014 – With or Without Medicaid Expansion

Current Medicaid

- Combination of financial and categorical criteria
- Based on the number of related persons residing in the household and their income
- Income disregards for each working parent

MAGI

Modified Adjusted Gross Income

- Utilizes last tax return; IRS filing
- Based on total household, total income
- Across the board 5% income disregard
- No other disregards permitted
Impact of Eligibility Changes

• For children transitioning between Medicaid and SCHIP, families may experience:
  • Modifications in premium payments (up and down)
  • Potentially a change in health plans
  • Different benefits packages between Medicaid & SCHIP
  • Monthly premium payment requirement & co pays for services
  • Some families may no longer qualify for any subsidy
  • Loss of Medicaid coverage: child qualifies for SCHIP for one year
Impact of Eligibility Changes

• For Adults –

  – If Medicaid expanded, additional coverage options
  
  – Parent cannot enroll if an eligible child is not also enrolled
Current Medicaid Eligibility Continues

- Current Medicaid eligibility calculations will remain for some populations

- Non-MAGI populations include:
  - Supplemental Security Income (SSI) cash recipients
  - Aged, blind and disabled
  - Foster care children

- Eligibility could be conducted using both the old and new methods depending on the recipient’s status
Application & Enrollment

• Simplification requirements for enrollment and renewal
  – Streamlined, online enrollment system
  – Secure, electronic interface

• Medicaid and SCHIP interface with Exchange
  – Coordinate enrollment
  – Coordinate oversight of outreach navigators and assisters

• Assist applicants with process (initial and renewal)
• Florida’s Response to SCHIP – Combination of old and new programs
  – Cited as one of the models in 1997 federal enabling legislation
  – State has modified over lifetime of the program
  – Coordinated effort among 3 state agencies (AHCA, DCF, DOH/CMS) and Florida Healthy Kids Corporation (FHKC)
Florida’s SCHIP

- Florida KidCare – Enacted in 1998 and consists of four key program components:
  - Medicaid (children under 1 year old)
  - Medikids (children 1 – 5 years old)
  - Children’s Medical Services Network (special needs)
  - Florida Healthy Kids Corporation (children 6 – 18 years old)
Considerations for SCHIP

• Title XXI – SCHIP
  – Re-authorized in 2009 through 2013
  – PPACA extended Program funding through 2015
  – Extended Program authorization through 2019
  – Increased Federal Medical Assistance
    Percentages (FMAP) for SCHIP FFY 2015 - FFY 2019

• SCHIP is not an entitlement
  – Limited federal funds and state can set enrollment caps
  – If funds exhausted for SCHIP, child referred to Exchange
    for coverage
Decision Points

Expansion: If and When?
- Short term and long term funding
- Relationship to statewide Medicaid managed care implementation

Coordination: How and How Much?
- Medicaid plans in exchanges
- Family enrollment
- Basic Health Plan

Children: Automatic or Optional?
- Florida Healthy Kids and Medicaid transitions
POTENTIAL FISCAL IMPACT
Four Aspects of Fiscal Impact on Medicaid

• Medicaid Eligibility Expansion (optional)
  – Effects on Caseload
  – Effects on Expenditures
• “Woodwork Effect”
• Primary Care Physician Rate Increase
• Medicaid Eligibility System
Potential PPACA Enrollment Impact

**Optional Medicaid Eligibility Expansion:**

- Under PPACA, states are directed to expand Medicaid eligibility to 138% of the Federal Poverty Level and receive enhanced federal match for the expansion population, beginning January 1, 2014.

- U.S. Supreme Court rendered optional the PPACA’s requirement for states to expand Medicaid eligibility in this way.

- Effect of Expansion on Enrollment:
  
  - In SFY 2013-14, between Medicaid and KidCare, an estimated 463,000 new enrollees would be added due to eligibility expansion (a gain of 528,000 in Medicaid and a loss of 65,000 in KidCare).

  - By SFY 2015-16, eligibility expansion would result in an estimated 845,000 additional enrollees (a gain of 912,000 in Medicaid and a loss of 67,000 in KidCare).

  - By SFY 2020-21, eligibility expansion would result in an estimated 892,000 additional enrollees (a gain of 972,000 in Medicaid and a loss of 80,000 in KidCare).
Potential PPACA Enrollment Impact

- “Woodwork Effect”:
  - Not everyone currently eligible for Medicaid is enrolled in the program.
  - In Florida, an estimated 79.7% of individuals currently eligible for Medicaid are actually enrolled.
  - The PPACA mandate for individual coverage could cause a higher percentage to become enrolled. The Social Service Estimating Conference SSEC classified this potential impact as “indeterminate.”
  - “Maximum exposure” could be significant, but SSEC assumes 100% woodwork is highly unlikely.
  - Woodwork effect, in theory, could happen regardless of state’s decision on Medicaid eligibility expansion.
  - Enhanced federal match would not apply to recipients eligible under preexisting standards.
Medicaid Expansion’s Impact on Enrollment

Estimated and Maximum Enrollment Increases due to Expansion to 138% FPL

Includes Medicaid enrollment only, without offsets in Kidcare program.  “Estimated” assumes indeterminate woodwork effect.  “Maximum” assumes 100% woodwork effect.

Data Source: Social Services Estimating Conference, Aug 14, 2012
Potential PPACA Fiscal Impact

• Optional Medicaid Eligibility Expansion:
  – Federal match for expansion population is 100% for first three calendar years (2014, 2015, and 2016), then is phased-down to 90% by 2020.
  – Expenditures: First Three Years
    • No net increase in state costs during first three years due to expansion are estimated.
      – Small increase in state Medicaid costs would be offset by identical reductions in state KidCare costs.
    • Significant increases in federal costs in first three years.
      – In SFY 2013-14, over $900 in million additional federal costs.
        By SFY 2015-16, federal costs would increase by roughly $3.2 billion.
Potential PPACA Fiscal Impact

• Optional Medicaid Eligibility Expansion (cont.):
  – Expenditures: State Costs in out-years
    • In SFY 2016-17, the state would begin paying for expansion population.
    • State costs (for Medicaid and KidCare combined) would increase by an estimated $79 million in SFY 2016-17.
      • In SFY 2017-18, state costs would increase by an estimated $176 million.
      • By SFY 2020-21, state costs would increase by an estimated $330 million.
    – These estimates are for eligibility expansion only and do not include other PPACA aspects.
    – These estimates also are based on an “indeterminate” woodwork effect, which means no potential woodwork effect costs are included.
Expansion’s Impact on State Medicaid Costs

Estimated and Maximum Increases due to Expansion to 138% FPL

Includes costs of Medicaid eligibility expansion only, without costs of PCP rate increase and without offsets in Kidcare.
“Estimated” assumes indeterminate woodwork effect. “Maximum” assumes 100% woodwork effect.
Potential PPACA Fiscal Impact

• **Primary Care Physician Rate Increase**
  
  – States are required to pay Medicare rates to Medicaid primary care physicians providing primary care services during calendar years 2013 and 2014.
  
  – Federal government pays 100% of the difference during those two years.
  
  – Requirement ends in 2015, as does the 100% match.
  
  – If Florida continues with increase beyond CY 2014, state Medicaid costs would increase at least $174 million in SFY 2014-15 and $345 million in 2015-16.
Impact of PCP Rate Increase on State Costs

Primary Care Rate Increase: Estimated and Maximum State Costs

Assumes state continues PCP rate increase beyond 2014 CY.
“Estimated” assumes indeterminate woodwork effect. “Maximum” assumes Medicaid expansion and 100% woodwork effect.
Potential PPACA Budget Impacts

• Medicaid Eligibility System
  – States are required to use Modified Adjusted Gross Income (MAGI) to determine Medicaid and KidCare eligibility starting January 2014.
  – The PPACA provides 90% match for technology infrastructure upgrades.
  – Various options:
    • Full replacement of all current eligibility technology housed at Dept. of Children and Families (FLORIDA system)
    • Remediate Medicaid and KidCare eligibility systems only
    • Transfer all or part of eligibility determination to PPACA Exchange (state-based, federally facilitated, or partnership)
IMPACT ON EMPLOYERS
Employer Mandate

- Employers with 50 or more fulltime employees must offer insurance benefits or face penalties
- The amount and scope of benefits offered must meet the requirements of PPACA
- Employer contributions for the purchase of these benefits must meet certain standards
- Employers failing to provide the mandated benefits at the specified contribution level are subject to certain penalties
Employer Penalties

• For failure to offer insurance, the penalty = $2,000 for each full-time employee (excluding the first 30)
  • “Full time employees” are those working more than 30 hours per week.

• For failure to offer “affordable” insurance that covers at least 60% of the cost of the plan, the penalty is the lesser of:
  • $3,000 per employee who enrolls in the exchange
  • $2,000 for every FTE, minus the first 30.

• “Affordable” means the cost of coverage does not exceed 9.5% of family income
State Group Health Insurance

• Florida is a “large employer” under PPACA

• OPS employees currently cannot participate in the State Group Plan
  – Florida will be subject to penalties if coverage is not extended to all employees working 30 hours or more a week.

• Employees who currently choose not to participate in the State Group Plan may do so to comply with the individual mandate
State Group Health Insurance

• Impact Estimates
  – OPS enrollment: 3,864 eligible; 2,552 estimated
  – Opt-out enrollment: 14,897 eligible; 2,979 estimated
  – Various regulatory changes

• Estimated cost of “no coverage” penalty:
  – $312 million annually

• Estimated costs to comply with employer aspects of PPACA:
  – SFY 2012–’13 - $0.38 million
  – SFY 2013–’14 - $48.8 million
  – SFY 2014–’15 - $117.6 million
  – SFY 2015–’16 - $127.6 million
Decision Points

Private Employers: What Assistance?
• Future of Florida Health Choices
• Future of flex plans, etc

State Group: What Changes?
• Eligibility
• Coverage
• Plan design
More Information

State of Florida Long-Range Financial Outlook, Fiscal Year 2013-14 through 2015-16
http://edr.state.fl.us/Content/long-range-financial-outlook/

Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010; Final Rule

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule

Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Correction

Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act; Self-Insurance Estimating Conference State Employees’ Health Insurance Trust Fund
http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceImpact.pdf
Acronyms

- AHCA - Agency for Health Care Administration
- FFE - Federally-Facilitated Exchange
- F/SP - Federal/State Partnership Exchange
- FMAP - Federal Medical Assistance Percentages
- FHKC - Florida Healthy Kids Corporation
- MLR - Medical Loss Ratios
- MAGI - Modified Adjusted Gross Income
- OIR - Office of Insurance Regulation
- QHPs - Qualified Health Plans
- SBE - State Based Exchange
- SCHIP - State Children’s Health Insurance Plan
- SHOP - Small Business Health Options Program
- SSI - Supplemental Security Income
## Civilian Noninstitutionalized Uninsured Population by State and District of Columbia

<table>
<thead>
<tr>
<th>State</th>
<th>Estimated Number of Uninsured</th>
<th>Number, Percent, and Ranking of Uninsured</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number based on Uninsured</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Uninsured</td>
<td>Total</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percentage of</td>
<td>Population</td>
</tr>
<tr>
<td>United States</td>
<td>46,282,214</td>
<td>15.2%</td>
<td></td>
</tr>
<tr>
<td>Alabama</td>
<td>668,171</td>
<td>14.2%</td>
<td>22</td>
</tr>
<tr>
<td>Alaska</td>
<td>136,901</td>
<td>19.9%</td>
<td>41</td>
</tr>
<tr>
<td>Arizona</td>
<td>1,059,460</td>
<td>16.8%</td>
<td>12</td>
</tr>
<tr>
<td>Arkansas</td>
<td>491,512</td>
<td>17.2%</td>
<td>29</td>
</tr>
<tr>
<td>California</td>
<td>6,694,764</td>
<td>18.2%</td>
<td>1</td>
</tr>
<tr>
<td>Colorado</td>
<td>770,062</td>
<td>15.6%</td>
<td>20</td>
</tr>
<tr>
<td>Connecticut</td>
<td>312,564</td>
<td>8.9%</td>
<td>34</td>
</tr>
<tr>
<td>Delaware</td>
<td>87,105</td>
<td>9.9%</td>
<td>47</td>
</tr>
<tr>
<td>District of Columbia</td>
<td>42,291</td>
<td>7.1%</td>
<td>51</td>
</tr>
<tr>
<td>Florida</td>
<td>3,900,667</td>
<td>21.0%</td>
<td>3</td>
</tr>
<tr>
<td>Georgia</td>
<td>1,846,064</td>
<td>19.4%</td>
<td>5</td>
</tr>
<tr>
<td>Hawaii</td>
<td>95,985</td>
<td>7.3%</td>
<td>45</td>
</tr>
<tr>
<td>Idaho</td>
<td>264,576</td>
<td>17.1%</td>
<td>37</td>
</tr>
<tr>
<td>Illinois</td>
<td>1,686,201</td>
<td>13.3%</td>
<td>6</td>
</tr>
<tr>
<td>Indiana</td>
<td>924,431</td>
<td>14.5%</td>
<td>14</td>
</tr>
<tr>
<td>Iowa</td>
<td>268,050</td>
<td>8.9%</td>
<td>36</td>
</tr>
<tr>
<td>Kansas</td>
<td>369,170</td>
<td>13.2%</td>
<td>33</td>
</tr>
<tr>
<td>Kentucky</td>
<td>625,254</td>
<td>14.7%</td>
<td>24</td>
</tr>
<tr>
<td>Louisiana</td>
<td>779,363</td>
<td>17.6%</td>
<td>17</td>
</tr>
<tr>
<td>Maine</td>
<td>134,915</td>
<td>10.3%</td>
<td>43</td>
</tr>
<tr>
<td>Maryland</td>
<td>622,676</td>
<td>11.0%</td>
<td>25</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>274,799</td>
<td>4.2%</td>
<td>35</td>
</tr>
<tr>
<td>Michigan</td>
<td>1,171,977</td>
<td>12.0%</td>
<td>10</td>
</tr>
<tr>
<td>Minnesota</td>
<td>471,883</td>
<td>9.0%</td>
<td>30</td>
</tr>
<tr>
<td>Mississippi</td>
<td>520,554</td>
<td>17.9%</td>
<td>27</td>
</tr>
<tr>
<td>Missouri</td>
<td>779,273</td>
<td>13.3%</td>
<td>18</td>
</tr>
<tr>
<td>Montana</td>
<td>172,441</td>
<td>17.7%</td>
<td>40</td>
</tr>
<tr>
<td>Nebraska</td>
<td>207,793</td>
<td>11.5%</td>
<td>39</td>
</tr>
<tr>
<td>Nevada</td>
<td>589,593</td>
<td>22.1%</td>
<td>26</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>136,089</td>
<td>10.4%</td>
<td>42</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1,122,684</td>
<td>12.9%</td>
<td>11</td>
</tr>
<tr>
<td>New Mexico</td>
<td>399,283</td>
<td>19.7%</td>
<td>32</td>
</tr>
<tr>
<td>New York</td>
<td>2,213,914</td>
<td>11.6%</td>
<td>4</td>
</tr>
<tr>
<td>North Carolina</td>
<td>1,539,960</td>
<td>16.5%</td>
<td>7</td>
</tr>
<tr>
<td>North Dakota</td>
<td>64,252</td>
<td>9.7%</td>
<td>49</td>
</tr>
<tr>
<td>Ohio</td>
<td>1,365,101</td>
<td>12.0%</td>
<td>8</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>689,967</td>
<td>18.8%</td>
<td>21</td>
</tr>
<tr>
<td>Oregon</td>
<td>631,645</td>
<td>16.6%</td>
<td>23</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1,245,849</td>
<td>10.0%</td>
<td>9</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>119,068</td>
<td>11.5%</td>
<td>44</td>
</tr>
<tr>
<td>South Carolina</td>
<td>775,238</td>
<td>17.1%</td>
<td>19</td>
</tr>
<tr>
<td>South Dakota</td>
<td>95,893</td>
<td>12.0%</td>
<td>46</td>
</tr>
<tr>
<td>Tennessee</td>
<td>896,750</td>
<td>14.3%</td>
<td>16</td>
</tr>
<tr>
<td>Texas</td>
<td>5,795,809</td>
<td>23.4%</td>
<td>2</td>
</tr>
<tr>
<td>Utah</td>
<td>409,580</td>
<td>14.9%</td>
<td>31</td>
</tr>
<tr>
<td>Vermont</td>
<td>47,860</td>
<td>7.7%</td>
<td>50</td>
</tr>
<tr>
<td>Virginia</td>
<td>974,989</td>
<td>12.5%</td>
<td>13</td>
</tr>
<tr>
<td>Washington</td>
<td>923,249</td>
<td>13.9%</td>
<td>15</td>
</tr>
<tr>
<td>West Virginia</td>
<td>264,369</td>
<td>14.5%</td>
<td>38</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>518,252</td>
<td>9.2%</td>
<td>28</td>
</tr>
<tr>
<td>Wyoming</td>
<td>83,918</td>
<td>15.1%</td>
<td>48</td>
</tr>
</tbody>
</table>

Source: US Census Bureau, 2009-2011 American Community Survey 3-Year Estimates, Table S2702.
INSURANCE REGULATION

Select Committee on Patient Protection and Affordable Care Act

December 3, 2012
# Provisions of PPACA Relating to Insurance Regulation

<table>
<thead>
<tr>
<th>Federal Provision/Citation</th>
<th>Summary of Provision</th>
<th>Plan Application</th>
<th>Effective Date</th>
<th>Florida Statutory Provision or Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual and Lifetime Limits (1001)</strong></td>
<td>Prohibits lifetime and annual limits on the dollar value of essential health benefits.</td>
<td>Lifetime limits: all plans. Annual limits: all plans except grandfathered individual plans.</td>
<td>Plan years beginning on or after 9/23/2010</td>
<td>N/A general limits. Some mandated benefits have limits, such as autism ($35,000 annual/$200,000 lifetime).</td>
</tr>
<tr>
<td><strong>Rescissions (1001)</strong></td>
<td>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.</td>
<td>All plans</td>
<td>Plan years beginning on or after 9/23/2010</td>
<td>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.</td>
</tr>
</tbody>
</table>
| **Coverage of Preventive Health Services (1001)** | Requires coverage without cost-sharing (with exceptions) for:  
   - 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 by the Health Resources and Services Administration. | All non-grandfathered plans | Plan years beginning on or after 9/23/2010 | 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. Coverage provides child wellness benefits for children from birth to age 16 and is exempt from deductible. Requires newborn coverage and newborn hearing screening. Must allow one annual OB-GYN visit. Cost sharing generally allowed. |
<p>| <strong>Extension of Adult Dependent Coverage (1001)</strong> | 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 | All plans | Plan years beginning on or after | Group policies that insure dependent children of the policyholder must continue coverage at least until the end |</p>
<table>
<thead>
<tr>
<th>Federal Provision/Citation</th>
<th>Summary of Provision</th>
<th>Plan Application</th>
<th>Effective Date</th>
<th>Florida Statutory Provision or Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>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.</td>
<td>9/23/2010</td>
<td>of the calendar year, in which the child reaches age 25, if the child is dependent on policyholder for support and the child is living in the household of the policyholder or is a full-time or part-time student. Policies that insure dependent children must include coverage to age 30 if the child is unmarried and does not have a dependent, is a Florida resident, or is a student, and is not provided other coverage.</td>
<td></td>
</tr>
<tr>
<td>Preexisting Condition Exclusions (1201)</td>
<td>Prohibits a plan from imposing any preexisting condition exclusions.</td>
<td>All plans except grandfathered individual market plans</td>
<td>Plan years beginning on or after 9/23/2010 for children under the age of 19. Effective for plan years beginning on or after, 01/01/2014 for all other individuals.</td>
<td>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 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. Creditable coverage may reduce exclusion period.</td>
</tr>
<tr>
<td>Insurer Reporting of Claims and Enrollment Data (1001)</td>
<td>Requires plans to submit to HHS and state insurance regulators and make available to the public the following information in plain language: Claims payment policies and practices, Periodic financial disclosures, Data on enrollment and disenrollment,</td>
<td>All non-grandfathered plans</td>
<td>Plan beginning on or after 9/23/2010</td>
<td>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).</td>
</tr>
<tr>
<td>Federal Provision/Citation</td>
<td>Summary of Provision</td>
<td>Plan Application</td>
<td>Effective Date</td>
<td>Florida Statutory Provision or Rule</td>
</tr>
<tr>
<td>----------------------------</td>
<td>--------------------------------------------------------------------------------------------------------</td>
<td>------------------</td>
<td>----------------</td>
<td>--------------------------------------</td>
</tr>
<tr>
<td></td>
<td>• Data on the number of claims that are denied</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Data on rating practices,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Information on cost-sharing and payments with respect to out-of-network coverage, and</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Other information as determined by HHS.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurer Reporting of</td>
<td>Requires plans to submit annual reports to HHS on whether the benefits under the plan:</td>
<td>All non-</td>
<td>Plans years</td>
<td>N/A.</td>
</tr>
<tr>
<td>Quality of Care (1001)</td>
<td>• Improve health outcomes through activities such as quality reporting, case management, care</td>
<td>grandfathered</td>
<td>beginning on</td>
<td></td>
</tr>
<tr>
<td></td>
<td>coordination, chronic disease management;</td>
<td>plans</td>
<td>or after</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Implement activities to prevent hospital readmission;</td>
<td></td>
<td>9/23/2012</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Implement activities to improve patient safety and reduce medical errors; and Implement wellness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>and health promotion activities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insurer Reporting of</td>
<td>Requires plans to report to HHS information concerning the percent of premium revenue spent on</td>
<td>All fully insured</td>
<td>Plan years</td>
<td>Generally, the MLR for small group</td>
</tr>
<tr>
<td>Medical Loss Ratios (MLR)</td>
<td>claims for clinical services and activities (medical loss ratio). Requires insurers to provide a</td>
<td>plans, including</td>
<td>beginning on</td>
<td>and the guaranteed renewable</td>
</tr>
<tr>
<td>and Payment of Rebates</td>
<td>rebate to consumers if the percentage of premiums expended for clinical services and activities is</td>
<td>grandfathered</td>
<td>or after</td>
<td>individual policy is 65 percent. Rates</td>
</tr>
<tr>
<td>(1001)</td>
<td>less than 85% in the large group market and 80% in the small group and individual markets.</td>
<td>plans</td>
<td>1/1/2011</td>
<td>for large group are not subject to</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>approval by OIR. Calculation of MLR</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>and any applicable rebate is not</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>consistent with federal regulations.</td>
</tr>
<tr>
<td>Appeals and External</td>
<td>Requires plans to implement an internal appeals and external review process. For the internal</td>
<td>All non-</td>
<td>Plan years</td>
<td>In 2012, legislation was enacted</td>
</tr>
<tr>
<td>Review (1001)</td>
<td>appeals process, group plans must incorporate the U.S. Department of Labor's claims and appeals</td>
<td>grandfathered</td>
<td>beginning on</td>
<td>which addressed some of the provisions</td>
</tr>
<tr>
<td></td>
<td>procedures and update them to reflect standards established by the Secretary of Labor. Individual</td>
<td>plans</td>
<td>or after</td>
<td>relating to internal grievances.</td>
</tr>
<tr>
<td></td>
<td>plans must incorporate applicable law requirements and update them to reflect standards established</td>
<td></td>
<td>9/23/2010</td>
<td>Additional changes are necessary to</td>
</tr>
<tr>
<td></td>
<td>by HHS.</td>
<td></td>
<td></td>
<td>comply with PPACA.</td>
</tr>
<tr>
<td></td>
<td>For the external review process, all plans must comply with applicable state external review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>processes that, at a minimum, include consumer protections in the NAIC Uniform External Review</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Model Act (Model 76) or with minimum standards established by HHS that is similar to the NAIC model.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care</td>
<td>A plan that provides for designation of a primary care provider</td>
<td>All non-</td>
<td>Plan years</td>
<td>Insurers/HMOs may require higher</td>
</tr>
<tr>
<td></td>
<td></td>
<td>grandfathered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Federal Provision/Citation</td>
<td>Summary of Provision</td>
<td>Plan Application</td>
<td>Effective Date</td>
<td>Florida Statutory Provision or Rule</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------</td>
<td>------------------</td>
<td>----------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Physicians, Emergency Room Coverage, and OB-GYN coverage (1001)</td>
<td>must allow the choice of any participating primary care provider who is available to accept them. If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. 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. 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.</td>
<td>grandfathered plans</td>
<td>beginning on or after 9/23/2010</td>
<td>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 for emergency care, based on determination by hospital physician or other personnel, provided by either a participating or nonparticipating provider. Copayments and reimbursement for services and subscriber charges addressed. 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. 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 follow-up care.</td>
</tr>
<tr>
<td>State Review of Insurers Premium Increases (1003)</td>
<td>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.</td>
<td>All non-grandfathered fully-insured plans</td>
<td>Plan years beginning on or after 1/1/2010</td>
<td>Individual and small group rates filings are subject to prior approval by the OIR. Rate filings are available on the OIR website.</td>
</tr>
<tr>
<td>Rating and Underwriting Standards (1201)</td>
<td>Allows variations in the premiums of Individual and small group premiums only by:</td>
<td>Non-grandfathered fully insured small group and individual plans. Fully insured</td>
<td>Plan years beginning on or after 1/01/2014</td>
<td>Individual market: case traits used for rating include age, gender, family composition, area by county, tobacco usage, effective date, and trend.</td>
</tr>
<tr>
<td>Federal Provision/Citation</td>
<td>Summary of Provision</td>
<td>Plan Application</td>
<td>Effective Date</td>
<td>Florida Statutory Provision or Rule</td>
</tr>
<tr>
<td>----------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>-------------------------------------</td>
</tr>
<tr>
<td>Guaranteed Availability of coverage (1201)</td>
<td>Requires plans to accept every employer and every individual that applies for coverage. However, insurer/HMO may restrict enrollment based upon open or special enrollment periods.</td>
<td>Non-grandfathered fully insured plans.</td>
<td>Plan years beginning on or after 1/01/14</td>
<td>Guaranteed issue available in the individual market for HIPPA-eligible individuals. Guaranteed issue in the group market.</td>
</tr>
<tr>
<td>Non Discrimination Based On Health status (1201)</td>
<td>Prohibits a plan from establishing 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, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or • Any other health-status related factor deemed appropriate by HHS</td>
<td>All non-grandfathered plans</td>
<td>Plan years beginning on or after 01/01/14</td>
<td>Insurers and HMOs offering group coverage prohibited from establishing rules for eligibility based on same specified health-status related factors.</td>
</tr>
<tr>
<td>Prohibition on Waiting Periods (1201)</td>
<td>Prohibits plans from imposing waiting periods that exceed 90 days.</td>
<td>All group plans</td>
<td>Plan years beginning on or after 01/01/14</td>
<td>Generally this is a contractual issue.</td>
</tr>
<tr>
<td>Coverage for Clinical Trial Participants (1201)</td>
<td>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.</td>
<td>All nongrandfathered plans</td>
<td>Plan years beginning on or after 01/01/14</td>
<td>Several insurers and self-insured governmental entities entered into a voluntary agreement to provide routine patient care costs related to clinical trials for all those insured, diagnosed with cancer, and accepted into a Phase II, Phase III, or Phase IV clinical trial for cancer, group health plan</td>
</tr>
<tr>
<td>Grandfathered</td>
<td>Provides that certain provisions of PPACA will not apply to</td>
<td>All coverage in force</td>
<td>Date of</td>
<td>N/A.</td>
</tr>
<tr>
<td>Federal Provision/Citation</td>
<td>Summary of Provision</td>
<td>Plan Application</td>
<td>Effective Date</td>
<td>Florida Statutory Provision or Rule</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------</td>
<td>-----------------</td>
<td>----------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td><strong>Plans</strong></td>
<td>group or individual coverage in which an individual was enrolled as of the date of enactment. The following provisions will apply to group and individual grandfathered plans: Excessive waiting periods, Lifetime limits only, Rescissions, Extension of dependent coverage, Uniform summary of benefits and coverage and standardized definitions, Medical loss ratios, Provisions applicable only to group health plans. Provisions of PHSA §2711 relating to annual limits and of PHSA §2704 relating to preexisting condition exclusions apply to grandfathered group health plans for plan years beginning when they would first otherwise apply. Additional family members may enroll in grandfathered coverage, and new employees may enroll in grandfathered group coverage.</td>
<td>as of the date of enactment.</td>
<td>enactment (3/23/10)</td>
<td>N/A. Administered by the federal government.</td>
</tr>
</tbody>
</table>
| **Individual Mandate (1501)** | All U.S. citizens and lawful residents are required to obtain essential health benefits coverage. If a taxpayer fails to maintain minimum essential coverage, they will be required to pay an annual tax penalty of the greater of $95 for each household member, up to three, or 1% of household income in 2014, $325 or 2% of household income in 2015, and $695 or 2.5% of income in following years. Taxpayers are exempted from the tax if any of the following conditions are met:  
  ● The individual has a religious objection to purchasing health insurance or is enrolled in a health care sharing ministry.  
  ● The cost of the taxpayer’s premium contribution for employer-sponsored coverage or for the lowest-cost bronze level coverage available in the exchange exceeds 8% of household income.  
  ● The taxpayer’s household income is below the federal income tax filing threshold.  
  ● The taxpayer is a member of a recognized Indian tribe. | Plan years beginning on or after 1/1/2014 | N/A. Administered by the federal government. |
<table>
<thead>
<tr>
<th>Federal Provision/Citation</th>
<th>Summary of Provision</th>
<th>Plan Application</th>
<th>Effective Date</th>
<th>Florida Statutory Provision or Rule</th>
</tr>
</thead>
</table>
| Employer Coverage Penalties (1513) | • The break in coverage is less than three months.  
• HHS determines that the taxpayer has suffered a hardship with respect to their ability to obtain coverage.  
• The individual is not lawfully present in the United States.  
• The individual is incarcerated.  
• The individual resides outside of the United States. | Employers with more than 50 employees. | 01/01/2014 | N/A. Administered by federal government. |
| Essential Health Benefits, Benchmark Plan, and Levels of Coverage (1302) | If an employer fails to offer minimum essential coverage and one of its employees receives a premium tax credit or cost-sharing subsidy through the exchange, the employer will be subject to a penalty of $2,000 per employee.  
For employers offering coverage who have an employee receiving a premium tax credit or cost-sharing subsidy through the exchange, the employer will be subject to a penalty of $3,000 per employee receiving a premium tax credit or cost-sharing subsidy. The penalty shall not exceed $2,000 times the number of full-time employees.  
Employers of 50 or fewer employees are exempt from these requirements, and the first 30 employees are disregarded in calculating the penalty. | Plan years beginning on or after 01/01/2014  
Benchmark plan options based on enrollment as of 3/31/2012. States must select benchmark | Current Florida law mandates coverage of numerous benefits, services, and providers of services. However, there is no mandated essential health benefit plan. |
<table>
<thead>
<tr>
<th>Federal Provision/Citation</th>
<th>Summary of Provision</th>
<th>Plan Application</th>
<th>Effective Date</th>
<th>Florida Statutory Provision or Rule</th>
</tr>
</thead>
</table>
|                            | • Preventive and wellness services and chronic disease management  
• Pediatric services, including oral and vision care |                  | and supplement as needed by the 3rd quarter 2012 or default applies. However, deadline has been extended. |                              |
|                            | States have the flexibility to select a benchmark plan that reflects the scope of services offered by a “typical employer plan.” State may choose one of the following benchmark plans:  
• One of the three largest small group plans in the state by enrollment;  
• One of the three largest employee health plans by enrollment;  
• One of the three largest federal employee health plan options by enrollment; or  
• The largest HMO plan offered in the state’s commercial market by enrollment. |                  |                |                              |
|                            | If a state does not choose a benchmark plan, the default benchmark plan will be the small group plan with the largest enrollment in the state. A benchmark plan must cover all categories of essential benefits. States may mandate additional benefits if it defrays the expenses of enrollees for the additional cost of these benefits. |                  |                |                              |
|                            | Exchanges as well as individual and small group markets must offer the following levels of coverage:  
• **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. |                  |                |                              |
<table>
<thead>
<tr>
<th>Federal Provision/Citation</th>
<th>Summary of Provision</th>
<th>Plan Application</th>
<th>Effective Date</th>
<th>Florida Statutory Provision or Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>American Health Benefit Exchanges (1311, 1313, 1321)</strong></td>
<td>Each state shall establish, as a governmental agency or nonprofit entity, an exchange that facilitates the purchase of qualified health plans and provides for the establishment of a Small Business Health Options Program (referred to as a “SHOP Exchange”) to assist qualified employers in facilitating the enrollment of employees in small group qualified health benefits plans. States may choose to establish a single exchange that performs both functions. Exchanges must be self-sustaining beginning in 2015, and may generate revenue through assessments, user fees, or other taxing mechanisms. If HHS determines in 2013 that a state is not electing to operate a state exchange, or a federal partnership, or that it will not have the exchange operational by January 1, 2014, or has not taken necessary actions to implement the market reforms, the HHS shall operate an exchange, directly or through an agreement with a nonprofit entity. An exchange must certify qualified health benefits plans consistent with regulations and guidelines developed by HHS. Other duties of an exchange include, but are not limited to:</td>
<td>Individual and small group</td>
<td>12/14/2012 deadline for states to submit application for state exchange. By 1/1/2013 HHS will certify states’ plans to run their own exchange in 2014. If a state chooses to operate an exchange in partnership with the federal government, an application to HHS must be received by 2/15/2013.</td>
<td>Not authorized in law. No state-based exchange has been created. Florida Healthy Kids determines eligibility for coverage as well as eligibility for subsidies, and provides access for range of insurance coverage for children. Florida Health Choices is designed to function as an interactive marketplace to provide access to insurance coverage.</td>
</tr>
</tbody>
</table>

Only U.S. citizens and lawful residents may purchase coverage through the exchange.
<table>
<thead>
<tr>
<th>Federal Provision/Citation</th>
<th>Summary of Provision</th>
<th>Plan Application</th>
<th>Effective Date</th>
<th>Florida Statutory Provision or Rule</th>
</tr>
</thead>
<tbody>
<tr>
<td>employed individuals. Federal funds for the establishment of exchanges may not be used for the payment of navigator grants. Initial, open enrollment for the exchange begins 10/1/2013. On 1/01/2014, exchanges for individuals and small groups begin operations. States may expand exchanges to include offering coverage to large employers on or after 01/01/2017.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Federal Program to Assist Establishment and operation of Nonprofit, Member-Run Health Issuers (Co-ops) (1322)</strong></td>
<td>Requires HHS to provide co-op plans with loans to assist with start-up costs and grants to assist with meeting solvency requirements. In making the loans and grants, HHS must give priority to plan that offer qualified health plans on a statewide basis, use integrated care models, and have significant private support and ensure that there is sufficient funding to establish at least one co-op plan in each state. Loans must be repaid within 5 years and grants must be repaid within 15 years. $6 billion is appropriated to fund the loans and grants. Any entity receiving a loan or grant must be organized under state law as a nonprofit, member corporation, may not have been a health insurance issuer prior to 7/16/2009, and may not be sponsored by a state or local government. Governance of the organization must avoid insurance industry involvement. Any profits made by the organization must be used to lower premiums, improve benefits, or improve the quality of care. The organization must meet all requirements that are required of other qualified health plans. Co-Op plans may not offer coverage in a state until the state has adopted the market reforms of PPACA.</td>
<td>No later than 7/1/2013</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td><strong>Multistate Plans (1334)</strong></td>
<td>The federal Office of Personnel and Management (OPM) shall contract with insurers to offer at least 2 multistate qualified health benefits plans through the exchange in each state to provide individual and small group coverage. The OPM may</td>
<td>01/01/2014</td>
<td>N/A. Federal program.</td>
<td></td>
</tr>
<tr>
<td>Federal Provision/Citation</td>
<td>Summary of Provision</td>
<td>Plan Application</td>
<td>Effective Date</td>
<td>Florida Statutory Provision or Rule</td>
</tr>
<tr>
<td>---------------------------</td>
<td>---------------------</td>
<td>-----------------</td>
<td>---------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td></td>
<td>set standards for multistate plans regarding medical loss ratios, profit margins, premiums, and other terms and conditions in the interests of enrollees. Participating insurers must be licensed in each state where it sells coverage.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Multistate Health Care Choice Compacts (1333) | Authorizes two or more states to enter into a “health care choice compact” under which individual market plans could be offered in all compacting states, subject to the laws and regulations of the state where coverage was written or issued. Issuers would continue to be subject to the following laws of the purchaser's home state:  
  - Market conduct;  
  - Unfair trade practices;  
  - Network adequacy;  
  - Consumer protection standards, including rating rules; and  
  - Laws addressing performance of the contract. | | 01/01/16 | N/A |
| Waiver for State Innovation (1332) | A state may apply for waivers of the following requirements:  
  - Requirements for qualified health benefits plans  
  - Requirements for exchanges  
  - Requirements for reduced cost-sharing in qualified health benefits plans and premium subsidies  
  - Requirements for the employer mandate  
  - Requirements for the individuals mandate  

The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver. State waiver plans must provide coverage that is at least as comprehensive as coverage offered through an exchange, must cover at least as many state residents as this title would cover and may not increase the federal deficit. Waivers are valid for 5 years and are renewable unless HHS disapproves a request for renewal within 90 day of receipt. | Plan years beginning on or after 1/1/2017. | | N/A |
<p>| Temporary reinsurance program for | 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 | All plans must pay assessments. Nongrandfathered | Plan years beginning in 2014 through | N/A. No statutory authority to operate reinsurance program. |</p>
<table>
<thead>
<tr>
<th><strong>Federal Provision/Citation</strong></th>
<th><strong>Summary of Provision</strong></th>
<th><strong>Plan Application</strong></th>
<th><strong>Effective Date</strong></th>
<th><strong>Florida Statutory Provision or Rule</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>individual market</strong>&lt;br&gt;(1341)</td>
<td>offsetting claims for high-cost individuals in nongrandfathered plans for the first three years of the exchange operations.&lt;br&gt;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.&lt;br&gt;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.</td>
<td>individual plans may receive payments.</td>
<td>2016.&lt;br&gt;HHS collection of reinsurance contributions begins 1/15/2014.</td>
<td></td>
</tr>
<tr>
<td><strong>Temporary Risk Corridors for Plans in Individual and Small Group Markets</strong>&lt;br&gt;(1342. 1343)</td>
<td>Requires HHS to establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program 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%.&lt;br&gt;Qualified individual and small group health plans. Nongrandfathered individual and small group plans.</td>
<td>Calendar years 2014-2016</td>
<td>N/A. HHS administers.</td>
<td></td>
</tr>
<tr>
<td><strong>Risk Adjustment</strong>&lt;br&gt;(1343)</td>
<td>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.&lt;br&gt;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.</td>
<td>Nongrandfathered individual and small group plans</td>
<td>01/01/14</td>
<td>N/A. No statutory authority to administer program.</td>
</tr>
</tbody>
</table>
Uninsured Population Overview

Select Committee on the Patient Protection and Affordable Care Act

DECEMBER 3, 2012
Who are the Uninsured?

• Based on 2009-2011 American Community Survey 3 Year Estimates (ACS)

• Social Services Estimating Conference will meet again on December 10\textsuperscript{th} to update its figures from the August 14\textsuperscript{th} conference
  – The August 2012 Conference used 2008-2010 3-Year ACS Estimates

• Not all of the uninsured may qualify for a subsidy even if appear income eligible – must meet other eligibility requirements
# Uninsured by Age

<table>
<thead>
<tr>
<th>Age Band</th>
<th>Total Population</th>
<th>Number of Uninsured</th>
<th>Percent Uninsured</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under Age 18</td>
<td>3,985,822</td>
<td>530,787</td>
<td>13.3%</td>
</tr>
<tr>
<td>Age 18 to 64</td>
<td>11,334,018</td>
<td>3,324,657</td>
<td>29.3%</td>
</tr>
<tr>
<td>65 years and older</td>
<td>3,216436</td>
<td>45,223</td>
<td>1.4%</td>
</tr>
<tr>
<td><strong>Total:</strong></td>
<td><strong>18,536,276</strong></td>
<td><strong>3,900,667</strong></td>
<td><strong>21%</strong></td>
</tr>
</tbody>
</table>
## Uninsured by Poverty Level

<table>
<thead>
<tr>
<th>Poverty Level Range</th>
<th>Number Uninsured</th>
<th>Percent Uninsured of Population under this Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 138% FPL</td>
<td>1,577,315</td>
<td>35.2%</td>
</tr>
<tr>
<td>138% FPL to 199% FPL*</td>
<td>725,184</td>
<td>30.2%</td>
</tr>
<tr>
<td>200% FPL and over</td>
<td>1,577,850</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

*Subsidized coverage under Medicaid or SCHIP in Florida is available up to 200% FPL for children*
### Uninsured by Income Level

<table>
<thead>
<tr>
<th>Household Income Level (2011 Inflation Adjusted Dollars)</th>
<th>Number Uninsured</th>
<th>Percent Uninsured of Total Population under this Income Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under $25,000</td>
<td>1,122,258</td>
<td>29.8%</td>
</tr>
<tr>
<td>$25,000 - $49,999</td>
<td>1,327,910</td>
<td>27.4%</td>
</tr>
<tr>
<td>$50,000 - $74,999</td>
<td>741,723</td>
<td>20.2%</td>
</tr>
<tr>
<td>$75,000 - $99,999</td>
<td>344,865</td>
<td>14.6%</td>
</tr>
<tr>
<td>$100,000 – and over</td>
<td>325,160</td>
<td>8.7%</td>
</tr>
</tbody>
</table>
### 2012 Federal Poverty Levels

<table>
<thead>
<tr>
<th>Household Size</th>
<th>100% FPL</th>
<th>200% FPL</th>
<th>400% FPL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$11,170</td>
<td>$22,340</td>
<td>$44,680</td>
</tr>
<tr>
<td>2</td>
<td>$15,130</td>
<td>$30,260</td>
<td>$60,520</td>
</tr>
<tr>
<td>3</td>
<td>$19,090</td>
<td>$38,180</td>
<td>$76,360</td>
</tr>
<tr>
<td>4</td>
<td>$23,050</td>
<td>$46,100</td>
<td>$92,200</td>
</tr>
<tr>
<td>5</td>
<td>$27,010</td>
<td>$54,020</td>
<td>$108,040</td>
</tr>
</tbody>
</table>

- Individuals or families would qualify for Medicaid, CHIP or subsidized coverage, depending on the state’s coverage decisions, with a household income up to 400% FPL.
THE FLORIDA SENATE

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

December 3, 2012
Meeting Date

Topic  Mandated health insurance

Name    Paul Henry

Job Title

Address PO Box 698
Street
Monticello FL 32345
City State Zip

Bill Number
(if applicable)

Amendment Barcode
(if applicable)

Phone 850-629-9550

E-mail paul@liberty2010.com

Speaking:  □ For  □ Against  □ Information

Representing  Paul Henry & Associates

Appearing at request of Chair: □ Yes  □ No

Lobbyist registered with Legislature: □ Yes  □ No

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

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

S-001 (10/20/11)
THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date 12/03/2012

Topic Health Insurance Exchange

Name Michael Rosenthal

Bill Number (if applicable)

Amendment Barcode (if applicable)

Job Title

Address 4095 Kilmarin Dr

Tallahassee, FL 32309

Phone

E-mail

Speaking:  □ For  □ Against  □ Information

Representing Self

Appearing at request of Chair:  □ Yes  □ No

Lobbyist registered with Legislature:  □ Yes  □ No

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

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

S-001 (10/20/11)
THE FLORIDA SENATE
APPEARANCE RECORD
(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date 12-3-2012

Topic OBAMACARE

Name Terri Fogler

Job Title Homemaker

Address 644 Ponderosa Cir

Street

City Midway

State

Zip

Bill Number __________________________ (if applicable)

Amendment Barcode __________________________ (if applicable)

Phone __________________________

E-mail fogler_75@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

Representing myself

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.
Meeting Date: 12-3-12

Topic: Senate Select Comm: PPACA Health

Name: Kathy Cooper

Job Title: 

Address: 295 NW Commons Loop #150

City: Lake City, FL

Phone:

E-mail:

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

Representing:

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

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

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

This form is part of the public record for this meeting.
3 Dec 2012
Meeting Date

Topic  Health Care Bill Exchanges
Name  Marge Kloess
Job Title  NA
Address  5030 Oyster Cove
New Port Richey, FL  34652

Speaking:  ☑ Against  ☐ Information
Representing

Bill Number  (if applicable)
Amendment Barcode  (if applicable)
Phone  727-848-7944
E-mail  edmarine@earthlink.net

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

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

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

APPEARANCE RECORD

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

Meeting Date

Topic Constituency Dec 3

Bill Number (if applicable)

Name Rev Cooper

Amendment Barcode (if applicable)

Job Title Tax Payer

Phone

Address 995 NW Commons Loop Ste 115-312

E-mail

City

State

Zip

Speaking: □ For □ Against □ Information

Representing

Appearing at request of Chair: □ Yes □ No

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

This form is part of the public record for this meeting.
THE FLORIDA SENATE
APPEARANCE RECORD
(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date 12/3/___

Topic Affordable Health Care Act

Name Yoanne Heikkilinen

Job Title

Address 3361 Green Acres Rd.

Street St Augustine, FL

City State Zip 32084

Bill Number ________________________ (if applicable)

Amendment Barcode ________________________ (if applicable)

Phone 904 829.3896

E-mail yoannay1911@att.net

Speaking:  □ For  □ Against  □ Information

Representing

Appearing at request of Chair: □ Yes □ No

Lobbyist registered with Legislature: □ Yes □ No

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

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

APPEARANCE RECORD

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

Meeting Date

Topic

Health Care Exchange

Bill Number (if applicable)

Name

DAVID HEIMBOED, SR.

Amendment Barcode (if applicable)

Job Title

Chief St. Augustine Ten Party

Phone

904-575-553-7312

Address

112 Manresa Rd

E-mail

D.P. Heimbold@mylive.com

St., Aug., FL 32084

City State Zip

Speaking: □ For □ Against □ Information

Representing

Ten Party, St. Augustus

 Appearing at request of Chair: □ Yes □ No

Lobbyist registered with Legislature: □ Yes □ No

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

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

APPEARANCE RECORD

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

12/3/12
Meeting Date

Topic Patient Protection & Affordable Care Act

Name Peter Lee

Job Title Director

Address 1450 Lyceum Cir
Orlando FL 32826

Phone 321-800-8683
E-mail Peter.eastsidetemparty.org

Speaking: ☐ For ☐ Against ☑ Information

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

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

Meeting Date

Topic State Health Care Exchanges

Name Linda O'Laughlin

Job Title RN, BSN

Address 16936 Comenwood Dr

Orlando, Otto 32820

Phone 6142884554

E-mail Lindaol2012@gmail.com

Speaking: ☐ For ☑ Information

Representing myself

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

This form is part of the public record for this meeting.
THE FLORIDA SENATE
APPEARANCE RECORD

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

Meeting Date

Topic

Bill Number

Name Shirley A. Bruch

Amendment Barcode

Job Title AP

(if applicable)

Address

Phone 727-845-1830

9158 Moor Gate Ct.

E-mail

State

34154

City

NEW Port Richey. Fl.

Speaking:

For

Against

Information

Representing

Appearing at request of Chair: No

Lobbyist registered with Legislature: No

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

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

APPEARANCE RECORD

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

**Meeting Date**
12-3-12

**Topic**
Health Care Exchange

**Name**
BRYAN D. DUKEMAN

**Job Title**

**Address**
PORT ORANGE, FL

**City**

**State**
Florida

**Zip**

**Bill Number**

**Amendment Barcode**

**Phone**
386-322-9045

**E-mail**
udueman@cf.rr.com

**Speaking**

For

Against

Information

Representing
EVERYONE WHO LOVES A FREE AMERICA

** Appearing at request of Chair**

Yes [ ]

No [ ]

**Lobbyist registered with Legislature**

Yes [ ]

No [ ]

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

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

APPEARANCE RECORD

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

Meeting Date

Topic ACA

Name Staw Whittekar

Job Title RNCP

Address 6294 NW Torrey Rd

City Brissdl

State FL

Zip 32011

Bill Number ____________________

Amendment Barcode ____________________

Phone 850-545-8301

E-mail Staw Whitte Ad.l.com

Speaking:  [ ] For    [ ] Against    [x] Information

Representing [x] Association of Nurse Practitioners

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

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

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

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

S-001 (10/20/11)
Dec. 3 2012
Meeting Date

Topic Affordable Care

Bill Number (if applicable)

Name Robert H. Musey, Jr.

Amendment Barcode (if applicable)

Job Title Retired

Phone 386-226-2257

Address 911 Daytona Ave.

E-mail None

Holly Hill, FL 32117

City State Zip

Speaking: □ For √ Against □ Information

Representing Self

Appearing at request of Chair: □ Yes √ No

Lobbyist registered with Legislature: □ Yes √ No

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

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

APPEARANCE RECORD

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

Meeting Date

Topic AFRORDABLE CAR EXCHANGES

Bill Number ____________________________ (if applicable)

Name Bob Root

Amendment Barcode ____________________________ (if applicable)

Job Title N/A

Phone 850-584-8311

Address 110 LAK PLEASANT LN

E-mail taylor6teaparty@ hotmail.com

SHADY GROVE, FL 32357

City State Zip

Speaking: □ For □ Against □ Information

Representing MYSELF

Appearing at request of Chair: □ Yes □ No

Lobbyist registered with Legislature: □ Yes □ No

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

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

S-001 (10/20/11)
THE FLORIDA SENATE

APPEARANCE RECORD

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

Meeting Date

Topic
Health Care Act

Name
Bever J. Wilcox

Job Title
Retired

Address
181 E. 18 St
CVilla FL 32766

Bill Number
FFAC
(if applicable)

Amendment Barcode
(if applicable)

Phone
321 460 2100

E-mail
missbeathy2865@gmail.com

Speaking:
□ For □ Against □ Information

Representing
SELF

Appearing at request of Chair: □ Yes □ No

Lobbyist registered with Legislature: □ Yes □ No

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

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

S-001 (10/20/11)
THE FLORIDA SENATE
APPEARANCE RECORD
(Deliver BOTH copies of this form to the Senator or Senate Professional Staff conducting the meeting)

Meeting Date

Topic  HEALTH CARE

Name  NELSON A. PRYOR

Job Title  RETIRED

Address  195 12TH ST. N E

City  LEE

State  FL

Zip

Speaking:  ☐ For  ☐ Against  ☑ Information

Representing  SELF

Bill Number

(if applicable)

Amendment Barcode

(if applicable)

Phone  (850) 971-5285

E-mail

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)
Meeting Date: 12/3/12

Topic: Health Care exchange

Name: Ron Beyea

Job Title: 

Address: 1638 Montez Dr.
Street: Guam Breeze
City: 
State: 
Zip: 

Speaking: □ For □ Against □ Information

Representing: 

Bill Number: (if applicable)

Amendment Barcode: (if applicable)

Phone: 850-486-6022
E-mail: ronbeyea@belkboth.net

 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.
3 Dec 2012

Meeting Date

Topic: Affordable Health Care

Name: Bob Rettie

Job Title: 

Address: 317 Sudduth Circle

Fort Walton Beach, FL 32548

Phone: 850-243-1763

E-mail: rettie@cox.net

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

Representing: [X] Panhandle Patriots

Bill Number: ________________________________

 Amendement Barcode: ________________________________

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

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

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

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

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

Meeting Date 3Dec 2012

Topic State Exchanges

Name Debbie Gunnoe

Job Title Retired

Address 8143 Chatsworth Dr

City Navarre FL State 32566 Zip

Bill Number (if applicable)

Amendment Barcode (if applicable)

Phone (850) 515-0217

E-mail debbie.gunnue@putbedfirst.co

Speaking: ☒ For ☐ Against ☐ Information

Representing Self

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

This form is part of the public record for this meeting.
12-3-12  
Meeting Date

Topic: ACA STATE EXCHANGE COMMITTEE  
Name: TERRANCE J. SHOEMAKER  
Job Title: RET AF  
Address: 31 RUBY CIR  
MARY ESTHER, FL 32569  
Phone: 850 362-0043  
E-mail: tjshoe@oox.net

Speaking: ☑ For  ☑ Against  ☑ Information

Representing: PANHANDLE PATRIOTS TEA PARTY

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

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

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

APPEARANCE RECORD

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

Meeting Date 12-3-12

Topic Health Care

Name Judy Bartlett

Job Title

Address 1908 S. Dean Rd

Orlando Fl 32825

Phone 407 273-6063

E-mail jujube@bellsouth.net

Speaking: □ For □ Against □ Information

Representing Self

 Appearing at request of Chair: □ Yes □ No

Lobbyist registered with Legislature: □ Yes □ No

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

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

S-001 (10/20/11)
Dec. 3 2012
Meeting Date

Topic

Name KRIS ANNE HALL

Job Title

Address 8229 25th Drive
WEIBORNE, FL 32094

Phone 386 466 4556

E-mail krisanne@krisannehall.com

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

Representing Constitutional Education & Consulting.

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

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

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

This form is part of the public record for this meeting.
THE FLORIDA SENATE
APPEARANCE RECORD

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

Meeting Date: 12/3/12

Topic: Health Exchange

Name: John Lacauye

Job Title: Owner

Address: 8125 264th St. Branford, FL 32008

Phone: 386-935-1705

E-mail: jlacauye@yahoo.com

Bill Number: (if applicable)

Amendment Barcode: (if applicable)

Speaking: [ ] For [ ] Against [x] Information

Representing: John Lacauye Pinestraw

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

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

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

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

APPEARANCE RECORD

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

Meeting Date 12-3-12

Topic ____________________________________________________________

Bill Number ____________________________ (if applicable)

Name  LANCE THATE ____________________________________________

Amendment Barcode ____________________________ (if applicable)

Job Title ______________________________________________________

Address  PO Box 840271

Phone  904 461 0100

ST AUGUSTINE FL 32080

E-mail  LTHATE@COAST.NET

State Zip

Speaking:  ☐ For  ☐ Against  ☑ Information

Representing ____________________________________________________

 Appearing at request of Chair:  ☐ Yes  ☑ No

Lobbyist registered with Legislature:  ☐ Yes  ☑ No

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

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

S-001 (10/20/11)
The Florida Senate

Appearance Record

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

Meeting Date

12/31/12

Topic

Name Rod Gonzalez

Job Title Business Admin / Risk Mgmt

Address 24514 NW 38th Ave

Phone 352-244-0671

E-mail roderickf@msn.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)

Meeting Date

Topic

Bill Number
(if applicable)

Name LAURIE NEWSOM

Amendment Barcode
(if applicable)

Job Title ADMINISTRATOR/BUSINESS OWNER

Phone 352-377-7733

Address 2521 NW 41 ST

E-mail laurie@gainesville.com

City GAINESVILLE

Zip

Speaking: ☐ For ☐ Against ☑ Information

Representing

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

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

Meeting Date

Dec 3

Topic ____________________________

Insurance Mandate

Bill Number ________________________ (if applicable)

Name _____________________________

Janet Smith

Amendment Barcode __________________ (if applicable)

Job Title ___________________________

Address ___________________________

600 Capitol Cir

Phone ____________________________

904-705-6956

City _____________________________

Tallahassee

E-mail ____________________________

32102

schwede@senate.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)
Dec 3 2012
Meeting Date

Topic HEALTH CARE EXCHANGE DEBATE

Name JOHN KNAPP

Job Title PRIVATE CITIZEN

Address 2333 264TH STREET
          O'BRIEN, FLA  32071

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

Representing MYSELF / MANY MANY OTHERS

Bill Number N/A (if applicable)

Amendment Barcode N/A (if applicable)

Phone 386-935-2961

E-mail minutemen09@gmail.com

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

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

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

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

Appearance Record

Meeting Date: 11/3/12

Topic: State exchanges ACA

Bill Number: ________________________

(fif applicable)

Name: James C. Hall

Amendment Barcode: ________________________

(fif applicable)

Job Title: Pastor- Baptist Coalition of N. Florida

Address: 8229 25th Dr W Wellborn

Phone: 386 466 4542

Wellborn FL 32094

E-mail: contactmercy@gmail.com

Speaking: □ For □ Against □ Information

Representing: Baptist Coalition of N. Florida

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.
12-3-12
Meeting Date

Topic
Health Exchange

Name
Sharon Higgins

Job Title

Address
21256 49th Drive
Lake City, FL 32024

City
State
Zip

Bill Number
(if applicable)

Amendment Barcode
(if applicable)

Phone
(386) 935-0821

E-mail
shiggins@windstream.net

Speaking:
[ ] For
[ ] Against
[ ] Information

Representing
re: legislation

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

Lobbyist registered with Legislature:
[ ] Yes
[ ] No

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

This form is part of the public record for this meeting.
The Honorable Joe Negron
412 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Negron:

I would like to respectfully request to be excused from the Monday, December 3, 2012 meeting of the Select Committee on Patient Protection and Affordable Care Act. I have a prior commitment that day and will not be able to attend.

Sincerely yours,

[Signature]
David Simmons

cc: Steve Burgess, Staff Director
Meeting called to order
Quorum present
Sen. Negron
Sen. Simmons excused
Sen. Negron comments
Member Introductions
Sen. Sobel
Sen. Bean
Sen. Grimsley
Sen. Legg
Sen. Gibson
Sen. Smith
Sen. Brandes
Sen. Soto
Sen. Negron
Committee Staff Introductions
Sen. Negron - meeting plan
Lisa Johnson, Banking and Insurance Committee
Sen. Sobel question
Lisa Johnson answer to age question
Sen. Sobel benchmark default plan
Lisa Johnson, answer
Sen. Soto, question about exchanges
question deferred
Sandra Stoval, Health Policy Committee
Sen. Negron, questions/comments
Sandra Stoval, answer
Sen. Gibson, question
Sandra Stoval, answers re grant money
Sen Negron comments
Sen. Sobel, question
Sandra Stoval answer
Sen. Sobel,
Sen. Negron response
Jennifer Lloyd, Health Policy Committee
Jennifer Lloyd, Health Policy Committee
Sen. Negron, question
Jennifer Lloyd
Sen Gibson, question
Sen. Negron
Sen Gibson
Jennifer Lloyd
Allen Brown, HHS Appropriations
Sen. Bean, questions
Allen Brown re: rates
Sen Gibson, question
re: projections
Amy Baker, EDR, response to question
Sen. Brandes, question, impact of new eligibility requirements
Allen Brown, answer
Amy Baker, comment on response
Sen Sobel, question
<table>
<thead>
<tr>
<th>Time</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>4:04:03 PM</td>
<td>Where did figures come from?</td>
</tr>
<tr>
<td>4:04:11 PM</td>
<td>Amy Baker responds</td>
</tr>
<tr>
<td>4:04:26 PM</td>
<td>Sen. Sobel, questions</td>
</tr>
<tr>
<td>4:05:15 PM</td>
<td>Allen Brown</td>
</tr>
<tr>
<td>4:05:29 PM</td>
<td>Sen. Negron</td>
</tr>
<tr>
<td>4:05:55 PM</td>
<td>Sen. Sobel</td>
</tr>
<tr>
<td>4:06:12 PM</td>
<td>Allen Brown</td>
</tr>
<tr>
<td>4:07:33 PM</td>
<td>Carol Gormley, Senior Policy Advisor</td>
</tr>
<tr>
<td>4:16:32 PM</td>
<td>Sen. Negron</td>
</tr>
<tr>
<td>4:16:56 PM</td>
<td>Sen Legg, questions re: 30 hr employees</td>
</tr>
<tr>
<td>4:17:15 PM</td>
<td>Carol Gormley, response</td>
</tr>
<tr>
<td>4:18:54 PM</td>
<td>Sen. Negron comments</td>
</tr>
<tr>
<td>4:19:55 PM</td>
<td>Public Comments</td>
</tr>
<tr>
<td>4:19:59 PM</td>
<td>Sharon Higgins, Lake City</td>
</tr>
<tr>
<td>4:20:35 PM</td>
<td>James Hall, Wellborn, FL</td>
</tr>
<tr>
<td>4:24:28 PM</td>
<td>John Knapp, O'Brien</td>
</tr>
<tr>
<td>4:29:33 PM</td>
<td>Rod Gonzalez, Alachua, FL</td>
</tr>
<tr>
<td>4:30:22 PM</td>
<td>John Lacquey, Branford, FL</td>
</tr>
<tr>
<td>4:31:31 PM</td>
<td>Kris Anne Hall, Wellborn, FL</td>
</tr>
<tr>
<td>4:41:44 PM</td>
<td>Nelson Pryor, Lee, Florida</td>
</tr>
<tr>
<td>4:44:52 PM</td>
<td>Stan Whittaker, Bristol, FL</td>
</tr>
<tr>
<td>4:48:56 PM</td>
<td>Peter Lee, Orlando, FL</td>
</tr>
<tr>
<td>4:50:51 PM</td>
<td>David Heimbold, Sr. St. Augustine, FL</td>
</tr>
<tr>
<td>4:53:39 PM</td>
<td>Michael Rosenthal, Tallahassee, FL 32309</td>
</tr>
<tr>
<td>4:56:08 PM</td>
<td>Sen. Smith, Minority Leader, comments</td>
</tr>
<tr>
<td>4:59:02 PM</td>
<td>Sen Negron, comments</td>
</tr>
<tr>
<td>4:59:35 PM</td>
<td>Paul Henry, Monticello, FL</td>
</tr>
<tr>
<td>5:00:53 PM</td>
<td>Sen. Negron, closing comments.</td>
</tr>
</tbody>
</table>