

COMMITTEE MEETING EXPANDED AGENDA

SELECT COMMITTEE ON PATIENT PROTECTION AND AFFORDABLE CARE ACT

Senator Negron, Chair
Senator Sobel, Vice Chair

MEETING DATE: Monday, January 14, 2013
TIME: 4:00 —6:00 p.m.
PLACE: *Pat Thomas Committee Room, 412 Knott Building*

MEMBERS: Senator Negron, Chair; Senator Sobel, Vice Chair; Senators Bean, Brandes, Flores, Gibson, Grimsley, Legg, Simmons, Smith, and Soto

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Overview of Employer Impacts and Trends Justin Kindy, Senior Vice President, Aon Hewitt Jon Urbanek, Senior Vice President, Sales and Marketing for Employer Markets, Blue Cross and Blue Shield of Florida		Presented
2	Panel Discussion of Employer Impacts Justin Kindy, Senior Vice President, Aon Hewitt Brad Register, Director of Compensation & Benefits, TECO Energy Kevin Reynolds, Partner, Daszkal Bolton LLP Jon Urbanek, Senior Vice President, Sales and Marketing for Employer Markets, Blue Cross Blue Shield of Florida Kim Williams, President, Marpan Supply Company and Global CNC Solutions		Presented
3	Public Testimony		
4	Other Related Meeting Documents		



FLORIDA

An Independent Licensee of the
Blue Cross and Blue Shield Association



Jon Urbanek

Senior Vice President, Sales and Marketing for Employer Markets

Jon Urbanek is Blue Cross and Blue Shield of Florida's senior vice president of sales and marketing for employer markets. In this role, he is responsible for the top-line revenue of the enterprise, the marketing process, the acquisition and retention of all commercial business including local and national groups, (including federal and state employee programs), and all agent distribution channels. Urbanek is also accountable for implementing the strategic programs that enhance our presence in local communities.

Since joining BCBSF in 1989, Urbanek has held a number of key positions. Most recently, he served as group vice president of sales, distribution and local presence. He served as vice president of products and expansion markets, vice president and chief underwriting officer and also held positions leading sales process improvements and automation.

Prior to joining BCBSF, Urbanek was an independent agent and also worked with large self-funded customers while employed by a third-party health plan administrator. He is currently a director on the board of Florida Health Care Plan, Inc. and was recently appointed to the board of directors of OptaComp, Inc.

Urbanek holds a Bachelor of Science in Psychology from Florida State University. He has achieved the designation of Certified Employee Benefit Specialist (CEBS) from the Wharton School at the University of Pennsylvania and the International Foundation of Employee Benefits and is a fellow of the International Society of Certified Employee Benefit Specialists.

Blue Cross and Blue Shield of Florida is a leader in Florida's health industry. Since 1944, the company has been dedicated to meeting the diverse needs of all those it serves by offering an array of choices. BCBSF is a not-for-profit, policyholder-owned, tax-paying mutual company. Headquartered in Jacksonville, Fla., BCBSF is an independent licensee of the Blue Cross and Blue Shield Association, an association of independent Blue Cross and Blue Shield companies. For more information concerning BCBSF, please see its Web site at www.bcbsfl.com.



Justin Kindy, FSA, MAAA

Senior Vice President

Justin Kindy is a Senior Vice President in the health and welfare practice of Aon Hewitt's Denver office. Justin has nearly 15 years of health and welfare experience, with a focus in both actuarial and consulting disciplines. His areas of expertise include pricing, funding strategy, reserving, plan management, health care reform, and retiree health care for all health and welfare plans. Justin has substantial experience within the public sector, having testified in front of various state employee healthcare plan boards, legislators, and governors throughout the last ten years. Further, in the retiree health arena, Justin has performed numerous retiree health valuations in accordance with the rules and regulations as stated in GASB 43 and 45. Justin has led engagements with several states on projects associated with the development of state based exchanges; such as the assessment of various benchmark plan options in determining essential health benefits and projections of fiscal impact under different scenarios of state based exchange landscapes.

Justin has served as lead actuary and/or lead strategic consultant on numerous state plans within the past ten years; including Hawaii, Kansas, Kentucky, Nebraska, Nevada, New Mexico, Oklahoma, and Tennessee.

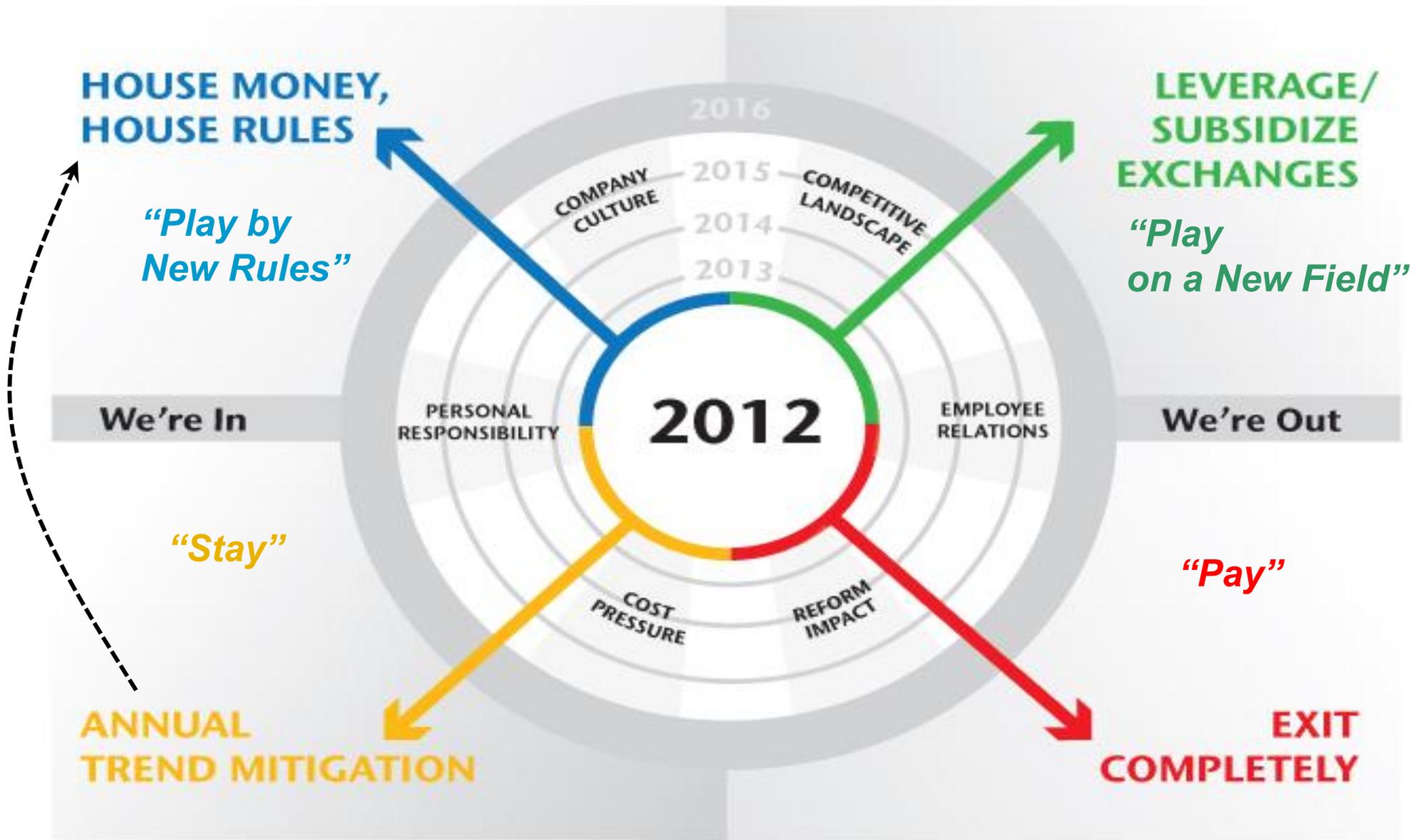
Justin is a Fellow of the Society of Actuaries and a Member of the American Academy of Actuaries. He graduated from Purdue University with Bachelor of Science degrees in Actuarial Science, Statistics, and Mathematics with Computer Science emphasis.

Employer Healthcare Landscape: Under the Affordable Care Act

January 14, 2013



Shifting Options in Employer HC Marketplace



Macro Level Impact of ACA to Employers

- Small Employers (<100 EEs)
 - Generally leaner benefits
 - ACA creates various directions
- Mid Market Employers (100 – 2500 EEs)
 - Cross-over market
 - Depending on current benefit and financial situation, ACA could be relatively impactful
- Large Market Employers (2500+ EEs)
 - Relatively and generally speaking, less material impact from ACA as a market
 - Impact highly dependent on industry

ACA Provision Breakdown: Employer's Perspective

Tactical Provisions

- Dependent to 26
- Elimination of Lifetime/Annual Maximums
- Transitional Reinsurance
- Auto Enrollment
- Minimum Waiting Periods
- 100% Preventive Care
- Rescissions Prohibited

Strategic Provisions

- Affordability
- Minimum Essential Health Coverage
- Part-time Definition and Associated Benefits
- State Exchange and Medicaid Interaction

Other Employer Considerations or Strategies

- Consider Employee Reaction
 - Benefits may impact ability to attract and retain top talent
- “Optimal ACA Decision = Optimal Business Decision”
 - This does not always hold true
- Minimal Guidance on Discrimination Issues
 - Differing levels of employee subsidization, benefit options, and/or eligibility provisions creates potential risk
 - Firm structured into multiple legal entities appears OK
- Counseling or Advocacy
 - Educate employees on public options available to them
 - Help to optimize healthcare benefits decision

Bradley J. Register Bio

Brad is an employee of Tampa Electric Company, the largest subsidiary of TECO Energy. With corporate headquarters in Tampa, Florida, TECO Energy is a leading energy company with three core businesses. TECO's Florida utility businesses include: Tampa Electric, a regulated electric utility serving nearly 677,000 customers in and around Hillsborough County, and Peoples Gas System, Florida's largest natural gas distributor serving more than 340,000 customers. TECO Coal is coal mining company with operations in Kentucky and Virginia.

With over 27 years at TECO working in positions throughout the electric utility operation, Brad has served in various engineering and management positions in Human Resources, Energy Delivery, Telecommunications, Facilities, Energy Supply, and Marketing. Most recently, Brad has served as a strategic leader in the area of human resources with a concentration on the human resource needs of the Florida utility operations and the parent company.

In September 2009, Brad assumed his current role as Director of Compensation and Benefits with responsibility for all benefit programs including compensation, pension and retirement savings, healthcare, and payroll. Prior to that, Brad served three years as Director of Employee Relations, responsible for a variety of employee related functions including all labor relations matters.

Before joining the human resources team, Brad served as Director of Telecommunications and Facility Services responsible for all of TECO's voice and data communications throughout Florida and all facility services for Tampa Electric. During the early part of his career, he spent over 11 years in various Energy Delivery engineering and engineering management positions in the areas of planning, standards, and operations.

Brad graduated from the University of South Florida with a degree in Electrical Engineering in 1985 and is a registered Professional Engineer in the State of Florida. He also holds a Senior Professional in Human Resources certification from the Society of Human Resource Management. Brad is a 2012 graduate of Leadership Florida.

A lifelong Floridian, Brad was born in Tampa and continues to reside in Hillsborough County. Throughout the past thirty years, Brad has been active in several churches in the Riverview/Brandon area while serving in a variety of church business leadership positions. He also served as a scouting leader for eight years. Brad and his wife Sandy enjoy traveling and they have two children who both attend the University of South Florida.



Healthcare Reform Impact

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

Presenter: Brad Register

Director – Compensation & Benefits

TECO Energy

January 14, 2013

TECO Energy

- **Corporate headquarters located in Tampa, Florida**
- **Core Businesses: Tampa Electric, Peoples Gas, TECO Coal**
- **3,000 active team members in Florida**
 - 91% covered by TECO Energy's Health Plans (6,800 lives)
- **2,065 retirees covered by TECO Energy's Retiree Health Plans (3,050 lives)**
- **Self-insured for all health care related expenses (medical, prescription drug, dental, EAP)**

Health Plan Offerings

- **Prior to 2009: Traditional health care plans (PPO's & HMO's)**
 - Experienced substantial cost increases each year (double digits)
 - Team members not fully engaged in health care cost responsibility
 - No specific provisions to save for future retiree medical expenses
- **2009: Implemented consumerism into our approach to health care**
 - Full replacement of traditional plans with consumer driven plans
 - Introduced two high deductible health plan options with company provided funding accounts and contributions (HSA & HRA)
 - Expanded wellness and disease management programs
 - Expanded preventative care coverage

Coverage Impacts

Healthcare Reform Mandates

- Coverage to age 26 for all dependents
- Eliminated pre-existing conditions
- Eliminate lifetime maximums
- Preventative services without cost sharing

TECO Before Healthcare Reform

- Coverage to age 25 for IRS recognized dependents
- No pre-existing condition provisions
- \$2M lifetime maximum
- Preventative services without cost sharing

Given the comprehensive plan changes we made in 2009, the coverage impacts required by healthcare reform were minor for TECO. However, we did experience a 6% increase in dependent enrollment as compared to team member enrollment due to the age 26 requirement.

Administrative Impacts

- **Staff time/expense and consultant expense to track and implement all healthcare reform requirements**
- **Healthcare cost reporting addition on form W-2**
- **Summary of Benefits and Coverage requirement**
- **Higher Third Party Administrator expense due to their compliance with Healthcare Reform**

Direct Tax Impacts: Team Members and Companies

- **OTC drugs can no longer be purchased tax free via FSA/HSA**
- **Annual Healthcare FSA limit reduced from \$5,000 to \$2,500**
- **Eliminated tax free status of the Retiree Drug Subsidy (Post-65 Rx)**
 - Caused a tax change recognition charge in 2010
 - Caused TECO to implement an EGWP for post-65 Rx in 2013 to control rising costs
- **New Patient-Centered Outcomes Research Fund Fee**

Unintended Consequences

Action

- Healthcare cost reporting addition on form W-2
- Donut hole phase out on Medicare Part-D: Requires drug manufacturers to discount brand drugs in the donut hole by 50%
- New tax on medical devices

Potential Unintended Consequence

- Team members believe they will ultimately be taxed on their healthcare benefit
- Drug manufacturers increase all drug prices to make up for the Part-D discount
- Manufacturers pass the new tax along to consumers

Unintended Consequences (cont.)

Action

- **Employer Coverage Mandate for full-time employees**

Potential Unintended Consequence

- **Employer chooses to reduce individual employee schedules to 29 hours per week to avoid full-time status**
- **Employer decides to pay the coverage mandate penalty and not provide healthcare coverage thus reducing their overall benefit costs**

The Future

- **Transitional Reinsurance Fee (New Tax in 2014-2016): \$63 per plan participant**
- **Exchanges – Based on our current healthcare offering, we do not anticipate any team members participating in the exchanges.**
- **2018 “Cadillac Plan” Tax – At this time, we do not anticipate any impact.**

KEVIN E. REYNOLDS, CPA

Kevin is a Partner in the Tax Services Department and is based in the Boca Raton office. With over 18 years of experience in public accounting, his goal is to help clients with tax planning and compliance to minimize their total tax liability while making financially sound business decisions. Focusing his practice in the areas of healthcare, family wealth, and retirement plans, Kevin is able to provide expertise and guidance with complex issues such as succession planning, mergers and acquisitions, corporate structuring, cost segregation studies and tax-free exchanges.

As Partner-in-Charge of the Firm's Healthcare Practice, Kevin works closely with clients on cash flow management, contract negotiations, compensation planning, buy-sell agreements, employment and stockholder agreements, risk management, and due diligence services.

As a leader in the Firm's Retirement Plan Advisory Practice, Kevin provides assistance in planning and structuring retirement plans, ensuring that the plans are designed for maximum tax advantage.

Kevin is a longtime member of the Healthcare Financial Management Association and the Boca Raton Community Hospital Professional Advisors Committee where he is a resource for strategic ideas and direction as well as financial issues. He works closely with the Caridad Center, Family Central, and the Boca Raton Chamber of Commerce as well as the Fort Lauderdale Chamber of Commerce on tax issues and compliance.

Recently, his expertise has been tapped for a series of seminars that discuss the tax impact of new regulations and demystify the new healthcare reform laws that create changes in the compliance process for healthcare providers, and show how changes in HIPPA, ICD-10 and EHR will impact processes and compliance.

Kevin obtained his Bachelor of Business Administration degree in Accounting from the University of Central Arkansas and is a Certified Public Accountant with licensure in both Florida and Arkansas. Kevin is a member of the American and Florida Institutes of Certified Public Accountants.



Expertise



DaszkalBolton LLP

CERTIFIED PUBLIC ACCOUNTANTS



Healthcare Reform: What Lies Ahead.....

Presented by Kevin E. Reynolds, CPA

Employer Knowledge

- ◆ Premiums are increasing
- ◆ Does the new law apply?
- ◆ How would the exchanges work?
- ◆ What other solutions are out there?



Employer Incentive

◇ Small Business Health Care Tax Credit

❖ Years 2010-13

- 10 FTE / \$25k wages = 35% of premiums
- Phase-out up to 25 FTE / \$50k wages
- Non-profit organizations 25%
- Small business owners excluded

❖ Exchange Years (2014-forward)

- Max credit increases to 50% of premiums



Small Business Health Care Tax Credit



Facts: 19 FTEs: 7 single / 12 family
 Average Annual wages of \$33,000 per FTE
 Premiums: \$4,800 single; \$12,000 family
 Employer pays 50% of coverage

Computation:

Total employer premiums	\$ 88,800	
Credit percentage	35%	
Tentative credit amount	<u>\$ 31,080</u>	A
Number FTEs > 10	9	
Divided by	<u>15</u>	
Excess FTE reduction %	<u>60%</u>	
Credit reduction for excess FTEs	18,648	B
Average salary > \$25,000	8,000	
Divided by	<u>25,000</u>	
Excess salary reduction %	<u>32%</u>	
Credit reduction for excess salaries	9,946	C
Net credit amount	<u><u>\$ 2,486</u></u>	A - B - C
Savings percentage	2.8%	

Employer Response

❖ Drastic Measures

- ❖ Pay or Play
- ❖ Pass on cost increases (deductibles, out-of-pocket)
- ❖ Downsizing
- ❖ Hour/Wage Reductions
- ❖ Price Increases
- ❖ Liquidation
- ❖ Do Nothing



Employer Response

◆ Reasonable Measures

- ❖ Employee Retention
- ❖ Exchange Market Trial Period
- ❖ PEOs
- ❖ Defined Contribution Approach
- ❖ Alternative Plans (HDHP / HSA / HRA)
- ❖ Voluntary Benefits
- ❖ Employee Wellness Programs / Incentives



Thank you!



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561-367-1040

Kim Williams, President, Marpan Supply Company

Marpan, from garbage container rental services and Construction debris hauling and materials processing (recycling) to safety equipment, to a large inventory of energy efficient light bulbs, Marpan is in the container services, supply and recycling business.

Kim's career at Marpan, a family owned business, began part time in High School in 1967. He has served as President of the company since 1985. As an owner/developer of commercial real estate, he is managing partner of the Heritage at Commonwealth, Hamilton Industrial Park and Commerce Industrial Center.

He has a long history of community involvement. A founding board member and past President of Southside Business Association. He is a past Chair of the Tallahassee Chamber and was the 2006 recipient of the Godfrey Smith Past-Chair award. He served 8 years on the Board of the Tallahassee Housing Authority and on the Board of Goodwill. He is a past Board member and immediate past Chair of Tallahassee Memorial Healthcare, current board member of Capital City Bank, Florida State University Research Foundation and immediate past Chair of the Economic Development Council.

As a native Tallahasseean, Kim is committed to encouraging economic growth so that our children and our graduates will be able to find opportunity here, while maintaining our quality of life. His wife Mayda recently sold her business, Target Copy, to her daughter Tracey Cohen. Kim and Mayda have 4 children, Matthew, Johanna, Tracey and Andrew and four grand-daughters Molly, Lily and Paige, all living in Tallahassee.

Kim's other business interest includes majority ownership of Global CNC Solutions, a machine shop.

Number of Establishments by Establishment Class Size by Industry for 1st Quarter 2012

Industry Title by Supersector	Number of Employees Per Establishment										
	Fewer than 5	5 to 9	10 to 19	20 to 49	50 to 99	100 to 249	250 to 499	500 to 999	1000 or more	1 to 49	50 or more
Total, all industries	391,769	88,446	56,770	35,784	12,210	7,171	1,565	558	247	572,769	21,751
Goods-producing	54,299	11,540	7,300	4,629	1,480	805	199	61	23	77,768	2,568
Natural resources and mining	2,782	877	644	555	215	162	41	12	6	4,858	436
Construction	41,296	7,787	4,511	2,462	629	216	43	5	2	56,056	895
Manufacturing	10,221	2,876	2,145	1,612	636	427	115	44	15	16,854	1,237
Service-providing	337,470	76,906	49,470	31,155	10,730	6,366	1,366	497	224	495,001	19,183
Trade, transportation, and utilities	84,591	23,892	15,061	7,699	2,899	2,406	418	94	23	131,243	5,840
Information	6,987	1,042	879	698	247	162	50	26	5	9,606	490
Financial activities	45,241	9,700	5,107	2,250	671	385	108	73	23	62,298	1,260
Professional and business services	102,876	14,466	8,749	5,153	1,868	1,109	330	117	49	131,244	3,473
Education and health services	33,654	13,262	7,800	4,872	1,582	1,246	270	114	100	59,588	3,312
Leisure and hospitality	21,971	7,615	8,554	9,046	3,185	938	163	64	22	47,186	4,372
Other services	39,998	6,836	3,308	1,434	278	119	27	9	2	51,576	435
Unclassified	2152	93	12	3		1				2,260	1

Industry Title by NAICS Sector	Number of Employees Per Establishment										
	Fewer than 5	5 to 9	10 to 19	20 to 49	50 to 99	100 to 249	250 to 499	500 to 999	1000 or more	1 to 49	50 or more
Agriculture, forestry, fishing and hunting	2,539	809	604	527	210	157	40	11	6	4,479	424
Mining, quarrying, and oil and gas extraction	243	68	40	28	5	5	1	1		379	12
Utilities	340	129	93	109	61	22	13	5	1	671	102
Construction	41,296	7,787	4,511	2,462	629	216	43	5	2	56,056	895
Manufacturing	10,221	2,876	2,145	1,612	636	427	115	44	15	16,854	1,237
Wholesale trade	29,776	5,769	3,379	2,065	563	315	65	22	6	40,989	971
Retail trade	44,698	16,290	10,414	4,664	1,922	1,815	264	32	4	76,066	4,037
Transportation and warehousing	9,777	1,704	1,175	861	353	254	76	35	12	13,517	730
Information	6,987	1,042	879	698	247	162	50	26	5	9,606	490
Finance and insurance	20,597	5,617	3,330	1,452	447	269	80	62	21	30,996	879
Real estate and rental and leasing	24,644	4,083	1,777	798	224	116	28	11	2	31,302	381
Professional and technical services	70,674	9,035	5,017	2,660	733	374	80	15	9	87,386	1,211
Management of companies and enterprises	2,427	423	349	271	125	102	43	15	9	3,470	294

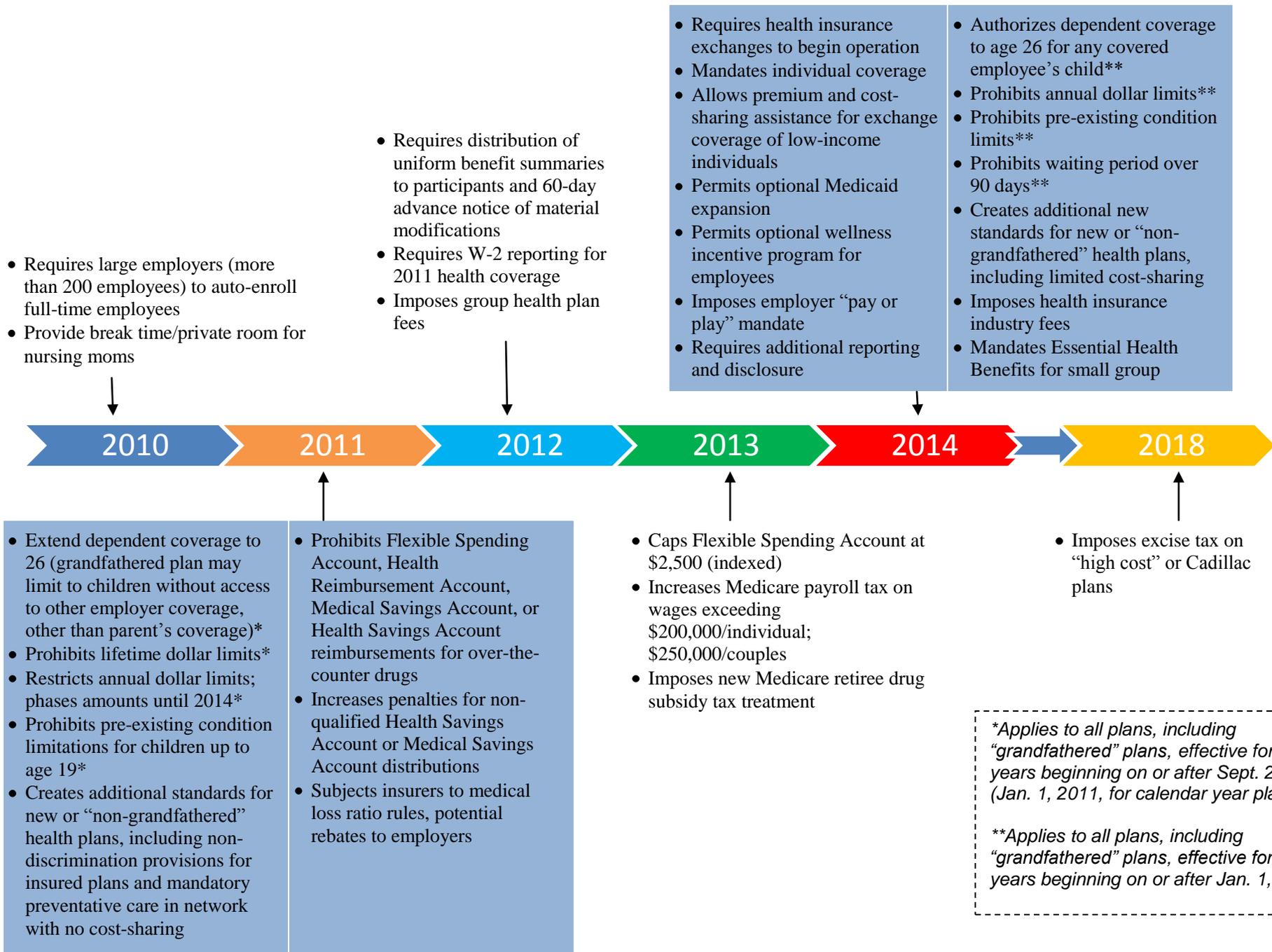
	Number of Employees Per Establishment										
	Fewer than 5	5 to 9	10 to 19	20 to 49	50 to 99	100 to 249	250 to 499	500 to 999	1000 or more	1 to 49	50 or more
Administrative and waste services	29,775	5,008	3,383	2,222	1,010	633	207	87	31	40,388	1,968
Educational services	4,059	839	745	761	314	173	30	18	9	6,404	544
Health care and social assistance	29,595	12,423	7,055	4,111	1,268	1,073	240	96	91	53,184	2,768
Arts, entertainment, and recreation	6,018	1,018	813	885	390	216	46	21	6	8,734	679
Accommodation and food services	15,953	6,597	7,741	8,161	2,795	722	117	43	16	38,452	3,693
Other services, except public administration	39,998	6,836	3,308	1,434	278	119	27	9	2	51,576	435
Unclassified	2,152	93	12	3		1				2,260	1
Total, all industries	391,769	88,446	56,770	35,784	12,210	7,171	1,565	558	247	572,769	21,751

Source: The U.S. Department of Labor, Bureau of Labor Statistics, Quarterly Census of Employment and Wages 2012

CY2011 Accident and Health Report of Gross Annual Premium and Enrollment Statewide Data: Summary by Major Medical Lines of Business

	(A) DIRECT PREMIUMS EARNED FOR NEW AND RENEWAL BUSINESS	(B) DIRECT LOSSES INCURRED	(C) DIRECT PREMIUMS EARNED FOR NEW BUSINESS ONLY	(D) EMPLOYER GROUPS	(E) PRIMARY INSURED	(F) COVERED DEPENDENTS	(H) COVERED LIVES
Guarantee Issue	\$90,461,795	\$81,259,746	\$12,797,745	0	22,078	12,407	34,485
Individually Underwritten	\$1,555,152,018	\$1,162,150,570	\$289,065,214	0	448,843	221,695	670,538
Self-Employed or Sole Proprietor	\$144,946,593	\$138,253,335	\$3,166,146	12,526	12,564	4,089	16,653
2 - 5 Member Groups	\$977,267,430	\$756,312,517	\$58,218,910	45,846	127,273	88,368	215,641
6 - 50 Member Groups	\$2,386,710,414	\$1,713,863,630	\$208,152,838	49,570	373,261	237,610	610,871
51+ Member Groups	\$7,732,637,795	\$6,443,822,943	\$446,947,106	14,081	986,553	829,081	1,815,634
Short Term Major Medical	\$4,172,953	\$3,021,695	\$2,704,567	1	1,428	420	1,848
Conversion	\$127,103,657	\$174,312,125	\$15,555,758	0	21,133	11,044	32,177
Out-of-State Guarantee Issue	\$18,785,163	\$24,432,201	\$4,160,661	0	1,717	230	1,947
Out-of-State Individually Underwritten	\$449,018,169	\$287,074,696	\$76,564,279	14,325	102,119	69,387	171,506
Out-of-State Self-Employed or Sole Proprietor	\$330,837	\$319,042	\$71,947	204	204	174	378
Out-of-State 2 - 5 Member Groups	\$1,317,117	\$1,480,386	\$76,057	147	372	262	634
Out-of-State 6 - 50 Member Groups	\$5,423,224	\$2,955,295	\$725,154	25	253	186	439
Out-of-State 51+ Member Groups	\$238,503,217	\$208,994,682	\$12,119,386	4,027	38,240	34,593	72,833
Out-of-State Short Term Major Medical	\$10,246,569	\$4,940,887	\$5,233,176	724	4,553	1,729	6,282
Out-of-State Conversion	\$575,966	\$1,076,629	\$421,673	0	1,490	54	1,544

Key Elements of PPACA Reforms for Employers



Key Employer-Related Provisions of PPACA

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
2010			
Automatic Enrollment for Employees of Large Employers (1511)	Requires employers with more than 200 employees offering a health benefits plan to automatically enroll all new employees in one of the plans and automatically continue the enrollments of current employees, unless the new or current employee opts out.	Employers with more than 200 full-time employees.	The U.S. Dept. of Labor has indicated that guidance may not be adopted by 2014.
Break Time/Private Area for Nursing Mothers (4207)	Requires employers to provide reasonable break time for an employee for one year after the child's birth. Employers are also required to provide a place, other than a bathroom, that is shielded from view and free from intrusion from coworkers and the public.	An employer that has less than 50 employees is not be subject to the requirements of this subsection, if such requirements would impose an undue hardship by causing the employer significant difficulty or expense when considered in relation to the size, financial resources, nature, or structure of the employer's business.	3/23/2010
2011			
Extension of Adult Dependent Coverage (1001)	Requires plans that provide dependent coverage to extend coverage to adult children until age 26. 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. a plan or issuer may not define dependent for purposes of eligibility for dependent coverage of children other than in terms of the relationship between the child and the participant. Examples of factors that cannot be used for defining dependent for purposes of eligibility (or continued eligibility) include financial dependency on the participant or primary subscriber (or any other person), residency with the participant or primary subscriber (or any other person), student status, employment, eligibility for other coverage, or any combination of these. Carriers are not required to cover children of adult dependents.	All plans. <i>Grandfathered plans may limit to dependents without access to other employer coverage over than parent's coverage.</i>	Plan years beginning on or after 9/23/2010
Annual and Lifetime Limits (1001)	Prohibits lifetime and annual limits on the dollar value of essential health benefits. Plans may only establish restricted limits prior to January 1, 2014 on essential benefits. Annual limits on essential benefits are limited to:	Lifetime limits: all plans. Annual limits: all plans except grandfathered individual plans.	Plan years beginning on or after 9/23/2010

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
	<ul style="list-style-type: none"> • \$750,000 for plan years beginning 9/23/2010-9/23/2011 • \$1.25 million for plan years beginning 9/23/2011-9/23/2012 • \$2 million for plan years beginning 9/23/2012-12/31/2013 		
Preexisting Condition Exclusions (1201)	Prohibits a plan from imposing any preexisting condition exclusions for children under age 19.	All plans except grandfathered individual market plans	Plan years beginning on or after 9/23/2010
Prohibition on Discrimination Based on Salary (1001)	Extends current law provisions prohibiting discrimination in favor of highly compensated employees in self-insured group plans to fully insured group plans. The Secretary of HHS will develop rules.	Fully insured non-grandfathered group health plans	9/23/2010
Mandatory Coverage of Preventive Health Services Without Cost Sharing (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 by the Health Resources and Services Administration. 	All non-grandfathered plans	Plan years beginning on or after 9/23/2010
Flexible Spending Arrangements—Qualified Medical Expenses for Reimbursement (9003)	Revises eligibility for qualified medical expense. For Health Savings Account (HSA), Medical Savings Account (MSA), Flexible Spending Arrangements (FSA), and Health Reimbursement Arrangements (HRA) purposes, a medicine or drug will be a qualified medical expense only if the medicine or drug: <ol style="list-style-type: none"> 1. Requires a prescription, 2. Is available without a prescription (an over-the-counter medicine or drug) and a prescription is obtained for it, or 3. Is insulin. 	All plans.	1/1/2011
Tax on HSA or MSA Distributions Not Used for Qualified Medical	Increases the additional tax on distributions to individuals that are not used for qualified medical expenses from 10% to 20% for HSAs and 15% to 20% for MSAs. Distributions from a HSA or MSA that are used to pay qualified medical expenses are not taxed.		2011

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
Comparative Effectiveness Research Fee (6301)	Requires carriers and plan sponsors to collect and pay fee for plan and policy years that end after 9/23/2012, and before 10/1//2019. For plan years 10/1/2012-9/30/2013, the fee is \$1 per year multiplied by the number of covered lives. For policy years ending on or after 10/1/2014, the fee is indexed based on increases in the projected per capita amount of National Health Expenditures. The fee will be used to fund the private, nonprofit corporation, the Patient Centered Outcomes Research Institute.	All plans.	2012
2013			
Flexible Spending Account Cap (9005)	Caps calendar year FSAs for medical expenses to \$2,500 (indexed every year). Employers with a plan year FSA will not be subject to the revised limits until the plan renews in 2013.		1/1/2013
Additional Medicare Payroll Tax (9015)	Requires employers to withhold an additional 0.9% tax that applies to an individual's wages, Railroad Retirement Tax Act compensation, and self-employment income that exceeds a threshold amount based on the individual's filing status. The threshold amounts are \$250,000 for married taxpayers who file jointly, \$125,000 for married taxpayers who file separately, and \$200,000 for all other taxpayers. An employer is responsible for withholding the Additional Medicare Tax from wages or compensation it pays to an employee in excess of \$200,000 in a calendar year. There is no employer match for the additional Medicare tax.		1/1/2013
Medicare Part D Subsidy Employer Deduction (9012)	<p>Eliminates the tax deduction for expenses allocable to the Medicare Part D Subsidy paid to employers that maintain prescription drug plans for their Medicare Part D eligible retirees.</p> <p>Currently, an employer offering retiree prescription drug coverage that is at least as valuable as Medicare Part D coverage is entitled to a federal retiree drug subsidy. Employers can claim a deduction for the entire cost of providing the prescription drug coverage even though a portion of the cost is offset by the subsidy they receive. PPACA repeals the current rule permitting deduction of the portion of the drug coverage expense that is offset by the Medicare Part D subsidy. This provision was originally effective for taxable years beginning after 12/31/2010. The effective date of this provision has been changed to be effective for taxable years beginning after December 31, 2012.</p>		1/1//2013

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
2014			
Health Exchanges (1311, 1313, 1321)	<p>Requires each state to 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.</p> <p>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, effective 1/1/2014.</p> <p>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:</p> <ul style="list-style-type: none"> • Maintain a website to provide standardized comparative information on qualified health benefits plans; • Screen and enroll eligible individuals in the state's Medicaid program, CHIP program and determine eligibility for premium tax credits and cost sharing subsidies; • Certify exemptions from the individual mandate; and • Establish a navigator program to provide public education, facilitate enrollment, and provide referrals of complaints for entities with relationships to employers and employees, consumers, or self-employed individuals. Federal funds for the establishment of exchanges may not be used for the payment of navigator grants. 	Individual and small group	<p>By 1/1/2013 HHS will certify states' plans to run their own exchange in 2014.</p> <p>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.</p> <p>Initial open enrollment begins for exchanges. 10/1/2013.</p>
Individual Coverage Mandate	<p>All U.S. citizens and lawful residents are required to obtain minimum essential health benefits coverage. If a taxpayer fails to maintain such coverage, he or she is required to pay an annual tax penalty of the greater</p>		1/1/2014

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
(1501)	<p>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 coverage mandate/tax if any of the following conditions are met:</p> <ul style="list-style-type: none"> • 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. • 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. 		
Premium and Cost-Sharing Assistance for Low-Income Individuals (1401, 1402)	<p>Authorizes a federal premium- assistance tax credit for qualified taxpayers with an income between 100% and 400% FPL that covers the difference between a percentage of household income and the second-lowest cost silver level plan available through the exchange in the individual’s rating area. Federal cost sharing (e.g., out-of-pocket limits, deductibles, coinsurance, and copayments) assistance will be available to certain individuals eligible with income between 100% and 400% of FPL.</p>	Individual plans offered in the exchange.	2014
Optional Medicaid Expansion (2001)	<p>States have the option to expand Medicaid eligibility to individuals under age 65 with income up to 138% of FPL.</p>		
Employer Wellness Programs (1201)	<p>Permits employers to offer employees rewards—in the form of premium discounts, waivers of cost-sharing requirements, or benefits that would otherwise not be provided—of up to 30% of the cost of coverage for participating in a wellness program and meeting certain health-related standards. Incentive was previously capped at 20%.</p>		2014
Employer “Pay or Play” Mandate (1513)	<p>Creates a penalty for an employer that <i>fails to offer</i> 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.</p>	Employers with more than 50 employees.	01/01/2014

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
	<p>Creates a penalty for an employer that <i>offers</i> coverage and has 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.</p> <p>Employers of 50 or fewer employees are exempt from these requirements, and the first 30 employees are disregarded in calculating the penalty.</p>		
<p>Employer Reporting Requirements (1502, 1512)</p>	<p>Requires plans to report coverage information to the IRS.</p> <p>Requires employers to provide employees written notice that they may be eligible to obtain coverage through an exchange in lieu of participating in employer-sponsored coverage if the plan covers less than 60% of the cost of covered benefits.</p>	<p>Grandfathered and non-grandfathered plans.</p> <p>Employers subject to the Fair Labor Standards Act</p>	<p>2013 and 2014</p> <p>3/1/2013 for current employees and at the time of hiring for new employees.</p>
<p>Essential Health Benefits, Benchmark Plan (1302)</p>	<p>Requires a qualified health plan offered through an exchange as well as coverage offered outside of an exchange in the individual and small group markets to 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 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</p>	<p>All non-grandfathered plans.</p>	<p>Plan years beginning on or after 01/01/2014</p> <p>Benchmark plan options based on enrollment as of 3/31/2012. States must select benchmark and supplement as needed by the 3rd quarter 2012 or default applies.</p>

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
	<p>the following benchmark plans:</p> <ul style="list-style-type: none"> • 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. <p>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.</p>		
Extension of Adult Dependent Coverage to All Grandfathered Plans (1001)	Requires plans that provide dependent coverage to extend coverage to adult children until age 26. 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. Examples of factors that cannot be used for defining dependent for purposes of eligibility (or continued eligibility) include financial dependency on the participant or primary subscriber (or any other person), residency with the participant or primary subscriber (or any other person), student status, employment, eligibility for other coverage, or any combination of these. Carriers are not required to cover children of adult dependents.	<i>All plans. Prior to 2014, a dependent may enroll for dependent coverage on a grandfathered plan only if such dependent is not eligible for employer-based coverage other than the parents.</i>	Plan years beginning on or after 9/23/2010
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 for lifetime limits. 1/1/2014
Preexisting Condition Exclusions (1201)	Extends prohibition on plans from imposing preexisting condition exclusion to individuals age 19 and older.	All plans except grandfathered individual market plans	Plan years beginning on or after 9/23/2010 for children under the age of 19. Effective for plan years beginning on

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
			or after, 01/01/2014 for all other individuals.
Prohibition on Waiting Periods (1201)	Prohibits plans from imposing waiting periods that exceed 90 days.	All group plans	Plan years beginning on or after 01/01/14
Additional Requirements for Non-Grandfathered Plans (1201)	<p>Rating and Underwriting Standards -Allows variations in the premiums of individual and small group premiums only by:</p> <ul style="list-style-type: none"> • Age (3:1 maximum) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family <p>Non Discrimination Based On Health Status - Prohibits a plan from establishing rules for eligibility based on any of the following health status-related factors:</p> <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. <p>Coverage for Clinical Trial Participants- 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.</p>	Non-grandfathered fully insured small group and individual plans.	Plan years beginning on or after 1/01/2014
Health Insurance Annual Fee (9010,10905)	Imposes an annual fee on any covered entity engaged in the business of providing health insurance. The aggregate annual fee is apportioned among entities based on a ratio designed to reflect relative market share. The first \$25 million of net premiums are exempt from the fee. For net premiums greater than \$25 million and less than \$50 million, fees are assessed on 50% of net premiums written. 100% of net premiums in excess of \$50 million would be subject to the fees.	Excludes self-insured entities, governmental units, nonprofits, and other entities specified.	2014

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date
	<p>For tax-exempt insurance providers, only 50% of net premiums are included for purposes of calculating the fee. The annual, aggregate fee amount is:</p> <ul style="list-style-type: none"> ▪ 2014: \$8 billion; ▪ 2015 and 2016: \$11.3 billion; ▪ 2017: \$13.9 billion; ▪ 2018: \$14.3 billion; and ▪ thereafter: the fee is indexed to the rate of premium growth. 		
2018			
Excise Tax on High-Cost (“Cadillac”) Insurance (9001)	Imposes 40% excise tax on insurers of employer-sponsored health plans for coverage that exceeds thresholds of \$10,200 for individuals and \$27,500 for families, indexed for inflation. Higher thresholds exist for high-risk professions and retirees ages 55-64 (\$11,850 individual and \$30,950 family).	Health insurers and health plan administrators	2018



Date: December 10, 2012

Subject: Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid

EXCHANGES & MARKET REFORMS

State-Based Exchanges and State Partnership Exchanges

1. *Does HHS plan to further extend deadlines for states to decide on their level of involvement in implementing Exchanges?*

- A.** No. As mentioned in the [two letters](#) that Secretary Sebelius sent to governors in November 2012, states have been and will continue to be partners in implementing the health care law and we are committed to providing states with the flexibility, resources and time they need to deliver the benefits of the health care law to the American people.

In response to various governors' requests for additional time, we extended the deadline for a Blueprint Application to operate a State-Based Exchange from November 16, 2012 to December 14, 2012. If a state is pursuing a State Partnership Exchange, we will accept Declaration Letters and Blueprint Applications and make approval determinations for State Partnership Exchanges on a rolling basis. A state that plans to operate the Exchange in its state in partnership with the federal government starting in 2014 will need to submit its Declaration Letter and Blueprint Application declaring what partnership role they would like to have by February 15, 2013.

A state may apply at any time to run an Exchange in future years.

2. *What federal funding is available to assist a state in creating and maintaining a State-Based Exchange? Will a state have to return federal funding if it decides not to implement a State-Based Exchange?*

- A.** By law, states operating Exchanges in 2014 must ensure that their Exchanges are financially self-sustaining by January 1, 2015. The costs to states for establishing a State-Based Exchange and testing Exchange operations during 2014 may be funded by grants under section 1311(a). Additionally, grants under section 1311 may be awarded until December 31, 2014, for approved establishment activities that fund first year start-up activities (i.e., activities in 2014). It is also permissible that under a State Partnership Exchange, a state may receive grants for activities to establish and test functions that the state performs in support of a Federally-Facilitated Exchange. This applies whether or not a state is a State Partnership Exchange. Generally, states will not be required to repay funds, provided funds are used for activities approved in the grant and cooperative agreement awards.

3. Will HHS charge fees to a state that utilizes federal data in connection with its State-Based Exchange?

- A. No. HHS is establishing a federally-managed data services hub to support information exchanges between states (Exchanges, Medicaid and CHIP agencies) and relevant federal agencies. In many cases, federal agencies other than HHS will be providing information through the hub. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there.

4. What is the approval process for a state that would like to participate in a State Partnership Exchange?

- A. To operate a State Partnership Exchange in 2014, a state must submit a declaration letter, complete the relevant portions of the [Exchange Blueprint](#) and be approved or conditionally approved by HHS for participation in a State Partnership Exchange. State Partnership Exchange approval standards mirror State-Based Exchange approval standards for plan management and the relevant consumer activities, where applicable, and include standards related to sharing data and coordinating processes between the state and a Federally-Facilitated Exchange. States have until February 15, 2013 to submit a declaration and Blueprint Application for approval as a State Partnership Exchange.

Federally-Facilitated Exchange

5. How will HHS work with state policymakers to make sure that the Federally-Facilitated Exchange accounts for the needs of a particular state? How will the Federally-Facilitated Exchange for each state ensure that it accurately incorporates state-specific laws and procedures into its business processes?

- A. To the greatest extent possible, HHS intends to work with states to preserve the traditional responsibilities of state insurance departments when establishing a Federally-Facilitated Exchange for a particular state. Additionally, HHS will seek to harmonize Exchange policy with existing state programs and laws wherever possible.

For example, qualified health plans that will be offered in a Federally-Facilitated Exchange must be offered by issuers that meet state licensure and solvency requirements and are in good standing in the state (section 1301(a)(1)(C) of the Affordable Care Act; 45 C.F.R. section 156.200(b)(4)). In addition, qualified health plans will be subject to requirements that apply to all individual and small group market products such as the [proposed market rules](#). Accordingly, states continue to maintain an important responsibility with respect to qualified health plans licensed and offered in their states, regardless of whether the Exchange is Federally-Facilitated or State-Based.

HHS is currently working to determine the extent to which activities conducted by state insurance departments such as the review of rates and policy forms could be recognized as part of the certification of qualified health plans by a Federally-Facilitated Exchange. For example, most states currently have an effective rate review program in place and HHS will rely on such processes in connection with qualified health plan certification decisions and oversight by a Federally-Facilitated Exchange. HHS will work with regulators in each state with a Federally-Facilitated Exchange to identify these efficiencies.

HHS is working with the National Association of Insurance Commissioners to enable states to use the System for Electronic Rate and Form Filing as part of the qualified health plan submission and certification process in a State Partnership Exchange. This will help ensure that state and federal regulators are using the same data for their reviews and simplify issuer compliance responsibilities.

HHS also will collect state-specific Medicaid and CHIP policy data so that the Federally-Facilitated Exchange is able to evaluate Medicaid and CHIP eligibility.

6. *Will Federally-Facilitated Exchange customer support personnel be familiar with state rules so that they can advise consumers adequately?*

- A.** Yes. HHS will operate the Federally-Facilitated and State Partnership Exchange call center and website, and personnel will be trained on relevant state insurance laws and Medicaid and CHIP eligibility standards so that they can advise consumers. In a state operating in a State Partnership Exchange, a state will be responsible for the day-to-day management of the Exchange Navigators and the development and management of another separate in-person assistance program, and may elect to conduct additional outreach and educational activities. The Affordable Care Act directs Navigators to conduct public education to target Exchange-eligible populations, assist qualified consumers in a fair and impartial manner with the selection of qualified health plans and distribute information on tax credits and cost-sharing reductions, and refer consumers to any consumer assistance or ombudsman programs that may exist in the state. Navigators must provide this information in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities.

7. *What restrictions will there be on a state regulator's authority to enforce state laws when consumers purchase coverage through a Federally-Facilitated Exchange? Will states retain their ability to protect consumers?*

- A.** States have significant experience and the lead role in insurance regulation, oversight, and enforcement. We will seek to capitalize on existing state policies, capabilities, and infrastructure that can also assist in implementing some of the components of a Federally-Facilitated Exchange. We also encourage states interested in improving this alignment to apply to conduct plan management through a State Partnership Exchange.

A Federally-Facilitated Exchange's role and authority are limited to the certification and management of participating qualified health plans. Its role and authority do not extend beyond the Exchange or affect otherwise applicable state law governing which health insurance products may be sold in the individual and small group markets. Several qualified health plans certification standards rely on reviews that some state departments of insurance may not currently conduct. Therefore, HHS will evaluate each potential qualified health plan against applicable certification standards either by deferring to the outcome of a state's review (e.g., in the case of licensure) or by performing a review necessary to verify compliance with qualified health plan certification standards. Federally-Facilitated Exchanges will consider completed state work to support this evaluation to the extent possible.

8. How will the Federally-Facilitated Exchange be funded?

- A. To fund the operation of the Federally-Facilitated Exchange, we proposed for comment in the draft Payment Notice that participating issuers pay a monthly user fee to support the operation of the Federally-Facilitated Exchange. For the 2014 benefit year, we proposed a monthly user fee rate that is aligned with rates charged by State-Based Exchanges. While we proposed that this rate be 3.5 percent of premium, it may be adjusted in the final [Payment Notice](#) to take into account State-Based Exchange rates. Exchange user fees will support activities such as the consumer outreach, information and assistance activities that health plans currently pay themselves. This policy does not affect the ability of a state to use grants described in section 1311 of the Affordable Care Act to develop functions that a state elects to operate under a State Partnership Exchange and to support state activities to build interfaces with a Federally-Facilitated Exchange.

9. If a state chooses to provide some services to a Federally-Facilitated Exchange, will the state be reimbursed for its costs?

- A. Yes in certain circumstances. HHS expects that states supporting the development of a Federally-Facilitated Exchange may choose to seek section 1311(a) Exchange Establishment cooperative agreement funding for activities including, but not limited to:
- Developing data system interfaces with the Federally-Facilitated Exchange;
 - Coordinating the transfer of plan information (e.g., licensure and solvency) from the state insurance department to the Federally-Facilitated Exchange; and
 - Other activities necessary to support (and related to the establishment of) the effective operations of a Federally-Facilitated Exchange.

After section 1311(a) funds are no longer available, HHS anticipates continued funding, under a different funding vehicle, for state activities performed on behalf of the Federally-Facilitated Exchange. To the extent permissible under applicable law, HHS intends to make tools and other resources used by the Federally-Facilitated Exchange available to state partners in State Partnership Exchanges, as well as to State-Based Exchanges.

Market Issues

10. How are Exchanges going to increase insurance market competition based on quality and cost? Some markets may be starting off from a position of having few local issuers.

- A. The introduction of Exchanges and the [insurance market rules](#) in 2014 will help promote competition based on quality and cost since consumers will have an unprecedented ability to compare similar products from different issuers and will be assured the right to purchase these products, regardless of their health condition. Further, consumers in many states will have new options such as the ability to purchase coverage from the Consumer Operated and Oriented Plans and Multi-State Plans created under the Affordable Care Act. Additionally, Exchanges can leverage market forces to drive further transformation in health care delivery.

We anticipate that the number of individuals who will be eligible for advance payments of premium tax credits and cost-sharing reductions – which are only available in connection with qualified health plan coverage purchased through an Exchange – will attract issuers to Exchanges where the certification process will encourage and reward high quality affordable insurance offerings. In addition, HHS is developing a Star Ratings system for qualified health plans purchased in an Exchange pursuant to section 1311(c)(3) of the Affordable Care Act.

11. When will we have final rules on essential health benefits, actuarial value, and rating?

- A. The proposed rules on [essential health benefits and actuarial value](#) and the [market reforms](#), including rating, were published on November 20, 2012. Public comments are due by December 26, 2012. On November 20, 2012, we also issued a [state Medicaid directors letter](#) on how we will propose essential health benefits be implemented in Medicaid. HHS will analyze the comments, adjust any policies accordingly, and publish final rules early next year.

12. What level of benefit is required in a specific benchmark to satisfy the ten essential health benefit categories? What process will be undertaken by HHS to select backfilling benefit options if a state defaults to the largest small group product?

- A. In section 156.100 of the proposed rule on Essential Health Benefits/Actuarial Value/Accreditation, we propose criteria for the selection process for a state that chooses to select a benchmark plan. The essential health benefits benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state. This approach and benchmark selection, which would apply for at least the 2014 and 2015 benefit years, would allow states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products. Since some base-benchmark plan options may not cover all ten of the statutorily required essential health benefits categories, we propose standards for supplementing a base-benchmark plan that does not provide coverage of one or more of the categories.

We also propose that if a base-benchmark plan option does not cover any items and services within an essential health benefits category, the base-benchmark plan must be supplemented by adding that particular category in its entirety from another base-benchmark plan option. The resulting plan, which would reflect a base-benchmark that covers all ten essential health benefits categories, must meet standards for non-discrimination and balance. After meeting these standards, it would be considered the essential health benefits-benchmark plan.

The proposed rule also outlines the process by which HHS would supplement a default base-benchmark plan, if necessary. We clarify that to the extent that the default base-benchmark plan option does not cover any items and services within an essential health benefits category, the category must be added by supplementing the base-benchmark plan with that particular category in its entirety from another base-benchmark plan option. Specifically, we propose that HHS would supplement the category of benefits in the default base benchmark plan with the first of the following options that offer benefits in that particular essential health benefits category: (1) the largest plan by enrollment in the second largest product in the state's small group market; (2) the largest plan by enrollment in the third largest product in the state's small group market; (3) the largest national

Federal Employees Health Benefit Program plan by enrollment across states that is offered to federal employees; (4) the largest dental plan under the Federal Employees Dental and Vision Insurance Program, for pediatric oral care benefits; (5) the largest vision plan under the Federal Employees Dental and Vision Insurance Program, for pediatric vision care benefits; and (6) habilitative services as described in section 156.110(f) or 156.115(a)(4).

Multi-State Plans

13. The Office of Personnel Management is required to certify Multi-State Plans that must be included in every Exchange. How will you ensure that Multi-State Plans compete on a level playing field and are compliant with state laws?

- A. The U.S. Office of Personnel Management released a proposed rule implementing the [Multi-State Plan Program on November 30, 2012](#). To ensure that the Multi-State Plans are competing on a level playing field with other plans in the marketplace, the proposed regulation largely defers to state insurance law and the standards promulgated by HHS and states related to qualified health plans. Under the proposal, Multi-State Plans will be evaluated based largely on the same criteria as other qualified health plans operating in Exchanges. The few areas in which the Office of Personnel Management proposes different regulatory standards from those applicable to qualified health plans are areas where the Office of Personnel Management has extensive experience through its administration of the Federal Employees Health Benefits Program. However, in order to ensure that these few differences will not create any unfair advantages, the Office of Personnel Management seeks comment from states and other stakeholders on these proposals. The regulation appeared in the Federal Register on December 5, 2012, and the comment period runs through January 4, 2013.

Bridge Plan

14. Can a state-based Exchange certify a Medicaid bridge plan as a qualified health plan?

- A. Yes. HHS has received questions about whether a state could allow an issuer that contracts with a state Medicaid agency as a Medicaid managed care organization to offer qualified health plans in the Exchange on a limited-enrollment basis to certain populations. This type of limited offering would permit the qualified health plan to serve as a “bridge” plan between Medicaid/CHIP coverage and private insurance. This would allow individuals transitioning from Medicaid or CHIP coverage to the Exchange to stay with the same issuer and provider network, and for family members to be covered by a single issuer with the same provider network. This approach is intended to promote continuity of coverage between Medicaid or CHIP and the Exchange.

In general, an Exchange may allow an issuer with a state Medicaid managed care organization contract to offer a qualified health plan as a Medicaid bridge plan under the following terms:

- *The state must ensure that the health insurance issuer complies with applicable laws, and in particular with section 2702 of the Public Health Service Act. Consistent with section 2702(c) of the Public Health Service Act, a health plan whose provider network reaches capacity may deny new enrollment generally while continuing to permit limited enrollment of certain individuals in order to fulfill obligations to existing group contract*

holders and enrollees. Therefore, if the issuer demonstrates that the provider network serving the Medicaid managed care organization and bridge plan has sufficient capacity only to provide adequate services to bridge plan eligible individuals and existing Medicaid and/or CHIP eligible enrollees, the bridge plan could generally be closed to other new enrollment. However, in order to permit additional enrollment to be limited to bridge plan eligible individuals, the state must ensure there is a legally binding contractual obligation in place requiring the Medicaid managed care organization issuer to provide such coverage to these individuals. We note that any such contract would need to have provisions to prevent cost-shifting from the non-Medicaid/CHIP population to the Medicaid/CHIP population. We also note that the guaranteed availability provision of section 2702 of the Public Health Service Act is an important protection that provides consumer access to the individual and small group markets. Accordingly, we plan to construe narrowly the network capacity exception to the general guaranteed issue requirement.

- *The Exchange must ensure that a bridge plan offered by a Medicaid managed care organization meets the qualified health plan certification requirements, and that having the Medicaid managed care organization offer the bridge plan is in the interest of consumers.*
- *As part of considering whether to certify a bridge plan as a qualified health plan, the Exchange must ensure that bridge plan eligible individuals are not disadvantaged in terms of the buying power of their advance payments of premium tax credits.*
- *The Exchange must accurately identify bridge plan eligible consumers, and convey to the consumer his or her qualified health plan coverage options.*
- *The Exchange must provide information on bridge plan eligible individuals to the federal government, as it will for any other individuals who are eligible for qualified health plans on the Exchange, to support the administration of advance payments of premium tax credits. This will be done using the same mechanism that will be in place for the larger Exchange population.*

Successful implementation of a Medicaid bridge plan will involve a high degree of coordination between the state Medicaid agency, department of insurance and the Exchange. States operating State-Based Exchanges will be best positioned to achieve the level of coordination needed to implement and support the offering of a Medicaid bridge plan on an Exchange. Additional guidance will be issued soon.

Pre-Existing Condition Insurance Plan and Other High-Risk Pools

15. Does the federal government intend to maintain the Pre-Existing Condition Insurance Plan program beyond 2014? How will state high risk pools be affected by the affordability and insurance market reforms in 2014?

- A. Under the Affordable Care Act, coverage for persons under the Pre-Existing Condition Insurance Plan program (whether federally-run or state-run in a state) will generally not extend beyond January 1, 2014, which is when all individuals will be able to access coverage without any pre-existing condition exclusions in the individual market. The transitional

reinsurance program is expected to help stabilize premiums in the individual market by reimbursing issuers who enroll high cost individuals, such as those currently enrolled in the Pre-Existing Condition Insurance Plan, as they enter that market.

In the [notice of proposed rulemaking](#) on the health insurance market rules (77 Fed. Reg. 70584; November 26, 2012), we noted that we are exploring ways in which states could continue to run their existing high risk pools (i.e., separate from the Pre-Existing Condition Insurance Pool program) beyond 2014.

Basic Health Plan

16. Will HHS issue federal guidance and regulation regarding implementation of the Basic Health Plan?

- A. Yes. HHS plans to issue guidance on the Basic Health Plan in the future. States interested in this option should continue to talk to HHS about their specific questions related to the implementation of the Basic Health Plan.

CONSUMERS

Consumer Outreach

17. How does HHS plan to conduct outreach about the Exchanges and new coverage options? Will outreach materials be tailored to each state? Will states be able to provide HHS with input in developing materials?

- A. Education and outreach are high priorities for implementing the changes coming in 2014. HHS plans to conduct outreach to consumers in a variety of ways, including the Navigator program, in-person assistance, the internet, and call centers. States and other stakeholders definitely will be able to provide input in developing its outreach approach to consumers.

18. How does HHS plan to operate the Navigator program for the Federally-Facilitated Exchanges? How many and what types of Navigators will there be in a particular state? What will their roles be? Can states require Navigators to hold a producer license? If not, what type of training or certification will they receive?

- A. Section 1311(i) of the Affordable Care Act directs an Exchange – whether a State-Based Exchange or a Federally-Facilitated Exchange – to establish a program under which it awards grants to Navigators. Section 1311(i) and 45 C.F.R. section 155.210 articulate the required duties of a Navigator. In addition, section 155.210(c)(2) directs that the Exchange select two different types of entities as Navigators, one of which must be a community and consumer-focused non-profit group. This program is further described in the [“General Guidance on Federally-facilitated Exchanges.”](#)

The number of Navigators per state served by a Federally-Facilitated Exchange will be contingent upon the total amount of funding available as well as the number of applications that we receive in each state in response to the forthcoming Navigator Grant Funding Opportunity Announcement that we plan to issue early next year to support the Federally-Facilitated Exchanges.

Additionally, a state or Exchange cannot require Navigators to hold a producer license (i.e., a license as an agent or broker) for the purpose of carrying out any of the duties required of Navigators in section 1311(i)(3) of the Affordable Care Act and 45 C.F.R. section 155.210(e). Because the law directs Navigators to carry out all required duties, linking a producer license to any one of those specific duties would have the effect of requiring all Navigator entities, their employees, and their sub-grantees to hold a producer license. As described above, this would prevent the application of the standard set forth in 45 C.F.R. section 155.210(c)(2) that at least two different types of entities must serve as Navigators. As such, and as provided by section 1321(d) of the Affordable Care Act, any state laws which would require all Navigators to hold a producer license would be preempted by 45 C.F.R. section 155.210(c)(2).

In Federally-Facilitated Exchanges and State Partnership Exchanges, individuals selected to receive Navigator grants or working for entities selected to receive Navigator grants must successfully participate in an HHS-developed and administered training program, which will include a certification examination pursuant to 45 C.F.R. section 155.210(b). In addition, under state law, states may impose Navigator-specific licensing or certification requirements upon individuals and entities seeking to operate as Navigators, so long as such licenses or certifications are not preempted by the requirement to award to different types of entities identified in 45 C.F.R. section 155.210(c)(2), such as producer licenses.

19. What does HHS expect that states in a State Partnership Exchange must do to fulfill their obligations regarding in-person consumer assistance? How will the state-specific in-person consumer assistance programs be integrated with the Navigator program?

- A. In-person assistance programs are an additional mechanism through which Exchanges may meet the consumer assistance responsibilities of the Exchange under 45 C.F.R. section 155.205(d) and (e). As described in the [Federally-facilitated Exchange Guidance](#), states operating under a State Partnership Exchange will build and operate an in-person assistance program, for which grant funding is available under section 1311 of the Affordable Care Act, distinct from the Navigator program for that Exchange. State-Based Exchanges may do so as well. The purpose of providing multiple tools for in-person assistance is to ensure that all consumers can receive help when accessing health insurance coverage through an Exchange.

Consumer Eligibility and Enrollment

20. What information will consumers provide in the single streamlined application? What is the process/timeline for the approval of a state-specific single streamlined application?

- A. Section 1413 of the Affordable Care Act directs HHS to develop a single, streamlined application that will be used to apply for coverage through qualified health plans, Medicaid and CHIP. In addition, it can be used by persons seeking the advance payment of premium tax credits and cost sharing reductions available for qualified health plans through the Exchange. In consultation with states and other stakeholders, and with the benefit of extensive consumer testing, HHS has been developing an on-line and paper version of the single, streamlined application. We are releasing information on a rolling basis both to seek public comment and to support states in their eligibility system builds.

In July 2012, HHS published a notice in the Federal Register outlining the initial data elements that will be included in the streamlined application for public comment. HHS received over 60 comments from states and other stakeholders that have helped inform our ongoing development work. These comments, coupled with ongoing consumer testing, have helped us refine and improve the application.

Consumer testing and extensive consultation with states and consumer groups continues. HHS expects to provide the final version of the online and paper application in early 2013 and will also work with states that seek Secretarial approval for their own application.

21. What will consumers be told if it appears they are not eligible for Medicaid, CHIP, or advance payments of premium tax credits?

- A. A qualified individual still will have the option to purchase a qualified health plan through the Exchange if he or she is not eligible for Medicaid, CHIP or an advance payment of a premium tax credit. As outlined in 45 C.F.R. section 155.310(g), Exchanges will provide timely written notice to an applicant of any eligibility determination made by the Exchange. 45 C.F.R. section 155.230(a) provides further detail on the content of notices, including that notices contain contact information for available customer service resources and an explanation of appeal rights, if applicable.

22. How will HHS help Exchanges with the eligibility process for exemptions from the shared responsibility payment for individuals?

- A. Section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange will issue certificates of exemption from the shared responsibility payment described in section 5000A of the Internal Revenue Code, which otherwise applies to individuals who do not maintain minimum essential coverage. In the “State Exchange Implementation Questions and Answers” released on November 29, 2011, we indicated that a State-Based Exchange could either conduct this assessment itself or use a federally-managed service for exemptions from the shared responsibility payment. We included this option in the Exchange Blueprint. State-Based Exchanges can also choose to conduct this function independently.

With this service, the Exchange will accept an application for an exemption, and then transfer the information contained on the application to HHS through a secure, electronic transaction. HHS will conduct relevant verifications and return an eligibility determination to the Exchange, which will then notify the individual who submitted the application. The Exchange and HHS will share responsibility for customer service. To the extent that an individual’s situation changes during the year, he or she would be required to submit an update to the Exchange, which will then transfer it to HHS to process. This configuration limits the level of effort required on the part of the Exchange, while ensuring that the Exchange complies with the statutory direction to issue certificates of exemption.

HHS will provide additional information regarding exemptions shortly, including technical specifications for the application and for the application transfer service.

Consumer Experience

23. How will the Federally-Facilitated Exchange display qualified health plan options to consumers? Will consumers see all of their options or just those that are “best” for them? Will the Federally-Facilitated Exchange allow individuals who are eligible for Medicaid or CHIP to purchase qualified health plans instead?

- A. Consumers will see all qualified health plans, including stand-alone dental plans, certified to be offered through the Federally-Facilitated Exchange, offered in their service area. HHS is developing ways for consumers to sort qualified health plan options based on their preferences.

Qualified individuals who are Medicaid or CHIP eligible are allowed to purchase qualified health plans instead of receiving coverage through the Medicaid or CHIP programs. However, they are not eligible to receive advance payments of premium tax credits or cost-sharing reductions to help with the cost of purchasing qualified health plans through an Exchange.

MEDICAID

Expansion

24. Is there a deadline for letting the federal government know if a state will be proceeding with the Medicaid expansion? How does that relate to the Exchange declaration deadline? Is HHS intending to provide guidance to states as to the process by which state plan amendments are used to adopt Medicaid expansion under the Affordable Care Act?

- A. No, there is no deadline by which a state must let the federal government know its intention regarding the Medicaid expansion. Nor is there any particular reason for a state to link its decision on the Exchange with its decision on the Medicaid expansion. States have a number of decision points in designing their Medicaid programs within the broad federal framework set forth in the federal statute and regulations, and the decision regarding the coverage expansion for low-income adults is one of those decisions.

As with all changes to the Medicaid state plan, a state would indicate its intention to adopt the new coverage group by submitting a Medicaid state plan amendment. If a state later chooses to discontinue coverage for the adult group, it would submit another state plan amendment to CMS. The state plan amendment process is itself undergoing modernization. As part of an overall effort to streamline business processes between CMS and states, in early 2013 CMS will begin implementing an online state plan amendment system to assist states in filing state plan amendments. We will be discussing the submission process for Affordable Care Act-related state plan amendments on our monthly State Operations and Technical Assistance calls with states and will be available to answer questions through that process.

While states have flexibility to start or stop the expansion, the applicable federal match rates for medical assistance provided to “newly eligible individuals” are tied by law to

specific calendar years outlined in the statute: states will receive 100 percent support for the newly eligible adults in 2014, 2015, and 2016; 95 percent in 2017, 94 percent in 2018, 93 percent in 2019; and 90 percent by 2020, remaining at that level thereafter.

25. *If a state accepts the expansion, can a state later drop out of the expansion program?*

- A. Yes. A state may choose whether and when to expand, and, if a state covers the expansion group, it may decide later to drop the coverage.

26. *Can a state expand to less than 133% of FPL and still receive 100% federal matching funds?*

- A. No. Congress directed that the enhanced matching rate be used to expand coverage to 133% of FPL. The law does not provide for a phased-in or partial expansion. As such, we will not consider partial expansions for populations eligible for the 100 percent matching rate in 2014 through 2016. If a state that declines to expand coverage to 133% of FPL would like to propose a demonstration that includes a partial expansion, we would consider such a proposal to the extent that it furthers the purposes of the program, subject to the regular federal matching rate. For the newly eligible adults, states will have flexibility under the statute to provide benefits benchmarked to commercial plans and they can design different benefit packages for different populations. We also intend to propose further changes related to cost sharing.

In 2017, when the 100% federal funding is slightly reduced, further demonstration opportunities will become available to states under State Innovation Waivers with respect to the Exchanges, and the law contemplates that such demonstrations may be coupled with section 1115 Medicaid demonstrations. This demonstration authority offers states significant flexibility while ensuring the same level of coverage, affordability, and comprehensive coverage at no additional costs for the federal government. We will consider section 1115 Medicaid demonstrations, with the enhanced federal matching rates, in the context of these overall system demonstrations.

27. *Do you still support the Medicaid blended FMAP (matching rate) proposal in your budget?*

- A. No. We continue to seek efficiencies and identify opportunities to reduce waste, fraud and abuse in Medicaid, and we want to work with Congress, states, and stakeholders to achieve those goals while expanding access to affordable health care. The Supreme Court decision has made the higher matching rates available in the Affordable Care Act for the new groups covered even more important to incentivize states to expand Medicaid coverage. The Administration is focused on implementing the Affordable Care Act and providing assistance to states in their efforts to expand Medicaid coverage to these new groups.

28. *How does the Supreme Court ruling affect the interaction between the Exchanges and Medicaid? Will a state's decision whether or not to proceed with the Medicaid expansion have implications for the Exchange's ability to make Medicaid eligibility determinations?*

- A. As the letter from Secretary Sebelius to Governors sent on July 10, 2012 and the letter from the CMS Acting Administrator Marilyn Tavenner sent on July 13, 2012 stated, the Supreme Court's decision affects the financial penalty that applies to a state that does not expand Medicaid coverage to 133% of the federal poverty level under the Affordable Care Act. No

other provisions of the law were affected. Thus regardless of whether a state adopts the Medicaid expansion, the provisions related to coordination with the Exchange, including the use of standard income eligibility methods, apply. An Exchange in each state will make either a Medicaid eligibility determination or a Medicaid eligibility assessment (at the state's option) based on the Medicaid rules in the state, including the income levels at which the state's Medicaid program provides coverage.

29. What help will be available to states to accommodate the added administrative burdens and costs they will have to bear if they expand coverage in Medicaid?

- A. We have provided 90 percent federal matching funds for the new or improved eligibility systems that states are developing to accommodate the new modified adjusted gross income rules and to coordinate coverage with the Exchange. To further reduce system costs, we have promoted ways for states to share elements of their system builds with each other, and we will be sharing the business rules for adopting modified adjusted gross income in the new eligibility systems. In addition we are designing, with extensive state and stakeholder consultation, a new combined and streamlined application that states can adopt (or modify subject to Secretarial approval). And, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes. These and other initiatives relating to state systems development will lower administrative costs.

Implementation of the on-line application system, the new data-based eligibility rules, verification and renewal procedures and states' access to the federally-managed data services hub ("the hub") will collectively help defray states' ongoing costs and result in greater efficiency in the long term. For example, states will be able to electronically verify eligibility factors through the hub, where previously they had to verify through multiple federal venues. This is expected to lower the per-person administrative costs of enrollment and renewal for both newly and currently eligible individuals. As stated in previous guidance, no charge will be imposed on states for use of the hub, nor for the required data accessed there. In addition, it is anticipated that many individuals—both those who are eligible under current state eligibility rules as well as those who are eligible under the adult expansion—will apply for coverage via the Exchange. Our rules provide states the option to have the Exchange determine eligibility for Medicaid or to assess eligibility for Medicaid, in both cases using the state's eligibility rules and subject to certain standards. No charge will be imposed on states for the Medicaid determinations or assessments conducted by the Exchanges.

30. CMS has released 90/10 funding in order for states to improve their eligibility systems for Medicaid. Will that funding continue?

- A. Yes. "90/10" funding remains available through December 31, 2015 for Medicaid eligibility system design and development, and the enhanced 75 percent matching rate will be available indefinitely for maintenance and operations of such systems as long as the systems meet applicable program requirements.

In [previous guidance](#), we have assured states that the 90/10 and 75/25 percent funding for eligibility systems will be available without regard to whether a state decides to expand its program to cover newly eligible low-income adults. We reiterate that system modernization will be supported and the enhanced matching funds will be available

regardless of a state's decision on expansion. Additionally, we will continue exploring opportunities to provide States additional support for the administrative costs of eligibility changes.

31. Will low-income residents in states that do not expand Medicaid to 133 percent of the FPL be eligible for cost sharing subsidies and tax credits to purchase coverage through an Exchange?

- A. Yes, in part. Individuals with incomes above 100 percent of the federal poverty level who are not eligible for Medicaid, the Children's Health Insurance Program (CHIP) or other minimum essential coverage will be eligible for premium tax credits and cost sharing reductions, assuming they also meet other requirements to purchase coverage in the Exchanges.

32. Can states that are "expansion states" under the law receive newly eligible matching rate for some populations in their state?

- A. Yes. The expansion state Federal Medical Assistance Percentage, or matching rate, described in section 1905(z)(2) of the Social Security Act is available to some states that expanded Medicaid coverage prior to enactment of the Affordable Care Act, but does not exclude those states from receiving the increased newly eligible match for expenditures for beneficiaries who meet the statutory qualifications. If a population covered by a state that qualifies as an expansion state meets the criteria for the newly eligible matching rate, the state will receive the newly eligible matching rate for that population. States will receive the highest matching rate possible for a given population; being an expansion state will never disadvantage the state in terms of matching rates for that population.

The following are several examples of circumstances in which an expansion state will receive the newly eligible matching rate for some beneficiaries:

- States are considered expansion states if, as of March 23, 2010, they provided coverage that meets the standards specified in section 1905(z)(3) of the Act to both childless adults and parents up to at least 100 percent of the federal poverty level. If a state provided Medicaid coverage up to 100 percent of the federal poverty level but not above, expenditures for individuals between 100 and 133 percent of the federal poverty level would qualify for the newly eligible matching rate.
- States that qualify as expansion states may have offered less than full benefits, benchmark benefits, or benchmark-equivalent benefits. Individuals who received limited benefits under a Medicaid expansion will qualify as "newly eligible" individuals and the newly eligible matching rate will apply.
- States that qualify as expansion states based on the provision of state-funded coverage will receive the newly eligible matching rate for people previously covered by the state-only program, since they will be newly eligible for Medicaid coverage.

The expansion state matching rate is only available for expenditures for non-pregnant, childless adult populations described in the new low-income adult group. CMS will work with states to ensure that the correct matching rate is applied to expenditures for populations in expansion states that qualify as newly eligible.

Flexibility for States

33. What specific plans and timeline do you have for enacting the reforms and flexibility options for Medicaid that you spoke of in 2009? When can states give further input on the needed reforms?

- A. CMS continues to work closely with states to provide options and tools that make it easier for states to make changes in their Medicaid programs to improve care and lower costs. In the last six months, we have released guidance giving states flexibility in structuring payments to better incentivize higher-quality and lower-cost care, provided enhanced matching funds for health home care coordination services for those with chronic illnesses, designed new templates to make it easier to submit section 1115 demonstrations and to make it easier for a state to adopt selective contracting in the program, and developed a detailed tool to help support states interested in extending managed care arrangements to long term services and supports. We have also established six learning collaboratives with states to consider together improvements in data analytics, value-based purchasing and other topics of key concern to states and stakeholders, and the Center for Medicare and Medicaid Innovation has released several new initiatives to test new models of care relating to Medicaid populations. Information about these and many other initiatives are available on [Medicaid.gov](http://www.Medicaid.gov). We welcome continued input and ideas from states and others. States can implement delivery system and payment reforms in their programs whether or not they adopt the low-income adult expansion. With respect to the expansion group in particular, states have considerable flexibility regarding coverage for these individuals. For example, states can choose a benefit package benchmarked to a commercial package or design an equivalent package. States also have significant cost-sharing flexibility for individuals above 100% of the federal poverty level, and we intend to propose other cost-sharing changes that will modernize and update our rules.

34. Will the federal government support options for the Medicaid expansion population that encourage personal responsibility?

- A. Yes, depending on its design. We are interested in working with states to promote better health and health care at lower costs and have been supporting, under a demonstration established by the Affordable Care Act, state initiatives that are specifically aimed at promoting healthy behaviors. Promoting better health and healthier behaviors is a matter of importance to the health care system generally, and state Medicaid programs, like other payers, can shape their benefit design to encourage such behaviors while ensuring that the lowest income Americans have access to affordable quality care. We invite states to continue to come to us with their ideas, including those that promote value and individual ownership in health care decisions as well as accountability tied to improvement in health outcomes. We note in particular that states have considerable flexibility under the law to design benefits for the new adult group and to impose cost-sharing, particularly for those individuals above 100% of the federal poverty level, to accomplish these objectives, including Secretary-approved benchmark coverage

35. Will CMS approve global waivers with an aggregate allotment, state flexibility, and accountability if states are willing to initiate a portion of the expansion?

- A. Consistent with the guidance provided above with respect to demonstrations available under the regular and the enhanced matching rates, CMS will work with states on their

proposals and review them consistent with the statutory standard of furthering the interests of the program.

MAGI

36. Will states still be required to convert their income counting methodology to Modified Adjusted Gross Income (MAGI) for purposes of determining eligibility regardless of whether they expand to the adult group? If so, how do states link the categorical eligibility criteria to the MAGI?

- A. Yes, as required by law. Conversion to modified adjusted gross income eligibility rules will apply to the nonelderly, nondisabled eligibility groups covered in each state, effective January 2014, without regard to whether a state expands coverage to the low-income adult group. The new modified adjusted gross income rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through Exchanges; the application of modified adjusted gross income to Medicaid and CHIP will promote a simplified, accurate, fair, and coordinated approach to enrollment for consumers. CMS has been working with states to move forward with implementation of the modified adjusted gross income rules, and consolidation and simplification of Medicaid eligibility categories.

DSH

37. The Disproportionate Share Hospital allotments will be reduced starting in 2014 using a methodology based on the reduction in the number of uninsured. One, when will HHS issue the regulations and methodology for this reduction? Two, for a state that does not see a decrease in its uninsured population, will the remaining states absorb the full reduction? Is HHS planning any modification to the manner in which it will reduce DSH allotments as it relates to states that do not expand?

- A. The law directs HHS to develop a methodology to reduce Disproportionate Share Hospital (DSH) funding over time in a way that is linked to reductions in the number of uninsured or how states target their funds. We have heard from states and health care providers about their concerns related to this change and are exploring all options. The Department will propose this methodology for public comment early next year.

COORDINATION BETWEEN EXCHANGES AND OTHER PROGRAMS

38. How can states use premium assistance to help families that are split among the Exchange, Medicaid, and the Children's Health Insurance Program (CHIP) enroll in the same plans?

- A. In 2014, some low-income children will be covered by Medicaid or CHIP while their parents obtain coverage on the Exchange with advance payments of the premium tax credit. Premium assistance, an option under current law, provides an opportunity for state Medicaid and CHIP programs to offer coverage to such families through the same coverage source, even if supported by different payers. Under Medicaid and CHIP statutory options, states can use federal and state Medicaid and CHIP funds to deliver Medicaid and CHIP coverage through the purchase of private health insurance. Most commonly, states have used premium assistance to help Medicaid/CHIP eligible families pay for available

employer-based coverage that the state determines is cost effective. There are cost sharing assistance and benefit wrap-around coverage requirements, to the extent that the insurance purchased with Medicaid and/or CHIP funds does not meet Medicaid or CHIP standards. In both Medicaid and CHIP, premium assistance is authorized for group health coverage and, under some authorities, for health plans in the individual market, which, in 2014 would include qualified health plans available through the Exchange. Please note that advance payments of the premium tax credit and cost-sharing reductions are not available for an individual who is eligible for Medicaid or CHIP. The statutory authorities that permit use of title XIX or title XXI funds to be used for premium assistance for health plans in the individual market, including qualified health plans in the Exchange, are sections 1905(a) and 2105(c)(3) of the Social Security Act.

For example, beginning in 2014, when a child is eligible for Medicaid/CHIP and the parent is enrolled in a qualified health plan through the Exchange, a state Medicaid or CHIP program could use existing premium assistance authority to purchase coverage for a Medicaid or CHIP-eligible child through that qualified health plan. The premium tax credit would not be available to help cover the cost of coverage for these children. As noted above, with respect to the children, the state would adhere to federal standards for premium assistance, including providing wrap-around benefits, cost sharing assistance, and demonstrating cost-effectiveness, as appropriate. A State-Based Exchange may be able to support such an option, and in states where a Federally-Facilitated Exchange is operating, a State Medicaid or CHIP agency may be able to take this approach by making arrangements with qualified health plans to pay premiums for individuals. We will be working with states interested in this option to consider how the state Medicaid and CHIP agency can coordinate with the Exchange to establish and simplify premium assistance arrangements.

39. How can states use premium assistance to promote continuity of care when individuals move between Exchange, CHIP, and Medicaid coverage?

- A. The Affordable Care Act envisions and directs that there be a coordinated system for making eligibility determinations between Medicaid, CHIP and the Exchange to avoid gaps in coverage as individuals' income fluctuates. Smooth eligibility transitions will not necessarily prevent people from having to select a new plan and/or provider when they lose eligibility for one insurance affordability program and gain eligibility for another. The extent to which such changes in plans and providers occur will depend on whether and to what degree plans participate in both the Exchange and in Medicaid and CHIP, and the networks in such plans.

Premium assistance can help address this issue, while encouraging robust plan participation in Medicaid, CHIP, and the Exchange. As discussed above, this option permits state Medicaid or CHIP programs to use premium assistance to enroll a Medicaid or CHIP eligible individual or family in a qualified health plan through the Exchange. States may be most interested in this option for families close to the top of the Medicaid income limit. Under this arrangement, if a family's income changes such that some or all members of the family become ineligible for Medicaid or CHIP and eligible for a premium tax credit to help cover the cost of a qualified health plan through the Exchange, it would be less likely that members moving into Exchange coverage would need to change plans or providers. Similarly, premium assistance could help increase the likelihood that individuals moving from Exchange coverage into Medicaid or CHIP may remain in the same qualified health plan in which they had been enrolled through the Exchange.

As discussed above, premium assistance options in Medicaid and CHIP are subject to federal standards related to wrap around benefits, cost sharing and cost effectiveness. There may also be an opportunity for states to promote continuity of coverage through “bridge plans” as described earlier.

APPEARANCE RECORD

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

1/14/13

Meeting Date

Topic Affordable Care Act

Bill Number _____
(if applicable)

Name Brad Register

Amendment Barcode _____
(if applicable)

Job Title Director - Compensation & Benefits

Address 702 N. Franklin St.

Phone 813-228-4555

Street

Tampa FL 33601

City

State

Zip

E-mail bregister@tecoenergy.com

Speaking: For Against Information

Representing TECO Energy

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 Reform

Bill Number _____
(if applicable)

Name Jon Urbaneck

Amendment Barcode _____
(if applicable)

Job Title Senior Vice President Florida Blue

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Phone (904) 905-2245

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State

Zip

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Speaking: For Against Information

Representing _____

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

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THE FLORIDA SENATE
APPEARANCE RECORD

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

1/14/13
Meeting Date

Topic MEDICAL EXPANSION Bill Number _____ (if applicable)
Name LAWRENCE P FLOKIANU MD Amendment Barcode _____ (if applicable)
Job Title PHYSICIAN
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JANOR SPRINGS FL 34688 E-mail LPFLOKIANU@AOL.COM
Street City State Zip

Speaking: For Against Information

Representing DOCTORS FOR AMERICA

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

VICE CHAIR

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

1/14/12
Meeting Date

Topic Medicaid expansion

Bill Number _____
(if applicable)

Name Owen Hinder MD PAEP

Amendment Barcode _____
(if applicable)

Job Title _____

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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.

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THE FLORIDA SENATE

APPEARANCE RECORD

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

01/14/2013

Meeting Date

Topic PPACA

Bill Number _____ (if applicable)

Name GERMAN VIVAS

Amendment Barcode _____ (if applicable)

Job Title Citizen of United States

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State

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Speaking: For Against Information

Representing Self

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

Attached 113 Page Notice of Non compliance by FL Medicaid

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.

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and CMS/HHS.

THE FLORIDA SENATE
APPEARANCE RECORD

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

January 14, 2013

Meeting Date

Topic PPACA

Bill Number _____
(if applicable)

Name Arie Strobel

Amendment Barcode _____
(if applicable)

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City

State

Zip

Speaking: For Against Information

Representing Self and Florida families

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.

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S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

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

11/14/2013

Meeting Date

Topic PPACA

Bill Number _____
(if applicable)

Name BRIAN PITTS

Amendment Barcode _____
(if applicable)

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City

State

Zip

Speaking: For Against Information

Representing JUSTICE-2-JESUS

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.

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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)

14 January 2013

Meeting Date

Topic Patient Protection and Affordable Care Act

Bill Number _____
(if applicable)

Name Joseph Cain

Amendment Barcode _____
(if applicable)

Job Title _____

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Phone 850-385-0227

Street

Tallahassee

FL

32312

City

State

Zip

E-mail joecain3@comcast.net

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)

1/14/2013
Meeting Date

Topic Senate Select Committee on the Implementation of
the Federal Health Care Reform Act Bill Number _____
(if applicable)

Name Kathy Winn Amendment Barcode _____
(if applicable)

Job Title _____

Address 1006 Brookwood Drive Phone (850) 877-0960
Street

Tallahassee FL 32308
City State Zip

E-mail kathywinnclan@
embarqmail.com

Speaking: For Against Information

Representing League of Women Voters of Florida

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

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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)

1-14-13
Meeting Date

Senate Select Committee

Topic Affordable Care Act

Bill Number _____
(if applicable)

Name David Jacobsen

Amendment Barcode _____
(if applicable)

Job Title President NWAFSCME Retiree

Address 3019 Windy Hill Ln
Tallahassee FL 32308
Street City State Zip

Phone 385-6504

E-mail devjacobson@msn.com

Speaking: For Against Information

Representing ACA AFSCME Retirees

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

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

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THE FLORIDA SENATE
APPEARANCE RECORD

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

1/14/13
Meeting Date

Topic PPACA

Bill Number —
(if applicable)

Name Anne Swerlick

Amendment Barcode —
(if applicable)

Job Title Deputy Director

Address 2425 Jolleya Drive
Street
Jel. FL 323
City State Zip

Phone 850-385-7900

E-mail anne@floridalegal.org

Speaking: For Against Information

Representing Florida Legal Services, Inc.

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.

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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)

Jan 14, 2013
Meeting Date

Topic PPACA - Public testimony Bill Number _____ (if applicable)
Name Richard Polangin Amendment Barcode _____ (if applicable)

Job Title Government Affairs Director
Florida Alliance for Retired Americans
Address 1300 N Duval St Phone (850) 224-4206

Tallahassee FL 32303 E-mail richardpolangin@
City State Zip hotmail.com

Speaking: For Against Information
Representing Florida Alliance for Retired Americans

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

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

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THE FLORIDA SENATE
APPEARANCE RECORD

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

1-14-13
Meeting Date

Topic Senate Select Committee on Obama Care

Bill Number _____
(if applicable)

Name Amy Datz

Amendment Barcode _____
(if applicable)

Job Title Retired

Address 1130 Crestview Ave

Phone 850 322-7599

Tallahassee FL, 32303
Street City State Zip

E-mail amalie.datz@mac.com

Speaking: For Against Information

Representing Self. Retired State employee Family

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.

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THE FLORIDA SENATE
APPEARANCE RECORD

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

1/14/13
Meeting Date

Topic Affordable Care Act

Bill Number _____
(if applicable)

Name Karen Woodall

Amendment Barcode _____
(if applicable)

Job Title Exec. Director

Address 579 E. Call St.
Street

Phone 850-321-9386

Tallahassee, FL 32301
City State Zip

E-mail kwtally@aol.com

Speaking: For Against Information

Representing Florida Center for Fiscal & Economic Policy

Appearing at request of Chair: Yes No

Lobbyist registered with Legislature: Yes No

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S-001 (10/20/11)

CourtSmart Tag Report

Room: KN 412

Case:

Type:

Caption: Select Committee on Patient Protection and Affordable Care Act

Judge:

Started: 1/14/2013 4:02:27 PM

Ends: 1/14/2013 6:01:12 PM

Length: 01:58:46

4:02:27 PM

4:02:33 PM Opening Remarks

4:02:44 PM Roll Call

4:03:23 PM Special welcome to Senator Simmons

4:05:05 PM Overview of Employer Impacts and Trends:

4:06:40 PM Justin Kindy, Senior Vice President Aon Hewitt

4:15:36 PM question by Senator Negron

4:15:53 PM Mr. Kindy to respond

4:16:28 PM Jon Urbanek, Senior Vice President, Sales and Marketing for Employer Markets/BCBS of Florida

4:21:48 PM question by Senator Negron - cut off

4:22:28 PM Mr. Urbanek to answer

4:29:02 PM question by Senator Soto

4:30:35 PM Comments by Senator Negron

4:31:07 PM Mr. Urbanek to follow-up

4:32:14 PM Senator Negron

4:32:19 PM question by Senator Simmons

4:32:41 PM Mr. Urbanek to answer

4:33:30 PM question by Senator Sobel

4:33:55 PM Mr. Urbanek to answer

4:35:19 PM question by Senator Sobel

4:35:31 PM Mr. Urbanek to answer

4:35:35 PM Senator Sobel w/followup

4:37:19 PM question by Senator Bean

4:37:44 PM Mr. Urbanek to answer

4:38:14 PM Senator Bean w/follow-up

4:38:35 PM question by Senator Brandes

4:38:56 PM Mr. Urbanek to answer

4:40:19 PM Senator Negron w/comments

4:40:23 PM Panel Discussion of Employer Impacts

4:40:28 PM Kim Williams, President, Marpan Supply Company and Global CNC Solutions

4:47:38 PM Senator Negron w/comments

4:48:20 PM Kevin Reynolds, CPA, Partner, Daszkal Bolton, LLP

4:57:52 PM Senator Negron w/comments

4:58:08 PM Bradley J. Register, Director of Compensation and Benefits, TECO Energy

5:09:23 PM question by Senator Gibson

5:09:34 PM Mr. Register to answer

5:10:20 PM question by Senator Sobel

5:10:48 PM Mr. Register to answer

5:11:05 PM Senator Sobel w/follow-up

5:11:17 PM Mr. Register

5:11:21 PM Senator Sobel

5:11:47 PM Mr. Register

5:11:51 PM question by Senator Gibson

5:12:41 PM question by Senator Soto

5:12:52 PM Mr. Register

5:13:05 PM Senator Soto w/follow-up

5:13:18 PM Mr. Register

5:13:34 PM Senator Negron w/comments

5:15:26 PM Senator Sobel w/introductions

5:16:17 PM Owen Linder, M.D., Safety Harbor, FL

5:21:36 PM Senator Negron w/comments

5:22:35 PM question by Senator Sobel

5:23:21 PM Lawrence P. Floriani, M.D., Member Doctors of America
5:28:18 PM Senator Negron w/comments
5:33:58 PM Senator Sobel w/comments
5:34:41 PM Senator Negron
5:35:01 PM question by Senator Gibson
5:35:53 PM Senator Negron to answer
5:36:55 PM Senator Gibson w/follow-up
5:38:22 PM Senator Negron to respond
5:40:12 PM Senator Gibson w/follow-up
5:43:02 PM Joseph Cain, Ph.D.
5:44:19 PM Kathy Winn, League of Women Voters of Florida
5:48:32 PM David Smith for David Jacobsen, AFSCME Retirees
5:50:29 PM Anne Swerlick, Florida Legal Services
5:51:28 PM Richard Polangin, Florida Alliance for Retired Americans
5:52:10 PM Brian Pitts, Justice 2 Jesus
5:54:27 PM Arie Strobel, Palm Beach Gardens
5:57:17 PM German Vivas, Kidney transplant
6:01:13 PM Meeting Adjourned