The Florida Senate

COMMITTEE MEETING EXPANDED AGENDA

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

MEETING DATE: Monday, December 3, 2012
TIME: 3:00 —5:00 p.m.
PLACE: *Pat Thomas Committee Room,* 412 Knott Building

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

TAB	BILL NO. and INTRODUCER	BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
1	Introduction of Committee Members and Staff		Discussed
2	Discussion of the Committee's Charge		Discussed
3	Overview of the Patient Protection and Affordable Care Act		Presented
	Insurance Regulation		Presented
	Purchasing and Financing		Presented
	Medicaid and State Children's Health Insurance Program (SCHIP)		Presented
	Employer Impact - Private and Public		Presented
4	Other Related Meeting Documents		Discussed

SELECT COMMITTEE ON PATIENT PROTECTION AND AFFORDABLE CARE ACT

December 3, 2012

INSURANCE REGULATION

Regulation of Insurance in Florida

Office of Insurance Regulation (OIR)

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

Agency for Health Care Administration (AHCA)

- Responsible for ensuring HMO's meet quality of care standards
    - Networks are adequate to serve members
    - Internal and external dispute processes are adequate

Early Reforms

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

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

2014 Market Reforms

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

Decision Points

Market Regulation: Who Does What?

- Federal role
- State flexibility (OIR / AHCA authority)
- Comparability of regulations e.g. open enrollment
- Exchange functions

Consumer Protections: Who Enforces?

- Minimum essential health benefits
- Complaints
- Grievance resolution

Rate Review: Who Evaluates?

- Adequacy of rates
- Mitigation of market disruptions and insolvencies
- Compliance with medical loss ratio and rebate requirements
- Methodology e.g. regional vs. statewide

Decision Points

Coverage Requirements: What Benchmarks?

- The current benchmark is the default plan
- States can modify in the future

PURCHASING AND FINANCING

EXCHANGES

- Provide seamless consumer experience to obtain affordable health care coverage

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

Minimum Functions of an Exchange

- Consumer Assistance
- Plan Management
- Eligibility
- Enrollment
- Financial Management & Security
- SHOP – specific functions to assist small employers
- Provide for appeal of determinations

Minimum Functions of an Exchange

- Consumer assistance
  - Outreach and education
  - Call center
  - In person
  - Navigator program
  - Internet web site
  - Correspondence and notifications

Minimum Functions of an Exchange

- Plan Management
  - Certification/recertification of QHPs
  - Data collection and quality reporting
  - Plan monitoring and oversight
  - Risk adjustment and reinsurance
  - Assess rate increases

Minimum Functions of an Exchange

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

Minimum Functions of an Exchange

- Enrollment
  - Facilitate enrollment in Medicaid and SCHIP
  - Enroll applicant in chosen QHP (reenrollment)
  - Transmit information to the QHP / HHS
  - Provide open enrollment periods and enrollment per triggering events
  - Continuously monitor plan enrollment

Minimum Functions of an Exchange

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

Minimum Functions of an Exchange

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

EXCHANGE OPTIONS

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

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

State may participate in FFE but operate its own reinsurance program

State Based Exchange

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

Approval Process for State Based Exchange (SBE)

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

State Based Exchange (SBE) – Potential Participants

- Existing State Agencies / Entities performing some or similar activities
  - Agency for Health Care Administration
  - Office of Insurance Regulation
  - Department of Financial Services
  - Department of Children and Families
  - Florida Healthy Kids Corporation
  - Florida Health Choices
- New Entity(ies)

Federal / State Partnership Exchange (F/SP)

- HHS has ultimate responsibility for and authority over partnership exchange
- Declaration Letter of Intent / Application by February 15, 2013
- State can assist in operating all plan management functions, some consumer assistance functions (in-person assistance to applicants and consumers, the Navigator program), or both

Federal / State Partnership Exchange (F/SP)

- State must agree to ensure cooperation from the State's insurance, Medicaid, and SCHIP agencies to coordinate business processes, systems, data/information, and enforcement
- State can use Exchange grant funding for these functions

Federally-Facilitated Exchange (FFE)

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

Decision Points

Exchange: What Type?

- Federally Facilitated Exchange
- Partnership
- State Based Exchange

Exchange Functions: Who Does What?

- Consumer Assistance
- Plan Management
- Eligibility
- Enrollment
- Financial Management & Security

Decision Points

If Florida Operates an Exchange: Who Does What?

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

Market Participation: Who Decides?

- Selective vs. open
- Integration of Medicaid and private markets

Medicaid &
State Children's Health Insurance Plan (SCHIP)

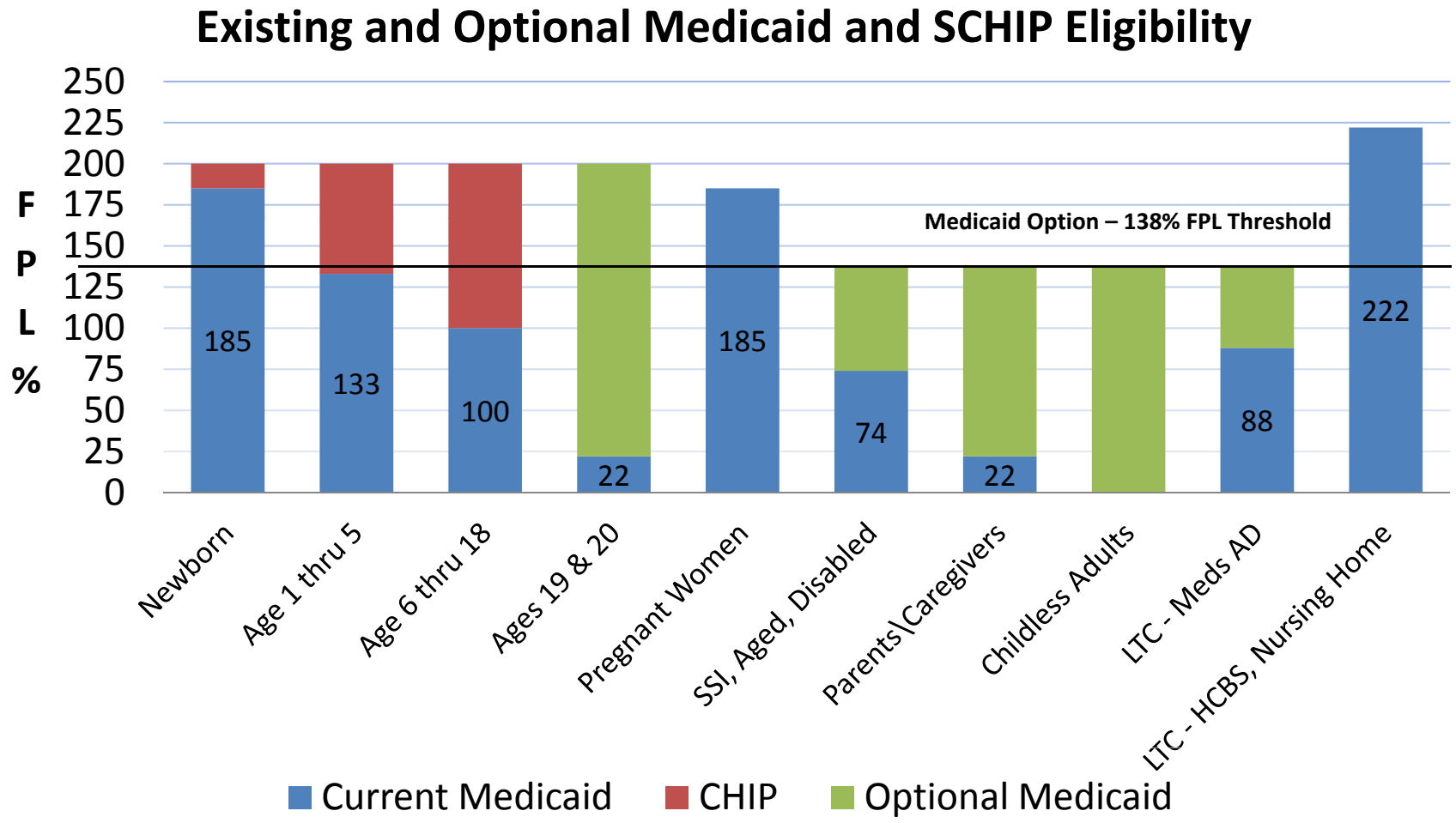
Optional Medicaid Expansion

- Supreme Court Ruling – State Option to Expand
  - 133% FPL with 5% disregard = 138% FPL
- Expansion remains in the law, the penalty is unenforceable
- No deadline to notify federal CMS of expansion

Optional Medicaid Expansion

- Initial guidance indicates states may be allowed to expand partially
- States may retract the expansion at any time
- Expansion\Retractions through Medicaid state plan amendments

Medicaid & SCHIP Overview



Medicaid & SCHIP Provisions

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

- What does that mean?
  - Maintain eligibility standards as of March 23, 2010
  - Maintain income standards, methodologies and procedures for children in Medicaid and SCHIP

Changes in Eligibility Determination

Effective January 1, 2014 – *With or Without* Medicaid Expansion

Current Medicaid

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

MAGI

Modified Adjusted Gross Income

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

Impact of Eligibility Changes

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

Impact of Eligibility Changes

- For Adults –
  - If Medicaid expanded, additional coverage options
  - Parent cannot enroll if an eligible child is not also enrolled

Current Medicaid Eligibility Continues

- Current Medicaid eligibility calculations will remain for some populations

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

- Eligibility could be conducted using both the old and new methods depending on the recipient's status

Application & Enrollment

- Simplification requirements for enrollment and renewal
  - Streamlined, online enrollment system
  - Secure, electronic interface
- Medicaid and SCHIP interface with Exchange
  - Coordinate enrollment
  - Coordinate oversight of outreach navigators and assisters
- Assist applicants with process (initial and renewal)

Background – Florida SCHIP

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

Florida's SCHIP

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

Considerations for SCHIP

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

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

Decision Points

Expansion: If and When?

- Short term and long term funding
- Relationship to statewide Medicaid managed care implementation

Coordination: How and How Much?

- Medicaid plans in exchanges
- Family enrollment
- Basic Health Plan

Children: Automatic or Optional?

- Florida Healthy Kids and Medicaid transitions

POTENTIAL FISCAL IMPACT

Four Aspects of Fiscal Impact on Medicaid

- Medicaid Eligibility Expansion (optional)
  - Effects on Caseload
  - Effects on Expenditures
- "Woodwork Effect"
- Primary Care Physician Rate Increase
- Medicaid Eligibility System

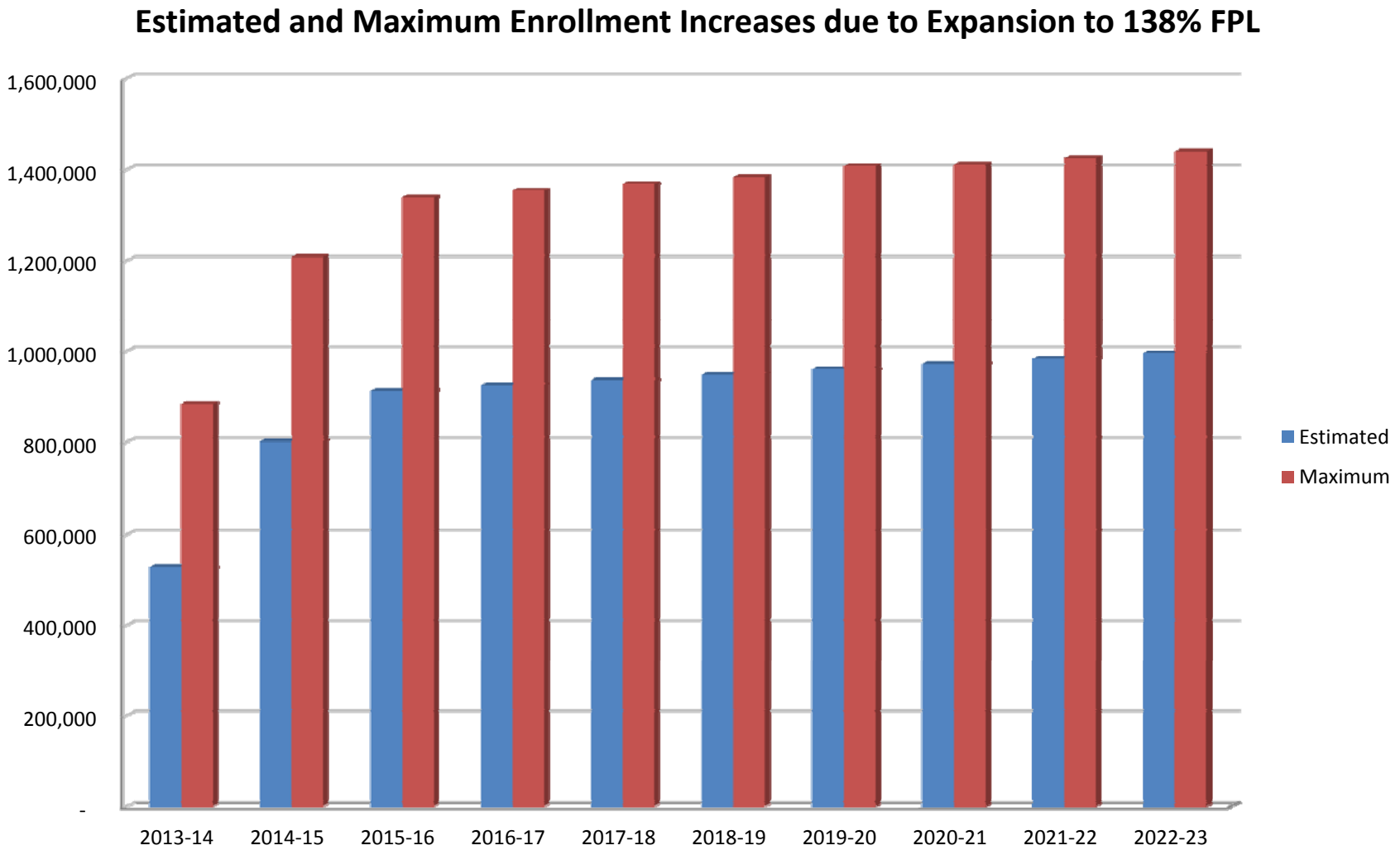
Potential PPACA Enrollment Impact

- **Optional Medicaid Eligibility Expansion:**
  - Under PPACA, states are directed to expand Medicaid eligibility to 138% of the Federal Poverty Level and receive enhanced federal match for the expansion population, beginning January 1, 2014.
  - U.S. Supreme Court rendered optional the PPACA's requirement for states to expand Medicaid eligibility in this way.
  - Effect of Expansion on Enrollment:
    - In SFY 2013-14, between Medicaid and KidCare, an estimated 463,000 new enrollees would be added due to eligibility expansion (a gain of 528,000 in Medicaid and a loss of 65,000 in KidCare).
    - By SFY 2015-16, eligibility expansion would result in an estimated 845,000 additional enrollees (a gain of 912,000 in Medicaid and a loss of 67,000 in KidCare).
    - By SFY 2020-21, eligibility expansion would result in an estimated 892,000 additional enrollees (a gain of 972,000 in Medicaid and a loss of 80,000 in KidCare).

Potential PPACA Enrollment Impact

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

Medicaid Expansion's Impact on Enrollment



Includes Medicaid enrollment only, without offsets in Kidcare program.
"Estimated" assumes indeterminate woodwork effect. "Maximum" assumes 100% woodwork effect.
Data Source: Social Services Estimating Conference, Aug 14, 2012

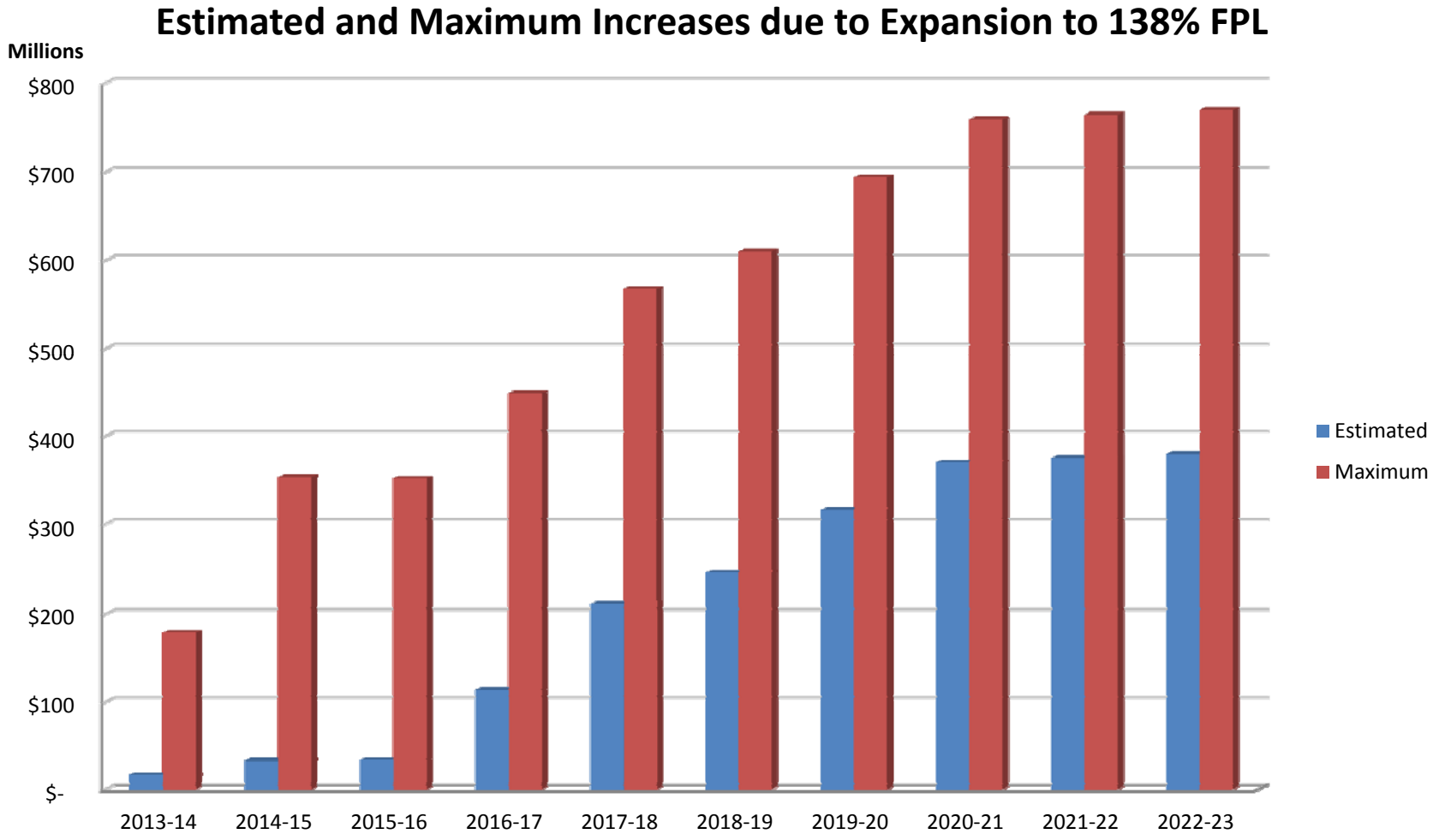
Potential PPACA Fiscal Impact

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

Potential PPACA Fiscal Impact

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

Expansion's Impact on State Medicaid Costs

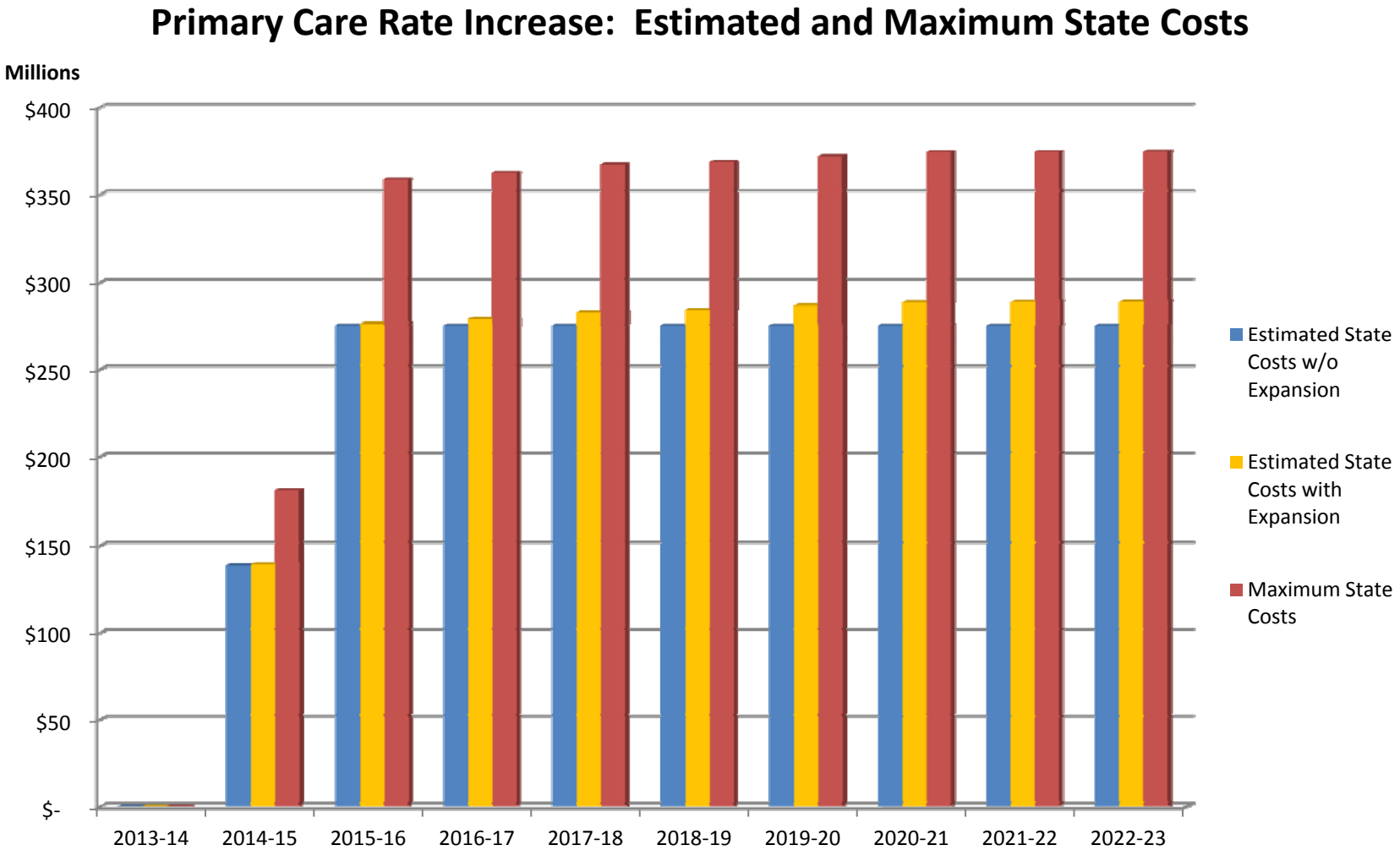


Includes costs of Medicaid eligibility expansion only, without costs of PCP rate increase and without offsets in Kidcare.
"Estimated" assumes indeterminate woodwork effect. "Maximum" assumes 100% woodwork effect.
Data Source: Social Services Estimating Conference, Aug 14, 2012.

Potential PPACA Fiscal Impact

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

Impact of PCP Rate Increase on State Costs



Assumes state continues PCP rate increase beyond 2014 CY.
"Estimated" assumes indeterminate woodwork effect. "Maximum" assumes Medicaid expansion and 100% woodwork effect.
Data Source: Social Services Estimating Conference, Aug 14, 2012.

Potential PPACA Budget Impacts

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

IMPACT ON EMPLOYERS

Employer Mandate

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

Employer Penalties

- For failure to offer insurance, the penalty = $2,000 for each full-time employee (excluding the first 30)
    - "Full time employees" are those working more than 30 hours per week.
- For failure to offer "affordable" insurance that covers at least 60% of the cost of the plan, the penalty is the lesser of:
    - $3,000 per employee who enrolls in the exchange
    - $2,000 for every FTE, minus the first 30.
- "Affordable" means the cost of coverage does not exceed 9.5% of family income

State Group Health Insurance

- Florida is a “large employer” under PPACA
- OPS employees currently cannot participate in the State Group Plan
  - Florida will be subject to penalties if coverage is not extended to all employees working 30 hours or more a week.
- Employees who currently choose not to participate in the State Group Plan may do so to comply with the individual mandate

State Group Health Insurance

- Impact Estimates
  - OPS enrollment: 3,864 eligible; 2,552 estimated
  - Opt-out enrollment: 14,897 eligible; 2,979 estimated
  - Various regulatory changes
- Estimated cost of “no coverage” penalty:
  - $312 million annually
- Estimated costs to comply with employer aspects of PPACA:
  - SFY 2012–’13 - $0.38 million
  - SFY 2013–’14 - $48.8 million
  - SFY 2014–’15 - $117.6 million
  - SFY 2015–’16 - $127.6 million

Decision Points

Private Employers: What Assistance?

- Future of Florida Health Choices
- Future of flex plans, etc

State Group: What Changes?

- Eligibility
- Coverage
- Plan design

More Information

State of Florida Long-Range Financial Outlook, Fiscal Year 2013-14 through 2015-16

http://edr.state.fl.us/Content/long-range-finacial-outlook/

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

http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf

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

http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

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

http://www.gpo.gov/fdsys/pkg/FR-2012-05-29/pdf/2012-12914.pdf

Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act; Self-Insurance Estimating Conference State Employees' Health Insurance Trust Fund

http://edr.state.fl.us/Content/conferences/healthinsurance/HealthInsuranceImpact.pdf

Acronyms

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

Civilian Noninstitutionalized Uninsured Population by State and District of Columbia

Number, Percent, and Ranking of Uninsured

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

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

INSURANCE REGULATION

Select Committee on Patient Protection and Affordable Care Act

December 3, 2012

Provisions of PPACA Relating to Insurance Regulation

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
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	N/A general limits. Some mandated benefits have limits, such as autism ($35,000 annual/$200,000 lifetime).
Rescissions (1001)	Authorizes plan to rescind coverage only for fraud or intentional misrepresentation of material fact, as prohibited by the terms of the policy. Must provide 30 days advance notification to policyholder.	All plans	Plan years beginning on or after 9/23/2010	After 2 years from the issue date, only fraudulent misstatements in the application may be used to void the policy or deny any claim starting. As an alternative insurer can have incontestability provisions that provide that after policy has been in force for 2 years, insurer cannot contest statements in the application or deny claims for preexisting conditions. Requires insurer/HMO to provide 45 days prior notice of cancellation.
Coverage of Preventive Health Services (1001)	Requires coverage without cost-sharing (with exceptions) for: • Services recommended by the US Preventive Services Task Force (except for current breast cancer screening recommendation); • Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC; • Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration; and • Preventive care and screenings for women supported by the Health Resources and Services Administration.	All non-grandfathered plans	Plan years beginning on or after 9/23/2010	Plans must include coverage for a baseline mammogram for a woman age 40-49, every year for a woman age 50 or older, and one or more per year based on a physician's recommendation for a woman who is at risk based on specified criteria. Coverage provides child wellness benefits for children from birth to age 16 and is exempt from deductible. Requires newborn coverage and newborn hearing screening. Must allow one annual OB-GYN visit. Cost sharing generally allowed.
Extension of Adult Dependent Coverage (1001)	Requires plans that provide dependent coverage to extend coverage to adult children until age 26. Dependents can be married. A plan or issuer may not define dependent for	All plans	Plan years beginning on or after	Group policies that insure dependent children of the policyholder must continue coverage at least until the end

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	purposes of eligibility for dependent coverage other than in terms of the relationship between the child and the participant. Carriers are not required to cover children of adult dependents.		9/23/2010	of the calendar year, in which the child reaches age 25, if the child is dependent on policyholder for support and the child is living in the household of the policyholder or is a full-time or part-time student. Policies that insure dependent children must include coverage to age 30 if the child is unmarried and does not have a dependent, is a Florida resident, or is a student, and is not provided other coverage.
Preexisting Condition Exclusions (1201)	Prohibits a plan from imposing any preexisting condition exclusions.	All plans except grandfathered individual market plans	Plan years beginning on or after 9/23/2010 for children under the age of 19. Effective for plan years beginning on or after, 01/01/2014 for all other individuals.	Individual policies/contracts may not exclude preexisting conditions for more than 24 months and may relate to conditions that manifested themselves during the 24-month period. Policy may exclude coverage for named or specific conditions without any time limit. Group policies/contracts may not exclude preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee and may only relate to conditions that manifested themselves during the 6-month period prior to coverage. Creditable coverage may reduce exclusion period.
Insurer Reporting of Claims and Enrollment Data (1001)	Requires plans to submit to HHS and state insurance regulators and make available to the public the following information in plain language: • Claims payment policies and practices, • Periodic financial disclosures, • Data on enrollment and disenrollment,	All non-grandfathered plans	Plan beginning on or after 9/23/2010	Insurers/HMOs are required to submit financial audits and statements as well as enrollment, claims, and rating information to the Office of Insurance Regulation (OIR).

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	• Data on the number of claims that are denied • Data on rating practices, • Information on cost-sharing and payments with respect to out-of-network coverage, and • Other information as determined by HHS.			
Insurer Reporting of Quality of Care (1001)	Requires plans to submit annual reports to HHS on whether the benefits under the plan: • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management; • Implement activities to prevent hospital readmission; • Implement activities to improve patient safety and reduce medical errors; and Implement wellness and health promotion activities.	All non-grandfathered plans	Plans years beginning on or after 9/23/2012	N/A.
Insurer Reporting of Medical Loss Ratios (MLR) and Payment of Rebates (1001)	Requires plans to report to HHS information concerning the percent of premium revenue spent on claims for clinical services and activities (medical loss ratio). Requires insurers to provide a rebate to consumers if the percentage of premiums expended for clinical services and activities is less than 85% in the large group market and 80% in the small group and individual markets.	All fully insured plans, including grandfathered plans	Plan years beginning on or after 1/1/2011	Generally, the MLR for small group and the guaranteed renewalable individual policy is 65 percent. Rates for large group are not subject to approval by OIR. Calculation of MLR and any applicable rebate is not consistent with federal regulations.
Appeals and External Review (1001)	Requires plans to implement an internal appeals and external review process. For the internal appeals process, group plans must incorporate the U.S. Department of Labor's claims and appeals procedures and update them to reflect standards established by the Secretary of Labor. Individual plans must incorporate applicable law requirements and update them to reflect standards established by HHS. For the external review process, all plans must comply with applicable state external review processes that, at a minimum, include consumer protections in the NAIC Uniform External Review Model Act (Model 76) or with minimum standards established by HHS that is similar to the NAIC model.	All non-grandfathered plans	Plan years beginning on or after 9/23/2010	In 2012, legislation was enacted which addressed some of the provisions relating to internal grievances. Additional changes are necessary to comply with PPACA.
Primary Care	A plan that provides for designation of a primary care provider	All non-	Plan years	Insurers/HMOs may require higher

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
Physicians, Emergency Room Coverage, and OB-GYN coverage (1001)	must allow the choice of any participating primary care provider who is available to accept them. If a plan provides coverage for emergency services, the plan must do so without prior authorization, regardless of whether the provider is a participating provider. Services provided by nonparticipating providers must be provided with cost-sharing that is no greater than that which would apply for a participating provider and without regard to any other restriction other than an exclusion or coordination of benefits, an affiliation or waiting period, and cost-sharing. A plan may not require authorization or referral for a female patient to receive obstetric or gynecological care from a participating provider and must treat their authorizations as the authorization of a primary care provider.	grandfathered plans	beginning on or after 9/23/2010	copayments for urgent care or primary care provided in an emergency department and higher copayments for use of out-of-network emergency departments. HMOs must provide coverage without prior authorization for emergency care, based on determination by hospital physician or other personnel, provided by either a participating or nonparticipating provider. Copayments and reimbursement for services and subscriber charges addressed. Insurers issuing EPO contracts must cover non-exclusive providers if the services are for symptoms requiring emergency care and a network provider is not reasonably accessible. Insurers issuing EPO contracts and HMOs must allow, without prior authorization, subscriber to visit contracted OB/GYN for one annual visit and for medically necessary follow-up care.
State Review of Insurers Premium Increases (1003)	Requires HHS, in conjunction with the states, to develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the state and HHS a justification for an unreasonable premium increase and post it online. Insurers that have a pattern of unreasonable increases may be prohibited from participation in an exchange.	All non-grandfathered fully-insured plans	Plan years beginning on or after 1/1/2010	Individual and small group rates filings are subject to prior approval by the OIR. Rate filings are available on the OIR website.
Rating and Underwriting Standards (1201)	Allows variations in the premiums of Individual and small group premiums only by: • Age (3:1 maximum) • Tobacco (1.5:1 maximum)	Non-grandfathered fully insured small group and individual plans. Fully insured	Plan years beginning on or after 1/01/2014	Individual market: case traits used for rating include age, gender, family composition, area by county, tobacco usage, effective date, and trend.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	• Geographic rating area • Whether coverage is for an individual or a family	large group plans in states that allow them to purchase through the Exchange.		Small group: premiums may vary based on same case traits as individuals. Separate rating category allowed for size of household. Adjustments allowed for claims experience, health status, and duration of coverage (+/- 15% of approved rate). Adjustments allowed for administration and acquisition expenses, too.
Guaranteed Availability of coverage (1201)	Requires plans to accept every employer and every individual that applies for coverage. However, insurer/HMO may restrict enrollment based upon open or special enrollment periods.	Non-grandfathered fully insured plans.	Plan years beginning on or after 1/01/14	Guaranteed issue available in the individual market for HIPPA-eligible individuals. Guaranteed issue in the group market.
Non Discrimination Based On Health status (1201)	Prohibits a plan from establishing rules for eligibility based on any of the following health status-related factors: • Health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or • Any other health-status related factor deemed appropriate by HHS	All non-grandfathered plans	Plan years beginning on or after 01/01/14	Insurers and HMOs offering group coverage prohibited from establishing rules for eligibility based on same specified health-status related factors.
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	Generally this is a contractual issue.
Coverage for Clinical Trial Participants (1201)	Prohibits an individual or small group plan from denying a qualified individual from participating in an approved clinical trial; denying or limiting conditions on the coverage of routine patient costs for items and services provided in connection with the trial; and discriminating against qualified individuals on the basis of such participation.	All nongrandfathered plans	Plan years beginning on or after 01/01/14	Several insurers and self-insured governmental entities entered into a voluntary agreement to provide routine patient care costs related to clinical trials for all those insured, diagnosed with cancer, and accepted into a Phase II, Phase III, or Phase IV clinical trial for cancer, group health plan
Grandfathered	Provides that certain provisions of PPACA will not apply to	All coverage in force	Date of	N/A.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
Plans	group or individual coverage in which an individual was enrolled as of the date of enactment. The following provisions will apply to group and individual grandfathered plans: Excessive waiting periods, Lifetime limits only, Rescissions, Extension of dependent coverage, Uniform summary of benefits and coverage and standardized definitions, Medical loss ratios, Provisions applicable only to group health plans Provisions of PHSA §2711 relating to annual limits and of PHSA §2704 relating to preexisting condition exclusions apply to grandfathered group health plans for plan years beginning when they would first otherwise apply. Additional family members may enroll in grandfathered coverage, and new employees may enroll in grandfathered group coverage.	as of the date of enactment.	enactment (3/23/10)	
Individual Mandate (1501)	All U.S. citizens and lawful residents are required to obtain essential health benefits coverage. If a taxpayer fails to maintain minimum essential coverage, they will be required to pay an annual tax penalty of the greater of $95 for each household member, up to three, or 1% of household income in 2014, $325 or 2% of household income in 2015, and $695 or 2.5% of income in following years. Taxpayers are exempted from the tax if any of the following conditions are met: • The individual has a religious objection to purchasing health insurance or is enrolled in a health care sharing ministry. • The cost of the taxpayer's premium contribution for employer-sponsored coverage or for the lowest-cost bronze level coverage available in the exchange exceeds 8% of household income. • The taxpayer's household income is below the federal income tax filing threshold. • The taxpayer is a member of a recognized Indian tribe.		Plan years beginning on or after 1/1/2014	N/A. Administered by the federal government.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	• The break in coverage is less than three months. • HHS determines that the taxpayer has suffered a hardship with respect to their ability to obtain coverage. • The individual is not lawfully present in the United States. • The individual is incarcerated. • The individual resides outside of the United States.			
Employer Coverage Penalties (1513)	If an employer fails to offer minimum essential coverage and one of its employees receives a premium tax credit or cost-sharing subsidy through the exchange, the employer will be subject to a penalty of $2,000 per employee. For employers offering coverage who have an employee receiving a premium tax credit or cost-sharing subsidy through the exchange, the employer will be subject to a penalty of $3,000 per employee receiving a premium tax credit or cost-sharing subsidy. The penalty shall not exceed $2,000 times the number of full-time employees. Employers of 50 or fewer employees are exempt from these requirements, and the first 30 employees are disregarded in calculating the penalty.	Employers with more than 50 employees.	01/01/2014	N/A. Administered by federal government.
Essential Health Benefits, Benchmark Plan, and Levels of Coverage (1302)	Generally, a qualified health plan offered through an exchange as well as coverage offered in the individual and small group markets must provide the following categories of services (essential health benefits package): • 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		Plan years beginning on or after 01/01/2014 Benchmark plan options based on enrollment as of 3/31/2012. States must select benchmark	Current Florida law mandates coverage of numerous benefits, services, and providers of services. However, there is no mandated essential health benefit plan.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	• Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care States have the flexibility to select a benchmark plan that reflects the scope of services offered by a "typical employer plan." State may choose one of the following benchmark plans: • One of the three largest small group plans in the state by enrollment; • One of the three largest employee health plans by enrollment; • One of the three largest federal employee health plan options by enrollment; or • The largest HMO plan offered in the state's commercial market by enrollment. If a state does not choose a benchmark plan, the default benchmark plan will be the small group plan with the largest enrollment in the state. A benchmark plan must cover all categories of essential benefits. States may mandate additional benefits if it defrays the expenses of enrollees for the additional cost of these benefits. Exchanges as well as individual and small group markets must offer the following levels of coverage: • **Bronze level**-provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan. • **Silver level**- provides benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan. • **Gold level**- provides benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan. • **Platinum level**-provides benefits that are actuarially equivalent to 90% of the full actuarial value of		and supplement as needed by the 3rd quarter 2012 or default applies. However, deadline has been extended.	

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	benefits under the plan. Only U.S. citizens and lawful residents may purchase coverage through the exchange.			
American Health Benefit Exchanges (1311, 1313, 1321)	Each state shall establish, as a governmental agency or nonprofit entity, an exchange that facilitates the purchase of qualified health plans and provides for the establishment of a Small Business Health Options Program (referred to as a "SHOP Exchange") to assist qualified employers in facilitating the enrollment of employees in small group qualified health benefits plans. States may choose to establish a single exchange that performs both functions. Exchanges must be self-sustaining beginning in 2015, and may generate revenue through assessments, user fees, or other taxing mechanisms. If HHS determines in 2013 that a state is not electing to operate a state exchange, or a federal partnership, or that it will not have the exchange operational by January 1, 2014, or has not taken necessary actions to implement the market reforms, the HHS shall operate an exchange, directly or through an agreement with a nonprofit entity. An exchange must certify qualified health benefits plans consistent with regulations and guidelines developed by HHS. Other duties of an exchange include, but are not limited to: • 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-	Individual and small group	12/14/2012 deadline for states to submit application for state exchange. By 1/1/2013 HHS will certify states' plans to run their own exchange in 2014. If a state chooses to operate an exchange in partnership with the federal government, an application to HHS must be received by 2/15/2013.	Not authorized in law. No state-based exchange has been created. Florida Healthy Kids determines eligibility for coverage as well as eligibility for subsidies, and provides access for range of insurance coverage for children. Florida Health Choices is designed to function as an interactive marketplace to provide access to insurance coverage.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	employed individuals. Federal funds for the establishment of exchanges may not be used for the payment of navigator grants. Initial, open enrollment for the exchange begins 10/1/2013. On 1/01/2014, exchanges for individuals and small groups begin operations. States may expand exchanges to include offering coverage to large employers on or after 01/01/2017.			
Federal Program to Assist Establishment and operation of Nonprofit, Member-Run Health Issuers (Co-ops) (1322)	Requires HHS to provide co-op plans with loans to assist with start-up costs and grants to assist with meeting solvency requirements. In making the loans and grants, HHS must give priority to plan that offer qualified health plans on a statewide basis, use integrated care models, and have significant private support and ensure that there is sufficient funding to establish at least one co-op plan in each state. Loans must be repaid within 5 years and grants must be repaid within 15 years. $6 billion is appropriated to fund the loans and grants. Any entity receiving a loan or grant must be organized under state law as a nonprofit, member corporation, may not have been a health insurance issuer prior to 7/16/2009, and may not be sponsored by a state or local government. Governance of the organization must avoid insurance industry involvement. Any profits made by the organization must be used to lower premiums, improve benefits, or improve the quality of care. The organization must meet all requirements that are required of other qualified health plans. Co-Op plans may not offer coverage in a state until the state has adopted the market reforms of PPACA.		No later than 7/1/2013	N/A
Multistate Plans (1334)	The federal Office of Personnel and Management (OPM) shall contract with insurers to offer at least 2 multistate qualified health benefits plans through the exchange in each state to provide individual and small group coverage. The OPM may		01/01/2014	N/A. Federal program.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	set standards for multistate plans regarding medical loss ratios, profit margins, premiums, and other terms and conditions in the interests of enrollees. Participating insurers must be licensed in each state where it sells coverage.			
Multistate Health Care Choice Compacts (1333)	Authorizes two or more states to enter into a "health care choice compact" under which individual market plans could be offered in all compacting states, subject to the laws and regulations of the state where coverage was written or issued. Issuers would continue to be subject to the following laws of the purchaser's home state: • Market conduct; • Unfair trade practices; • Network adequacy; • Consumer protection standards, including rating rules; and • Laws addressing performance of the contract.		01/01/16	N/A
Waiver for State Innovation (1332)	A state may apply for waivers of the following requirements: • Requirements for qualified health benefits plans • Requirements for exchanges • Requirements for reduced cost-sharing in qualified health benefits plans and premium subsidies • Requirements for the employer mandate • Requirements for the individuals mandate The state will receive funds for implementing the waiver equal to any subsidies or tax credits for which residents would otherwise receive if the state had not received a waiver. State waiver plans must provide coverage that is at least as comprehensive as coverage offered through an exchange, must cover at least as many state residents as this title would cover and may not increase the federal deficit. Waivers are valid for 5 years and are renewable unless HHS disapproves a request for renewal within 90 day of receipt.		Plan years beginning on or after 1/1/2017.	N/A
Temporary reinsurance program for	Requires each state or HHS to establish a temporary reinsurance program for plan years beginning in 2014-2016. The goal of the program is to stabilize premiums by partially	All plans must pay assessments. Nongrandfathered	Plan years beginning in 2014 through	N/A. No statutory authority to operate reinsurance program.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
individual market (1341)	offsetting claims for high-cost individuals in nongrandfathered plans for the first three years of the exchange operations. Insurers and TPAs, on behalf of self-insured plans, must make payments to the reinsurance entity. Nongrandfathered, individual market insurers that cover high -risk individuals will receive payments from the entity if they cover high-risk enrollees in the individual market. State may: 1) operate own program and collect from the fully insured market and allow HHS to collect contributions from the self-insured market; or 2)operate own program including the payment function, and defer all collection duties to HHS. If the HHS operates a state's reinsurance program, HHS will collect all contributions and perform payment functions.	individual plans may receive payments.	2016. HHS collection of reinsurance contributions begins 1/15/2014.	
Temporary Risk Corridors for Plans in Individual and Small Group Markets (1342. 1343)	Requires HHS to establish and administer a risk corridor program for 2014-2016 based upon the risk corridor program for Medicare Prescription Drug Plans. Plans will receive payments if their ratio of nonadministrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.	Qualified individual and small group health plans. Nongrandfathered individual and small group plans.	Calendar years 2014-2016	N/A. HHS administers.
Risk Adjustment (1343)	Requires each state to assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees are have an actuarial risk that is below the average actuarial risk in that state. HHS, in consultation with the states, shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans.	Nongrandfathered individual and small group plans	01/01/14	N/A. No statutory authority to administer program.

Uninsured Population Overview

Select Committee on the Patient Protection and Affordable Care Act

DECEMBER 3, 2012

Who are the Uninsured?

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

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

- Not all of the uninsured may qualify for a subsidy even if appear income eligible – must meet other eligibility requirements

Uninsured by Age

Age Band	Total Population	Number of Uninsured	Percent Uninsured
Under Age 18	3,985,822	530,787	13.3%
Age 18 to 64	11,334,018	3,324,657	29.3%
65 years and older	3,216436	45,223	1.4%
Total:	18,536,276	3,900,667	21%

Uninsured by Poverty Level

Poverty Level Range	Number Uninsured	Percent Uninsured of Population under this Range
Under 138% FPL	1,577,315	35.2%
138% FPL to 199% FPL*	725,184	30.2%
200% FPL and over	1,577,850	13.7%

**Subsidized coverage under Medicaid or SCHIP in Florida is available up to 200% FPL for children*

Uninsured by Income Level

Household Income Level (2011 Inflation Adjusted Dollars)	Number Uninsured	Percent Uninsured of Total Population under this Income Level
Under $25,000	1,122,258	29.8%
$25,000 - $49,999	1,327,910	27.4%
$50,000 - $74,999	741,723	20.2%
$75,000 - $99,999	344,865	14.6%
$100,000 – and over	325,160	8.7%

2012 Federal Poverty Levels

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

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

THE FLORIDA SENATE

APPEARANCE RECORD

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

December 3, 2012
Meeting Date

Topic Mandated health insurance

Bill Number _____ *(if applicable)*

Name Paul Henry

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address PO Box 698
Street

Monticello FL 32345
City *State* *Zip*

Phone 850-629-9550

E-mail paul@liberty2010.com

Speaking: ☐ For ☐ Against ☑ Information

Representing Paul Henry & Associates

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☑ Yes ☐ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

12/03/2012
Meeting Date

Topic Health Insurance Exchange

Bill Number _____ *(if applicable)*

Name Michael Rosenthal

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 4045 Kilmartin Dr
Street
Tallahassee FL 32309
City *State* *Zip*

Phone _____

E-mail _____

Speaking: ☐ For ☐ Against ☐ Information

Representing self

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)

12-3-2012
Meeting Date

Topic OBAMACARE

Bill Number _____ *(if applicable)*

Name Terri Fogler

Amendment Barcode _____ *(if applicable)*

Job Title Homemaker

Address 644 Ponderosa Cir
Street

Phone _____

Midway
City *State* *Zip*

E-mail fogler.t5@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

Representing myself

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)

12-3-12
Meeting Date

Topic Senate Select Comm PPACA Health Care

Bill Number _____ *(if applicable)*

Name Kathy Cooper

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 295 NW Commons Loop #15-32
Street

Phone _____

Lake City, FL
City *State* *Zip*

E-mail _____

Speaking: ☐ For ☐ Against ☒ Information

Representing _____

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)

3 Dec 2017
Meeting Date

Topic Health Care Bill Exchanges

Bill Number _____ *(if applicable)*

Name Marge Kloess

Amendment Barcode _____ *(if applicable)*

Job Title NA

Address 5030 Oyster Cove
Street
New Port Richey FL 34652
City *State* *Zip*

Phone 7278487944

E-mail edmarge@earthlink.net

Speaking: ☐ For ☑ Against ☒ Information

Representing _____

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)

_____
Meeting Date

Topic Constitution Dec 3 Bill Number _____ *(if applicable)*

Name Rex Cooper Amendment Barcode _____ *(if applicable)*

Job Title Tax Payer

Address 295 NW Commons Loop Ste 115-312 Phone _____
Street

_____ E-mail _____
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing _____

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)

12/3/
Meeting Date

Topic Affordable Health Care Act

Bill Number _____ *(if applicable)*

Name Yvonne Heikkinen

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 3361 Green Acres Rd.
Street
St Augustine FL 32084
City *State* *Zip*

Phone 904 829.3896

E-mail ranchy1911@att.net

Speaking: ☐ For ☒ Against ☒ Information

Representing _____

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)

Meeting Date

Topic Health Care Exchange

Bill Number *(if applicable)*

Name DAVID HEIMBOLD, SR.

Amendment Barcode *(if applicable)*

Job Title Chair St. Augustine Tea Party

Address 112 Manresa Rd *Street*

St. Aug, FL 32084 *City* *State* *Zip*

Phone 904 ~~570~~ 553-7312

E-mail DPHeimbold@yahoo.com

Speaking: ☐ For ☑ Against ☐ Information

Representing Tea Party, St Augustine, FL

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)

12/3/12
Meeting Date

Topic Patient Protection + Affordable Care Act

Bill Number _____ *(if applicable)*

Name Peter Lee

Amendment Barcode _____ *(if applicable)*

Job Title Director

Address 14501 Lycastle Cir
Street

Phone 321-800-8683

Orlando FL 32826
City *State* *Zip*

E-mail Peter@eastsideteaparty.org

Speaking: ☐ For ☐ Against ☒ Information

Representing _____

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)

Meeting Date

Topic State Health Care Exchanges

Bill Number _____ *(if applicable)*

Name Linda O'Laughlin

Amendment Barcode _____ *(if applicable)*

Job Title RN, BSN

Address 16936 Comerwood Dr *Street*

Orlando, Ohio 32820 *City* *State* *Zip*

Phone 6142884554

E-mail lindao12012@gmail.com

Speaking: ☐ For ☒ ~~Against~~ ☒ Information

Representing myself

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

12/3/12
Meeting Date

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

Topic _____ Bill Number _____ *(if applicable)*

Name Shirley A. Bruch Amendment Barcode _____ *(if applicable)*

Job Title N/A

Address 7418 Moorgate Ct. Phone 727-845-1836
Street

New Port Richey Fl. 34654 E-mail
City *State* *Zip*

Speaking: ☐ For ☒ Against ☒ Information

Representing _____

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

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

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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)

12-3-12
Meeting Date

Topic ST Health Care Exchanges

Bill Number _____ *(if applicable)*

Name BRIAN D. DUKEMAN

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address PORT ORANGE, FL
Street

Phone 386-322-2045

E-mail rdukeman@cfl.rr.com

City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

Representing EVERYONE WHO LOVES A FREE AMERICA

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)

Meeting Date

Topic ACA

Bill Number *(if applicable)*

Name Stan Whittaker

Amendment Barcode *(if applicable)*

Job Title ARNP

Address 6294 NW Torreya Rt Rd
Street

Phone 850-545-8301

Bristol FL 32321
City *State* *Zip*

E-mail StanWhitte AOL.com

Speaking: ☐ For ☐ Against ☒ Information

Representing Fl Association of Nurse Practicers

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)

Dec. 3 2012
Meeting Date

Topic Affordable Care

Bill Number _____ *(if applicable)*

Name Robert H. Mizelle, Jr.

Amendment Barcode _____ *(if applicable)*

Job Title Retired

Address 911 Daytona Ave.
Street

Phone 386-226-2257

Holly Hill FL 32117
City *State* *Zip*

E-mail None

Speaking: ☐ For ☑ Against ☐ Information

Representing Self

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)

Meeting Date

Topic AFFORDABLE CARE EXCHANGES

Bill Number *(if applicable)*

Name BOB ROOT

Amendment Barcode *(if applicable)*

Job Title N/A

Address 1110 LAK PLEASANT LN.
Street
SHADY GROVE, FL 32357
City *State* *Zip*

Phone 850-584-8311

E-mail taylorteaparty@hotmail.com

Speaking: ☐ For ☐ Against ☒ Information

Representing MYSELF

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☐ No N/A

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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)

Meeting Date

Topic HEALTH CARE ACT

Bill Number PPAC *(if applicable)*

Name BARRY J. MCMAHON

Amendment Barcode *(if applicable)*

Job Title RETIRED

Address 131 E. 1ST ST *Street*

Phone 321 460 2100

CANOVA FL 32766 *City* *State* *Zip*

E-mail missbetty2865@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

Representing SELF

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)

Meeting Date

Topic HEALTH CARE

Bill Number — (if applicable)

Name NELSON A. PRYOR

Amendment Barcode (if applicable)

Job Title RETIRED

Address 195 12TH St., NE (Street)

LEE, FL. (City / State / Zip)

Phone (850) 971-5285

E-mail

Speaking: ☐ For ☐ Against ☒ Information

Representing SELF

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)

12/3/12
Meeting Date

Topic Health Care exchange

Bill Number _____ *(if applicable)*

Name Ron Beyea

Amendment Barcode _____ *(if applicable)*

Job Title ~~Pres.~~

Address 1638 Market Dr.
Street

Phone 850-686-6022

Gulf Breeze
City *State* *Zip*

E-mail ronbeyea@bellsouth.net

Speaking: ☒ For ☐ Against ☐ Information

Representing Navarre Patriots

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)

3 Dec 2012
Meeting Date

Topic Affordable Health Care

Bill Number _____ *(if applicable)*

Name Bob Rettie

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 317 Sudduth Circle
Street
Fort Walton Beach, FL 32548
City *State* *Zip*

Phone 850 243 1763

E-mail rettie@cox.net

Speaking: ☐ For ☐ Against ☒ Information

Representing FL Panhandle Patriots

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)

3 Dec 2012
Meeting Date

Topic State Exchanges

Bill Number _____ *(if applicable)*

Name Debbie Gumnoe

Amendment Barcode _____ *(if applicable)*

Job Title Retired

Address 2143 Chatsworth Dr
Street
Navarre FL 32566
City *State* *Zip*

Phone (850) 515-0217

E-mail debbie.gumnoe@putgodfirst.co

Speaking: ☐ For ☒ Against ☐ Information

Representing Self

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)

12-3-12
Meeting Date

Topic ACA STATE EXCHANGE COMMITTEE Bill Number _____ *(if applicable)*

Name TERRANCE J. SHOEMAKER Amendment Barcode _____ *(if applicable)*

Job Title RET AF

Address 31 RUBY CIR Phone 850 362-0043
Street

MARY ESTHER, FL 32569 E-mail tjshoe@cox.net
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

Representing PANHANDLE PATRIOTS TEA PARTY

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)

12-3-12
Meeting Date

Topic Health Care

Bill Number _____ *(if applicable)*

Name Judy Bartlett

Amendment Barcode _____ *(if applicable)*

Job Title —

Address 1908 S. Dean Rd
Street
Orlando FL 32825
City *State* *Zip*

Phone 407 273-6063

E-mail jujube@bellsouth.net

Speaking: ☐ For ☐ Against ☑ Information

Representing Self

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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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)

Dec. 3 2012
Meeting Date

Topic _____ Bill Number _____ *(if applicable)*

Name Kris Anne Hall Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 8229 25th Drive Phone 386 466 4556
Street

Wellborn, FL 32094 E-mail krisanne@krisannehall.com
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing Constitutional Education & Consulting.

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)

12/3/12
Meeting Date

Topic Health Exchange

Bill Number _____ *(if applicable)*

Name John Lacquey

Amendment Barcode _____ *(if applicable)*

Job Title Owner

Address 8125 264th St.
Street

Phone 386-935-1705

Branford Fl. 32008
City *State* *Zip*

E-mail jlacquey@yahoo.com

Speaking: ☐ For ☐ Against ☒ Information

Representing John Lacquey Pinestraw

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)

12-3-12
Meeting Date

Topic _____ Bill Number _____ *(if applicable)*

Name LANCE THATE Amendment Barcode _____ *(if applicable)*

Job Title _____

Address PO Box 840271 Phone 9044610100
Street

ST AUGUSTINE FL 32080 E-mail LTHATE@COMCAST.NET
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing _____

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)

12/3/12
Meeting Date

Topic _____ Bill Number _____ *(if applicable)*

Name Rod Gonzalez Amendment Barcode _____ *(if applicable)*

Job Title Business Adm / Risk Mgmt

Address 24514 NW 78 AVE Phone 352 244-0671
Street

Alachua FL 32615 E-mail roderickf@msn.com
City *State* *Zip*

Speaking: ☐ For ☐ Against ☒ Information

Representing _____

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)

12/3/12
Meeting Date

Topic _____ Bill Number _____ *(if applicable)*

Name LAURIE NEWSOM Amendment Barcode _____ *(if applicable)*

Job Title ADMINISTRATOR / BUSINESS OWNER

Address 2521 NW 41 ST Phone 352 377 7733
Street

GAINESVILLE, FL
City *State* ~~Zip~~

E-mail laurie@gainesvillelegal.org

Speaking: ☐ For ☐ Against ☑ Information

Representing _____

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)

Dec 3
Meeting Date

Topic Insurance mandates

Bill Number _____ *(if applicable)*

Name Janet Smith

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 60 Canton Pl
Street

Phone 904-705-6856

Weleka, FL 32193
City *State* *Zip*

E-mail zelwerda@yahoo.com

Speaking: ☐ For ☐ Against ☑ Information

Representing _____

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)

DEC 3 2012
Meeting Date

Topic HEALTH CARE EXCHANGE DEBATE Bill Number N/A *(if applicable)*

Name JOHN KNAPP Amendment Barcode N/A *(if applicable)*

Job Title PRIVATE CITIZEN

Address 2333 264TH STREET Phone 386-935-2961
Street

O'BRIEN, FLA 32071 E-mail MINUTEMEN09@GMAIL.COM
City *State* *Zip*

Speaking: ☐ For ☒ Against ☐ Information

Representing MYSELF / MANY MANY OTHERS

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)

11/3/12
Meeting Date

Topic State exchanges ACA

Bill Number _____ *(if applicable)*

Name James C. Hall

Amendment Barcode _____ *(if applicable)*

Job Title Pastor - Baptist Coalition of N. Florida

Address 8229 25th Dr ~~Wellborn~~
Street

Phone 386 466 4542

Wellborn FL 32094
City *State* *Zip*

E-mail contactmercy@yahoo.com

Speaking: ☐ For ☐ Against ☐ Information

Representing Baptist Coalition of N. 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)

12-3-12
Meeting Date

Topic Health Exchange

Bill Number _____ *(if applicable)*

Name Sharon Higgins

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 21256 49th Drive
Street

Phone (386) 935-0821

Lake City FL 32024
City *State* *Zip*

E-mail shiggins@windstream.net

Speaking: ☐ For ☐ Against ☐ Information

Representing re: legislation

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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S-001 (10/20/11)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

COMMITTEES:
Banking and Insurance, *Chair*
Appropriations Subcommittee on Education
Appropriations Subcommittee on Finance and Tax
Criminal Justice
Education
Governmental Oversight and Accountability
Rules

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

SENATOR DAVID SIMMONS
10th District

November 30, 2012

The Honorable Joe Negron
412 Senate Office Building
404 South Monroe Street
Tallahassee, FL 32399-1100

Dear Senator Negron:

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

Sincerely yours,

David Simmons

cc: Steve Burgess, Staff Director

REPLY TO:
☐ 251 Maitland Avenue, Suite 304, Altamonte Springs, FL 32701 (407) 262-7578
☐ 406 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5010

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

DON GAETZ
President of the Senate

GARRETT RICHTER
President Pro Tempore

CourtSmart Tag Report

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

Started: 12/3/2012 3:03:19 PM
Ends: 12/3/2012 5:01:17 PM **Length: 01:57:59**

3:03:30 PM	Meeting called to order
3:04:17 PM	quorum present
3:04:22 PM	Sen Negron
3:04:25 PM	Sen. Simmons excused
3:04:34 PM	Sen Negron comments
3:07:33 PM	Member Introductions
3:07:40 PM	Sen. Sobel
3:09:01 PM	Sen. Bean
3:10:07 PM	Sen. Grimsley
3:10:22 PM	Sen. Legg
3:10:38 PM	Sen. Gibson
3:11:29 PM	Sen. Smith
3:11:36 PM	Sen. Brandes
3:11:47 PM	Sen. Soto
3:11:59 PM	Sen. Negron
3:12:13 PM	Committee Staff Introductions
3:13:10 PM	Sen. Negron - meeting plan
3:13:49 PM	Lisa Johnson, Banking and Insurance Committee
3:20:50 PM	Sen Sobel question
3:21:24 PM	Lisa Johnson answer to age question
3:21:48 PM	Sen Sobel benchmark default plan
3:22:00 PM	Lisa Johnson, answer
3:23:21 PM	Sen Soto, question about exchanges
3:23:46 PM	question deferred
3:23:58 PM	Sandra Stoval, Health Policy Committee
3:32:24 PM	Sen Negron, questions/comments ,
3:33:47 PM	Sandra Stovall, answer
3:34:05 PM	Sen. Gibson, question
3:34:47 PM	Sandra Stovall, answers re grant money
3:35:51 PM	Sen Negron comments
3:36:07 PM	Sen. Sobel, question
3:36:37 PM	Sandra Stoval answer
3:37:03 PM	Sen. Sobel,
3:37:12 PM	Sen. Negron response
3:37:27 PM	Jennifer Lloyd, Health Policy Committee
3:43:03 PM	Jennifer Lloyd, Health Policy Committee
3:46:06 PM	Sen. Negron, question
3:47:19 PM	Jennifer Lloyd
3:47:56 PM	Sen Gibson, question
3:49:09 PM	Sen. Negron
3:49:25 PM	Sen Gibson
3:49:50 PM	Jennifer Lloyd
3:50:36 PM	Allen Brown, HHS Appropriations
3:59:27 PM	Sen. Bean, questions
3:59:39 PM	Allen Brown re: rates
3:59:49 PM	Sen Gibson, question
4:00:09 PM	re: projections
4:00:45 PM	Amy Baker, EDR, response to question
4:01:42 PM	Sen. Brandes, question, impact of new eligibility requirements
4:02:13 PM	Allen Brown, answer
4:02:42 PM	Amy Baker, comment on response
4:03:45 PM	Sen Sobel, question

4:04:03 PM where did figures come from?
4:04:11 PM Amy Baker responds
4:04:26 PM Sen. Sobel, questions
4:05:15 PM Allen Brown
4:05:29 PM Sen. Negron
4:05:55 PM Sen. Sobel
4:06:12 PM Allen Brown
4:07:33 PM Carol Gormley, Senior Policy Advisor
4:16:32 PM Sen. Negron
4:16:56 PM Sen Legg, questions re: 30 hr employees
4:17:15 PM Carol Gormley, response
4:18:54 PM Sen. Negron comments
4:19:55 PM Public Comments
4:19:59 PM Sharon Higgins, Lake City
4:20:35 PM James Hall, Wellborn, FL
4:24:28 PM John Knapp, O'Brien
4:29:33 PM Rod Gonzalez, Alachua, FL
4:30:22 PM John Lacquey, Branford, FL
4:31:31 PM Kris Anne Hall, Wellborn, FL
4:41:44 PM Nelson Pryor, Lee, Florida
4:44:52 PM Stan Whittaker, Bristol, FL
4:48:56 PM Peter Lee, Orlando, FL
4:50:51 PM David Heimbold, Sr. St. Augustine, FL
4:53:39 PM Michael Rosenthal, Tallahassee, FL 32309
4:56:08 PM Sen. Smith, Minority Leader, comments
4:59:02 PM Sen Negron, comments
4:59:35 PM Paul Henry, Monticello, FL
5:00:53 PM Sen. Negron, closing comments.