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, March 4, 2013
TIME: 8:30 —10:30 a.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
	This will be a joint meeting with the House Select Committee on PPACA (Patient Protection and Affordable Care Act)		
1	Economic Analysis of PPACA and Medicaid Expansion Amy Baker, Coordinator, Office of Economic and Demographic Research Devon Herrick, Senior Fellow, National Center for Policy Analysis		Presented
2	Other Related Meeting Documents		

Amy Baker, Coordinator, Office of Economic and Demographic Research

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

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

Economic Analysis of PPACA and Medicaid Expansion

Select Committees on Patient Protection and Affordable Care Act

March 4, 2013

Presented by:

The Florida Legislature
Office of Economic and Demographic Research
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Background

- The Office of Economic and Demographic Research was asked by the Senate and House to conduct an in-depth analysis of the Affordable Care Act and the potential effects it will have on the Florida economy.
- The analysis covers the mandatory provisions of the Act, as well as the optional Medicaid Expansion decision.
  - The mandatory provisions will be in effect regardless of future legislative actions.
  - The optional decision regarding Medicaid Expansion is under the control of the Legislature and the Governor.
- The current National and Florida Economic Outlooks have not fully taken into account the changes that will result from the mandatory provisions of the Act, so adjustments had to be made to the economic baseline.
- Due to the national nature of the legislation and the ultimate interplay among states, as well as the incomplete nature of the federal rules and regulations that will implement the Act, the Statewide Model results should be viewed not as specifics, but as suggestive of likely outcomes. Even the adjusted economic baseline should be regarded as a simulation.

Primary Data Source for Analysis

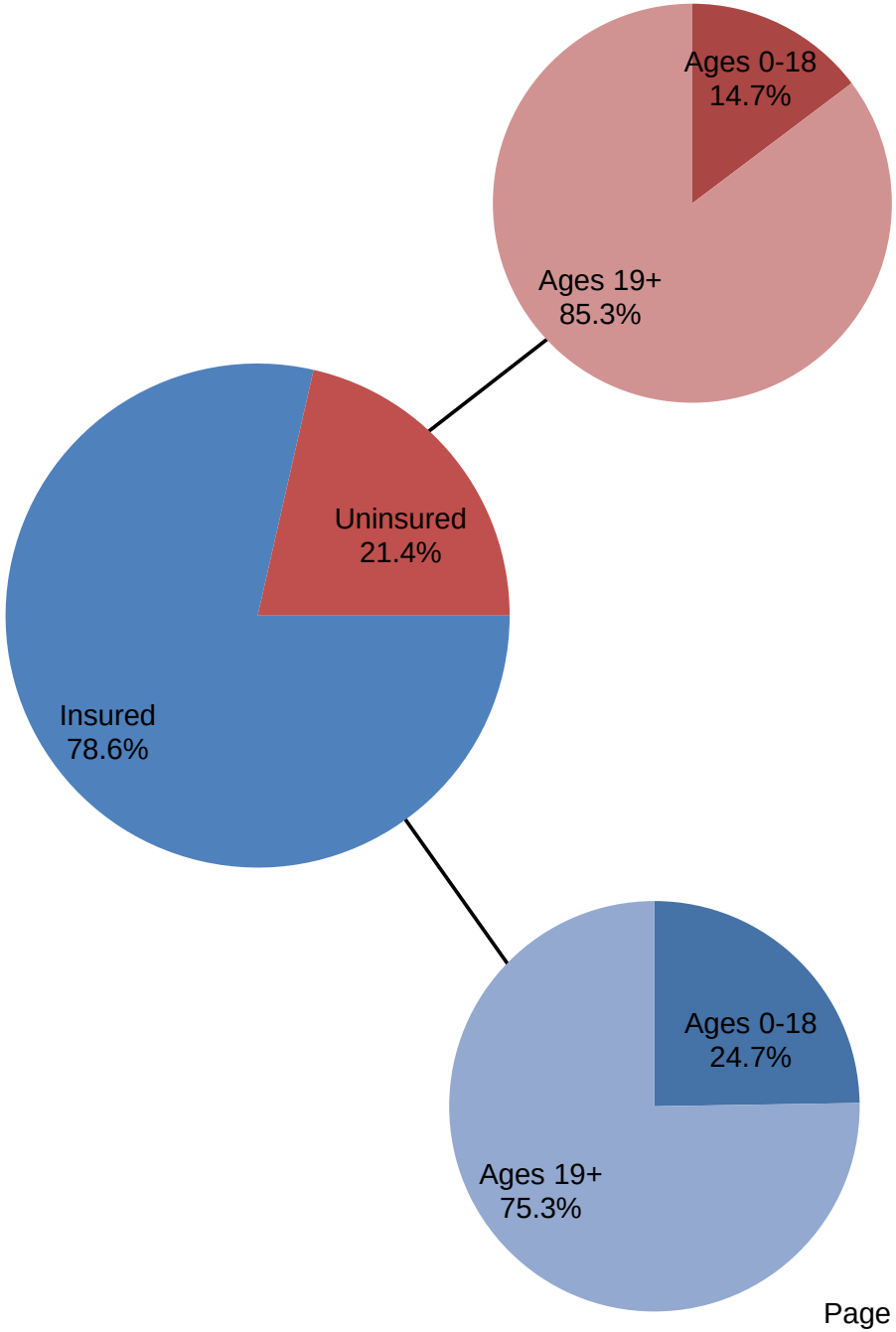
- The American Community Survey (ACS) Public Use Microdata Sample (PUMS) data show the full range of population and housing unit responses collected on individual ACS questionnaires.
- The data is detailed and shows how respondents answered questions regarding issues such as income, disabilities, household relationships, health coverage, and income.
- These responses are then weighted (using ACS weights) to produce estimates for the entire Florida population.
- The PUMS data provides the base for all Social Services Estimating Conference (SSEC) and EDR estimates related to the Act.
- For this analysis, the 2009-11 ACS 3-year PUMS data was used.

American Community Survey

Public Use Microdata Sample

2009-2011 Population Base

	Number	Percent
Total Population	18,849,600	100.00%
Insured	14,808,869	78.6%
Uninsured	4,040,731	21.4%
Insured	14,808,869	
Ages 0-18	3,664,365	24.7%
Ages 19+	11,144,504	75.3%
Uninsured	4,040,731	
Ages 0-18	594,935	14.7%
Ages 19+	3,445,796	85.3%

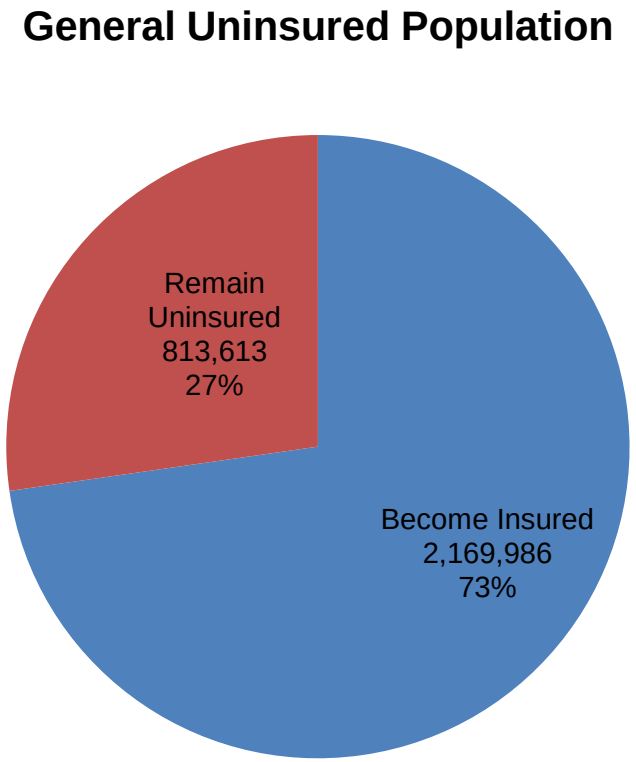


Medicaid Effects to Baseline

- Increased state budgetary costs and federal dollars associated with the mandatory Medicaid portions of the Act.
  - Primary Care Practitioners Fee Increase to Medicare Rate (100% federally funded during the authorized period).
    - $349.4 million in FY 2012-13
    - $698.8 million in FY 2013-14
    - $349.4 million in FY 2014-15
  - Health Insurance Tax Impact on Medicaid Managed Care (the cost will be split between increased federal reimbursements and a realignment within the state budget to provide the required match).
    - The total costs range from $31.6 million in FY 2013-14 to $471.0 million in FY 2022-23, the last year of the SSEC estimates.
    - Of this amount, the state costs range from $13.1 million in FY 2013-14 to $192.5 million in FY 2022-23, the last year of the SSEC estimates.
- Woodworking (participation by currently eligible but not enrolled individuals) is indeterminate as adopted by the SSEC. Therefore, no additional Medicaid or CHIP entrants are assumed in the adjusted baseline.

General Uninsured Population Effects to Baseline

- Increased insurance coverage associated with the mandatory portions of the Affordable Care Act resulting in a greater number of traditional insurance policies, self-insured programs and richer benefits.
  - The analysis has discrete assumptions based on age, employment status, size and type of employer, income, population growth, and ramp-up periods.
- These assumptions were then used to develop the levels of insurance coverage, penalties, individual subsidies, tax credits, and the associated state Insurance Premium Tax collections for both the newly and existing insured.
- In the PUMs data, 1,442,014 will receive policy coverage and 727,972 will fall under a self-insured program, for a total of 2,169,986 uninsured persons becoming insured. On an annual basis, these numbers are affected by assumptions regarding the ramp-up period.



General Uninsured Population Numbers

- Increased federal dollars and costs associated with the mandatory portions of the Act for the general uninsured population:
  - Healthcare premium volume for new policies ranges from $5.9 billion in FY 2013-14 to $12.1 billion in FY 2021-22 for businesses and individuals.
    - Offsetting the new policy premium volume, federal business tax credits range from $21.6 million to $70.2 million over the same period.
    - Offsetting the new policy premium volume, federal individual subsidies range from $970.7 million to $2.7 billion over the same period.
    - In addition, individual penalties range from $71.7 million to a high of $294.4 million before declining to $189.4 million at the end of the period.
  - Additional healthcare premium volume associated with existing policies ranges from $5.2 billion in FY 2013-14 to $6.8 billion in FY 2021-22 for businesses and individuals.
    - Offsetting the existing policy premium volume, federal business tax credits range from $209.3 million to $270.4 million over the same period.
    - Offsetting the existing policy premium volume, federal individual subsidies range from $5.4 to $6.1 billion over the same period.

Statewide Model

- The Statewide Model contains large amounts of data specific to the Florida economy to perform calculations that account for the responses of businesses and households to policy changes or “shocks” over a 10 year timespan.
- The key economic variables analyzed by the Statewide Model are:
  - Florida Gross Domestic Product
  - Personal income
  - Gross output
  - Household consumption
  - State government revenues and expenditures
  - Investment / Savings
  - Jobs
  - Population
- All differences in economic variables that account for policy change are shown relative to the baseline.

Economic Effects Definitions

- **Direct Economic Effects**: A change in expenditures by the industry directly impacted by the change in policy ─ for example, changes in the healthcare industry in response to the increased demand for healthcare services.

- **Indirect Economic Effects**: A change in expenditures by industries that supply goods or services to the directly impacted industry ─ for example, the increased demand for healthcare services results in increased manufacturing of medical devices.

- **Induced Economic Effects**: A change in expenditures by households for which income is changed by the direct and indirect activity ─ for example, the rippling effect of new healthcare workers spending their paychecks on other goods and services.

Key Assumptions

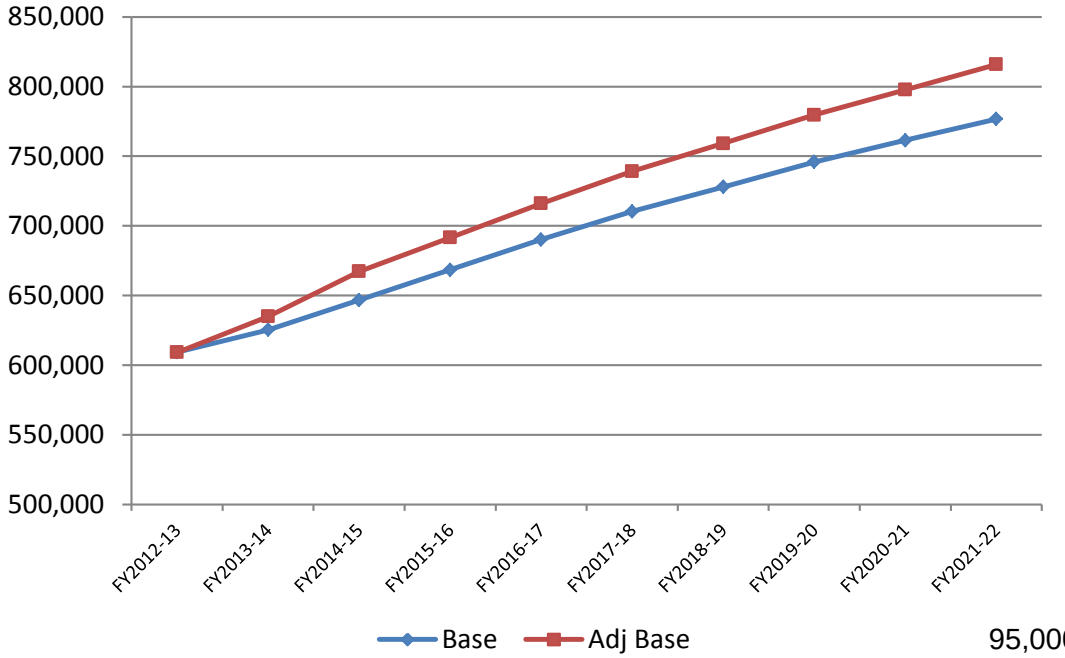
- Policy premiums:
  - Initially increase by 25% to reflect the richer benefit package.
  - Grow at a slower rate than they otherwise would as a result of the downward pressure from better health outcomes.
- Out-of-pocket healthcare spending today by the uninsured will generally convert to spending on copayments, deductibles, and incidentals.
- Today's uncompensated care will be reduced but not eliminated as a result of the newly insured.
- All large businesses will comply immediately with the new provisions to avoid negative effects on brand image, recruitment, and the like, that would put them at a competitive disadvantage.

Indeterminate Effects

- The business value associated with increased utility / productivity from better healthcare (reduced sick days, average workweek hours increased, and overall improved health).
- Effects from employers altering their practices regarding the provision of insurance (moving to self-funded pools to a greater extent than the historic trend, eliminating coverage altogether or reducing the scope of health benefits), as well as the extent to which businesses scale back or eliminate coverage but increase wages.
- The cost of implementing an exchange and its effect on eligibility determinations.
- The collection of excise taxes on “Cadillac Plans,” and the response by the providers of those plans.

Baseline vs. Adjusted Baseline

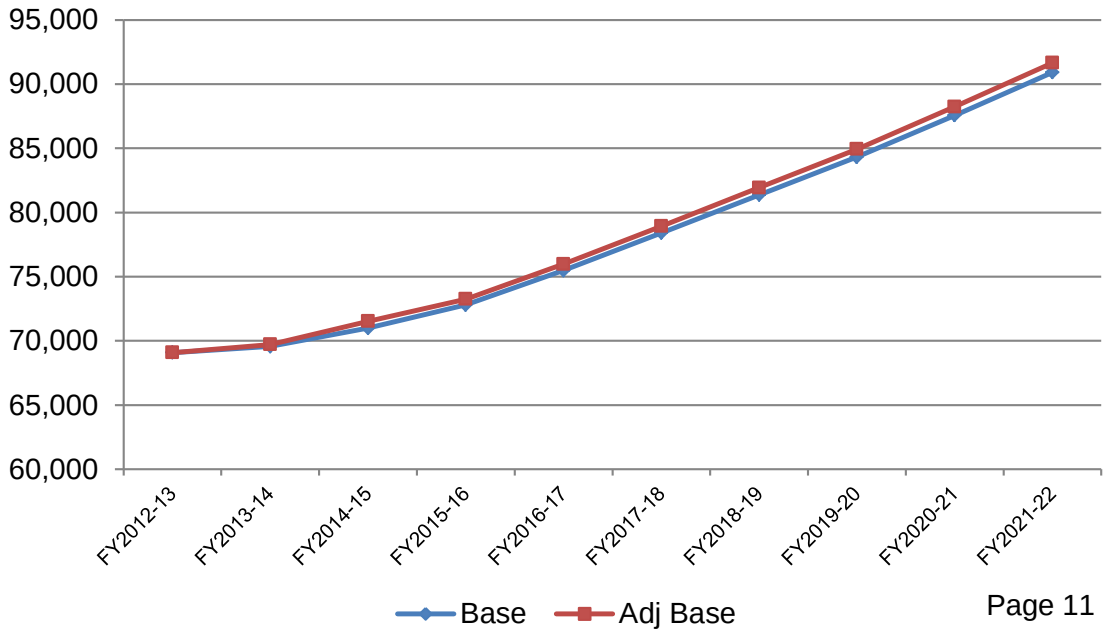
Consumption by Households and Government
(in Millions)



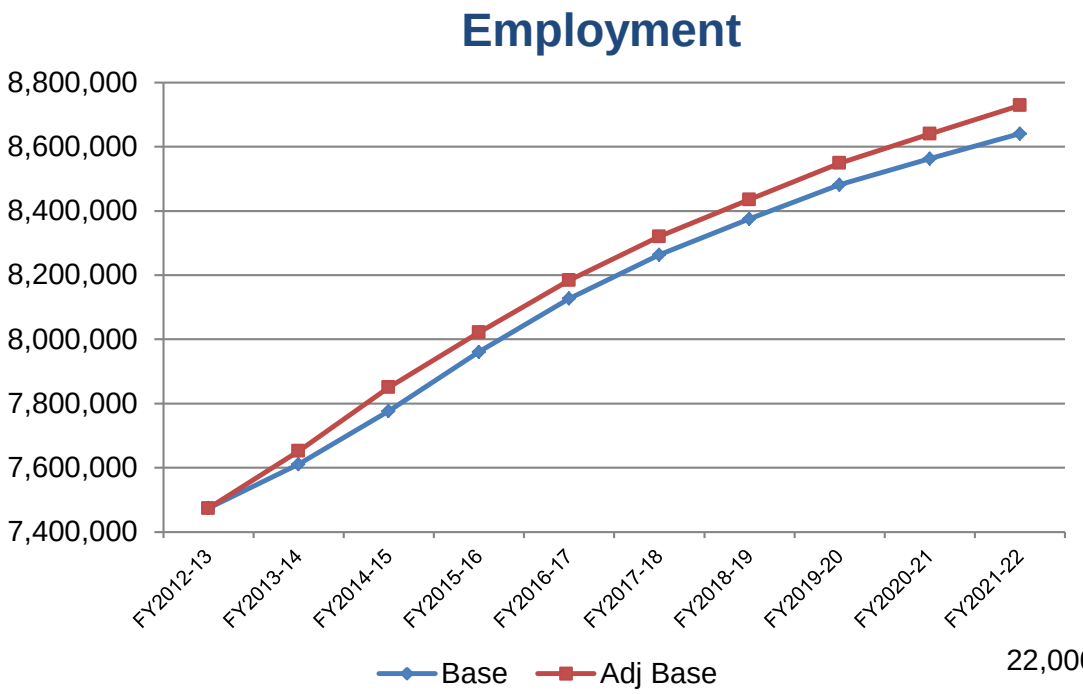
The increased demand for healthcare generates greater–and growing– consumption by households and government over the entire forecast period.

However, the adjustment to state revenues from the baseline is proportionately smaller because the increased demand for healthcare services is largely not taxable.

Total Net State Revenues
(in Millions)

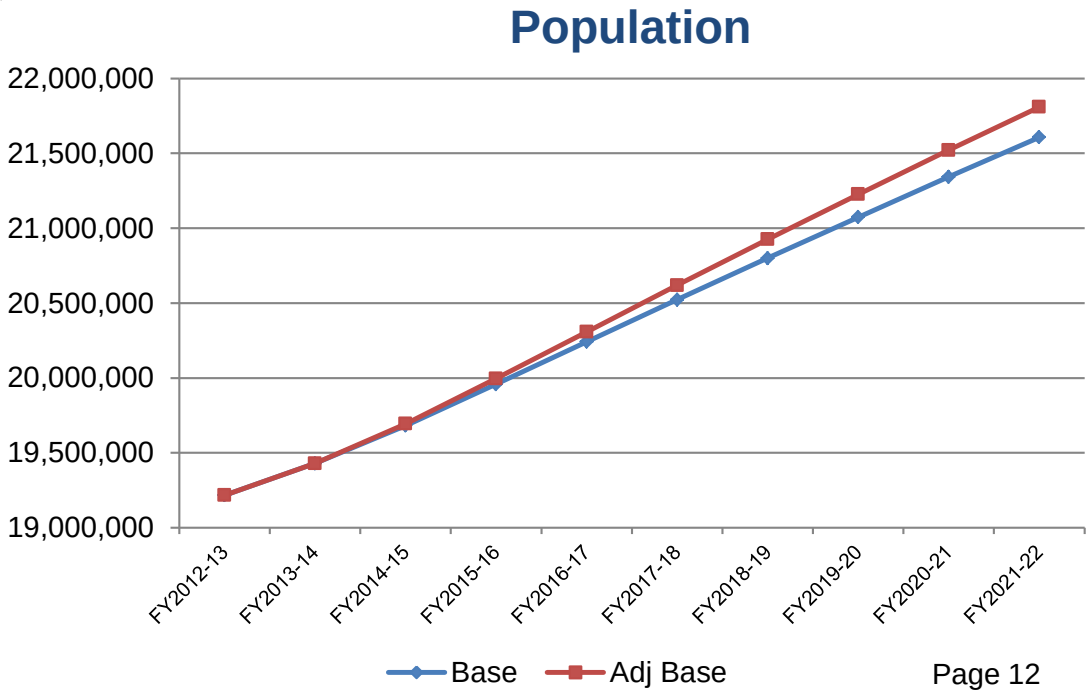


Baseline vs. Adjusted Baseline



The increased demand for healthcare services also generates more employment than expected in its absence.

Part of the typical solution to the need for additional employees is increased migration.

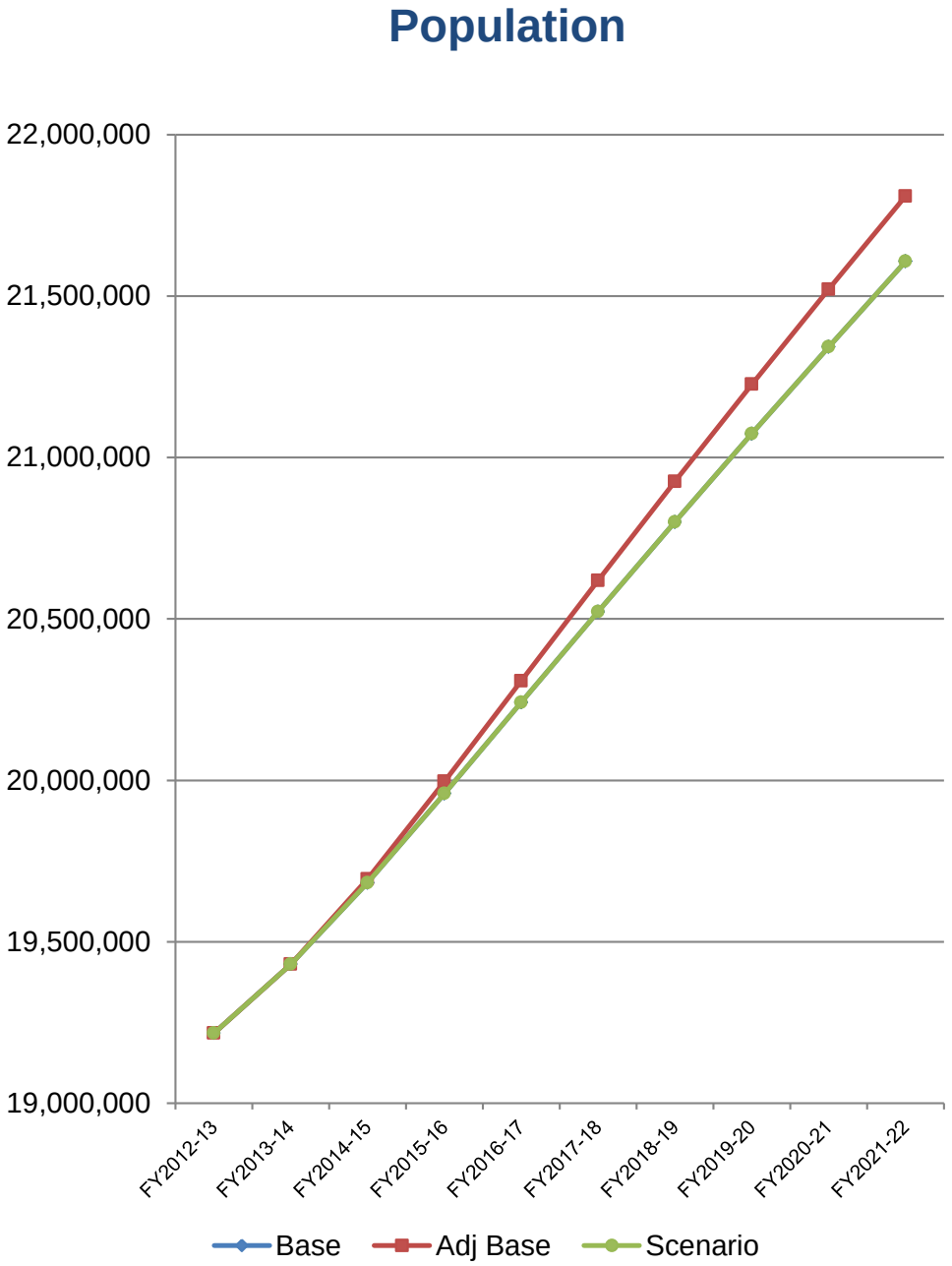


Risk Simulations

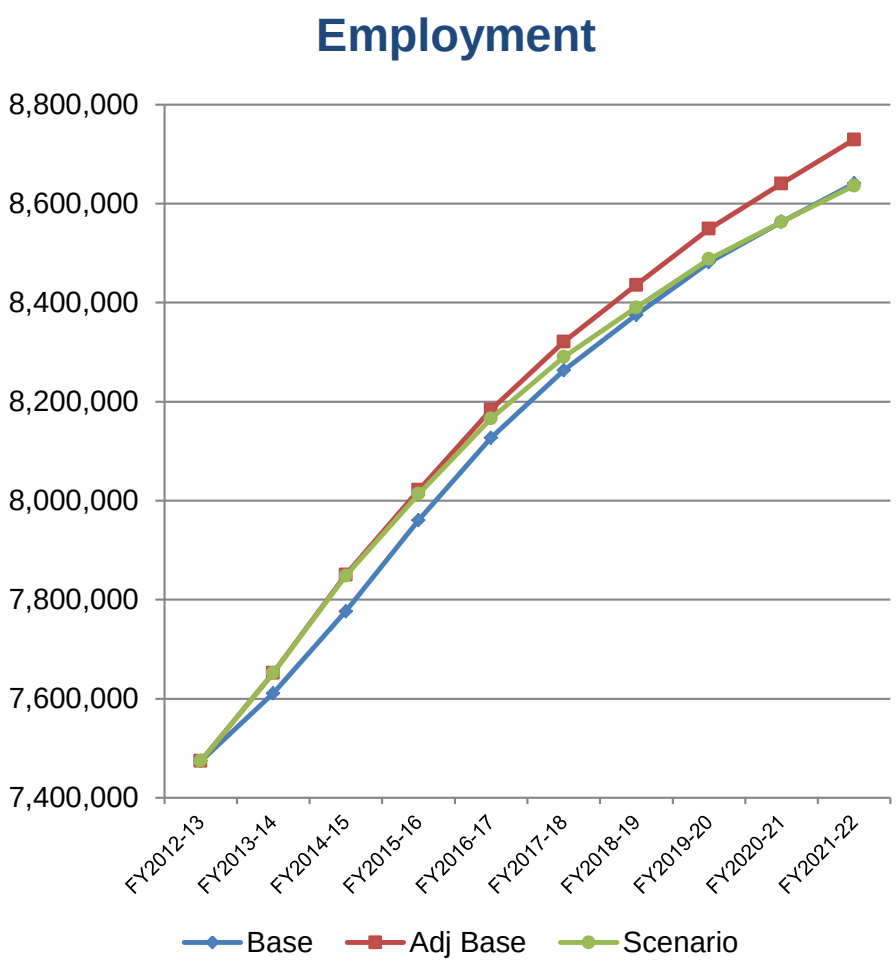
- The adjusted baseline can be considered the standard approach to modeling the Affordable Care Act “shock”, assuming everything works as designed without introducing atypical labor shortages, wage constraints or capacity issues.
- Alternative scenarios (#1 through #7) are provided to assess areas of potential risk or change and the impact they would have on the results.
  - The risk simulations are an attempt to quantify the adjusted baseline’s sensitivity to a worst case development, not necessarily a likely result.
  - Some of these simulations layer on the effects of the optional Medicaid Expansion decision.
- No attempt is made to gauge the likelihood of the alternative outcomes.

Risk Simulation 1

- Differs from adjusted baseline by incorporating a barrier on additional healthcare workers moving into the state to fill new job openings.
- Key features: potentially constrained infusion of federal dollars; no job-related migration.
- A change in the underlying assumption for the adjusted baseline of this magnitude will adversely affect results in all years and across all variables.



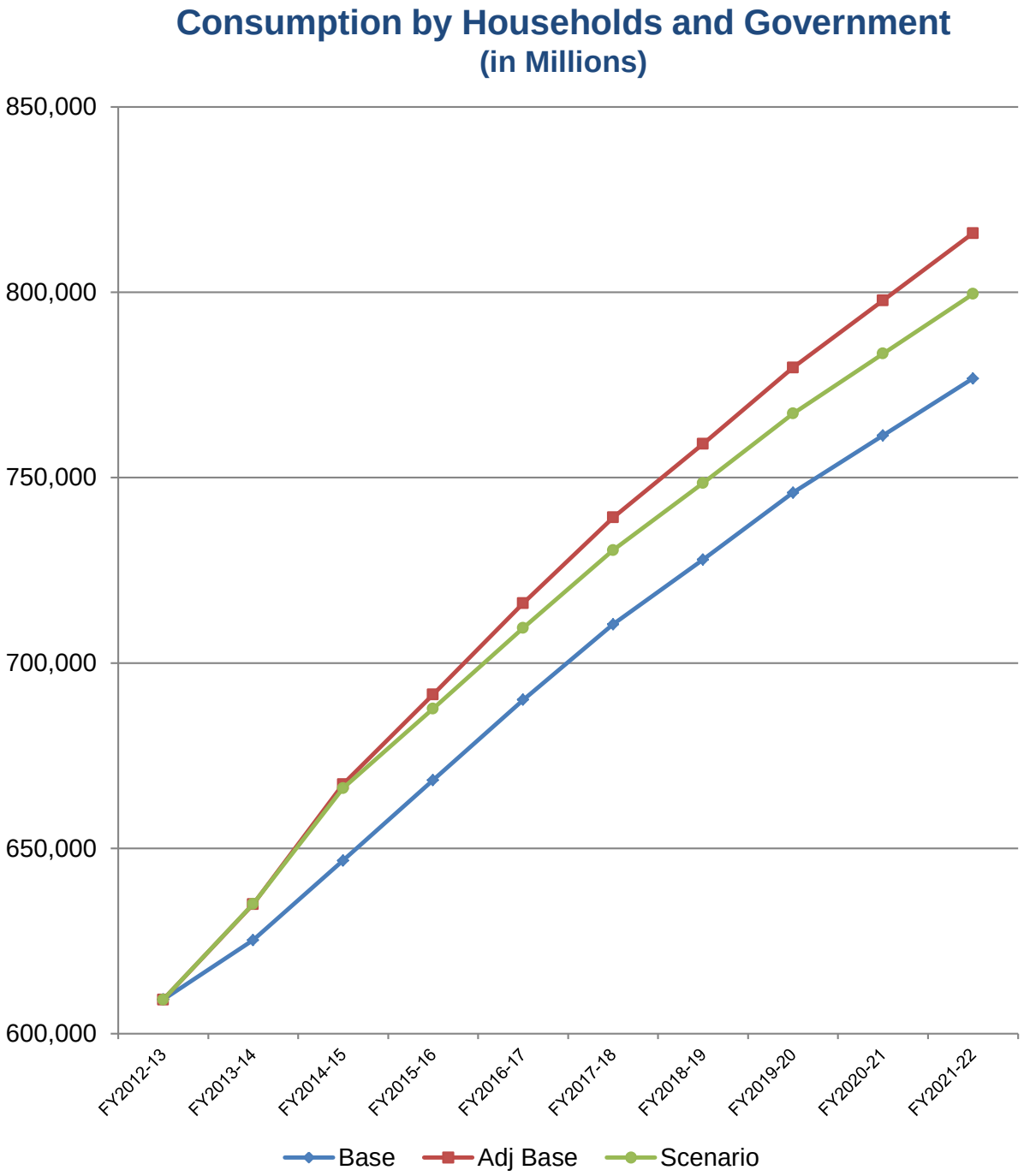
Risk Simulation 1 Results



- By the end of the forecast period:
  - Population is 202,470 lower than the adjusted baseline.
  - Total Employment is 93,154 lower than the adjusted baseline with the greatest impact in non-healthcare industries.
  - Real Output is $5 billion lower than the adjusted baseline.
  - Personal Income is $2 billion lower than the adjusted baseline.
  - State revenues experience a cumulative loss of nearly $1.3 billion over the entire forecast period.

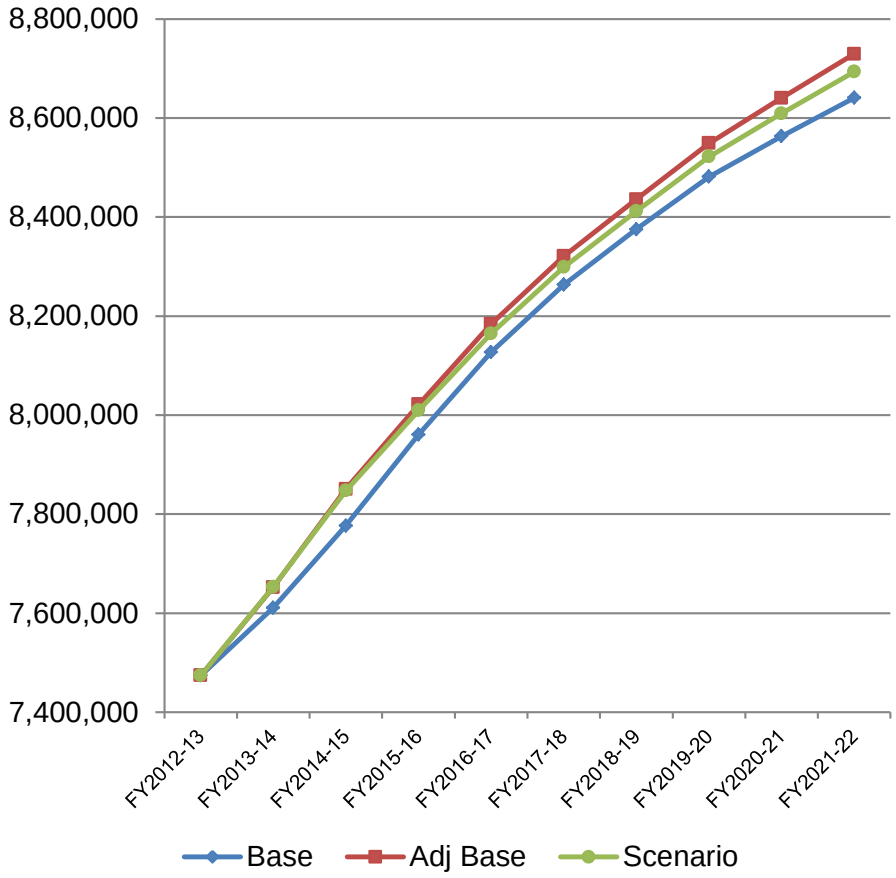
Risk Simulation 2

- Differs from adjusted baseline by assuming the uninsured today remain uninsured. Businesses and individuals originally buying policies for the uninsured instead pay penalties.
- Also assumes a complete erosion of insurance among existing small employers (1-50 employees, excluding self-employed). These previously covered employees obtain insurance through the Exchange and employers lose tax credits.
- Key features: increased penalties, reduced Insurance Premium Tax collections, and reduced federal tax credits.

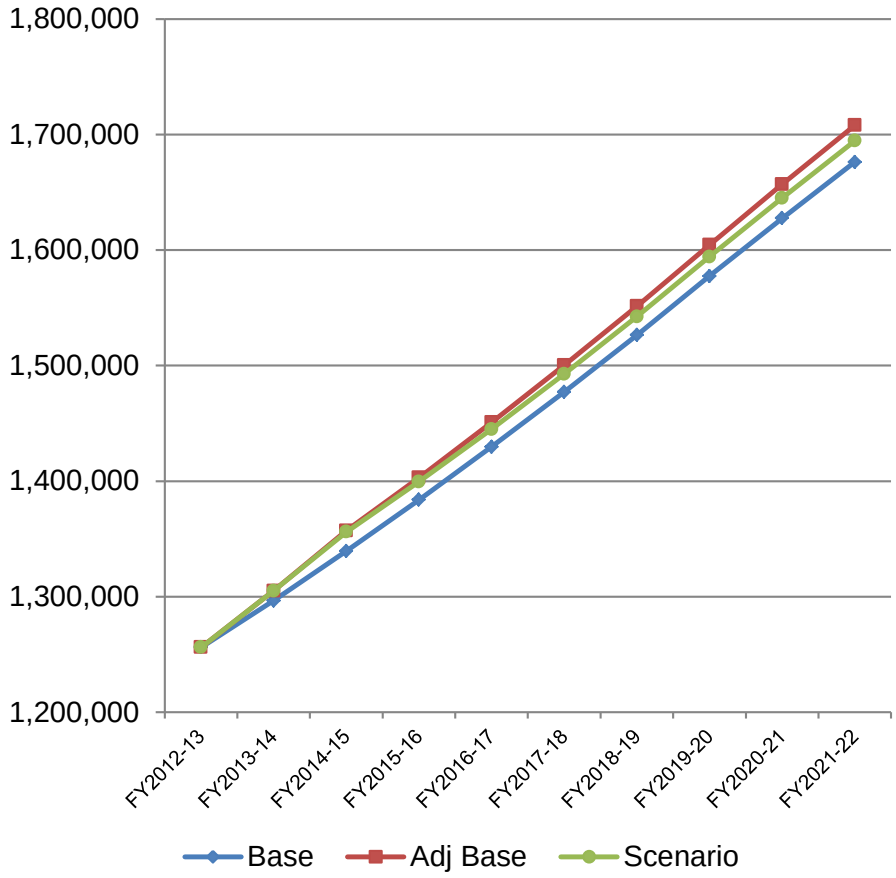


Risk Simulation 2 Results

Employment



Real Gross Domestic Product (in Millions)

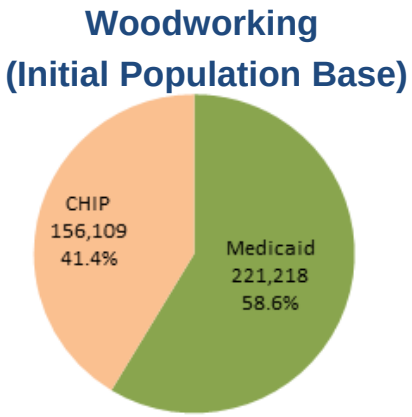


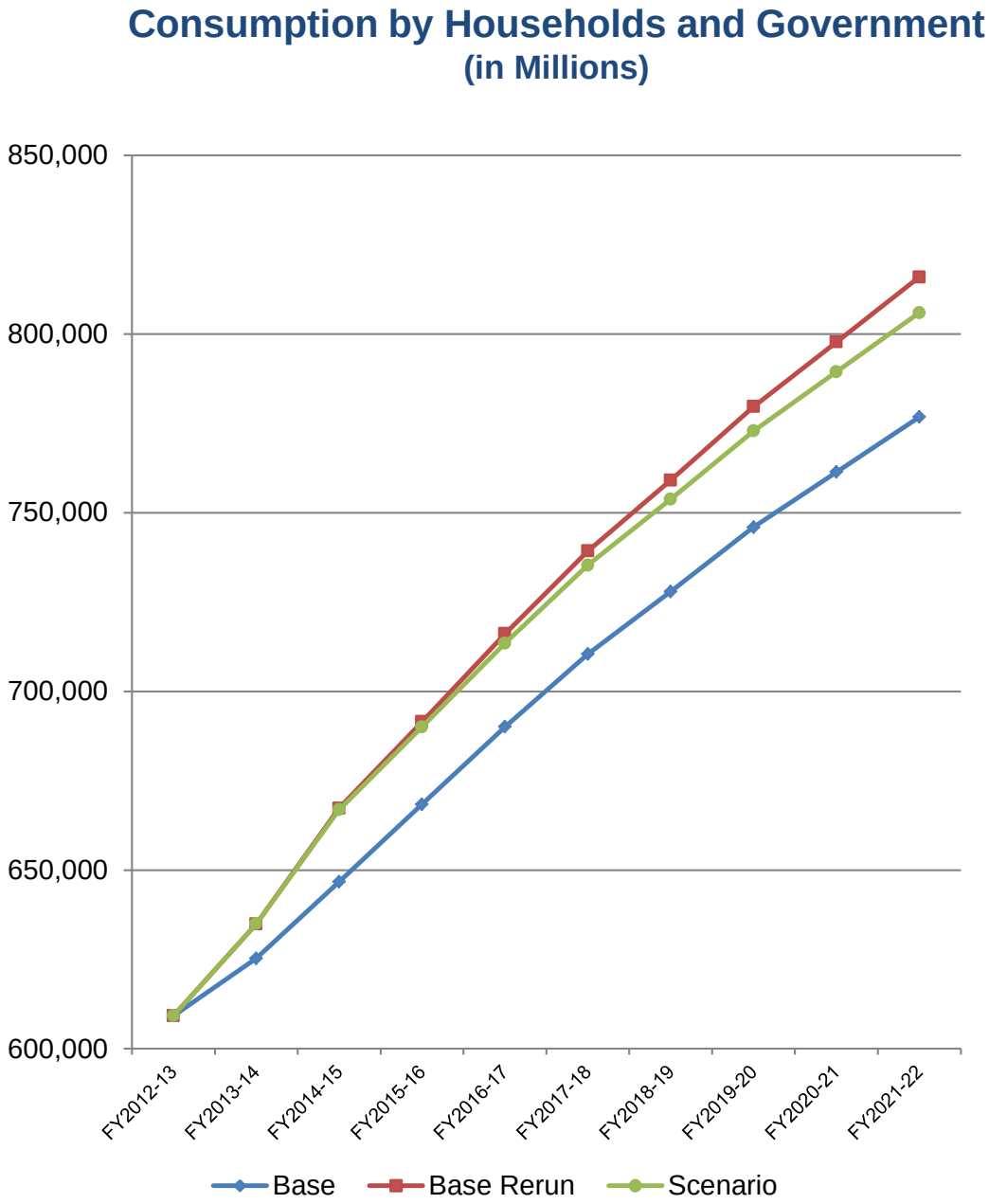
A change in the underlying assumption for the adjusted baseline of this magnitude will negatively affect results—and increasingly so over time as the penalties get larger.

Risk Simulation 3

- Differs from adjusted baseline by assuming 25% Woodworking effect in Medicaid and CHIP Programs.

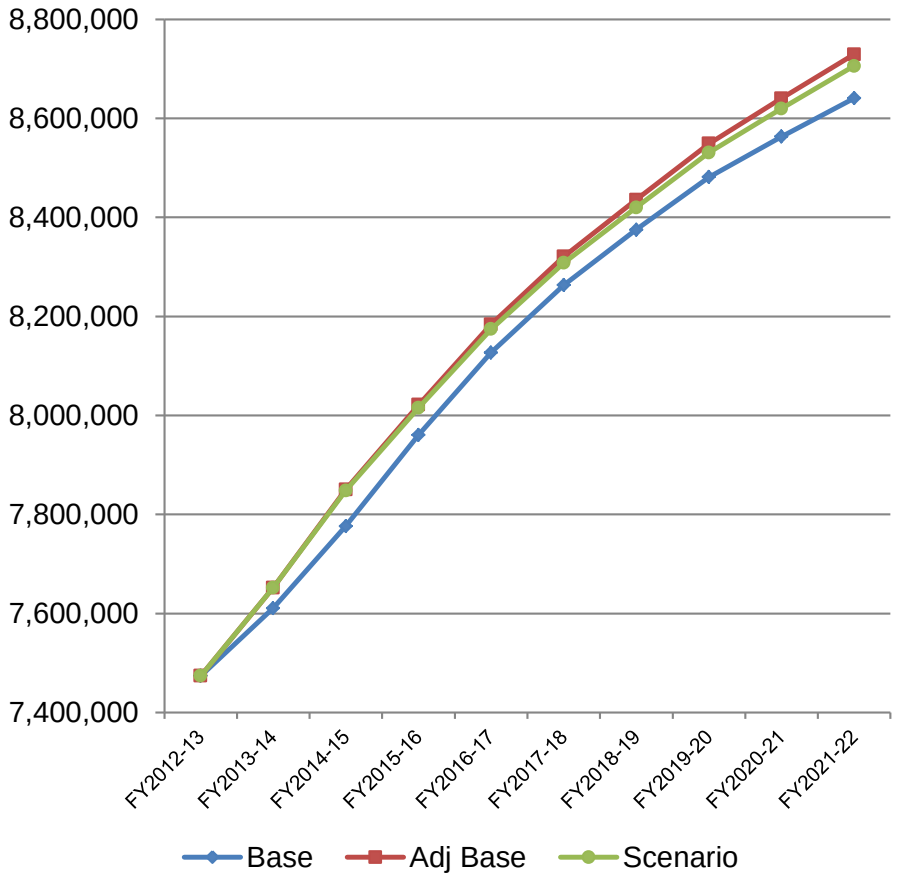
- Key features: infusion of federal dollars and redirected state dollars.



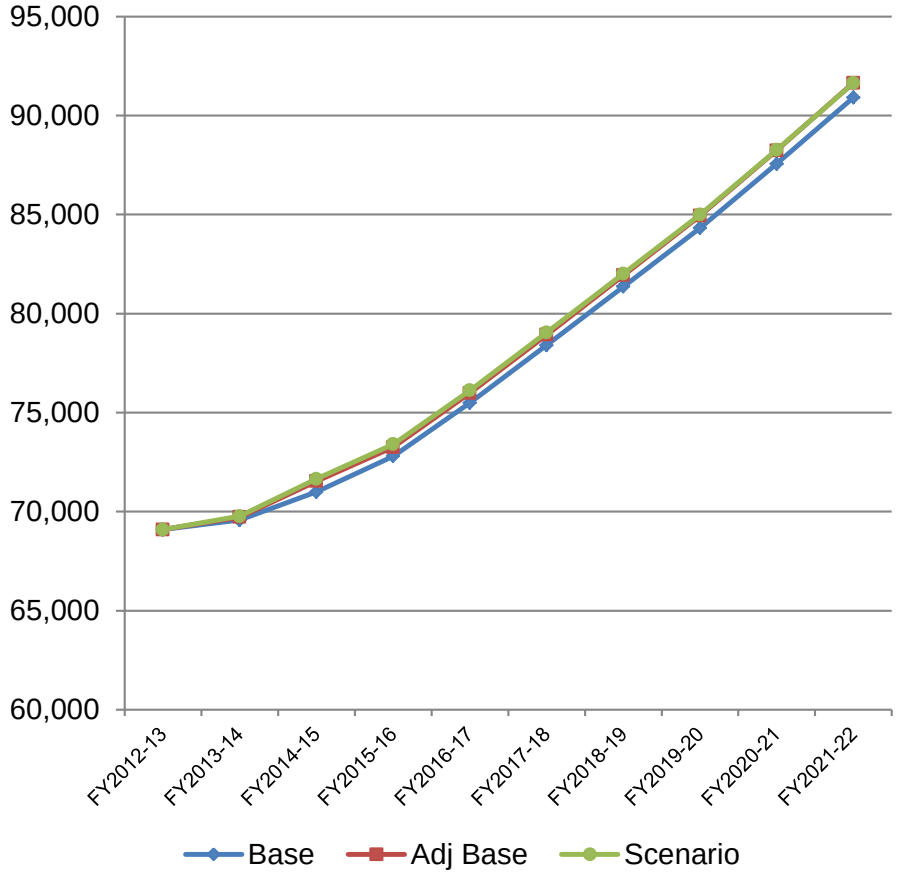


Risk Simulation 3 Results

Employment



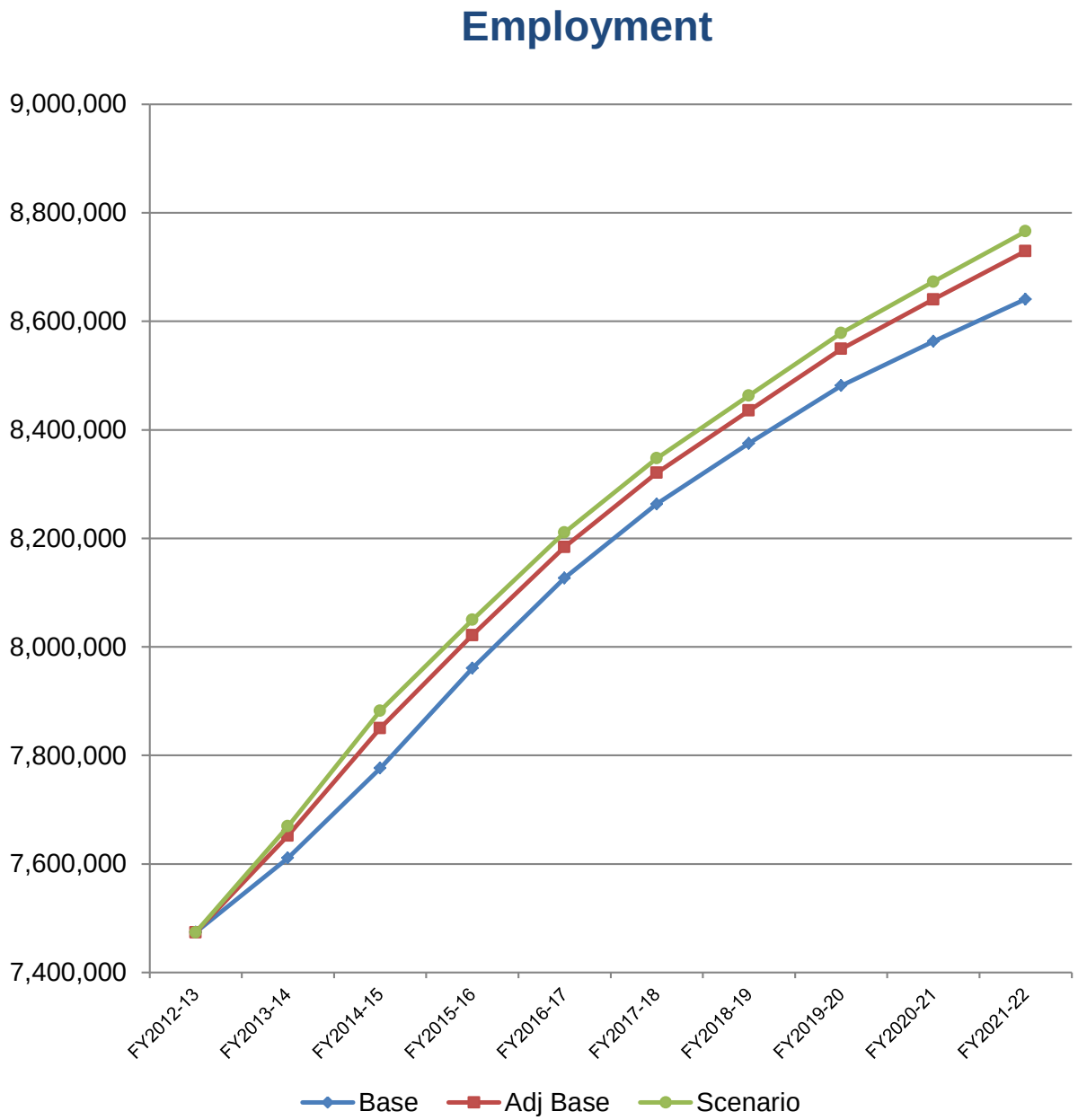
Total Net State Revenues (in Millions)



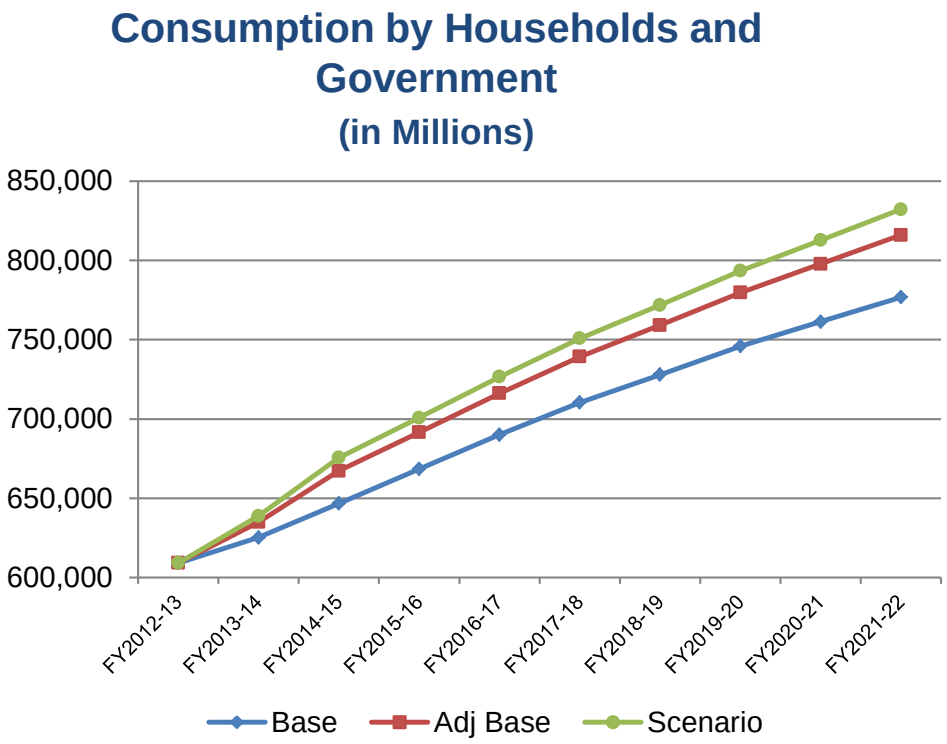
A change in the underlying assumption for the adjusted baseline of this magnitude will negatively affect results—and more so over time, but to a lesser extent than Risk Simulation #2 due to the increased federal dollars.

Risk Simulation 4

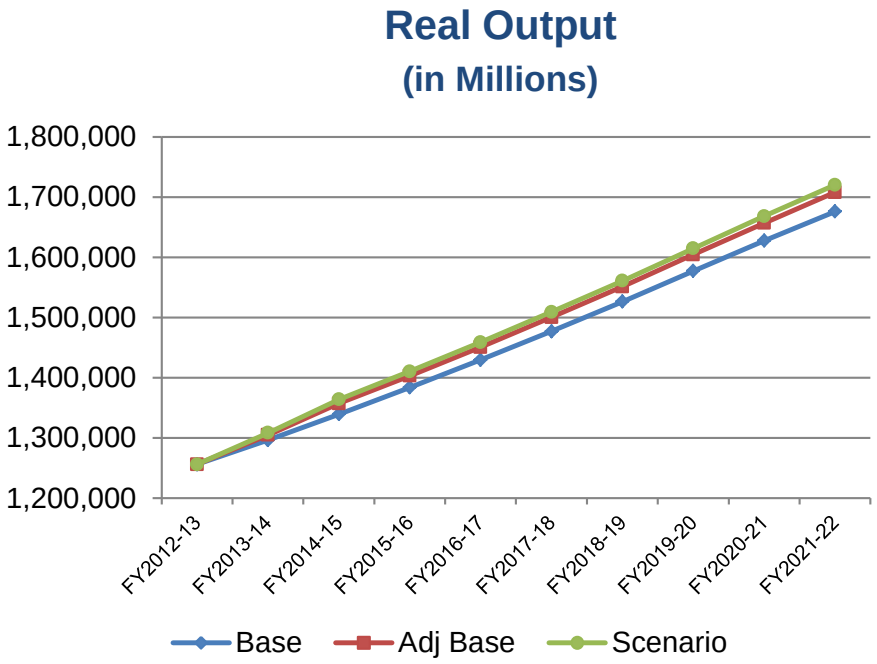
- Differs from adjusted baseline by assuming a 50% increase in premium costs rather than the previously assumed 25%.
- Key features: increased subsidies and increased Insurance Premium Tax.
- A change in the underlying assumption for the adjusted baseline of this magnitude will have positive effects.



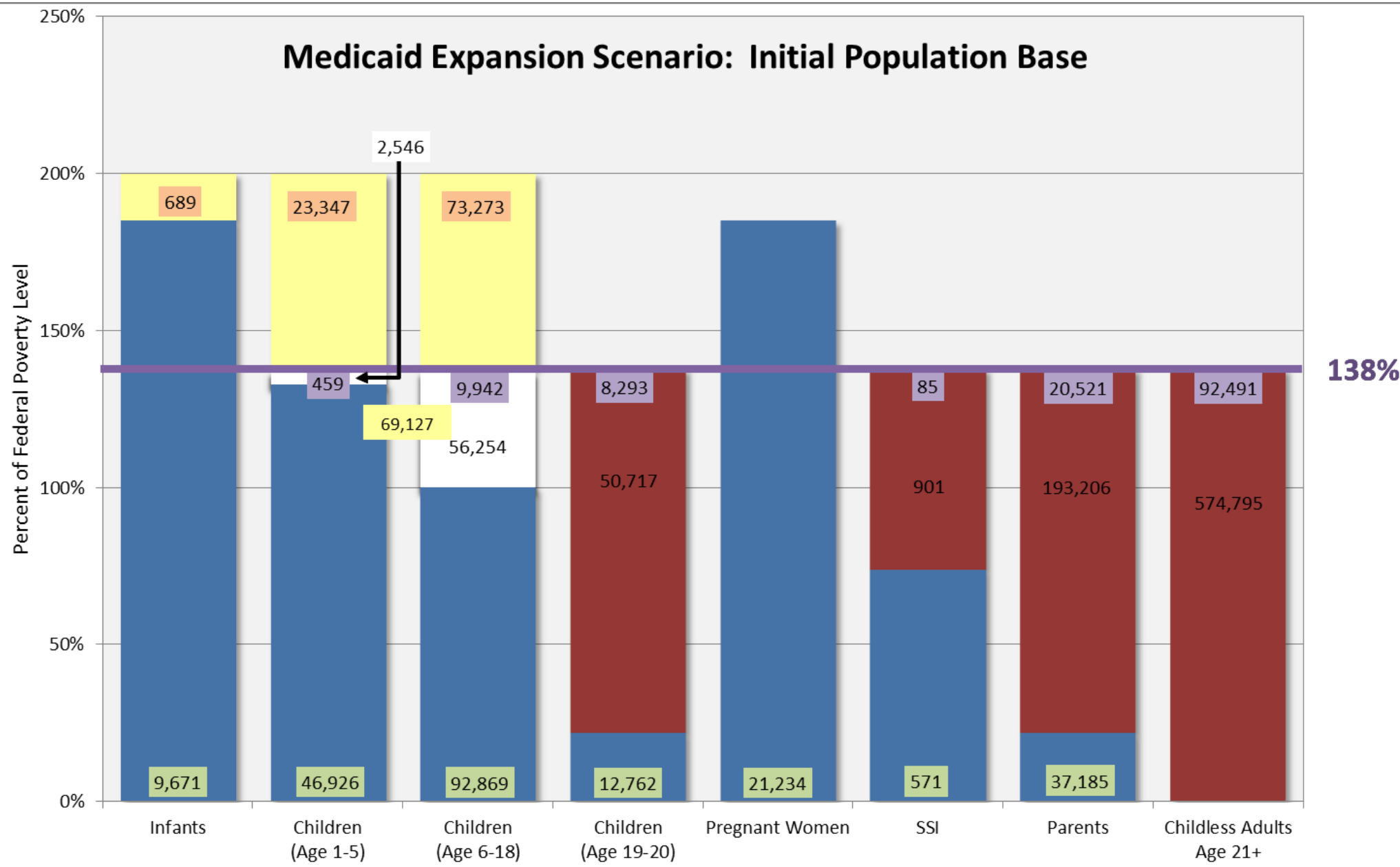
Risk Simulation 4 Results



Consumption by households and government increases as a result of greater federal subsidies.



Overall, real output shows little change.

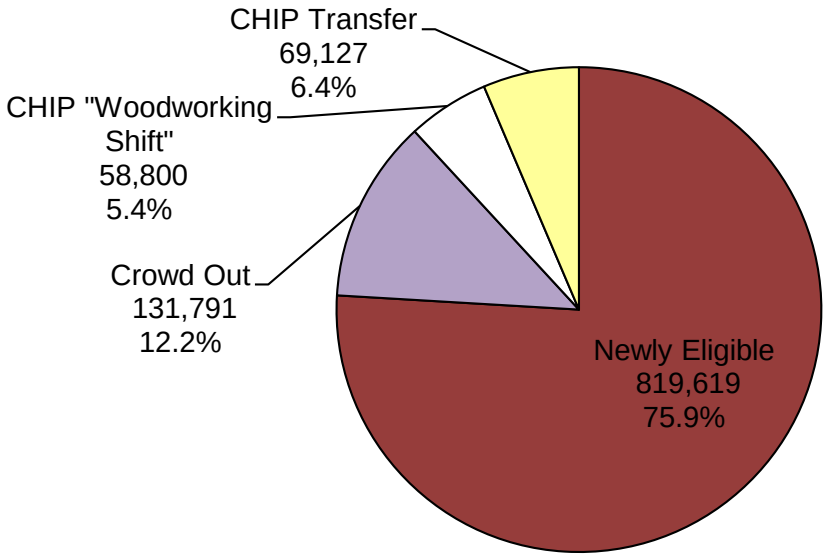


Bars:
Blue: Medicaid enrolled
Red: Newly eligible
Yellow: CHIP

Labels:
Green: Medicaid eligible, but not enrolled
Purple: Crowd Out related to expansion
White: CHIP "Woodworking Shift"
Orange: CHIP eligible, but not enrolled

Sources: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample and Florida Healthy Kids Corporation

Medicaid Expansion Assumptions



Universe: 1,079,337

Newly Eligible Population under Medicaid Expansion Option

- The SSEC assumed that only 79.7% of the Newly Eligible population will present for services.
- The eligible population will increase each year proportional to population growth.
- By fiscal year, the phase-in translates as follows:
  - FY 2013-14: 60%
  - FY 2014-15: 90%
  - FY 2015-16 and beyond: 100%

Assumptions (Continued)

Crowd Out Population under Medicaid Expansion Option

- Persons under 138% FPL who purchase insurance directly from an insurance company.
- By fiscal year, this phase-in translates as follows:
  - FY 2013-14: 40%
  - FY 2014-15: 80%
  - FY 2015-16 and beyond: 100%

Impact to CHIP Population under Medicaid Expansion Option

- Assumed that 69,127 children under 138% FPL will move from CHIP to Medicaid. This number was based on income status in the existing program.
  - 100% of the population will move to Medicaid upon implementation.
  - Net cost is zero as CHIP funding also transfers.

CHIP Woodworking Shift

- The 138% FPL threshold splits the current CHIP Woodworking into two components–one that remains in CHIP and one that moves to Medicaid. The latter is the CHIP Woodworking shift.

Medicaid Expansion Costs

- Healthcare costs for **Medicaid Expansion** recipients range from a grand total of $1.16 billion in FY 2013-14 to $4.87 billion in FY 2022-23.
  - The state portion of this cost starts in FY 2016-17 and ranges from $97.9 million to $487.2 million in FY 2022-23.
  - The federal portion of this cost ranges from $1.16 billion in FY 2013-14 to $4.39 billion in FY 2022-23.

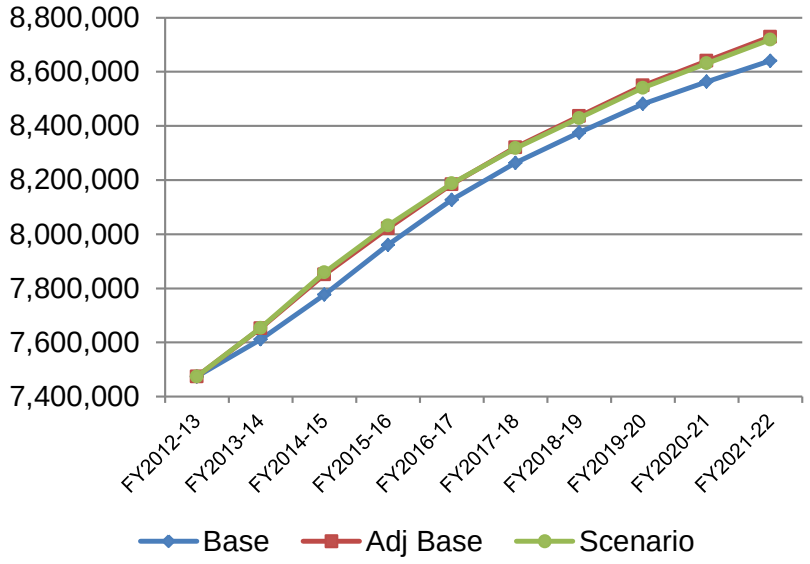
- In addition, the **Medicaid Woodworking** costs range from a grand total of $101.4 million in FY 2013-14 to $284.8 million in FY 2022-23.
  - The state portion of this cost ranges from $41.9 million in FY 2013-14 to $115.9 million in FY 2022-23.
  - The federal portion of this cost ranges from $59.5 million in FY 2013-14 to $168.9 million in FY 2022-23.

- In addition, the remaining **CHIP Woodworking** costs range from a grand total of $24.0 million in FY 2013-14 to $67.3 million in FY 2022-23.
  - The state portion of this cost ranges from $6.9 million in FY 2013-14 to $3.6 million in FY 2022-23. The reduction in cost is the result of the introduction of an enhanced federal matching rate.
  - The federal portion of this cost ranges from $17.0 million in FY 2013-14 to $63.7 million in FY 2022-23.

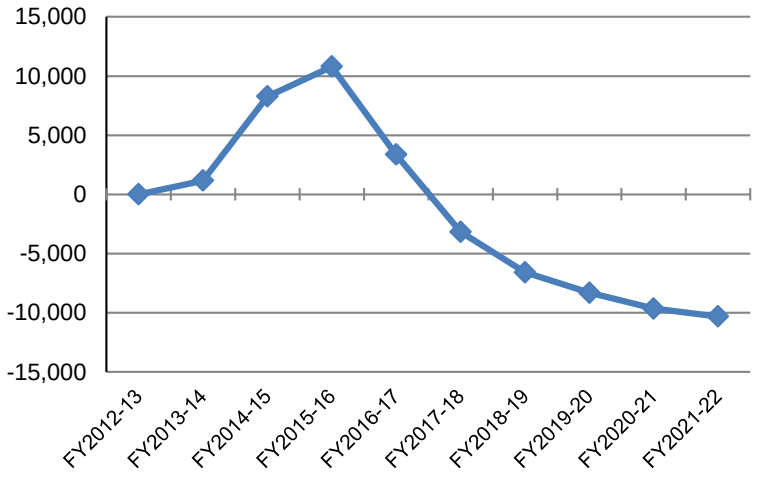
Risk Simulation 5

- Differs from adjusted baseline by incorporating Medicaid Expansion and a 25% Woodworking effect.
- Key features: infusion of federal dollars, redirected state dollars, and lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out population from the general uninsured population.
- A change in the underlying assumption for the adjusted baseline of this magnitude will have marginal effects overall, but leans positive in the short-run and negative in the long-run.

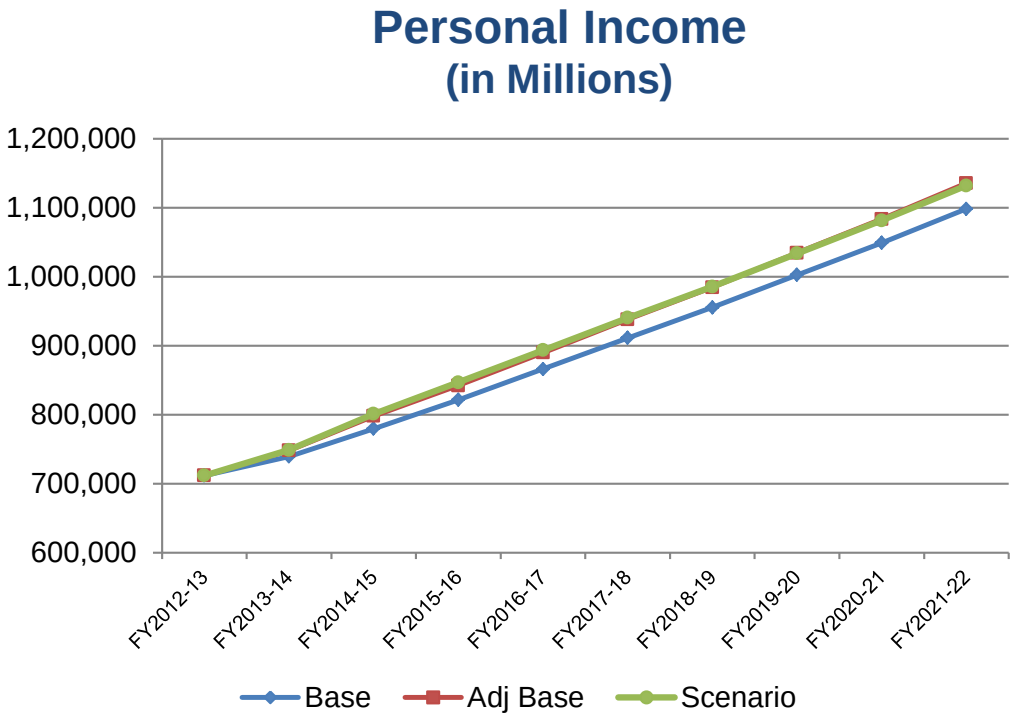
Employment



Employment
Difference from Adjusted Baseline

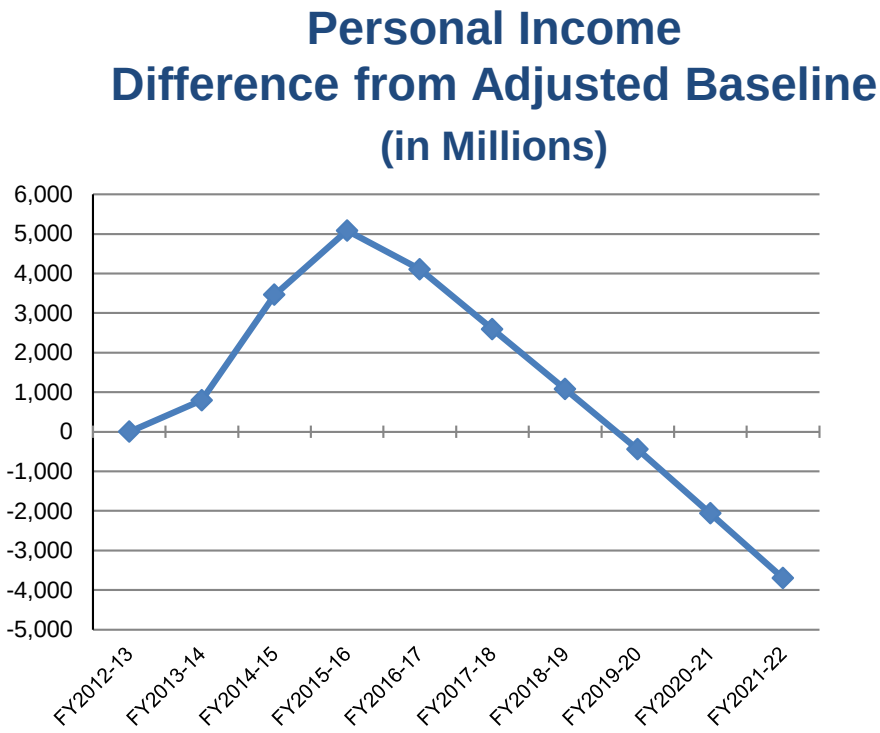


Risk Simulation 5 Results



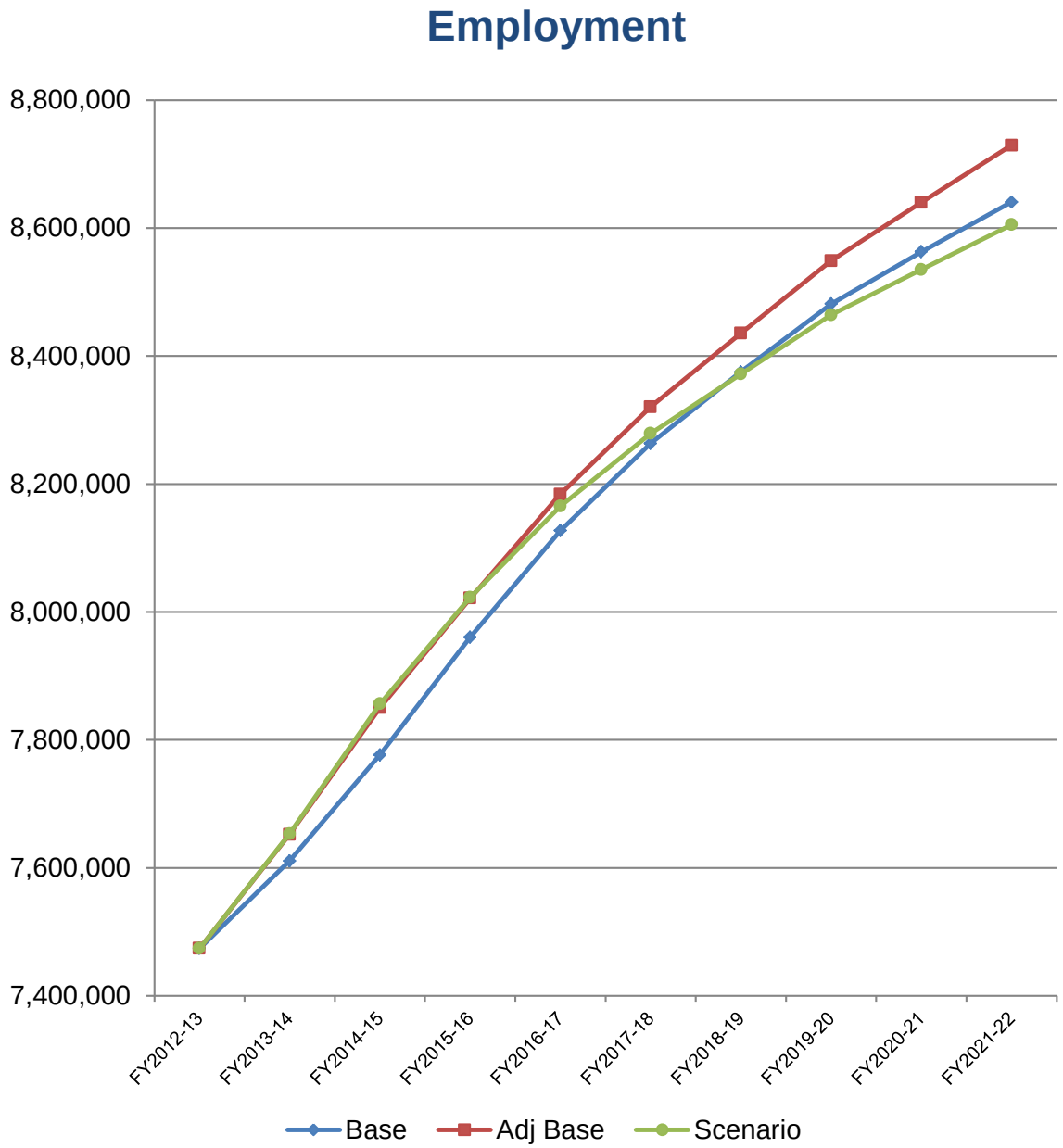
Personal income, like real output and consumption by households and government shows little difference from the adjusted baseline after Medicaid Expansion.

However, narrowly focusing on the difference in dollars each year shows that the infusion of federal dollars initially drives personal income upwards, and then back down as more state dollars match the federal dollars.



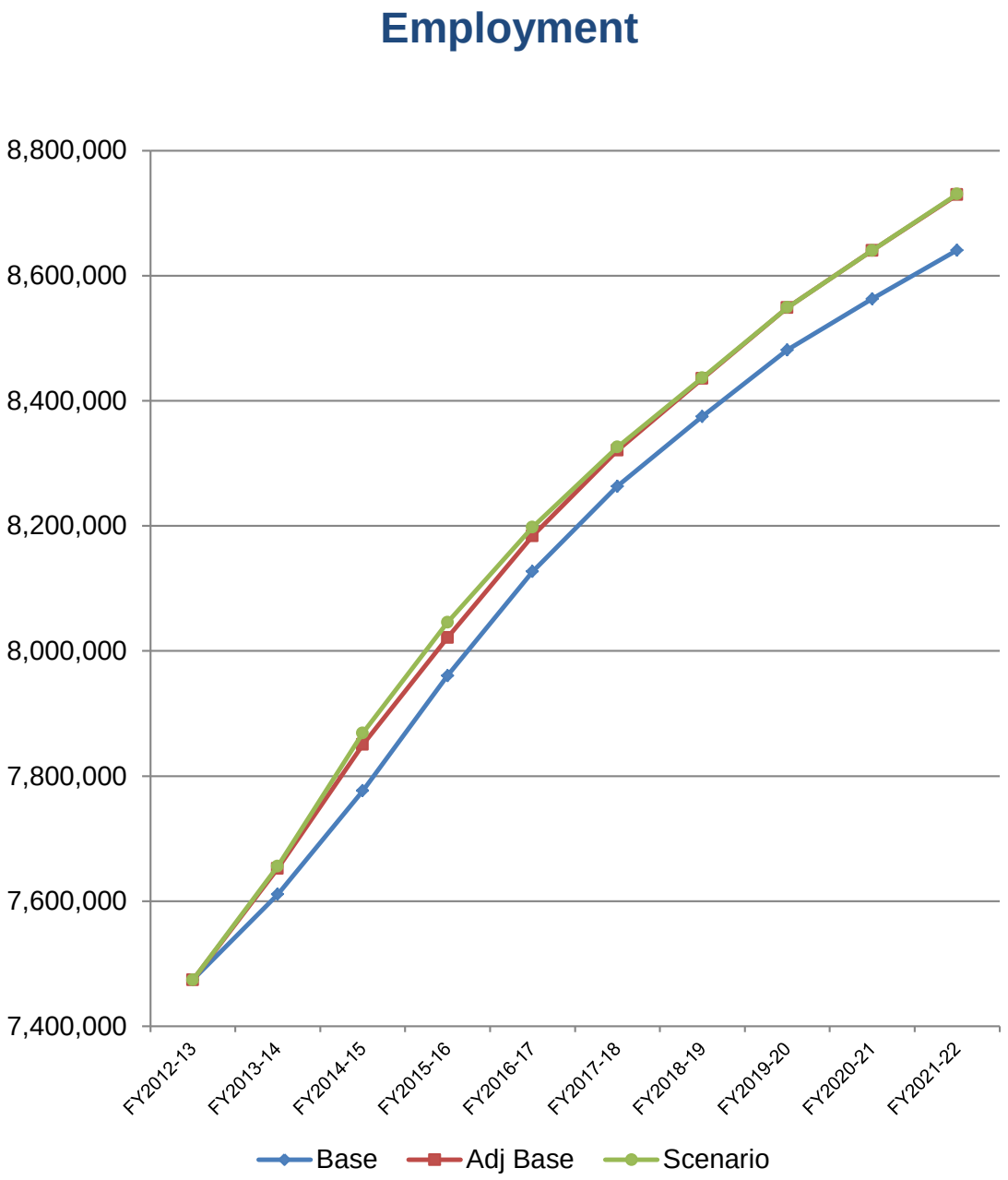
Risk Simulation 6

- Differs from adjusted baseline by incorporating a barrier on additional healthcare workers moving into the state to fill new job openings, in addition to including Medicaid Expansion and a 25% Woodworking effect.
- Key features: infusion of federal dollars, redirected state dollars, lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out population from the general uninsured population, and no job-related migration.
- Results in a very similar outcome to Risk Simulation #1 however, earlier periods are slightly positive across most variables in this scenario where Risk Simulation #1 was negative. The federal dollars associated with Medicaid Expansion effectively mitigate the negative risk in the early years.

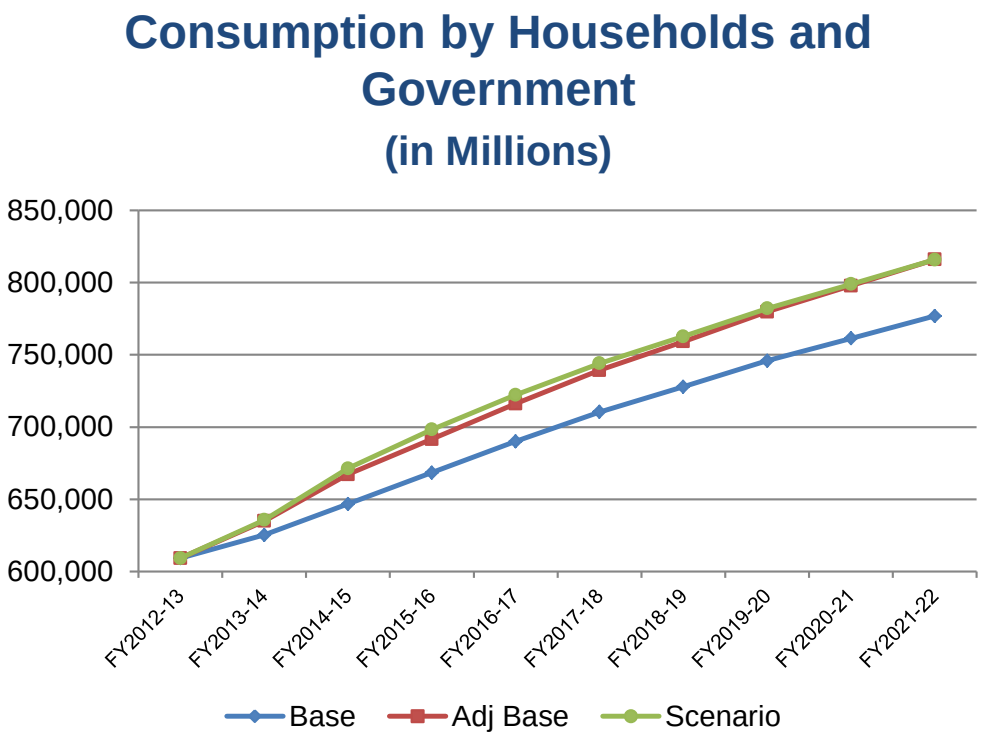


Risk Simulation 7

- Differs from adjusted baseline by including a 60% increase in annual payment rates for all Medicaid Expansion and Woodworking entrants.
- Key features: infusion of federal dollars, redirected state dollars, and lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out population from the general uninsured population.
- A change in the underlying assumption for the adjusted baseline of this magnitude will have marginal positive effects overall, but the positive effects generally diminish over time.

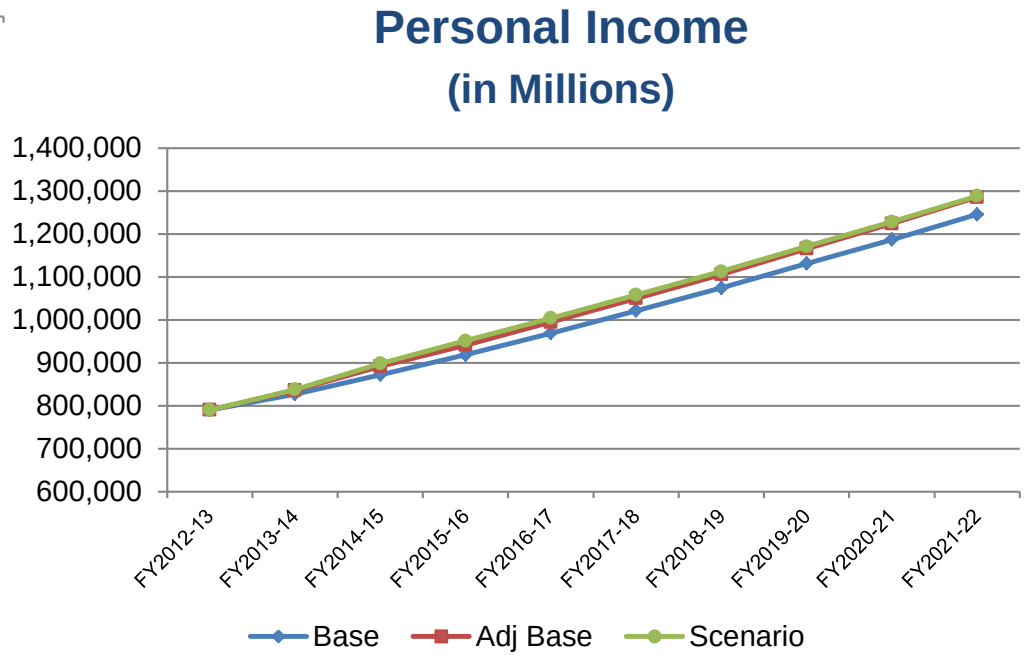


Risk Simulation 7 Results



Consumption by households and government goes slightly above the adjusted baseline throughout the forecast period as additional federal dollars come into the state, but drops below in the final year.

Personal income goes slightly above the adjusted baseline throughout the forecast period, as does real output.

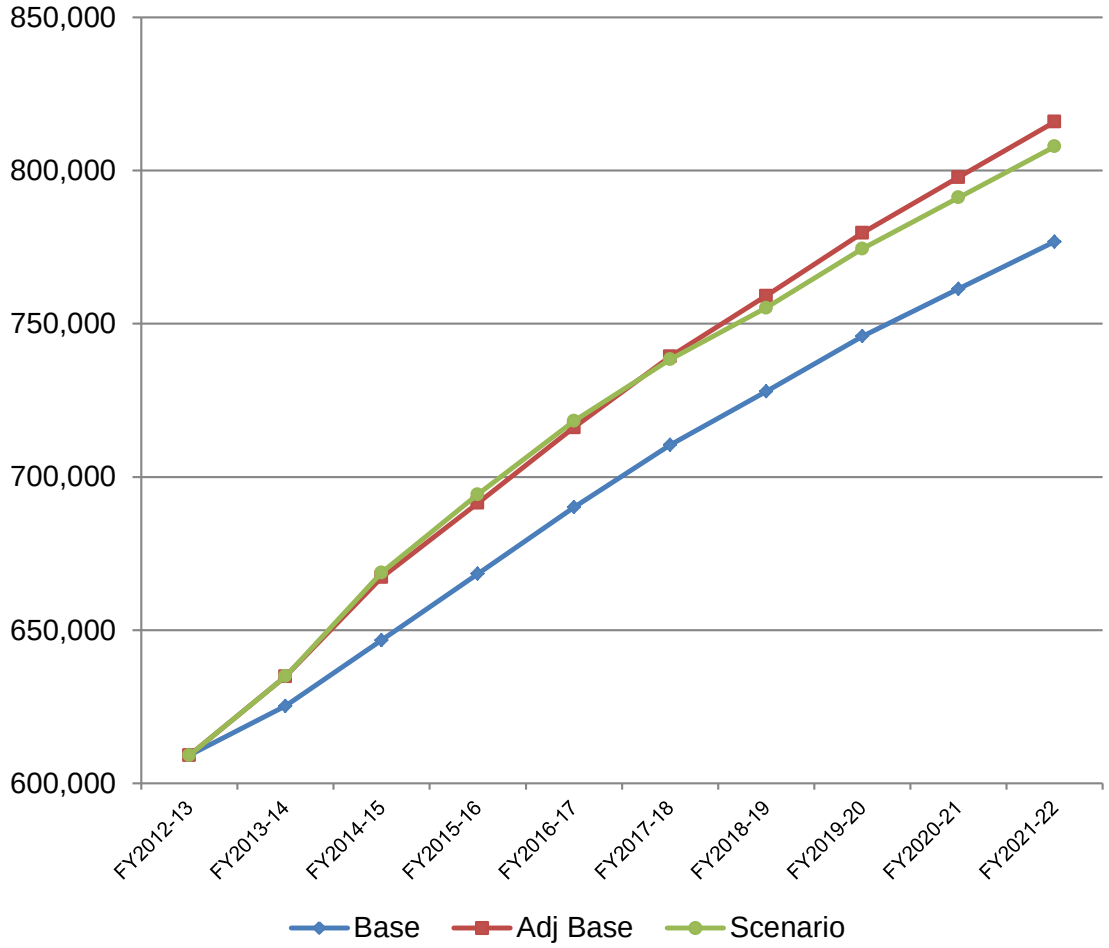


Break-Even Expansion Analysis

- This analysis makes incremental federal funding adjustments to Simulation #5 which incorporates the Medicaid Expansion and a 25% Woodworking effect.
- The loss in federal funds is offset with an equal infusion of state funds with overall budget reductions elsewhere.
- At the current FMAP percentage, the gains from expansion above the adjusted base are only marginally impacted downward as the state budget is redirected to this purpose.

Consumption by Households and Government

(in Millions)



Summary Statistics

	Adjusted Baseline		Adjusted Baseline with Woodworking		Adjusted Baseline with Woodworking and Medicaid Expansion	
	Number	Percent	Number	Percent	Number	Percent
Total Population	18,849,600		18,849,600		18,849,600	
Population Uninsured	4,040,731	21.4%	4,040,731	21.4%	4,040,731	21.4%
Newly Insured	2,169,986		2,264,318		2,567,318	
General Population	2,169,986		2,169,986		1,819,750	
Woodworking			94,332		79,632	
Medicaid Expansion					667,936	
Remain Uninsured	1,870,745	9.9%	1,776,413	9.4%	1,473,413	7.8%

In total, Medicaid Expansion would include 868,854 participants, which includes CHIP Transfer and Crowd Out.

Difference in Newly Insured	Adjusted Baseline with Woodworking	Adjusted Baseline with Woodworking and Medicaid Expansion
To Adjusted Baseline	94,332	397,332
To Adjusted Baseline with Woodworking	0	303,000

Numbers are only tied to the base population for 2011 and the ultimate levels will be higher due to population growth. Similarly, statistics are also drawn from the base population and the percentages would not be achieved until the conclusion of all ramp-up and phase-in periods.

Supplemental Materials:

Economic Analysis of PPACA and Medicaid Expansion

Select Committees on Patient Protection and Affordable Care Act

March 4, 2013

Presented by:

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

Affordable Care Act Analysis: Assumptions

Background:

Leadership in the Florida Senate and House of Representatives requested that the Legislative Office of Economic and Demographic Research (EDR) conduct an in-depth analysis of the Affordable Care Act (Act) and the potential effects it will have on the Florida Economy. The analysis covers the mandatory provisions of the Act, as well as the optional Medicaid Expansion decision. The mandatory provisions will be in effect regardless of future legislative actions. The optional decision regarding Medicaid Expansion is under the direct control of the Legislature and Governor.

The evaluation was performed by using static estimates developed by EDR as inputs for the recently-deployed Statewide Model. The Statewide Model was used to generate the direct, indirect and induced economic effects for Florida suggested by the static inputs. Since all 50 states will be simultaneously undergoing major transformations caused by the Act, some of the Florida-specific results will be further altered by the national nature of the legislation and the ultimate interplay among states, as well as by feedback results that are beyond the scope of this analysis.

The analysis has been further hampered by the incomplete nature of the federal rules and regulations that will implement the Act. While EDR has made decisions and assumptions based on the information now available, some of the underlying premises are still in flux and could change the outcomes generated by the Statewide Model. For example, it is still not clear whether individual subsidies will be available in exchanges set up and run by the federal government; however, this analysis assumes they will be.

For these reasons, the Statewide Model results should be viewed not as specifics, but as suggestive of likely outcomes. Even the adjusted baseline described below should be regarded as a simulation.

Premise:

The current National and Florida Economic Outlooks have not fully taken account of the economic changes that will result from the implementation of the Act. This means that the baseline for the Statewide Model had to be adjusted to address the provisions that will be in effect regardless of future legislative actions prior to looking at policy changes that are dependent on state legislative action. All discrete adjustments to the baseline are documented and discussed, with the results compared to the starting or prior baseline. [Note: EDR has reviewed the assumptions made by IHS Global Insight for the control national forecast; largely their adjustments were directed at the new federally required taxes and fees.]

Among the more significant adjustments to the baseline were:

(1) Increased state budgetary costs and federal dollars associated with the mandatory portions of the Affordable Care Act.

a. Primary Care Practitioners Fee Increase to Medicare Rate—an increase in the state budget by the amount of anticipated federal dollars; the increase in state budget is then directed to providers in the ambulatory area without a commensurate increase in services.
    i. Level pulled from the AHCA 12/12 Response (with state costs converted to federal: $349.4 million in FY 2012-13; $698.8 million in 2013-14; and $349.4 million in FY 2014-15.
b. Health Insurance Tax Impact on Medicaid Managed Care—as the new tax effectively increases managed care rates within the existing Medicaid Program, the cost will be split between increased federal reimbursements and realignment within the state budget to provide the required match. The increased federal reimbursements will effectively offset a portion of the dollars leaving the state to pay the initial tax.
    i. Level pulled from the AHCA 12/12 Response (state costs range from $13.1 million in FY 2013-14 to $192.5 million in FY 2022-23.
c. The cost of implementing the Exchange and its effect on eligibility determinations are indeterminate.

(2) Increased insurance coverage associated with the mandatory portions of the Act resulting in a greater number of traditional insurance policies, self-insured programs and richer benefits, as well as the knock-on effects from overall increased demand for healthcare from the entire population of uninsured.
a. Increased demand for healthcare services resulting from uninsured becoming insured: Increased Demand = # of Uninsured x Policy Cost
    i. In the PUMS data, 1,442,014 persons will receive policy coverage and 727,972 persons will fall under a self-insured program for a total of 2,169,986 uninsured persons becoming insured. These numbers are translated into percentages of the population and then allowed to grow over time as part the overall population growth within those shares.
        1. Applied four-year ramp-up period: 40%, 60%, 80% and 100%.
        2. Included aliens and the potential Medicaid Expansion population.
        3. Made a 10% adjustment for the non-compliant portion of the tax base (referred to generally as “non-filers”) in any given year.
        4. Made discrete assumptions based on age, employment status, size and type of employer, and income.
    ii. For policy coverage, assumed new premium of $6,157 in base year (preliminary data from OIR). This assumption was developed by taking into account the following: 70% actuarial value of the silver plan; trend growth; reinsurance subsidy; guaranteed issue feature of the contract; new fees related to the Act; area factor average reduction; and essential health benefits requirement. In essence, the policy premiums initially increase

by 25% to comply with the new law and then grow at one-half the rate they otherwise would have in the baseline. This result reflects the dual effects from the upward pressure on policy premiums associated with the "richer" benefit package and the downward effects from better health outcomes.

iii. Applied a scalar to the premium cost to reflect non-direct healthcare expenditures retained by insurance companies (based on EDR research: 18% non-health; 82% health). This non-health portion does not increase final demand for health services.

iv. Recognized the out-of-pocket healthcare spending today by the uninsured that will convert to spending on copayments, deductibles and incidentals: $583 per uninsured person that becomes covered (Health Affairs spending table).

v. Downwardly adjusted increased demand by the amount of today's uncompensated care that will shift to the newly insured (whether through self-insurance programs or private coverage). Assumed $536 per newly insured person = $1.16 billion (Health Affairs spending table).
    1. Assumed Disproportionate Share reductions will be largely offset by the shift from uncompensated care to newly insured care, resulting in no overall loss in spending.
    2. Used "Estimated Total Uncompensated Care" as reported in the 2011 Florida Hospital Uniform Reporting System (FHURS): $2.6 billion. Insured care will reduce this amount by $1.2 billion, leaving a remaining level of uncompensated care of $1.4 billion and freeing the resources previously directed to the $1.2 billion.
    3. Florida's federal Disproportionate Share allocation has ranged from $188.3 million to $206.6 million.

vi. Developed separate estimates related to the treatment of federal "subsidies" for individuals and tax credits for small businesses.
    1. Assumed individual subsidies will be limited to the non-working population with incomes greater than 100% and less than 400%.
    2. Assumed business tax credits will be limited to entities with less than 25 employees—and that they will be further constrained by the amount of liability present within any given year.

vii. In regard to incidence, assumed that:
    1. Premium policy costs for non-working individuals are entirely absorbed by households.

2. Premium policy costs for employees initially hit businesses, but households absorb 100% of the cost in the long-run.
3. Self-insurance programs are a complete cost-shift from today's spending by households to businesses due to the lower requirements for self-insurance programs.

viii. There is also an increased demand for health services associated with the richer benefit packages required for existing policy-holders. Based on OIR preliminary data, a 25% mark-up is expected on the average policy premium costs today (from $5,177 to $6,465).
1. Some existing policy-holders are non-employed and pay for insurance out-of-pocket. A portion of this group is eligible for individual subsidies.
2. Some of the small firms providing insurance today are eligible for the tax credits.

ix. Woodworking (the entry of individuals who are currently eligible for the Medicaid or CHIP programs but not enrolled) is indeterminate as adopted by Social Services Estimating Conference (SSEC).

b. Insurance Premium Tax value is added to state revenues, which increases the size of the overall budget expenditure on the generic market basket of goods.
c. The business value associated with increased utility / productivity from better healthcare (reduced sick days, average workweek hours increased, and improved health) is indeterminate.
d. Effects from employers altering their practices regarding the provision of insurance (moving to self-funded pools to a greater extent than the historic trend, eliminating coverage altogether or reducing the scope of health benefits) are indeterminate and excluded from the baseline analysis. Similarly, the extent to which businesses scale back or eliminate coverage but increase wages is deemed indeterminate.

(3) The loss of Florida discretionary income and/or increases to business costs to pay increased federal taxes and fees required by the Affordable Care Act, as well as the dead-weight loss of penalties and the excise taxes on "Cadillac" insurance plans:
a. Individual penalties assumptions:
i. Medicaid Expansion population is exempt from penalties due to the blanket "hardship" exemption provided by HHS. In addition, the general threshold for the requirement to pay federal income taxes is within the Medicaid Expansion population group.
ii. The permanent penalties will be incurred only by the following:
1. Non-working adults—all of those 25 and younger, and 10% of those 26 and older (essentially the non-filers).

2. 10% of the self-employed (essentially the non-filers).
3. The children associated with the above groups (10% of all children).

Moreover, only 50% of the non-filers will be identified within any given year and have to pay the penalty (including any back penalties).

iii. Temporary or time-limited penalties are assigned to certain individuals during the ramp-up period (1 minus the ramp-up period percentages). They will become compliant over time.

b. Business penalties assumption—Indeterminate
   i. Large firms will have total compliance due to competitive pressures related to their brand images and recruitment needs.
   ii. Small firms are not subject to business penalties.
c. Existing policy-holders are assumed to have 100% compliance, meaning no penalties will apply.
d. Increased federal taxes and fees were adequately treated in the underlying National and Florida Economic Outlooks.
e. Changes associated with some plans being deemed "Cadillac" are indeterminate.

(4) The model endogenously handles the shifting between industry sectors from "all else" into healthcare, including the knock-on effects, to meet the new demand.

Scenarios (compared to adjusted baseline described above):
The adjusted baseline can be considered the standard approach to modeling the Affordable Care Act "shock", assuming everything works as designed without introducing atypical labor shortages, wage constraints or capacity issues. The alternative scenarios (#1 through #7) are provided to assess areas of potential risk or change and the impact they would have on the results; however, no attempt is made to gauge the likelihood of the alternative outcomes. [Note: In the presentation PowerPoint, the various scenarios are referred to as "risk simulations".]

1. ADJUSTED BASELINE SCENARIO #1: Difference from the adjusted baseline after incorporating a barrier on additional healthcare workers moving into the state to fill jobs. [key features: potentially constrained infusion of federal dollars; no job-related migration]

2. ADJUSTED BASELINE SCENARIO #2: Difference from the adjusted baseline after assuming the uninsured today from the small business, self-employed, and non-working populations remain uninsured—meaning that those individuals originally buying policies instead pay penalties, as well as a complete erosion of existing insurance provision among small employers (1-50 employees, excluding self-employed)—meaning those employees move to individual coverage and the employers lose their tax credits. [key features: increased penalties; reduced Insurance Premium Tax collections; reduced federal tax credits]

3. ADJUSTED BASELINE SCENARIO #3: Difference from the adjusted baseline after assuming 25% entry rate for Woodworking. Woodworking values came from EDR. [key features: infusion of federal dollars; redirected state dollars]

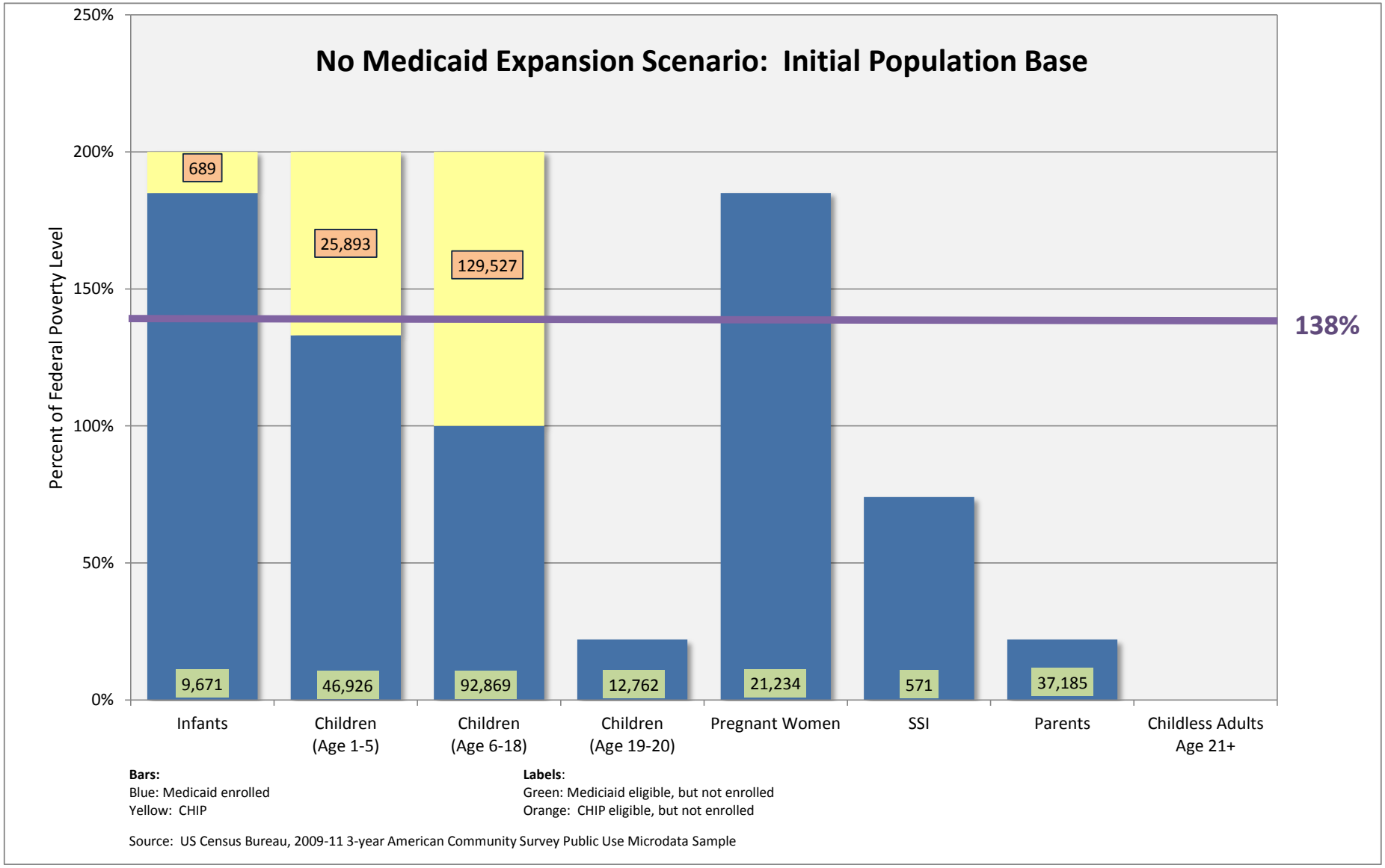
4. ADJUSTED BASELINE SCENARIO #4: Difference from the adjusted baseline after assuming that premium policy costs increase 50% from the existing blended level instead of the 25% assumed in the adjusted baseline, and that this higher level becomes the standard for all new policies. [key features: increased subsidies; increased Insurance Premium Tax]

5. ADJUSTED BASELINE SCENARIO #5 WITH MEDICAID EXPANSION: Difference from the adjusted baseline after incorporating the Medicaid Expansion coupled with an adjustment to assume 25% entry rate for Woodworking. Woodworking values came from EDR. The Medicaid Expansion values from the Social Services Estimating Conference have been updated to reflect new PUMS data and more recent "per member, per month" (PMPM) data. [key features: infusion of federal dollars; redirected state dollars; lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out populations]

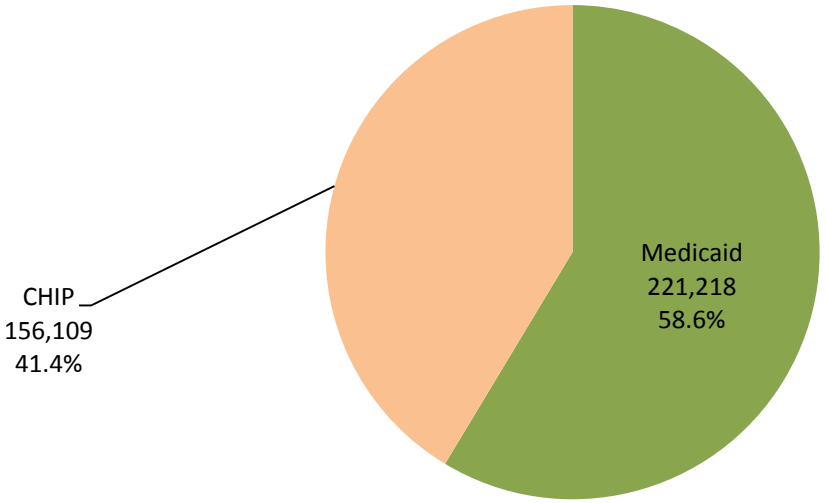
6. ADJUSTED BASELINE SCENARIO #6 WITH MEDICAID EXPANSION: Difference from the adjusted baseline after incorporating the Medicaid Expansion coupled with an adjustment to assume 25% entry rate for Woodworking and a barrier on additional healthcare workers moving into the state to fill jobs. Woodworking values came from EDR. The Medicaid Expansion values from the Social Services Estimating Conference have been updated to reflect new PUMS data and more recent PMPM data. [key features: infusion of federal dollars; redirected state dollars; lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out populations; no job-related migration]

7. ADJUSTED BASELINE SCENARIO #7 WITH MEDICAID EXPANSION: Difference from the adjusted baseline after incorporating the Medicaid Expansion coupled with an adjustment to assume 25% entry rate for Woodworking and a 60% increase in the annual costs implied by the PMPM rates for the Medicaid Expansion and Woodworking entrants. Woodworking and increased Medicaid Expansion values came from EDR. [key features: infusion of federal dollars; redirected state dollars; lower Insurance Premium Tax dollars due to the removal of the Medicaid Expansion and Crowd Out populations]

8. BREAK-EVEN FUNDING ANALYSIS FOR MEDICAID EXPANSION: Incremental federal funding adjustments to the scenario which incorporates the Medicaid Expansion with no other alterations (Scenario #5) to determine at what point the additional economic benefits are driven to zero. Loss of federal funds are offset through an equal infusion of state funds with overall budget reductions elsewhere. The selected welfare variable to measure the economic benefits is Domestic Consumption by Households and Government.


No Medicaid Expansion Scenario: Initial Population Base
Percent of Federal Poverty Level
250%
200%
150%
100%
50%
0%
138%
689
25,893
129,527
9,671
46,926
92,869
12,762
21,234
571
37,185
Infants
Children (Age 1-5)
Children (Age 6-18)
Children (Age 19-20)
Pregnant Women
SSI
Parents
Childless Adults Age 21+
Bars:
Blue: Medicaid enrolled
Yellow: CHIP
Labels:
Green: Mediciaid eligible, but not enrolled
Orange: CHIP eligible, but not enrolled
Source: US Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample

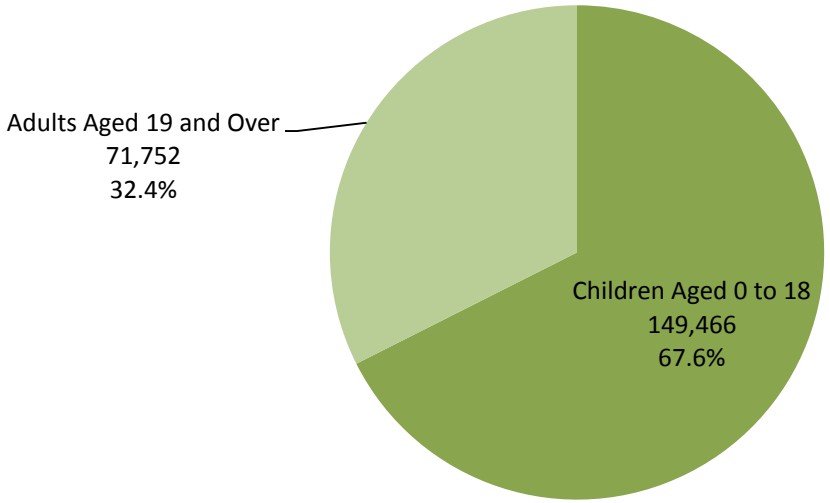
Eligible, but not Enrolled: No Expansion, Initial Population Base



Total: 377,327

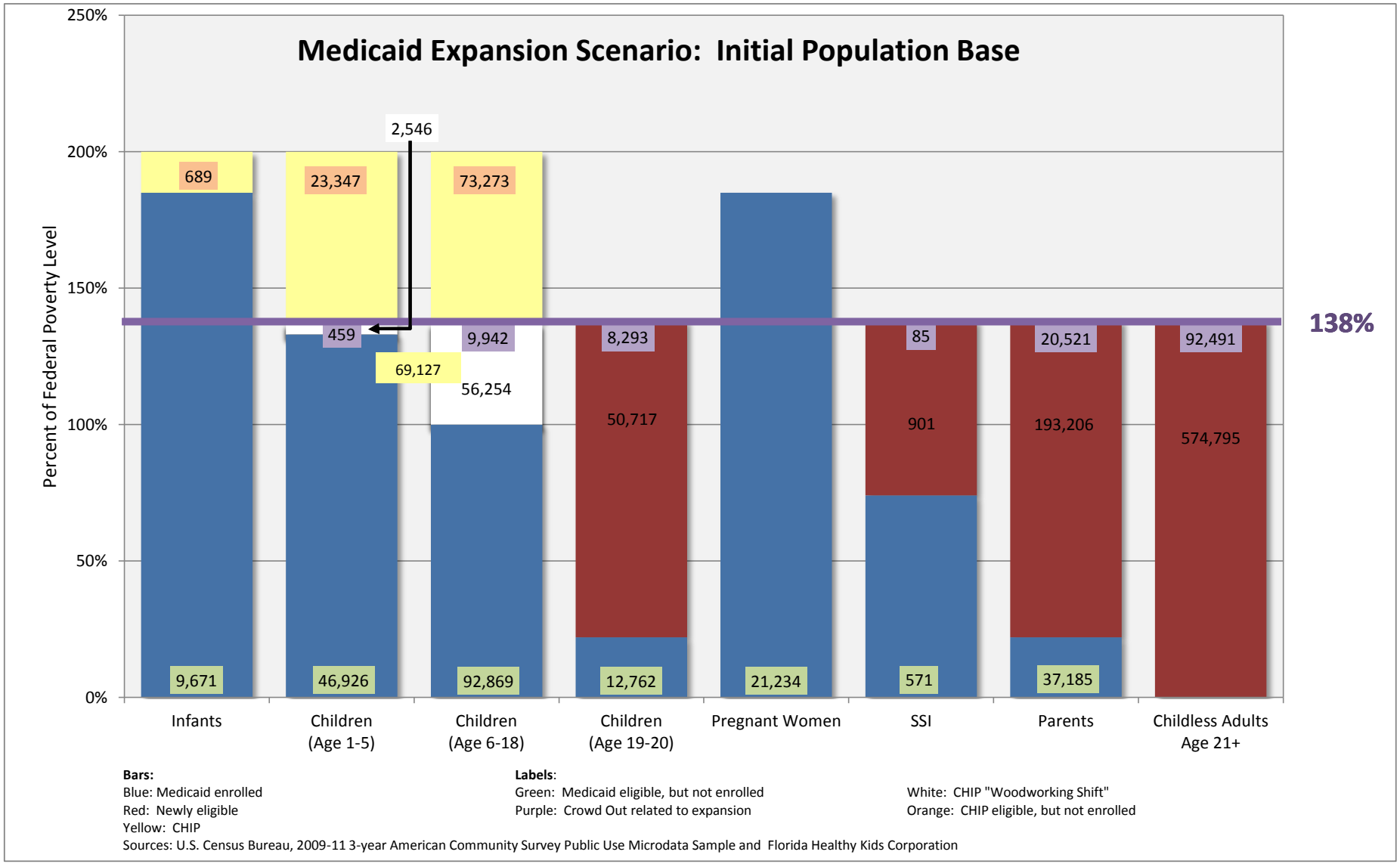
Source: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample

Eligible for Medicaid, but not Enrolled: Initial Population Base

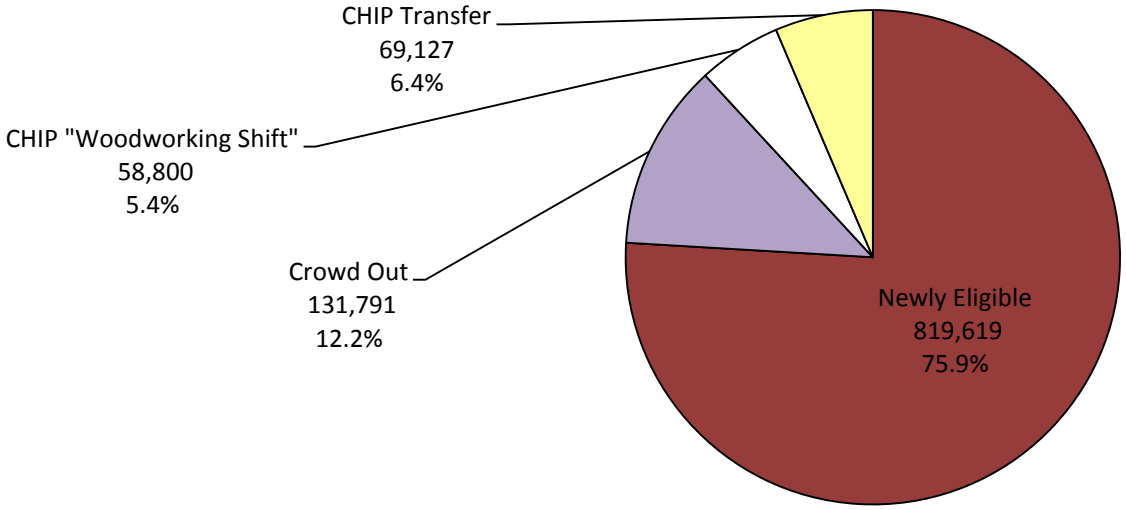


Total: 221,218

Source: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample


Medicaid Expansion Scenario: Initial Population Base
Percent of Federal Poverty Level
250%
200%
150%
100%
50%
0%
138%
2,546
689
23,347
73,273
459
9,942
69,127
56,254
8,293
50,717
85
901
20,521
193,206
92,491
574,795
9,671
46,926
92,869
12,762
21,234
571
37,185
Infants
Children (Age 1-5)
Children (Age 6-18)
Children (Age 19-20)
Pregnant Women
SSI
Parents
Childless Adults Age 21+
Bars:
Blue: Medicaid enrolled
Red: Newly eligible
Yellow: CHIP
Labels:
Green: Medicaid eligible, but not enrolled
Purple: Crowd Out related to expansion
White: CHIP "Woodworking Shift"
Orange: CHIP eligible, but not enrolled
Sources: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample and Florida Healthy Kids Corporation

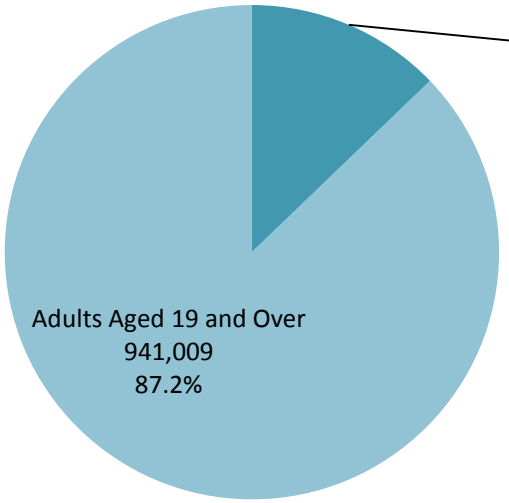
Medicaid Expansion Components: Initial Population Base



Total: 1,079,337

Sources: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample and Florida Healthy Kids Corporation

Medicaid Expansion Impact: Initial Population Base



Total: 1,079,337

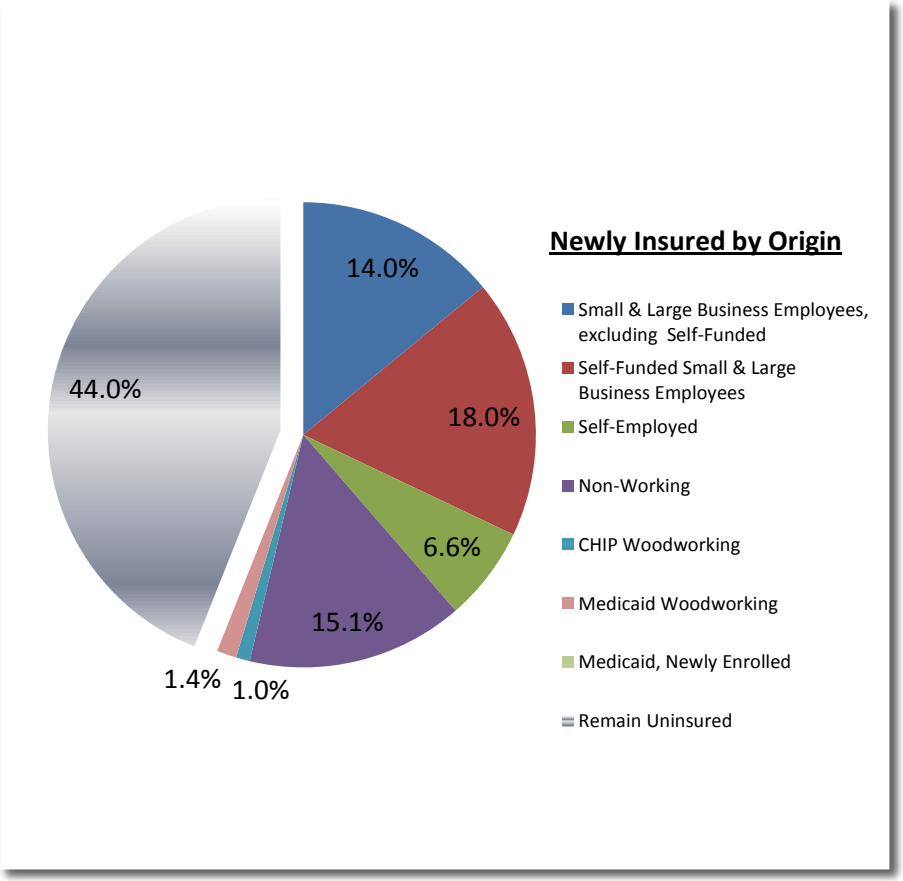
Note: 92.5% of Children Aged 0 to 18 are from CHIP (includes enrolled and those eligible, but not enrolled)

Sources: U.S. Census Bureau, 2009-11 3-year American Community Survey Public Use Microdata Sample and Florida Healthy Kids Corporation

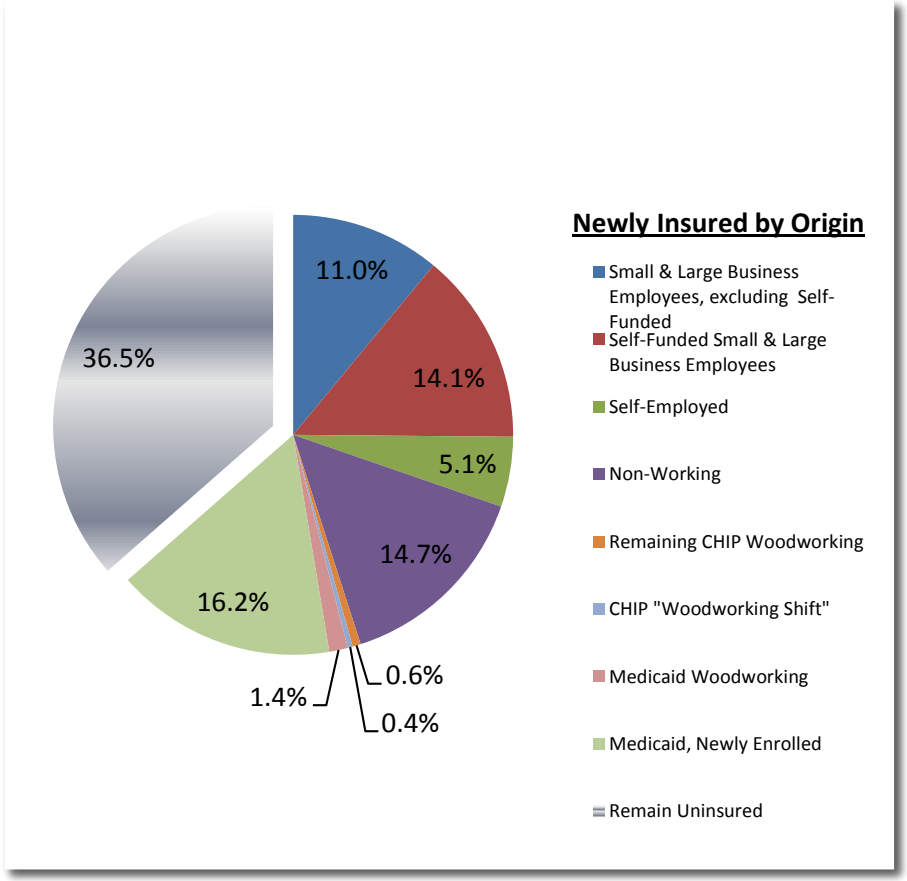
Newly Insured and Uninsured

Percent of Current Uninsured*

Adjusted Baseline with Woodworking**



Adjusted Baseline with Woodworking** and Medicaid Expansion



*4,040,731

** Woodworking are individuals that are currently eligible but not enrolled

Devon M. Herrick, Ph.D., Senior Fellow, National Center for Policy Analysis

Devon Herrick, Ph. D., is a preeminent expert on 21st century medicine, including the evolution of Internet-based medicine, consumer driven health care and key changes in the global health market. He was among the first to identify and publish in-depth studies on medical tourism, telemedicine, and "shopping for drugs" strategies.

Dr. Herrick concentrates on a variety of critical health care issues, such as health insurance and the uninsured, patient empowerment and trends in state health policy reform. He has conducted numerous cutting-edge research projects for the NCPA.

As a health care economist, Dr. Herrick is a preferred speaker on health policy issues and his comments have appeared in hundreds of newspapers nationwide as well as on television and radio. He writes regularly on health policy for the NCPA and other research organizations, and is a contributing editor of *Health Care News* and a regular contributor to *NABE News*.

Dr. Herrick received a Ph.D. in Political Economy and a Master of Public Affairs from the University of Texas at Dallas with a concentration in economic development. Dr. Herrick's dissertation research examined patient empowerment through empirical analysis of the Internet and disease advocacy. He also holds advanced degrees in finance.

Economic and Policy Analysis of Florida Medicaid Expansion

Preliminary Draft

By

Devon M. Herrick, Ph.D.

March 4, 2013

Introduction

Proponents of the Patient Protection and Affordable Care Act of 2010 (ACA) initially expected the new health care law to provide coverage for 32 million uninsured individuals and families when fully implemented. About half of the newly covered individuals were expected to obtain private coverage, while the remaining 16 million would enroll in an expanded Medicaid program. However, in June 2012, the U.S. Supreme Court ruled that provisions of the ACA rescinding federal Medicaid matching funds for states that refused to extend Medicaid eligibility to 138 percent of the federal poverty level (FPL) were unconstitutional. The ruling gives Florida the opportunity to compare the costs and benefits of expanding Medicaid eligibility.

Some individuals who otherwise would have qualified for a newly expanded Medicaid program could benefit from other provisions in the ACA. These provisions provide generous, sliding-scale subsidies to low-to-middle income individuals for the purchase of private health coverage in a Health Insurance Exchange that will be set up by the federal government.

Advocates for the poor and the Obama Administration have touted the benefits: the federal government promises to pay most costs for the newly eligible. What is missing from the debate is a discussion of the costs, obstacles and potential pitfalls that make Medicaid expansion a bad deal for Florida residents.

Background: How Medicaid Currently Works

Medicaid is a complex system of federal funds matched with state funds, with special pools of money limited to specific uses. At present, Medicaid is a 50-state patchwork of different

regulations. Under the current program, the federal government pays 58.62 percent of Florida's Medicaid benefits.[1]

Who Is Eligible for Medicaid? Prior to the ACA, Medicaid eligibility primarily covered expectant mothers, babies, young children, seniors and the disabled. States can elect to expand Medicaid eligibility to cover "optional" populations, including older children and adults above 100 percent of the poverty level, pregnant women and young children above 133 percent of the federal poverty level, and parents just above the Temporary Assistance for Needy Families income cut-off level. The income thresholds for individuals and families are shown in Table I.

Table I

Federal Poverty Level (2013)

	Individual	Family of Two	Family of Four
100%	$11,490	$15,510	$23,550
138%	$15,856	$21,404	$32,499
200%	$22,980	$31,020	$47,100
300%	$34,470	$46,530	$70,650
400%	$45,960	$62,040	$94,200

Medicaid under the Affordable Care Act

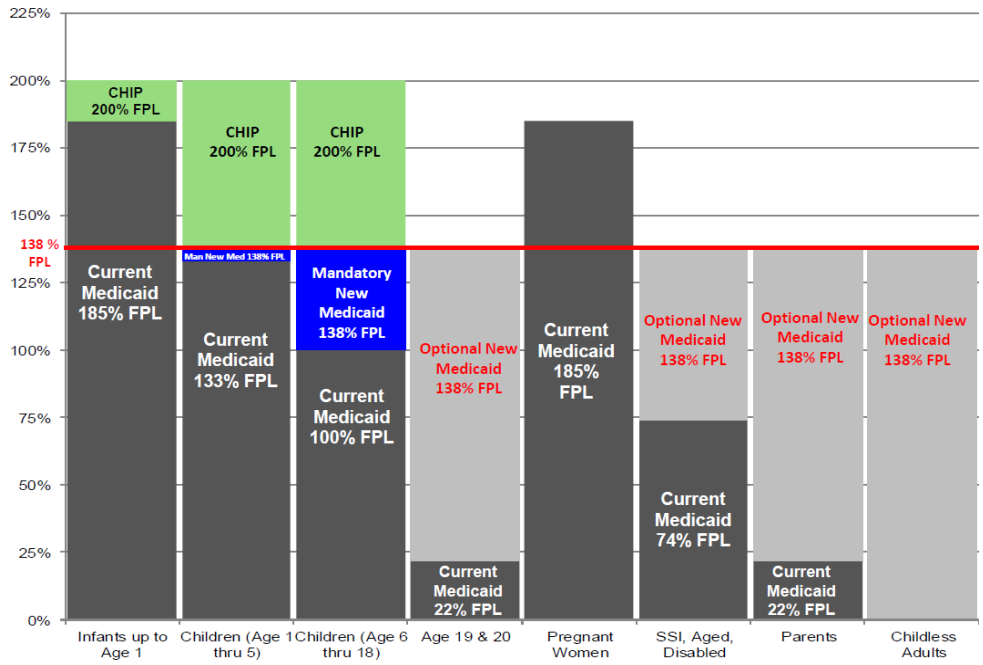
The ACA contains provisions designed to strongly encourage states to expand Medicaid eligibility to individuals earning up to 138 percent of the federal poverty level (FPL).[2] The federal government would initially pay 100 percent of the cost of benefits for adults who are newly eligible enrollees through 2016. The enhanced federal match drops to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent of cost in 2020 and thereafter.[3]

The federal government will also pay 100 percent of the cost of boosting low Medicaid reimbursement rates for *primary care* providers (not specialists) on par with Medicare physician fees — but only for a two-year period (2013 - 2014).[4] The cost of increasing primary care provider rates after 2014 falls to the states, as does the cost of boosting fees to encourage more specialists to treat Medicaid enrollees.

Florida Medicaid Under the Affordable Care Act

About 3.3 million people receive services from Florida Medicaid program — over half of those are children, adolescents and young adults.[5] Florida will spend about $21 billion on this population in the current fiscal year.[6] Figure I illustrates Medicaid and Children's Health Insurance Program eligibility in Florida before and after the ACA. [See Figure I.]

Figure I



Florida has about 5.5 million residents living on less than 138 percent of the federal poverty level. Approximately 2 million of these individuals are uninsured, many of whom (at least theoretically) would be eligible to enroll in an expanded Medicaid program.[7] About 257,000 of these are adults thought to be eligible under prior regulations but unenrolled in Medicaid. The Urban Institute estimates Florida can expect possibly 357,000 more enrollees due to the ACA — even if the state does not expand Medicaid eligibility.[8] Indeed, there are no reliable estimates of how many Florida residents currently eligible would enroll — with or without expansion.[9] Estimated take-up rates vary, but some of these will enroll when the individual mandate requiring all legal U.S. residents to have health coverage takes effect in 2014. If Florida does expand Medicaid, it eventually could have 1.6 million more enrollees. This equals about 1.3 million newly-eligible enrollees. Of those newly-eligible under an expanded

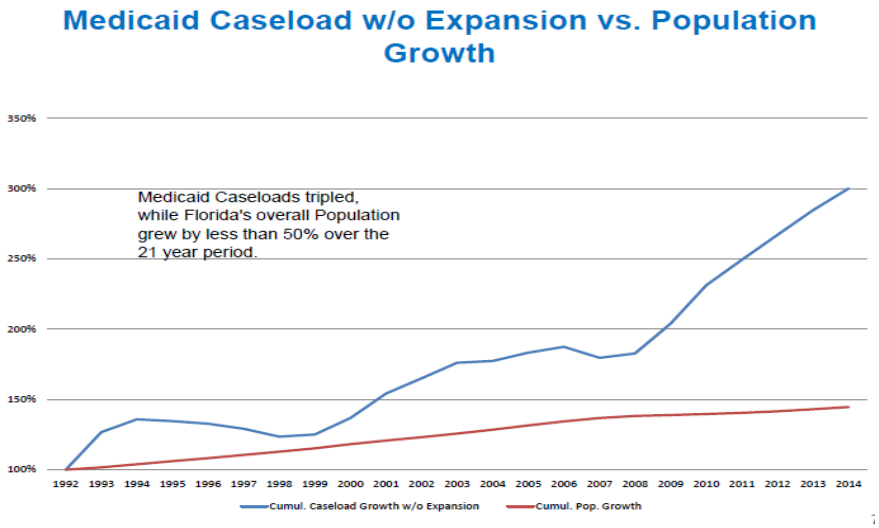
Medicaid program, slightly more than 1 million (83 percent) are thought to be healthy adults without dependent children.[10]

Medicaid Under the ACA Will Be Costly

The cost of the current Medicaid program in Florida is likely to rise whether or not Florida expands Medicaid eligibility. In addition, the costs for the Medicaid expansion population could be higher than anticipated for many of the reasons described below. Over the past two decades, the Medicaid caseload tripled, while the state population grew about 50 percent. During this same period, expenditures increased about 450 percent.[11] [See Figure II]

National estimates suggest that up to a third of the uninsured are already eligible for Medicaid but not enrolled. Florida would have to pay for more than 40 percent of the cost of the additional enrollees because the enhanced federal matching rate does not apply to those eligible for Medicaid before the ACA was passed.

Figure II



Despite generous federal payments, Jagadeesh Gokhale, a Cato Institute senior fellow, estimated the ACA would raise the amount of Florida's general revenues required to fund state Medicaid programs. According to Gokhale, Medicaid spending from general revenue in Florida

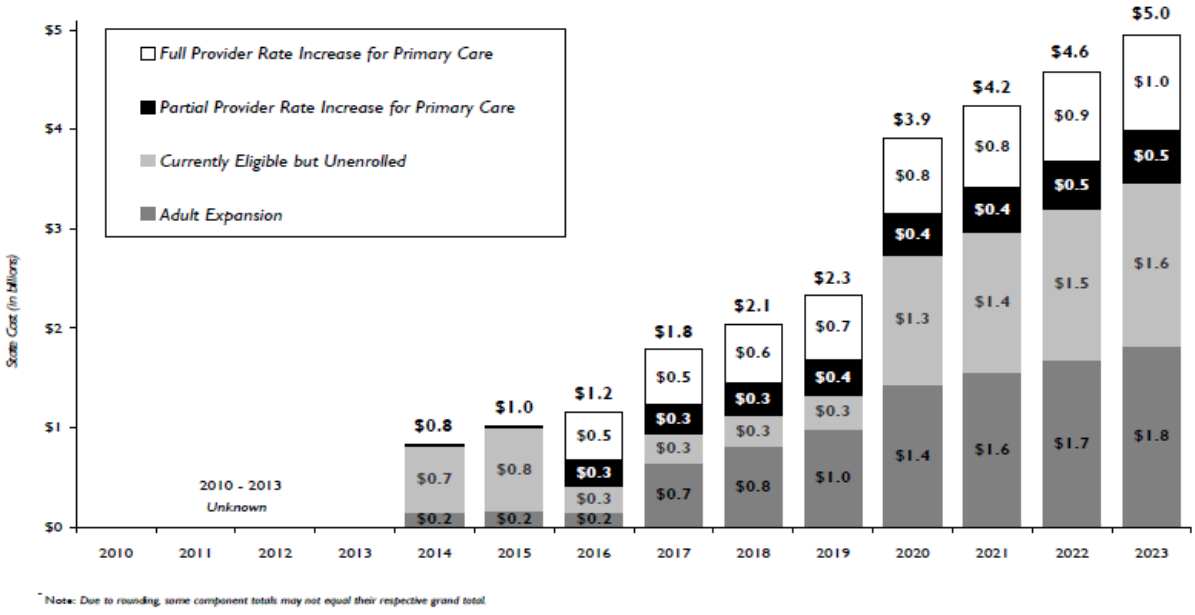
would rise from just over $6 billion in 2008 (prior to the ACA), to nearly $24 billion in 2030 under an expanded program.[12]

Texas is a good illustration of the costs Florida could expect. The Texas Health and Human Services Commission has predicted that 10 years after the ACA is implemented, Texas Medicaid rolls will rise by 2.4 million people.[13] Of these, only 1.5 million enrollees will be newly eligible. About 824,000 individuals will be those previously eligible but not enrolled.[14] The cost of covering those already eligible and boosting provider rates was a significant portion of Texas' cost. [See Figure III]

Figure III

Texas' Estimated State Costs Under the ACA

HHSC Medicaid/CHIP Cost Estimates by Level of Implementation, 2010 - 2023 *



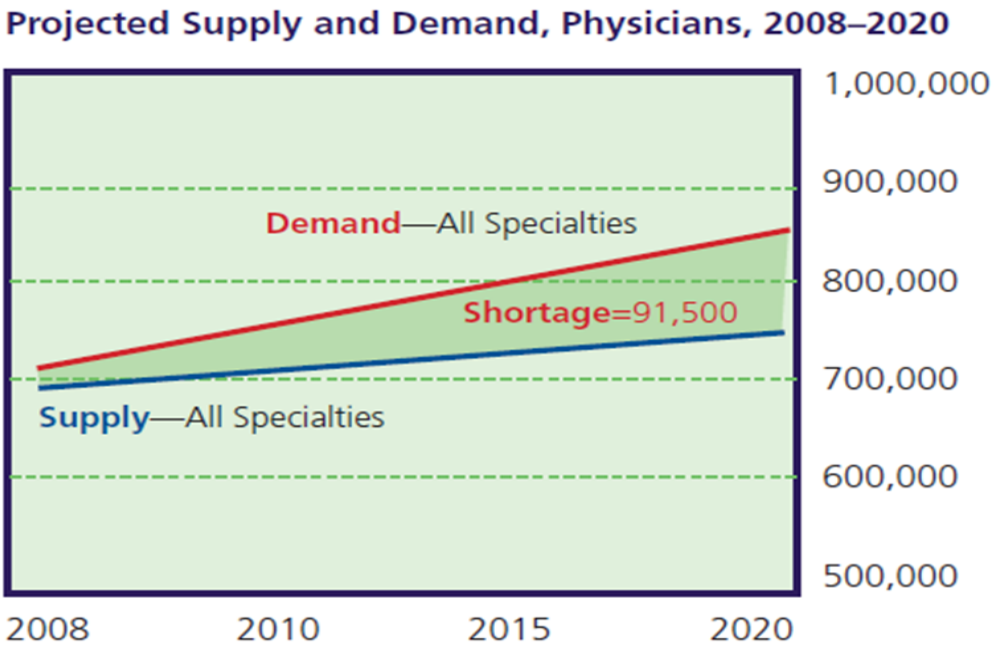
* Note: Due to rounding, some component totals may not equal their respective grand total.

Medicaid Expansion: Challenges to Overcome

Florida's Physician Shortage. Many aspects of the ACA affect the physician workforce.[15] Arguably, the main effect is that 27 million uninsured Americans are expected to gain health coverage — nearly half of them through Medicaid.[16] If economic studies are correct, the newly insured will try to nearly double their consumption of medical care.[17] In addition, over the next decade, 78 million Baby Boomers will need more medical care as they reach late middle-age and many retire. During this period, nearly one-third of physicians are expected to retire; however, the supply of new medical graduates is not expected to keep pace with the increasing demand.[18] [See Figure IV]

The United States graduates about 16,000 medical students annually, and they compete with foreign medical graduates to fill the 23,000 available first-year residency slots.[19] This isn't nearly enough to keep up with the growing demand. The Association of American Medical Colleges (AAMC) estimates the current shortage of 20,000 doctors will swell to 91,500 physicians in 2020 — increasing to 130,600 by 2025.[20]

Figure IV



Florida's impending physician shortage is arguably more severe than in other states.[21] By 2030, Florida's population is projected to grow to 23.6 million — nearly five times the number of Florida residents in 1960. During this period, the number of seniors will increase to nearly one-quarter of Florida's population.[22] Indeed, by 2030, Florida's senior population (age 65+) is expected to rise about 74 percent compared to the 2010 Census.[23]

Florida has about 45,000 actively practicing physicians. Many of Florida's physicians are aging and plan to retire in the next few years. According to the Florida Board of Governors, less than 14 percent of Florida's physicians are under 40 years of age; 86 percent are older. More than one-quarter (27 percent) are approaching (or past) retirement age — about half of whom report they plan to retire in the next five years.[24]

Florida physicians have little if any excess capacity to expand the number of patients they treat. The physician supply is relatively inelastic and cannot increase quickly to accommodate rising demand for medical services. Two-thirds of Florida physicians are working full-time; only 22 percent of doctors spend less than 30 hours per week on patient care. Half (49.9 percent) of Florida's doctors already see more than 75 patients per week. Nearly one-third (30.1) see more than 100 patients each week. Other health care workers are also in short supply, including nurses, physical therapists, occupational therapists and speech pathologists.[25] The Florida Center for Nursing is predicting a shortage of more than 50,000 nurses by 2025 — partly due to the higher demand created by the ACA.[26]

Low Provider Fees Under Medicaid. Nationally, Medicaid provider reimbursements average only about 53 percent of what a private insurer would pay for the same service, but the actual amount varies from state to state.[27] On average, Florida Fee-for-Service Medicaid pays physicians only about 57 percent of what Medicare would pay for the same service. For primary care, Medicaid only pays about half (49 percent) of what Medicare would pay.[28] Compared to commercial insurers, Florida's Medicaid program pays less than half (46 percent) what a private insurer would pay for the same service.[29] It is even less for primary care, for which it pays about $0.40 cents on the dollar compared to private insurers.[30]

Poor Access to Care Under Medicaid. Nationally, slightly less than one-third of physicians accept new patients enrolled in Medicaid. This is nearly double the rate of doctors whose practice is closed to new Medicare patients (17 percent) and to new privately insured

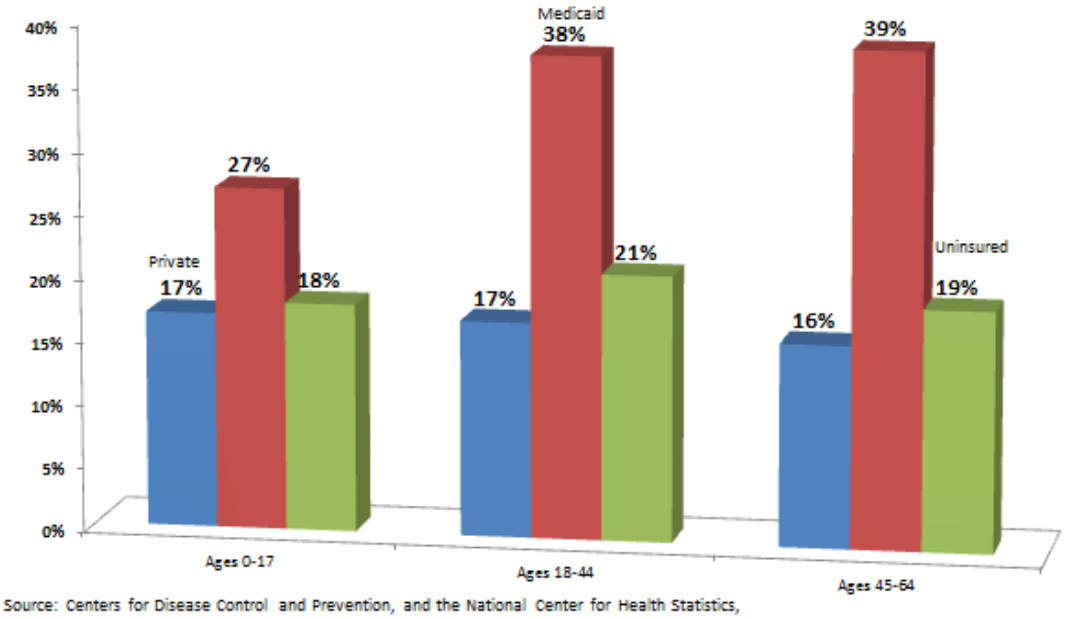
patients (18 percent). Physicians are four times more likely to turn away new Medicaid patients than those with no insurance (31 percent versus 8 percent).

Medicaid patients have more problems finding doctors who will see them. In Florida, the proportion of physicians whose practices are closed to new Medicaid patients is even higher than the national average. Only about 41 percent of Florida physicians will accept new Medicaid patients into their practices.[31] Studies show that even the uninsured have an easier time making doctors' appointments than Medicaid enrollees.[32] For instance, one survey finds that in Miami:[33]

- More than one-third (36 percent) of cardiologists won't accept Medicaid patients.
- Nearly three-quarters (72 percent) of OB/GYN specialists will not accept new Medicaid patients.
- Nearly two-thirds (64 percent) of orthopedic surgeons will not accept new Medicaid patients.
- About60 percent of family practitioners are not accepting new Medicaid patients.

Medicaid and Emergency Room Use. Americans see their doctors more than a billion times each year. They make another 136 million visits to hospital emergency rooms. Some of that care would be better performed elsewhere in a non-emergent setting.[34] Patients covered by Medicaid seek care in the ER more frequently than both the uninsured and those covered by private insurance. [See Figure V]

Figure V
Percentage of Individuals with Emergency Room Visits
(by age and insurance status)



Source: Centers for Disease Control and Prevention, and the National Center for Health Statistics, "Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?" National Health Interview Survey, 2010.

For instance, nearly one-third (32 percent) of Medicaid enrollees used the ER at least once during a 12-month. Individuals with private health coverage were only about half as likely (17 percent) to visit an ER, and a similar proportion—one in five—of individuals without health coverage did so. Medicaid enrollees were three times as likely (15 percent vs. 5 percent) as the privately insured, and twice as likely as the uninsured (15 percent vs. 7 percent), to have visited an ER twice in the previous year.[35]

An article published in *The Annals of Emergency Medicine*, looked at so-called *frequent fliers*, those who use the ER multiple times each year. It found only 15 percent of frequent ER users were uninsured. Nearly two-thirds (60 percent) of frequent visitors to the ER were covered by Medicaid or Medicare. Patients who frequent the ER may constitute only about 5-8 percent of ER patients, but they account for approximately one-quarter of all ER visits.[36]

Medicaid Displaces Private Insurance. Many of the newly insured under Medicaid will likely be those who previously had private coverage. *Crowd-out* is a condition where people who are already covered by employer or individual policy drop coverage to take advantage of the public option.[37] Analysis of past Medicaid expansions, dating back to the 1990s, by economists

and Obama Administration advisers David Cutler (Harvard) and Jonathan Gruber (MIT), found that when Medicaid eligibility is expanded, 50 percent to 75 percent of the newly enrolled were those who had dropped private coverage.[38] More recently, a 2007 analysis by Gruber found, on average, about 60 percent of newly enrolled children in State Children's Health Insurance Program (CHIP) were previously covered privately.[39] Thus, it is reasonable to conclude that some of the increase in Medicaid rolls will be individuals who were previously privately insured, suggesting the number of uninsured will not fall as expected. A reasonable assumption is that Medicaid rolls may have to rise by 1.4 people in order to reduce the uninsured by 1 person. Some of these undoubtedly have to come from those with private coverage.

Health Outcomes and Medicaid. On paper, Medicaid is a health plan far better than most Americans enjoy — with lower cost-sharing and nearly unlimited benefits. But by almost all measures, Medicaid coverage is inferior to private health insurance. If Medicaid coverage had to compete for enrollees in the marketplace with other forms insurance, it is doubtful that most Floridians would choose it over private coverage.

Various academic papers have illustrated that Medicaid enrollees sometimes fare worse than patients with private insurance.[40] A University of Virginia study, a study in the *Journal of the National Cancer Institute,* astudy in the journal *Cancer* and a study in the *Journal of Vascular Surgery* found Medicaid enrollees often had worse outcomes than the privately insured — and even those without coverage — even after adjusting for prior health status.

Alternatives to Medicaid Expansion under the Affordable Care Act

For moderate-income people ineligible for Medicaid, the ACA establishes health insurance exchanges where qualifying individuals and small businesses can purchase subsidized, individual health insurance starting in 2014. Those who have access to affordable health plans through their employer will not be eligible for exchange subsidies. However, qualifying individuals who do not have access to an employer-provided health plan or Medicaid will be eligible.[41] In states that do not expand their Medicaid programs under the ACA, individuals whose incomes are 100 percent to 133 percent of the federal poverty level will be eligible for subsidized coverage in the exchange at very little cost.[42]

Tailor Medicaid to Meet Florida's Needs.For moderate-income individuals earning more than 100 percent of poverty, subsidized private coverage in the health insurance exchange is a much better deal for Florida, doctors, hospitals and enrollees. This option is not available for those earning less than 100 percent of the poverty level.

The U.S. Department of Health and Human Service recently indicated so-called *partial expansion* will not be considered prior to 2017.[43] States attempting to selectively expand Medicaid eligibility cannot expect to receive 100 percent reimbursement from the federal government. Yet, the standard federal match would be available for targeted expansions. Florida's federal match provides that state spending of about 42 cents is matched by nearly 58 cents of federal money

Subsidies for private health insurance in the Exchange. Though people of any income level may purchase coverage in the exchange, subsidies will be available only to individuals and families with incomes below 400 percent of the federal poverty level — just over $94,200 for a family of four.[44] Families with incomes below 100 percent; and from 100 percent to 133 percent of poverty will be required to enroll in Medicaid if it is available.[45] For enrollees in the exchange who earn between 100 percent and 138 percent of the poverty level, their share of the premiums cannot exceed 2 percent of their income. Thus, their cost will often average less than $200 per covered individual. [See Table II] The remaining cost of premiums — potentially worth $15,000 for a family of four — will be paid for by the federal government.[46] Certainly, 2 percent of family income represents a significant amount of money for families making ends meet on a modest income. The maximum cost share for a family of four in two different income categories is shown below:

Table II

Annual Income	Percent of Poverty	Maximum Cost Share = 2%
$23,550	100%	$471per family or $118 per person
$32,499	138%	$650 per family or $162 per person

If Florida wanted to encourage enrollment for this moderate-income population, it could pay this portion of costs for about $750 million over a decade.

Currently, the Medicaid program in Florida covers children (and some parents) in families up to the poverty level. However, more than one-quarter of a million currently eligible individuals are not enrolled. Nearly 500,000 uninsured Florida residents are estimated to have incomes between 100 percent and 138 percent of the federal poverty level in 2014. If Medicaid is not available to them, federal law will give them another option: subsidized private insurance in a health insurance exchange.

Florida hospitals would benefit from policies that maximize the number of people with commercial insurance, because commercial reimbursements are higher. Medicaid expansion produces the opposite effect because an estimated 30 percent of adults in the 100 to 138 percent of federal poverty income range who have private insurance will drop it in favor of Medicaid.[47] In contrast, the fraction of that group with commercial insurance will increase significantly if Medicaid is not expanded, allowing them to receive generous federal subsidies through the exchange.

Other considerations include the fact that hospitals may need the increased commercial cushion in order to contend with coming cuts in Medicare reimbursements and federal disproportionate share payments.

If Florida does not expand Medicaid to those earning between 100 percent to 138 percent of poverty, the state will forgo about $12 billion in federal Medicaid money over the next 10 years. However, if Florida families take advantage of generous federal subsidies for private insurance that additional coverage will result in approximately $28 billion in additional health care spending by private insurers.[48] After accounting for Florida's share of new spending, the $15 billion difference represents an additional infusion of nearly $1.5 billion per year — including extra money for the state's doctors and hospitals. As mentioned earlier, Florida Medicaid pays provider fees that are less than half what private insurers pay for the same service. Thus, the federal money Florida would forgo by not expanding Medicaid could be replaced by private spending.[49]

Exchanging Medicaid for Private Coverage

In an expanded Medicaid program, federal spending on newly eligible individuals earning 100 percent to 133 percent of poverty would exceed $12 billion over the 10-year period (from 2014 to 2023), based on historic Medicaid spending patterns. Florida would bear an additional $1 billion in costs. Although the federal government will provide most of the funds for states to cover this newly eligible population, it will increase the state's fiscal burden.[50] Although some new enrollees may have health problems or chronic conditions, many of those newly eligible for Medicaid will be relatively healthy adults.[51]

If projected federal Medicaid spending was replaced by private insurers paying market rates for medical care, patients would enjoy better access to care and providers would receive an additional $15 billion in medical spending. An initiative to entice this low-income population to sign up for coverage would cost the state about $750 million to a possible $1 billion over a decade.

How Would Private Coverage Affect Providers? Medicaid payments to doctors and hospitals vary from state to state, and with only two exceptions (Alaska and Wyoming), private insurers pay much higher physician fees than Medicaid. If these individuals were privately insured, they would have easier access to doctors willing to treat them. Local doctors and hospitals could expect reimbursements far more generous than under Medicaid. How much more? A rule of thumb is that private insurers generally pay fees at least 50 percent higher — and often double — what Medicaid pays.

The comparison of Medicaid expansion and expanded private coverage must consider the combination of crowd-out and lower Medicaid payments. With Medicaid expansion, 30 percent of enrollees pay providers approximately half of what they would have received from those same individuals had they kept their private coverage. On the other hand, by supporting people who qualify for subsidized private insurance through the exchange, Florida may see as many as 350,000 uninsured (assuming a 70% take up rate among the 500,000 in this category) gain private coverage. Payments for these newly insured individuals will be twice the rate that would have been paid if the same people received coverage through Medicaid.

Does Medicaid Boost the Economy?

Many tout the benefits of "economic activity" that additional federal Medicaid funds might create within states.[52] The federal stimulus from 2008 is cited as an example of how federal spending on Medicaid can have a stimulus effect; for three years — from 2008 to 2010 — the federal government paid a larger share of Medicaid spending. Yet, it is difficult to calculate the actual value of any change in economic activity. One study of the Medicaid stimulus found each new dollar of Medicaid spending resulting in $2 dollars of economic activity.[53] The lead author of the study cautioned that his research should not be construed to mean Medicaid expansion would have the same effect. A primary reason is the economy nationwide is in far better shape than it was in 2008. As the economy approaches full employment, stimulus spending tends to reallocate resources from one sector to another.

Some economic impact studies overlook the fact that additional federal spending crowds out private activity and depends on additional government revenues extracted from the private sector. They assess the impact of an additional $1.00 of federal spending to Florida as if it is financed by equal tax liabilities on all states. Estimates of multipliers in this highly artificial case generally lie in the range of $0.50 to $2.00, meaning that the total effect of the new spending would range from $1.50 to $3.00 if the new $1.00 is included in the overall effect. [54] One study found that the multiplier actually might be negative because increases in federal spending cause individuals to think that they are wealthier, and wealthier people choose to work less and enjoy more leisure time.[55]

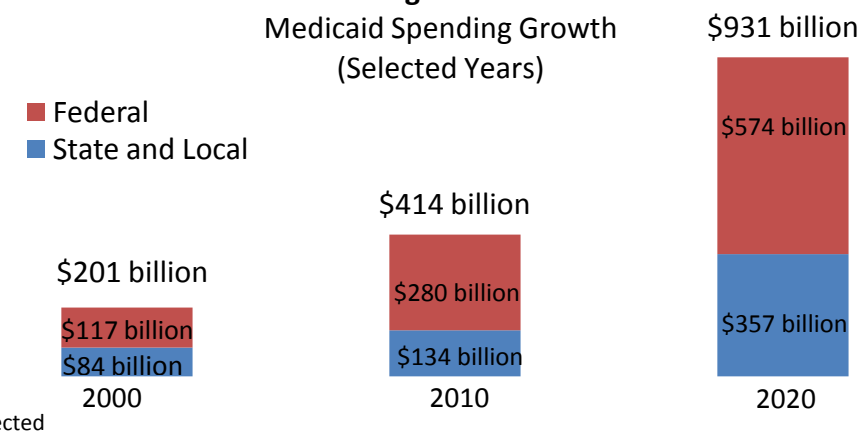
Macroeconomic studies of increased government spending for the nation as a whole suggest that since 1950 "balanced-budget multiplier" calculations (when expenditures are offset with the negative multipliers associated with increasing marginal tax rates) find a negative effect on national economic output of about -1.1.[56] If correct, these results suggest that the net effect of the health law is to reduce GDP as the federal government pulls more revenues from the citizens in each state to fund its programs. According to the RAND Corporation, most states can expect to see a net transfer of state resources to the federal government under the PPACA. Only poor states will experience more benefits than costs.[57]

Is Federal Spending Sustainable?[58]

Federal and state governments spent $389 billion on Medicaid in 2010.[59]Medicaid is the largest expense item in most state budgets — and it is growing at unsustainable rates. [See Figure VI.] For instance:

- State Medicaid spending was only $84 billion in 2000.
- It is projected to quadruple to $357 billion by 2020 — less than a decade from now.
- Federal spending on Medicaid was about one-quarter of a trillion dollars in 2009.
- Federal spending is projected to more than double by 2020 to $574 billion.

Figure VI
Medicaid Spending Growth
(Selected Years)



* Projected
Source: National Health Statistics Group, Office of the Actuary, Centers for Medicare and Medicaid

Medicaid isn't the only commitment the federal government has to fund into the distant future. At the federal level, health care is our most serious domestic policy problem. Medicare is the most important component. Every year for decades, Medicare spending has increased an average of 2 percentage points more than gross domestic product (GDP).[60] If this country continues consuming products whose cost is growing faster than national income, it will eventually crowd out every other thing we are consuming.

The combined deficits of Medicare and Social Security now require about 15 percent of general income tax revenues. As baby boomers begin to retire, however, that number will soar, and it will be increasingly difficult for the government to continue spending on other activities.

[See Figure VII.] In the absence of a tax increase, if the federal government keeps its promises to seniors and balances its budget:

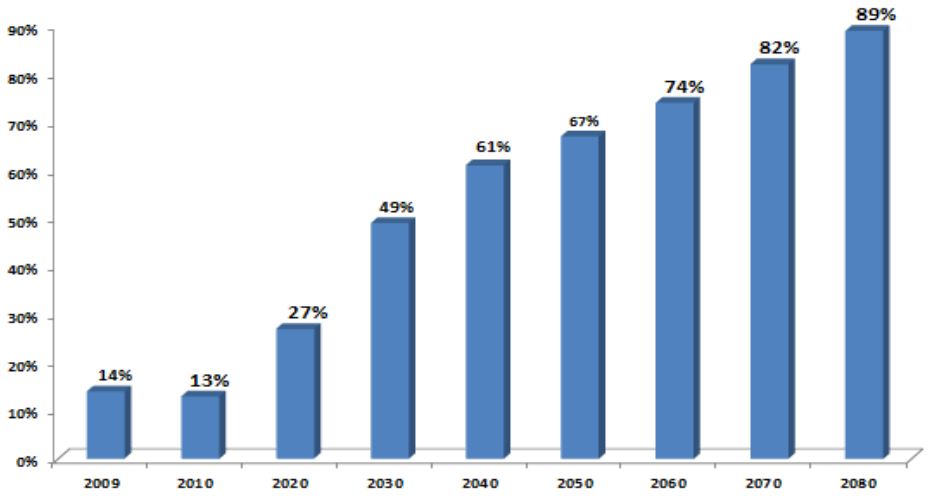
- By 2020, in addition to payroll taxes and premiums, Social Security and Medicare will require more than one in four federal income tax dollars.
- By 2030, about the midpoint of the baby boomer retirement years, the programs will require nearly half of all income tax dollars.
- By 2060, they will require nearly three out of four income tax dollars.

According to the Congressional Budget Office (CBO), if Medicare and Medicaid spending continues growing at this rate, by 2050, Social Security, Medicare and Medicaid (health care for the poor) will consume nearly the entire federal budget. By 2082, Medicare spending alone will consume nearly the entire federal budget.

The CBO also found that if federal income tax rates are adjusted to allow the government to continue its current level of activity and balance its budget:[61]

- The lowest marginal income tax rate of 10 percent would have to rise to 26 percent.
- The 25 percent marginal tax rate would increase to 66 percent.
- The current highest marginal tax rate (35 percent) would rise to 92 percent.

Figure VII
General Revenue Transfers to Social Security and Medicare
(percent of income tax revenues)



Source: 2009 Social Security and Medicare Trustees Report.

Conclusion

Medicaid comprises more than one of every five dollars spent by states — and is growing at unsustainable rates. Any decision to expand Florida's Medicaid program should consider economic and fiscal impacts as well as the potential costs and benefits for both patients and providers. The following points from this analysis should be considered:

- Medicaid is an inefficient way to reduce the number of uninsured.
- As much as 30 percent of new Medicaid enrollees will come from individuals who previously had private insurance.
- Although seemingly a broader benefit package, Medicaid coverage does not guarantee access to needed services.
- Limited provider participation in Medicaid due to low payments and labor shortages is the most significant barrier to access to care.
- As a result of limited access to providers in other settings, Medicaid patients are more likely to rely on hospital emergency departments to obtain the care they need.
- Without access to appropriate primary and specialty care, Medicaid patients often experience worse health outcomes compared to people with private insurance.
- Providers shift costs to private payers when public programs such as Medicare and Medicaid limit payment rates; such cost shifts increase the price of insurance.
- Expanding Medicaid may exacerbate the cost shift by limiting payment levels for a larger share of patients and limiting the number of private payers due to crowd out.

Florida can better serve those earning above 100 percent of the federal poverty level by encouraging them to seek subsidized coverage in the health insurance exchanges. To increase coverage among families earning less than 100 percent of poverty, Florida target certain optional populations and consider providing limited benefits to other groups. The amount of benefits and the populations covered should depend on preferences and priorities held by Florida taxpayers. To the extent possible Florida could structure this spending to still qualify for federal matching funds — albeit at a rate of about 60 percent rather than 90 percent. Helping more people obtain or retain private coverage will be better for Florida taxpayers, providers, and patients.

[1] State of Florida, November, 2012. Official FMAP Estimate. http://edr.state.fl.us/content/conferences/medicaid/fmap.pdf .

[2] Eligibility is actually limited to those earning 133 percent of FPL but applicants can ignore up to 5 percent of income.

[3] Future Congresses have the right to renew, alter or cancel the initiatives of past Congresses.

[4] This impacts slightly more than one-third of primary care provider billing codes. See "Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs." Social Services Estimating Conference, State of Florida, August 14, 2012. http://edr.state.fl.us/Content/conferences/medicaid/FederalAffordableHealthCareActEstimates.pdf.

[5] "Welcome to Medicaid!" Florida Agency for Health Care Administration, webpage: http://www.fdhc.state.fl.us/Medicaid/index.shtml.

[6] This includes the federal share. See "Welcome to Medicaid!" Florida Agency for Health Care Administration, webpage: http://www.fdhc.state.fl.us/Medicaid/index.shtml.

[7] Data available from StateHealthFacts.org. In 2012, 1,522,138 uninsured individuals had incomes below 100 percent of FPL; while 494,434 had income between 100 percent and 138 percent. However, foreign-born individuals who lack legal status would not qualify for Medicaid.

[8] Genevieve M. Kenney, Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley and Nathaniel Anderson. "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" Urban Institute, August 2012. http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[9] The Florida Social Services Estimating Conference finds the precise number "indeterminate", but is certainly greater than 0. See Social Services Estimating Conference, "Impact Cost Components: Existing, Optional and Mandatory Expansion," Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid), FINAL Per email from House received on December 20, 2012, p. 18. Available at: http://www.fdhc.state.fl.us/medicaid/pdffiles/Estimates_as_requested_by_House_Staff.pdf.

[10] Genevieve M. Kenney, Stephen Zuckerman, Lisa Dubay, Michael Huntress, Victoria Lynch, Jennifer Haley and Nathaniel Anderson. "Opting in to the Medicaid Expansion under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?" Urban Institute, August 2012, Appendix 2. http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[11] "Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) Program," p. 7. Available at: http://www.fdhc.state.fl.us/medicaid/pdffiles/SSEC_ACA_12-17-12_Medicaid_Estimates.pdf.

[12] Jagadeesh Gokhale, "The New Health Care Law's Effect on Medicaid Spending: A Study of the Five Most Populous States," Cato Institute, 2011. Available at http://www.cato.org/pubs/wtpapers/StateMedicaidSpendingWP.pdf.

[13] This assumes Texas' Medicaid eligibility conforms to the ACA and most of those eligible for Medicaid enroll.

[14] This estimate assumed high enrollment. This estimate has since been revised in light of the SCOTUS ruling. See Thomas M. Suehs, "Federal Health Care Reform — Impact on Texas Health and Human Services," House Select Committee on Federal Legislation, April 22, 2010. Available at: http://www.hhsc.state.tx.us/news/presentations/2010/HouseSelectFedHlthReform.pdf.

[15] For example, see Paul H. Keckley, "The Physician Workforce: Opportunities and challenges post-health care reform, Deloitte Center for Health Solutions, September 7, 2010. Available at: http://www.deloitte.com/assets/Dcom-UnitedStates/Local%20Assets/Documents/US_CHS_PhysicianWorkforce_101810.pdf.

[16] The CBO originally estimates the number of newly insured by 2019 at 32 million. This was revised in wake of the Supreme Court ruling. "CBO's February 2013 Estimate of the Effects of the Affordable Care Act on Health Insurance Coverage," Congressional; Budget Office, February 5, 2013. Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf.

[17]Jack Hadley and John Holahan, "Covering the Uninsured: How Much Would It Cost?" *Health Affairs* Web Exclusive W3.250 (2003): doi: 10.1377/hlthaff.w3.250.

[18] "Physician Shortages to Worsen Without Increases in Residency Training," Association of American Medical Colleges. https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf.

[19] "Highest Match Rate for U.S. Medical School Seniors in 30 Years," Association of American Medical Colleges, News Release, March 16, 2012. https://www.aamc.org/newsroom/newsreleases/276900/120316.html.

[20] "AAMC Physician Workforce Policy Recommendations," Association of American Medical Colleges, September 2012. Available at: https://www.aamc.org/download/304026/data/2012aamcworkforcepolicyrecommendations.pdf. Also see "Physician Shortages to Worsen Without Increases in Residency Training," Association of American Medical Colleges. Available at: https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf.

[21] "AAMC Physician Workforce Policy Recommendations," Association of American Medical Colleges, September 2012. Available at: https://www.aamc.org/download/304026/data/2012aamcworkforcepolicyrecommendations.pdf.

[22] Florida Demographic Estimating Conference, November 2011. Available at: http://www.edr.state.fl.us/Content/population-demographics/data/Pop_Census_Day.pdf.

[23] Ibid. This represents a 10-fold increase in seniors from the 1960 Census.

[24] "Physician Workforce Annual Report 2102, Florida Department of Health," November 2012. Also see Tanya Albert Henry, "Florida projects worsening doctor shortage," American Medical News (online) January 22, 2009. Available at: http://www.ama-assn.org/amednews/2009/01/19/prsd0122.htm.

[25] "Florida Hospitals' Workforce Challenges: 2012 Workforce Survey Highlights, Florida Hospital Association, November 2012.

[26] Mary Lou Brunell, "Nurse Workforce Issues Related to Implementation of the PPACA," Florida Center for Nursing, February 13, 2013.

[27] Author's calculations from data from Lewin Group and "Medicaid-to-Medicare Fee Index, 2012," Kaiser Family Foundation, 2013. Available at: http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4.

[28] "Medicaid-to-Medicare Fee Index, 2008," StateHealthFacts.org, Kaiser Family Foundation. Available at http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4. Also see Stephen Zuckerman, Aimee Williams and Karen Stockley, "Medicaid Physician Fees Grew by More Than 15 Percent From 2003 to 2008, Narrowing Gap With Medicare Physician Payment Rates," *Health Affairs*, April 2009. Available at http://www.kff.org/medicaid/kcmu042809oth.cfm.

[29] Like many other states, Florida is moving to managed care plans for Medicaid enrollees. Managed care plans are run by commercial insurers. The fees paid to doctors that participate in managed care plans can vary from what traditional, fee-for-service Medicaid would pay. These fees are generally higher than FFS, however, but not by much.

[30] Obstetric care is the exception. See "Medicaid-to-Medicare Fee Index, 2008," StateHealthFacts.org, Kaiser Family Foundation. Available at http://www.statehealthfacts.org/comparetable.jsp?ind=196&cat=4. Also see Stephen Zuckerman, Aimee Williams and Karen Stockley, "Medicaid Physician Fees Grew by More Than 15 Percent From 2003 to 2008, Narrowing Gap With Medicare Physician Payment Rates," *Health Affairs*, April 2009. Available at http://www.kff.org/medicaid/kcmu042809oth.cfm.

[31] Ibid.

[32] Brent R. Asplin et al., "Insurance Status and Access to Urgent Ambulatory Care Follow-up Appointments," *Journal of the American Medical Association*, Vol. 294, No. 10, September 14, 2005. Available at http://jama.ama-assn.org/cgi/content/abstract/294/10/1248.

[33] "2009 Survey of Physician Appointment Wait Times," Merritt Hawkins and Associates, 2009. Available at http://www.merritthawkins.com/pdf/mha2009waittimesurvey.pdf.

[34] Devon M. Herrick, "Report: Uninsured Emergency Room Use Greatly Exaggerated," *Health Care News*, July 7, 2010.

[35] Tamyra Carroll Garcia, Amy B. Bernstein, and Mary Ann Bush, "Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?" National Center for Health Statistics, NCHS Data Brief No. 38, May 2010. http://www.cdc.gov/nchs/data/databriefs/db38.pdf.

[36] Eduardo LaCalle and Elaine Rabin, "Frequent Users of Emergency Departments: The Myths, the Data, and the Policy Implications," *Annals of Emergency Medicine*, Vol. 56, No. 1 , July 2010, pp. 42-48.

[37] The estimated number of people dropping private coverage to take advantage of Florida Medicaid is 66,000 in 2014, rising to 166,000 in 2023. See "Estimates Related to Federal Affordable Care Act: Title XIX (Medicaid) & Title XXI (CHIP) Programs." Social Services Estimating Conference, State of Florida, August 14, 2012.

[38] David Cutler and Jonathan Gruber "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics*, Vol. 111, No. 2, May 1996, pages 391-430.

[39] The rate of substitution varied and was worse in some cases depending on eligibility factors. See Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Health Insurance?" National Bureau of Economic Research, NBER Working Paper No. 12858, January 2007. Available at: http://www.nber.org/papers/w12858.

[40] For a discussion of the literature and these studies, see Avik Roy, "UVA Study: Surgical Patients on Medicaid Are 13 Percent More Likely to Die Than Those Without Insurance," *National Review*, July 17, 2010. Available at: http://www.nationalreview.com/critical-condition/231147/uva-study-surgical-patients-medicaid-are-13-more-likely-die-those-without-.

[41] Health plans are deemed "affordable" if an employee's contributions do not cost more than 9.5 percent of wages.

[42] Devon Herrick, "Health Exchange Subsidies Will Reduce Employer Health Plans," National Center for Policy Analysis, Brief Analyses No. 758, November 16, 2011.

[43] Sam Baker, "States Cannot Do Partial Medicaid Expansion, Says Obama Administration, *The Hill* (Healthwatch), December 10, 2012. Available at: http://thehill.com/blogs/healthwatch/health-reform-implementation/272023-states-cant-do-partial-medicaid-expansion-hhs-says.

[44] The law allows individuals to exclude up to 5 percent of income, making the 133 percent of poverty cutoff effectively 138 percent of poverty.

[45] If Medicaid is available, families may exclude up to 5 percent of income in determining income eligibility—allowing individuals with incomes up to 138 percent of poverty to enroll.

[46] "Health Reform Subsidy Calculator," available at: http://healthreform.kff.org/subsidycalculator.aspx.

[47] Estimates from the 2012 Current Population Survey Annual Social and Economic Supplement suggested that there were 2.9 million people aged 18 to 64 with incomes below 138 percent of the poverty level in Florida, and that in 2011 about 856,000 of them, almost 30 percent, were covered by private insurance.

[48] Because private insurers pay higher fees than Medicaid, for every $1 of potential Medicaid spending would be replaced by $2.17 of private spending. Thus, $11,722 in potential federal and state Medicaid expenditure would result in $25.4 billion in private spending.

[49] Uninsured individuals without access to employer coverage or Medicaid will be eligible for generous federal subsidies in the state health insurance exchange. Individuals at this income will be required to pay no more than 2 percent of income (about $200 per individual coverage) for private coverage costing thousands.

[50] Devon Herrick, "Medicaid Expansion will Bankrupt the States," National Center for P3olicy Analysis, Brief Analysis No. 729, October 23, 2010. Available at http://www.ncpa.org/pub/ba729.

[51] Richard S. Foster, "The Financial Outlook for Medicare, Medicaid, and Total National Health Expenditures," testimony before the House Committee on the Budget, Office of the Actuary, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, February 28, 2012, page 13. Available at http://budget.house.gov/uploadedfiles/fostertestimony_2-28-22012.pdf. See also Stephen A. Somers et al., "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States," Center for Health Care Strategies, Inc., Policy Brief, August 2010. Available at http://www.chcs.org/usr_doc/Medicaid_Expansion_Brief.pdf.

[52] For instance, the argument follows that federal money is a multiple of state spending. The effect ripples throughout the economy from health care providers to their vendors and employees. See "The Role of Medicaid in State Economies: A Look at the Research," Kaiser Family Foundation, January 2009.

[53] Gabriel Chodorow-Reich, Laura Feiveson, Zachary Liscow and William Gui Woolston, "Does State Fiscal Relief During Recessions Increase Employment? Evidence from the American Recovery and Reinvestment Act," *American Economic Journal: Economic Policy*, Forthcoming. Available at: http://www.stanford.edu/~waw/papers/Chodorow-Reich_Feiveson_Liscow_Woolston_state_fiscal_relief__aug_2011.pdf.

[54] Valerie A. Ramey. 2011. "Can Government Purchases Stimulate the Economy? *Journal of Economic Literature,* 49, 3, 673-685.

[55] Lauren Cohen, Joshua Coval, and Christopher Malloy. March 2010. *Do Powerful Politicians Cause Corporate Downsizing?* Working Paper No. 15839, National Bureau of Economic Research. http://www.nber.org/papers/w15839

[56] Robert J. Barro and Charles J. Redlick. September 2009. *Macroeconomic Effects from Government Purchases and Taxes.* Working Paper No. 15369, National Bureau of Economic Research.

[57] Carter C. Price and Evan Saltzman, "The Economic Impact of the Affordable Care Act on Arkansas," RAND Corporation, Research Report, 2013. Available at: http://www.rand.org/content/dam/rand/pubs/research_reports/RR100/RR157/RAND_RR157.pdf.

[58] Selected calculations in this section are based on Pamela Villarreal, "Social Security and Medicare Projections: 2009," National Center for Policy Analysis, Brief Analyses No. 662, June 11, 2009. Available at: http://www.ncpa.org/pub/ba662.

[59] "Total Medicaid Spending FY2010**,"** StateHealthFacts.org. Available at: http://www.statehealthfacts.org/comparemaptable.jsp?ind=177.

[60] Andrew J. Rettenmaier and Thomas R. Saving, "Medicare: Past, Present and Future," National Center for Policy Analysis, NCPA Policy Report No. 299, July 1, 2007. Available at: http://www.ncpa.org/pub/st299.

[61] Peter R. Orszag, "Financing Projected Spending in the Long Run," Letter to the Honorable Judd Gregg, July 9, 2007. Available at http://www.cbo.gov/ftpdocs/82xx/doc8295/07-09-Financing_Spending.pdf.

THE FLORIDA SENATE

APPEARANCE RECORD

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

3-4-2013
Meeting Date

Topic Economic Analysis

Bill Number N/A *(if applicable)*

Name Amy J. Baker

Amendment Barcode N/A *(if applicable)*

Job Title Coordinator, EDR

Address Suite 574, Pepper Bldg *Street*

Phone 487-1402

Talla FL 32308
City *State* *Zip*

E-mail baker.amy@leg.state.fl.us

Speaking: ☐ For ☐ Against ☒ Information

Representing

Appearing at request of Chair: ☒ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

APPEARANCE RECORD

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

3/4/2013
Meeting Date

Topic Medicaid expansion

Bill Number _____ *(if applicable)*

Name Devon Herrick

Amendment Barcode _____ *(if applicable)*

Job Title Senior Fellow

Address 12770 Coit Road
Street
Dallas TX 75251
City *State* *Zip*

Phone 469 951 4558

E-mail devon.herrick@NCPA.org

Speaking: ☐ For ☒ Against ☐ Information

Representing National Center for Policy Analysis

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)

3/4/2013
Meeting Date

Topic PPACA

Bill Number _____ *(if applicable)*

Name SLATER BAILISS

Amendment Barcode _____ *(if applicable)*

Job Title _____

Address 215 S. MONROE ST
Street
TALLAHASSEE FL 32301
City *State* *Zip*

Phone 850-222-8900

E-mail SWB@cardenaspartners.com

Speaking: ☐ For ☐ Against ☒ Information

Representing ASSOCIATED INDUSTRIES OF 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)

3/4/13
Meeting Date

Topic Medicaid Expansion

Bill Number _____ *(if applicable)*

Name Michael Sheedy

Amendment Barcode _____ *(if applicable)*

Job Title Director of Public Policy

Address 201 W. Park Ave
Street

Tall. FL 32301
City *State* *Zip*

Phone _____

E-mail _____

Speaking: ☑ For ☐ Against ☐ Information

Representing Florida Conference of Catholic Bishops

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)

3/4/2013
Meeting Date

Topic Medicaid Expansion

Bill Number _____ *(if applicable)*

Name Heather Wildermuth

Amendment Barcode _____ *(if applicable)*

Job Title Director of Government Relations

Address 2619 Centennial Blvd, Suite 101
Street

Tallahassee FL 32308
City *State* *Zip*

Phone 850-201-7190

E-mail heather.wildermuth@cancer.org

Speaking: ☑ For ☐ Against ☐ Information

Representing American Cancer Society Cancer Action Network

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)

3-4-13
Meeting Date

Topic PP ACA

Bill Number PP ACA *(if applicable)*

Name Amy Datz

Amendment Barcode *(if applicable)*

Job Title Retired State Employee

Address 1130 Crestview Ave.
Street
Tallahassee FL 32303
City *State* *Zip*

Phone 850 322-7599

E-mail AmalieDatz@Mac.com

Speaking: ☑ For ☐ Against ☐ Information oBama Care Expansion.

Representing Self.

Appearing at request of Chair: ☐ Yes ☑ No

Lobbyist registered with Legislature: ☐ Yes ☑ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE

Tallahassee, Florida 32399-1100

SENATOR DARREN SOTO
Deputy Democratic Whip
14th District

COMMITTEES:
Judiciary, *Vice Chair*
Appropriations Subcommittee on Criminal and
Civil Justice
Appropriations Subcommittee on General Government
Community Affairs
Environmental Preservation and Conservation
Ethics and Elections

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

February 26, 2013

The Honorable Joe Negron
Select Committee on Patient Protection and Affordable Care Act
320 Knott Building
404 South Monroe Street
Tallahassee, FL 32399-1100

RE: Requested Excuse for Absence

Dear Chairman Negron,

I respectfully request to be excused from the Select Committee on Patient Protection and Affordable Care Act meeting scheduled to meet March 4th at 8:30 am. I have a previously scheduled hearing I must attend. I can assure you that this will not become a regular practice for me. I fully intend to be present at all future meetings of this committee.

If you have any questions, please contact me directly at 321-332-5308.

Sincerely,

Darren M. Soto
State Senator, District 14

REPLY TO:
☐ 220 Senate Office Building, 404 South Monroe Street, Tallahassee, Florida 32399-1100 (850) 487-5014

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: SJoint Select Committee on Patient Protection and Affordable Care Act **Judge:**

Started: 3/4/2013 8:32:42 AM
Ends: 3/4/2013 10:28:10 AM **Length: 01:55:29**

8:32:53 AM	Senator Negron
8:32:58 AM	Roll Call
8:33:07 AM	Roll Call (House)
8:34:00 AM	Opening Remarks by Senator Negron
8:34:03 AM	Senator Soto excused absence
8:34:48 AM	Amy Baker, Coordinator, Office of Economic and Demographic Research
9:26:27 AM	Senator Negron
9:26:36 AM	Senator Simmons w question
9:27:07 AM	Amy Baker to answer
9:27:11 AM	Senator Simmons w follow-up
9:27:56 AM	Amy Baker to answer
9:28:00 AM	Senator Simmons
9:28:48 AM	Amy Baker
9:29:02 AM	Senator Simmons
9:29:12 AM	Amy Baker
9:30:16 AM	Senator Simmons w comments and question
9:32:59 AM	Amy Baker to answer
9:34:26 AM	Senator Simmons
9:35:26 AM	Amy Baker
9:36:40 AM	Senator Simmons
9:37:42 AM	Amy Baker
9:38:49 AM	Senator Simmons
9:39:39 AM	Amy Baker to answer
9:40:12 AM	Senator Simmons
9:41:13 AM	Amy Baker
9:41:15 AM	Senator Negron w comments
9:41:29 AM	Rep. Schwartz w question
9:42:30 AM	Amy Baker to answer
9:42:39 AM	Rep. Swartz w follow-up
9:43:39 AM	Amy Baker to answer
9:45:08 AM	Rep. Schwartz w follow-up
9:45:20 AM	Rep. Dudley w questions
9:46:06 AM	Amy Baker to answer
9:46:14 AM	Rep. Dudley w follow-up
9:46:51 AM	Amy Baker to answer
9:48:13 AM	Rep. Dudley w follow-up
9:48:42 AM	Amy Baker to answer
9:49:33 AM	Senator Negron
9:49:50 AM	Senator Brandes w question
9:50:11 AM	Amy Baker
9:50:15 AM	Senator Brandes w followup
9:50:34 AM	Amy Baker to answer
9:51:12 AM	Senator Brandes
9:52:11 AM	Amy Baker
9:52:27 AM	Senator Brandes
9:52:38 AM	Amy Baker
9:53:11 AM	Senator Brandes
9:53:14 AM	Senator Negron
9:53:15 AM	Senator Flores w questions
9:53:43 AM	Amy Baker to answer
9:53:48 AM	Senator Flores
9:53:55 AM	Amy Baker

9:53:57 AM Senator Flores
9:54:29 AM Amy Baker
9:54:55 AM Senator Flores
9:55:12 AM Senator Negron
9:55:19 AM Senator Sobel w questions
9:56:12 AM Amy Baker to answer
9:56:26 AM Senator Sobel w follow-up
9:57:26 AM Amy Baker to answer
9:59:15 AM Rep. Stark w questions
10:00:10 AM Amy Baker to answer
10:01:00 AM Senator Negron
10:01:11 AM Dr. Devon Herrick, Senior Fellow, National Center for Policy Analysis
10:07:54 AM Senator Negron w question
10:08:00 AM Dr. Herrick
10:15:55 AM Amy Datz, Retired State Employee
10:16:59 AM Heather Wildermuth, American Cancer Society Cancer Action Network, Director of Government Relations
10:18:22 AM Michael Sheedy, Florida Conference of Catholic Bishops, Director of Public Policy
10:19:33 AM Slater Bailiss, Associated Industries of Florida
10:21:26 AM Senator Negron
10:21:30 AM Senator Simmons w question
10:21:50 AM Mr. Bailiss to answer
10:22:18 AM Senator Flores
10:22:33 AM Senator Negron
10:23:04 AM Senator Flores
10:23:09 AM Senator Negron
10:24:11 AM Senator Negron
10:24:33 AM Rep. Corcoran w closing remarks
10:24:41 AM Senator Negron w closing remarks
10:28:00 AM Meeting Adjourned