

COMMITTEE MEETING EXPANDED AGENDA**SELECT COMMITTEE ON PATIENT PROTECTION AND
AFFORDABLE CARE ACT****Senator Negron, Chair**
Senator Sobel, Vice Chair**MEETING DATE:** Monday, March 18, 2013**TIME:** 10:00 a.m.—12:00 noon**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

		BILL DESCRIPTION and SENATE COMMITTEE ACTIONS	COMMITTEE ACTION
TAB	BILL NO. and INTRODUCER		
1	Discussion and Recommendation on Insurance Regulation		Discussed
2	Discussion and Recommendation on State Group Health Insurance		Discussed
Other Related Meeting Documents			

Select Committee Options for Insurance Regulation Recommendations

Options	Comprehensive Enactment of PPACA Requirements	Targeted Enactment of PPACA Requirements	No Enactment of PPACA Requirements
Statutory Changes	1. General requirement for insurers and HMOs to comply with PPACA. 2. Extensive and detailed changes to Florida law to incorporate requirements of PPACA.	1. Specify that Florida's rating laws do not prohibit PPACA compliance. 2. Permit segregation of grandfathered plans for establishing rates and benefits.	1. No changes to Florida law. 2. Minor changes to Florida law, removing specific provisions subject to federal pre-emption.
Office of Insurance Regulation and Division of Consumer Services Authority and Role	1. General authority for OIR to monitor and enforce PPACA requirements. 2. Specific authority for OIR to enforce PPACA requirements when carrying out current regulatory functions: • Form review • Rate review • Market conduct examinations	1. Authorize OIR to review policy forms for compliance with PPACA and notify HHS of form review findings. 2. Temporarily suspend OIR authority to approve rates for non-grandfathered health plans. a. Direct OIR and insurers to inform consumers about the rating factors. b. Resume normal rate review/approval after specified period. 3. Maintain OIR authority for market conduct examinations, including conduct related to PPACA requirements, and authorize OIR to report potential violations to HHS. 4. Direct Division of Consumer Services to refer potential violations of PPACA to HHS.	1. Prohibit OIR from enforcing PPACA. 2. Prohibit Division of Consumer Services from performing PPACA defined consumer assistance services.
Relationship with Federal Health Insurance Regulations	Direct OIR to comply with HHS arrangement.	1. Direct OIR to negotiate revised arrangement with HHS. 2. Direct Division of Consumer Services to negotiate arrangement with HHS under which Division would report potential violations of PPACA to HHS.	1. Direct OIR to reject the arrangement proposed by HHS. 2. Direct Division of Consumer Services to reject the arrangement proposed by HHS.



March 12, 2013

Commissioner Kevin M. McCarty
Florida Office of Insurance Regulation
200 East Gaines Street
Tallahassee, Florida 32399-0305

Dear Commissioner McCarty:

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

I. COLLABORATIVE ARRANGEMENT

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

A. Policy Form Review

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

B. Rate Review

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

C. Perform Targeted Market Conduct Exams

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

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

The collaborative arrangement outlined above will become effective March 12, 2013. If the Florida Legislature adopts legislation giving the state direct enforcement authority for provisions consistent with the ACA and other federal laws under title XXVII of the PHS Act, the Office will notify HHS of this development. Until then, this letter will document our collaborative arrangement.

Thank you for your cooperation.

Sincerely,

Teresa D. Miller

A handwritten signature in black ink, appearing to read "Teresa D. Miller", written in a cursive style.

Acting Director
Oversight Group

Provisions of PPACA Relating to Insurance Regulation/Current Florida Law

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
Guaranteed Availability of Coverage (1201)	Requires health insurers and HMOs to accept every individual and every employer that applies for coverage. However, plans may limit enrollment to specified open or special enrollment periods. Regulations allow plans to limit enrollment based on network adequacy or insufficient financial reserves, under certain conditions.	All plans, except grandfathered plans. (See last page for description of grandfathered plans.)	Plan years beginning on or after 01/01/14	<u>Individual</u> : Individuals who lose group coverage (“HIPPA eligible”) have guaranteed availability of coverage from the prior group insurer (conversion policy) or, if conversion not available, from an individual carrier (two most popular policies). <u>Small Employers</u> : Small group carriers must offer to all small employers, on a guaranteed-issue basis, the standard and basic policies. Sole proprietors are limited to a one month (Aug.) open enrollment period.
Non-Discrimination Based On Health Status (1201)	Prohibits a plan from establishing rules for eligibility based on any of the following health status-related factors: - Health status, medical condition, claims experience, receipt of health care, medical history, genetic information, disability, evidence of insurability (including conditions arising out of domestic violence), or - Any other health-status related factor deemed appropriate by HHS	All plans, except grandfathered plans	Plan years beginning on or after 01/01/14	<u>Individual</u> : Other than HIPPA-eligible persons who lose group coverage, insurers may medically underwrite and deny coverage based on health-related factors. <u>Group</u> : Insurers and HMOs offering small group coverage are prohibited from establishing rules for eligibility based on same specified health-status related factors. For both small and large group policies, rules for eligibility of employees may not be based on these same health-status related factors.
Preexisting Condition Exclusions (1201)	Prohibits a plan from imposing any preexisting condition exclusions.	All plans, except grandfathered individual market plans	Plan years beginning on or after 9/23/2010 for children age 19 and	Individual policies/contracts may not exclude preexisting conditions for more than 24 months and may relate to conditions that manifested themselves during the 24-month period. Policy may exclude coverage for named or

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
			under. Plan years beginning on or after 01/01/2014 for all other individuals.	specific conditions without any time limit. Group policies/contracts may not exclude preexisting conditions for more than 12 months, or 18 months in the case of a late enrollee and may only relate to conditions that manifested themselves during the 6-month period prior to coverage. Prior creditable coverage reduces the exclusion period.
Essential Health Benefits, Benchmark Plan, and Levels of Coverage (1302)	Coverage offered in the individual and small group markets must provide the following categories of services (essential health benefits package): • Ambulatory patient services • Emergency services • Hospitalization • Maternity and newborn care • Mental health and substance abuse disorder services, including behavioral health treatment • Prescription drugs • Rehabilitative and habilitative services and devices • Laboratory services • Preventive and wellness services and chronic disease management • Pediatric services, including oral and vision care States were provided the opportunity to select a benchmark plan among various options that reflected the scope of services offered by a “typical employer plan.” Florida did not make a selection, resulting in the default benchmark plan being selected, which is the small group plan with the largest enrollment in the state. A benchmark plan must be supplemented, if necessary, to cover all categories of essential benefits. States may mandate additional benefits but must defray the expenses of enrollees for the additional cost of these	All individual and small group plans, except grandfathered plans.	Plan years beginning on or after 01/01/2014	Current Florida law mandates coverage of numerous benefits, services, and providers of services. However, there is no mandated essential health benefit plan.

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
	benefits. Individual and small group markets must offer the following levels of coverage: • Bronze level-provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan. • Silver level- provides benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan. • Gold level- provides benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan. • Platinum level-provides benefits that are actuarially equivalent to 90% of the full actuarial value of benefits under the plan. • Catastrophic coverage – Limited to adults under age 30 or individuals who are exempt from the individual mandate because affordable coverage is not available or they have a hardship exemption.			
Rating and Underwriting Standards (1201)	Premiums for individual and small group policies may vary only by: • Age (3:1 maximum for adults) • Tobacco (1.5:1 maximum) • Geographic rating area • Whether coverage is for an individual or a family The claims experience of all individual policies and all small group policies, respectively, must be pooled together for rating purposes. States may require that individual and small group policies be pooled together.	All fully insured individual and small group plans, except grandfathered plans. Also fully insured large group plans in states that allow them to purchase through the Exchange.	Plan years beginning on or after 01/01/2014	<u>Individual market</u>: Factors used for rating include age, gender, family composition, area by county, tobacco usage. Carriers may also surcharge or “rate up” based on health status. The claims experience of all policies providing similar benefits must be pooled together for rating purposes. <u>Small group</u>: Premiums may vary by gender, age, family composition, tobacco usage, and geographic area and premium adjustments of +/- 15% of the approved rate are allowed for claims experience, health status, and duration of coverage. The claims experience of

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
				all policies providing similar benefits must be pooled together, except that policies covering fewer than 2 employees may be separately pooled.
State Review of Insurers Premium Increases (1003)	Requires HHS, in conjunction with the states, to develop a process for the annual review of unreasonable premium increases for health insurance coverage. The process shall require insurers to submit to the state and HHS a justification for an unreasonable premium increase and post it online. Insurers that have a pattern of unreasonable increases may be prohibited from participation in an exchange.	All fully insured plans, except grandfathered plans	Plan years beginning on or after 1/1/2010	Individual and small group rates filings are subject to prior approval by the OIR. Rate filings are available on the OIR website.
Insurer Reporting of Medical Loss Ratios (MLR) and Payment of Rebates (1001)	Requires plans to report to HHS information concerning the percent of premium revenue spent on claims for clinical services and activities (medical loss ratio). Requires insurers to provide a rebate to consumers if the percentage of premiums expended for clinical services and activities is less than 85% in the large group market and 80% in the small group and individual markets.	All fully insured plans.	Plan years beginning on or after 1/1/2011	As a condition of prior approval of rates by OIR, the projected MLR for small group and guaranteed renewable individual policies is generally 65 percent. Rebates are not required if MLR is not met. Calculation of MLR is not consistent with federal regulations. Rates for large group policies are not subject to approval by OIR.
Annual and Lifetime Limits (1001)	Prohibits lifetime and annual limits on the dollar value of essential health benefits.	Lifetime limits: all plans. Annual limits: all plans except grandfathered individual plans.	Plan years beginning on or after 9/23/2010	No prohibition on lifetime or annual limits. Some mandated benefits have limits, such as autism (\$35,000 annual/\$200,000 lifetime).
Coverage of Preventive Health Services (1001)	Requires coverage without cost-sharing (with exceptions) for: - Services recommended by the US Preventive Services Task Force (except for current breast cancer screening recommendation); - Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC; - Preventive care and screenings for infants, children and adolescents supported by the Health Resources and Services Administration; and - Preventive care and screenings for women supported	All plans, except grandfathered plans	Plan years beginning on or after 9/23/2010	<u>Mammograms</u> : Plans must include coverage for a baseline mammogram for a woman age 40-49, every year for a woman age 50 or older, and one or more per year based on a physician's recommendation for a woman who is at risk based on specified criteria. <u>Well-child coverage</u> : Plans must cover child wellness benefits for children from birth to age 16 and is exempt

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

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

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

Federal Provision/Citation	Summary of Provision	Plan Application	Effective Date	Florida Statutory Provision or Rule
Plans in Individual and Small Group Markets (1342, 1343)	for Medicare Prescription Drug Plans. Plans will receive payments if their ratio of nonadministrative costs, less any risk adjustment and reinsurance payments, to premiums, less administrative costs, is above 103%. Plans must make payments if that ratio is below 97%.	health plans. Nongrandfathered individual and small group plans.	2016	
Risk Adjustment (1343)	Requires each state to assess health plans if the actuarial risk of all of their enrollees in a state is less than the average risk of all enrollees in fully-insured plans in that state and make payments to health plans whose enrollees are have an actuarial risk that is below the average actuarial risk in that state. HHS, in consultation with the states, shall establish criteria and methods for these risk adjustment activities, which may be similar to those for Medicare Advantage plans and Prescription Drug Plans.	Nongrandfathered individual and small group plans	01/01/14	N/A. No statutory authority to administer program.
Insurer Reporting of Claims and Enrollment Data (1001)	Requires plans to submit to HHS and state insurance regulators and make available to the public the following information in plain language: • Claims payment policies and practices, • Periodic financial disclosures, • Data on enrollment and disenrollment, • Data on the number of claims that are denied • Data on rating practices, • Information on cost-sharing and payments with respect to out-of-network coverage, and • Other information as determined by HHS.	All plans, except grandfathered plans	Plan years beginning on or after 9/23/2010	Insurers/HMOs are required to submit financial audits and statements as well as enrollment, claims, and rating information to the Office of Insurance Regulation (OIR).
Insurer Reporting of Quality of Care (1001)	Requires plans to submit annual reports to HHS on whether the benefits under the plan: • Improve health outcomes through activities such as quality reporting, case management, care coordination, chronic disease management; • Implement activities to prevent hospital readmission; • Implement activities to improve patient safety and reduce medical errors; and Implement wellness and health promotion activities.	All plans, except grandfathered plans	Plans years beginning on or after 9/23/2012	N/A.

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

THE FLORIDA SENATE
APPEARANCE RECORD

Insurance

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

03/18/2013
Meeting Date

Topic FLORIDA COMPREHENSIVE HEALTH ASSOC

Bill Number _____
(if applicable)

Name JEROME ASHFORD

Amendment Barcode _____
(if applicable)

Job Title EXECUTIVE DIRECTOR

Address 2928 WELLINGTON CIRCLE
Street

Phone 850.309.1200

TALLAHASSEE FL 32309
City State Zip

E-mail Jerry@FLcomphealth.org

Speaking: ☐ For ☐ Against ☒ Information

Representing FLORIDA COMPREHENSIVE HEALTH ASSOCIATION

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)

11/18/2013
Meeting Date

Topic Insurance Regulation

Bill Number _____
(if applicable)

Name Michael Garner

Amendment Barcode _____
(if applicable)

Job Title Pres & CEO

Address 200 W. College Ave., Suite 104
Street

Phone (850) 386-2904

Tallahassee FL 32301
City State Zip

E-mail michael@fahp.net

Speaking: ☐ For ☐ Against ☒ Information

Representing Florida Association of Health Plans

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)

3/18/13
Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name Michael Rosenthal

Amendment Barcode _____
(if applicable)

Job Title _____

Address 4045 Kilmarlin Drive

Phone 850-894-2362

Tallahassee FL 32309
City State Zip

E-mail michael.Rosenthal.TLH@gmail.com

Speaking: ☐ For ☐ Against ☐ Information

Representing self

Appearing at request of Chair: ☐ Yes ☒ No

Lobbyist registered with Legislature: ☐ Yes ☒ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

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

3-18-13

Meeting Date

Topic

PPACA

Bill Number

(if applicable)

Name

Amy Datz

Amendment Barcode

(if applicable)

Job Title

Retired State Worker

Address

1130 Crestview Ave.

Phone

850-322-7599

Street

Tallahassee

FL

32303

City

State

Zip

E-mail

amalielatz@Mac.com

Speaking:

☐

For

☐

Against

☐

Information

Representing

Self-as a Cobra Payer

Appearing at request of Chair:

☐

Yes

☒

No

Lobbyist registered with Legislature:

☐

Yes

☒

No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

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

Meeting Date _____

Topic Navigator License

Bill Number _____
(if applicable)

Name Tim Meenan

Amendment Barcode _____
(if applicable)

Job Title Attorney

Address 204 S. Monroe St.

Phone 850 681-6710

Street
Tallahassee FL 32301
City *State* *Zip*

E-mail Tme@Blankman.com

Speaking: ☐ For ☐ Against ☒ Information

Representing National Association of Insurance and Financial Advisors

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

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

Meeting Date

Topic Medicaid Expansion

Bill Number _____
(if applicable)

Name Chester Frazier

Amendment Barcode _____
(if applicable)

Job Title C.N.A

Address 2472 LAKE JACKSON CIR.

Phone _____

Street

APDPK9

FL.

32705

City

State

Zip

E-mail ChesterFrag21er33@gmail.com

Speaking: ☒ For ☐ Against ☐ Information

Representing 1199SEIU

Appearing at request of Chair: ☐ Yes ☐ No

Lobbyist registered with Legislature: ☐ Yes ☐ No

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

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

S-001 (10/20/11)

THE FLORIDA SENATE
APPEARANCE RECORD

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

Meeting Date _____

Topic Navigators

Bill Number _____
(if applicable)

Name Karen Woodall

Amendment Barcode _____
(if applicable)

Job Title _____

Address _____

Phone _____

Street

City

State

Zip

E-mail _____

Speaking: ☐ For ☐ Against ☒ Information

Representing FCFEP

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)

CourtSmart Tag Report

Room: KN 412

Case:

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

Type:

Judge:

Started: 3/18/2013 10:04:21 AM

Ends: 3/18/2013 11:26:37 AM

Length: 01:22:17

10:04:26 AM	Senator Negrón w opening
10:04:41 AM	Roll Call
10:05:04 AM	Senator Negrón
10:05:06 AM	Senator Flores w excused absence
10:06:11 AM	Jerome Ashford, Executive Director, Florida Comprehensive Health Association
10:08:02 AM	Senator Negrón
10:09:01 AM	Michael Garner, President and CEO, Florida Association of Health Plans
10:10:19 AM	Senator Sobel w question
10:11:19 AM	Michael Garner to answer
10:12:23 AM	Senator Sobel w follow-up
10:12:31 AM	Michael Garner to answer
10:13:29 AM	Michael Rosenthal, Tallahassee, FL
10:17:14 AM	Senator Simmons w question
10:18:22 AM	Michael Rosenthal to answer
10:19:20 AM	Senator Simmons w follow-up
10:19:54 AM	Michael Rosenthal to answer
10:21:12 AM	Senator Simmons w follow-up
10:21:32 AM	Michael Rosenthal to answer
10:21:50 AM	Senator Simmons
10:24:45 AM	Michael Rosenthal
10:26:17 AM	Senator Negrón
10:26:20 AM	Amy Datzm Tallahassee, FL
10:27:07 AM	Senator Negrón
10:27:13 AM	Tim Meenan, Attorney, National Association of Insurance and Financial Advisors
10:29:53 AM	Senator Negrón
10:29:55 AM	Senator Gibson w question
10:31:19 AM	Tim Meenan to answer
10:31:27 AM	Senator Gibson w follow-up
10:31:33 AM	Senator Negrón to answer
10:31:42 AM	Senator Sobel w question
10:32:11 AM	Tim Meenan to answer
10:32:51 AM	Senator Sobel w follow-up
10:33:49 AM	Tim Meenan to answer
10:35:42 AM	Senator Soto w question
10:35:47 AM	Tim Meenan to answer
10:37:01 AM	Senator Negrón
10:37:06 AM	Chester Frazier, Apopka, FL
10:40:39 AM	Senator Negrón
10:40:41 AM	Karen Woodall, FCFEP
10:42:08 AM	Senator Negrón
10:42:13 AM	Senator Sobel w question
10:42:17 AM	Karen Woodall to answer
10:42:40 AM	Senator Sobel w follow-up
10:42:53 AM	Karen Woodall to answer
10:43:15 AM	Senator Negrón w comments
10:43:45 AM	Senator Simmons
10:56:14 AM	Senator Negrón
10:56:21 AM	Senator Sobel w comments
10:57:38 AM	Senator Simmons
10:59:12 AM	Senator Sobel
10:59:55 AM	Senator Simmons
11:01:02 AM	Senator Sobel

11:01:45 AM	Senator Simmons
11:02:07 AM	Senator Negron
11:04:59 AM	Senator Sobel
11:06:22 AM	Senator Negron
11:06:48 AM	Senator Sobel
11:07:12 AM	Senator Negron
11:07:37 AM	Senator Gibson
11:08:28 AM	Senator Negron
11:10:57 AM	Senator Gibson
11:11:30 AM	Senator Negron
11:13:18 AM	Senator Simmons
11:14:49 AM	Senator Negron
11:16:53 AM	Senator Soto w question
11:17:25 AM	Senator Negron
11:17:29 AM	Senator Soto w follow-up
11:17:51 AM	Senator Negron
11:18:24 AM	Senator Soto
11:18:31 AM	Senator Gibson
11:18:51 AM	Senator Negron to respond
11:19:26 AM	Senator Sobel w comments
11:20:57 AM	Senator Negron
11:21:10 AM	Senator Sobel
11:21:13 AM	Senator Negron
11:22:42 AM	Senator Simmons
11:23:32 AM	Senator Negron w closing comments
11:24:31 AM	Senator Gibson w closing comments
11:25:29 AM	Senator Sobel w closing comments
11:25:31 AM	Meeting Adjourned