



THE FLORIDA SENATE

SELECT COMMITTEE ON PATIENT PROTECTION AND AFFORDABLE CARE ACT

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FREQUENTLY ASKED QUESTIONS

EXCHANGES

Q: What is an exchange?

A: An exchange is a marketplace where individuals can obtain affordable health care coverage. A person will be able to submit one application to find out whether he or she qualifies for Medicaid, insurance under the Children's Health Insurance Program (CHIP), or financial assistance to purchase private health insurance and health services. Qualified individuals will enroll in Medicaid, CHIP, or a health insurance plan selected from a group of plans authorized to participate in the exchange.

Q: When will I be able to get health care coverage under the exchange?

A: The Patient Protection and Affordable Care Act (PPACA) requires an exchange to be available for open enrollment beginning October 1, 2013, for coverage that begins on January 1 for calendar year 2014.

Q: Is the State of Florida going to operate the exchange beginning October 1, 2013?

A: No. Florida, and several other states, did not submit a letter to the Secretary of Health and Human Services by the December 14, 2012, deadline to indicate an intention to operate a State Based Exchange for health care coverage in calendar year 2014.

Q: Since Florida is not going to operate a State Based Exchange for calendar year 2014, how will Floridians access the affordable health care coverage contemplated under the Patient Protection and Affordable Care Act?

A: The federal government will provide an exchange for states that do not elect to operate one. An exchange operated by the federal government is referred to as a Federally Facilitated Exchange.

Q: Can the State of Florida operate a State Based Exchange at a later time?

A: Yes. Federal law and regulation permit states to request to operate an exchange at any time. The State's plan for an exchange is subject to review and approval by the federal government. The Florida Legislature will consider what, if any, action related to the operation of an exchange might be in the best interest of the State of Florida.

Q: As a business with only a few employees, will I be able to provide health insurance for my employees through the exchange?

A: Yes. One component of the exchange is the Small Business Health Options Program (SHOP). In the SHOP, small employers will select qualified health plans to offer to their employees. In addition, a small employer will set the amount it will contribute toward employees' premiums. A small business is defined as one with 50 or fewer employees. The State has the option to expand that definition to a business with 100 or fewer employees prior to 2016, when the definition automatically increases to 100 or fewer employees.

Q: Is there still an opportunity to receive grant funding for exchange activities?

A: Yes. The federal government has announced that grant funding will be awarded to states for exchange establishment activities through December 14, 2014. The grant funding may be used for approved activities for the grant period (1 – 3 years) after the date of the award. Several dates throughout calendar year 2013 and 2014 have been announced for additional grant application submission dates.

INSURANCE

Q: Beginning January 1, 2014, who has to buy insurance coverage under the federal law?

A: All U.S. citizens and lawful residents are required to maintain minimum health benefits coverage. If a taxpayer fails to maintain the coverage, he or she will be required to pay an annual tax penalty. A taxpayer is exempt from the mandated coverage and tax if any of the following conditions are met:

- The individual has a religious objection to buying health insurance;
- The cost of the taxpayer's premium contribution for employer-based coverage or for the lowest-cost bronze level coverage in the exchange is greater than 8 percent of household income;
- The break in insurance coverage is less than three months;
- The taxpayer's household income is below the federal income tax filing threshold;
- The U.S. Department of Health and Human Services determines that the taxpayer has suffered a hardship with respect to their ability to obtain coverage;
- The taxpayer is a member of a recognized Indian tribe;
- The individual is not lawfully present in the U.S.;
- The individual is incarcerated;
- The individual resides outside of the U.S.; or
- The individual is enrolled in a health care sharing ministry.

Q: What is the tax penalty for an individual who does not maintain health insurance coverage?

A: In 2014, the tax penalty for not maintaining health insurance coverage is the greater of \$95 for each household member, up to three, or 1 percent of household income in 2014. In 2015, the tax penalty for failing to maintain coverage is \$325 or 2 percent of household income, and \$695 or 2.5 percent of income in the following years.

Q: Can an insurer or health maintenance organization exclude a preexisting condition or refuse to cover an individual?

A: For plans beginning on or after September 23, 2010, the law prohibits insurers and health maintenance organizations (HMOs) from excluding any preexisting condition from coverage for individuals under age 19. Effective January 1, 2014, the law prohibits insurers and health maintenance organizations from excluding from coverage a preexisting condition for individuals age 19 and older.

Q: Can an insurer or health maintenance organization refuse to cover an individual or employer?

A: Starting January 1, 2014, insurers and HMOs are required to accept every employer and every individual that applies for coverage. However, an insurer or HMO may restrict enrollment based upon an open or special enrollment periods.

Q: What benefits are insurers and health maintenance organizations (HMOs) required to offer?

A: For plan years beginning on or after January 1, 2014, insurers and HMOs are required to offer coverage for the “minimum essential health benefits” that include services in the following ten categories:

- 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, and
- Pediatric services, including oral and vision care.

Q: Can an insurer or HMO impose annual or lifetime limits on coverage?

A: The federal law prohibits an insurer or HMO from imposing annual or lifetime limits on the 10 categories of essential health benefits.

MEDICAID/SCHIP

Q: What is Medicaid?

A: Medicaid is the jointly funded federal-state health insurance program for low to moderate income children, families and certain other individuals. Currently, eligibility for the program is based on the age of the individual, income and in some cases, the health condition of that person.

Individuals can apply for Medicaid online at <http://www.myflorida.com/accessflorida>.

Q: What is SCHIP or CHIP?

A: SCHIP or CHIP is the Children's Health Insurance Program (once known as the state Children's Health Insurance Program).

CHIP provides health insurance coverage for children whose family income is above the limits for the Medicaid program.

In Florida, the CHIP program is also known as Florida KidCare and families can apply online at www.floridakidcare.org or through a paper application which can be obtained by calling 1-888-352-5437. This application is also used to apply for Medicaid for children.

Q: What is the FPL that is always mentioned about Medicaid?

A: FPL stands for Federal Poverty Level and is the standard used to determine eligibility for different programs, including Medicaid, CHIP and the insurance affordability programs under the PPACA.

Q: My children are uninsured now. Can they get coverage?

A: Florida currently offers coverage for uninsured children under the Florida KidCare program for ages birth through age 18. Subsidized coverage is available for most children up to 200 percent FPL (\$46,100 – annual household income for a family of 4).

Full pay options are available for other children from age 1 through 18. To learn more about the program and to apply online, families can visit www.floridakidcare.org or call 1-888-352-5437 to request an application through the mail.

Q: What does the Medicaid Expansion mean?

A: Under the Patient Protection and Affordable Care Act (PPACA), the state can expand the Medicaid income limits for individuals to 133 percent of the Federal Poverty Level (FPL) with a 5 percent income disregard.

Q: What impact did the Supreme Court ruling have on the Medicaid expansion?

A: Under the original law, states were required to expand Medicaid to everyone or risk losing all of their state's Medicaid funding. In its ruling, the Supreme Court found that penalty was unconstitutional. As a result, the Medicaid expansion is still federal law, but it is now optional.

Q: If Florida does not expand Medicaid, will anything change about my child's Medicaid or Florida KidCare coverage?

A: Your child's coverage under Medicaid or CHIP might change in 2014.

Even if Florida does not expand Medicaid, a new way of looking at your family's household and income for Medicaid and Florida KidCare will go into effect beginning January 1, 2014. This process will use your family's income tax return as the basis for determining your income and consequently your eligibility for Medicaid or CHIP.

In most cases, an across the board 5 percent income deduction will be taken to determine your family's modified adjusted gross income (MAGI) and this will be the only deduction. There may be some exceptions and other factors may be taken into consideration for Medicaid determinations.

Because of changes in how income and household size will be counted, your child may move between Medicaid and other Florida KidCare programs (Healthy Kids, Medikids, Children's Medical Services Network). This may mean a change in health plans, providers, benefits, premiums or co-payments.

Q: Are there any individuals who won't be subject to the new eligibility guidelines after January 1, 2014?

A: Yes, there are some people whose eligibility will continue to be determined using the current Medicaid eligibility guidelines. Those populations include:

- Supplemental Security Income (SSI) cash recipients
- Aged, blind and disabled recipients
- Foster care children

Q: If Florida doesn't expand Medicaid now, can it be expanded later?

A: Yes, this expansion can be done at any time. There is not any deadline.

Q: How often will my eligibility under Medicaid or CHIP be reviewed?

A: Eligibility will be reviewed at least annually or at any time when a change in financial status has been reported.

Renewals will be processed electronically to the fullest extent possible, and in the same or similar manner as original applications are handled, so that families do not have to provide paper documentation unless absolutely necessary.

Families should also not have to provide the same information twice, as information will be gathered mainly through the federal data hub and other electronic data resources.

Q: My child is healthy and doesn't need coverage but I (the parent) do, can I still get for Medicaid coverage, if available?

A: No. If a child in the household is eligible for coverage such as Medicaid or CHIP and is not covered, then an adult parent cannot enroll in and receive Medicaid coverage until the eligible child is also enrolled in qualified coverage.

Q: What happens if the Florida KidCare Program is full in the future and I cannot enroll my child in a CHIP program?

A: The CHIP program is given a set amount of funds at both the federal and state level each year. If it becomes full after the exchanges are available, the child will be referred to the appropriate exchange for coverage options.

Q: Does the Patient Protection and Affordable Care Act's (PPACA) implementation in Florida change the Statewide Medicaid Managed Care (SMMC) program?

A: The State is still negotiating the SMMC waiver with the federal government but it is on track to meet its mid-2014 implementation date. How the SMMC will coordinate with the implementation activities of the PPACA will be a topic for the Senate Select Committee on Patient Protection and Affordable Care Act.

Q: What is the Basic Health Plan?

A: In very general terms, the Basic Health Plan (BHP) is an optional program that provides coverage to individuals between 133 percent and 200 percent FPL who are under age 65, not eligible for Medicaid, Medicare, CHIP or Employer Sponsored Insurance and are United States citizens or are lawfully present in the United States. The BHP will also cover those who are ineligible for Medicaid because of citizenship status because they were granted lawful permanent resident status within the last five years and have incomes at or below 133 percent FPL.

Under the BHP, plans must be selected through a competitive bid process, provide the essential health benefits, offer a choice of plans and have premiums that do not exceed what the consumer would have paid in the exchange.

Q: What are the choices the State needs to make about the Medicaid program?

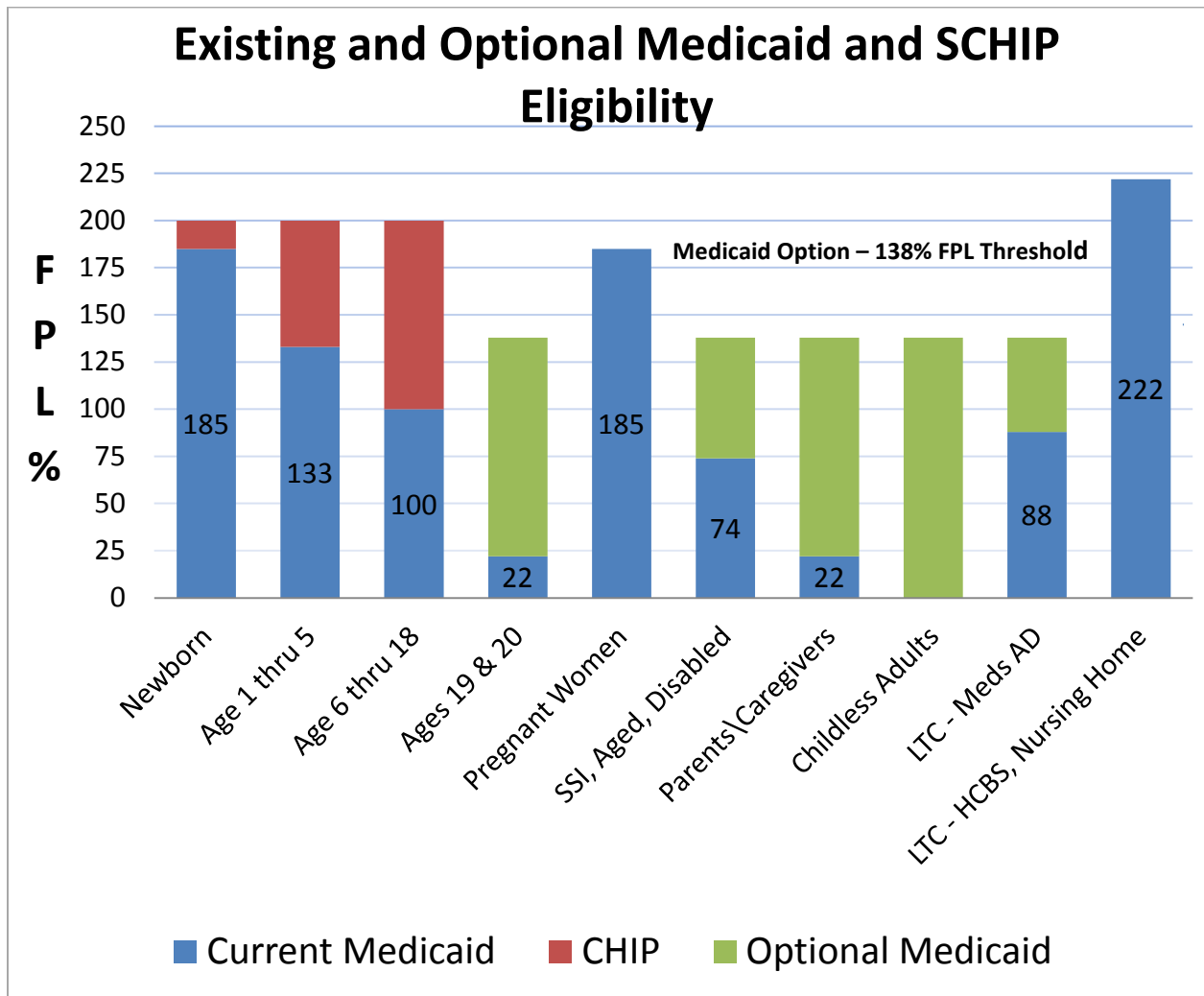
A: The State has many choices to make about the Medicaid program including:

- Should the State expand eligibility?
- What level of expansion is affordable and sustainable?
- If the State is going to expand Medicaid, when should the expansion be effective?
- What benefits should be offered to the new Medicaid enrollees? Should they be different than those offered to current enrollees?

FISCAL

Q: Who would be eligible to enroll in Medicaid if the program is expanded as authorized by the federal law?

A: The PPACA calls for states to expand Medicaid eligibility to 138 percent of the Federal Poverty Level on January 1, 2014. A comparison of Florida’s current eligibility and this new standard is shown:



Q: How many Floridians would be eligible if the expansion is authorized up to 138 percent FPL?

A: It is estimated that an additional 528,033 individuals would enroll in Medicaid between July 1, 2013, through June 30, 2014 due to the expansion. About 64,753 of those enrollees would transfer from Florida's Kidcare program, for a net increase of 463,280 additional enrollees in the two programs. For the next twelve months, a net gain of 845,312 additional enrollees is estimated.

Q: How much would the Medicaid eligibility expansion cost?

A: The federal law promises 100 percent federal funding to cover expanded eligibility during calendar years 2014, 2015, and 2016. The expected costs during these first three years, start at about \$863 million in State Fiscal Year 2013-14 and rise to about \$3.1 billion in fiscal year 2015-16. On January 1, 2017, states begin paying a portion of the costs for the new eligibles. State costs are estimated to reach \$176 million during that first fiscal. By State Fiscal Year 2020-21, the State costs are estimated at \$330 million.

Q: How much will it cost Florida Medicaid to pay primary care physicians at Medicare reimbursement rates, as called for under the PPACA?

A: The PPACA requires state Medicaid programs to pay primary care physicians the Medicare reimbursement rates for primary care services, beginning January 1, 2013, for two full calendar years. During those two years, the federal government will pay 100 percent of the difference between the Medicaid rates and Medicare rates. On January 1, 2015, the requirement to increase physician fees expires along with the 100 percent federal match. If Florida continues the fee increase beyond calendar year 2014, the State cost will be about \$174 million in State Fiscal Year 2014-15 and about \$345 million in fiscal year 2015-16.

STATE GROUP HEALTH INSURANCE

Q: Is the State of Florida subject to the PPACA requirement that employers provide employees affordable health insurance benefits or face penalties?

A: Yes. The PPACA requires all employers with 50 or more full-time employees to offer health insurance benefits or face penalties. A “full-time” employee is an employee who works 30 or more hours per week. To be considered “affordable,” the law requires that the cost of coverage for the employee not exceed 9.5 percent of the employee’s family income.

Q: What are the penalties if the State of Florida refuses to offer all of its full-time employees affordable health insurance benefits?

A: The penalty for failing to offer health insurance benefits to all full-time employees is \$2,000 for each full-time employee.

The penalty for failing to offer affordable coverage (i.e., coverage that costs the employee less than 9.5 percent of his or her family income) is the lesser of \$3,000 per employee who enrolls in a health insurance exchange or \$2,000 for each full-time employee, minus the first 30 employees.

Q: Does the State of Florida currently offer health insurance benefits to its employees?

A: Yes, the State provides salaried employees with health insurance alternatives for both individual coverage and family coverage. About 90 percent of all State employees elect to participate in the State’s group health insurance program.

However, there are some state employees (known as “OPS” or Other-Personnel Services employees) who currently are ineligible to participate in the State’s group health insurance program.

Current official estimates indicate that there are approximately 3,864 OPS employees who work 30 or more hours per week for the State and that slightly more than 2,500 OPS employees would elect State group health insurance coverage, if it was offered to them.

Q: What is the cost of the penalty if the State of Florida fails to allow all of its employees, including its OPS employees, the ability to participate in Florida's group health insurance program?

A: The State has more than 156,000 full-time employees; the estimated penalty would be in excess of \$318 million. Florida faces that penalty if "full-time" OPS employees are not offered health insurance benefits.

Q: The PPACA mandates that everyone obtain health insurance coverage. Will that cause some of the State employees who previously chose not to participate in the State's group health insurance program to participate?

A: Yes. Almost 15,000 State eligible employees currently do not participate in the State's group health insurance program. Many of those employees have other health insurance coverage available to them (e.g., their spouse has coverage through his or her employer).

Official estimates indicate that approximately 3,000 State employees will elect to begin participating in the State group health insurance program because of the PPACA's health insurance mandate.

Q: Overall, how much will it cost the State as an employer to comply with the employer aspects of the PPACA's health insurance requirements?

A: Official projections of the additional costs to the State as an employer are as follows:

- \$380,000 in State Fiscal Year 2012-13;
- \$48.8 million in State Fiscal Year 2013-14;
- \$117.6 million in State Fiscal Year 2014-15; and
- \$127.6 million in State Fiscal Year 2015-16.