

A Collins Center Special Report | February 2011

Making the Investments Work: Important Benefits and Key Challenges in Implementing Health Reform in Florida



By Jack Meyer and Sharon Silow-Carroll
Health Management Associates


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Feb. 7, 2011

Note to Readers:

The Collins Center for Public Policy recently completed a comprehensive review of the federal health reform law and its potential impact on Florida. The report, “Making the Investments Work: Important Benefits and Key Challenges in Implementing Health Reform in Florida,” explains the legislation and offers ways the state can maximize the law’s benefits.

On January 31, shortly after the report’s completion, a federal judge in Florida ruled the Patient Protection and Affordable Care Act unconstitutional. Another federal judge has ruled that the law’s requirement to purchase health coverage is unconstitutional but he did not invalidate the law as a whole, while two other federal judges have upheld the law. These differing legal opinions make it likely that the law’s fate will rest with the U.S. Supreme Court, but not for at least a year. While much remains up in the air legally and politically, we think it’s important to provide objective information about federal health reform to help Floridians form their own opinions.

Whether or not the law moves forward, Medicaid costs will continue to increase and the state’s four million uninsured residents will continue to place a financial strain on the health care system. The Collins Center recognizes the validity of constitutional questions surrounding the requirement that individuals purchase insurance. But there is more to the law than that one requirement. Already, children with pre-existing conditions are guaranteed affordable coverage, and young adults can remain on their parents’ insurance plans while finding their way in the world. Taken together, the various elements of the health reform law have the potential to improve the quality of health care for millions of Floridians, enhance patient safety, and manage costs more effectively.

Whatever the final outcome of the litigation, it is our sincere hope that the state stay focused on the need for substantial health care reform in Florida. The report concludes with an action plan making it clear that the pursuit of positive results would be greatly enhanced by a partnership among the state, the health care industry, and the business and labor communities.

Dr. Leda Perez, Vice-President for Health Initiatives,
Collins Center for Public Policy

ACKNOWLEDGEMENTS

About the Collins Center for Public Policy

Florida Gov. LeRoy Collins' legacy of uncompromising integrity in government and business continues at the Collins Center for Public Policy. Established in 1988 by distinguished Floridians who envisioned the need for an independent entity to find impartial solutions to controversial problems, the Collins Center is known as a Think Tank with muddy boots. With offices in Miami, Tallahassee, and Tampa Bay, our mission is to find smart solutions to important issues facing the people of Florida and the nation. We are independent, nonpartisan, nonprofit and passionately committed to lasting results.

About Health Management Associates

Health Management Associates (HMA) is a consulting firm specializing in the fields of health system restructuring, health-care program development, health economics and finance, program evaluation, and data analysis. HMA is widely regarded as a leader in providing technical and analytical services to health care purchasers, federal and state governments, and providers, with a special concentration on addressing the needs of the medically indigent and underserved people and assessing the new health reform legislation. Founded in 1985, Health Management Associates has offices in Lansing, Mich.; Chicago, Tallahassee, Indianapolis, Columbus, Ohio; Washington, D.C.; Austin, New York, Sacramento, Atlanta and Boston.

Gratitude

The authors would like to thank the Collins Center for Public Policy for supporting this project. Leda M. Perez provided very helpful oversight and many useful suggestions throughout the project. We would also like to thank Diana Rodin and Elaine Peters of Health Management Associates for their assistance with our research and policy analysis.

The Collins Center thanks the Foundation to Promote an Open Society, in partnership with the Open Society Institute, for their financial support.

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This report presents key features of the new national health reform law and explores the important potential benefits to Florida along with the main challenges. The report highlights the Medicaid expansion, health insurance exchange, and insurance market reform features of the Affordable Care Act. It also explains how the new benefits are funded and how that will affect Florida taxpayers. A few other important features of the law are briefly explained, such as the requirements placed on individuals to obtain insurance and larger employers to offer it or pay an assessment, and new grant opportunities related to improving health care delivery and financing.

EXECUTIVE SUMMARY

The major conclusions of the report are as follows:

- Florida has over 4 million uninsured, and the growing number of people without coverage leads to poor health outcomes; overuse and overcrowding of emergency rooms; a rising burden of uncompensated care provided by hospitals and physicians; reduced productivity and higher costs. The number of uninsured will continue to increase in the absence of reform.
- State spending on health care has been growing sharply for years, and without major reform, would continue its upward spiral.
- The Affordable Care Act would significantly reduce the number of uninsured people in Florida, improving the access of many residents to timely preventive health care.
- Expanding Medicaid will involve new state expenditures estimated at \$1.2 billion to \$2.5 billion between 2014 and 2019. Each state dollar invested in Medicaid will draw at least ten new federal dollars to the state during this period.
- By participating in national health reform, the state of Florida will invest money “on the front end” that will generate direct and indirect savings to the community as a whole (including the private sector) that, combined, exceed the new costs.
- While expanding the number of people with insurance will reduce the uncompensated care burden, it also will place some new pressures on the health care delivery system. Florida will need more physicians, nurses, and other providers to meet the new demand. Medicaid payments need to be adequate to obtain provider participation, including physicians, both primary care and specialist, and dentists.
- Coverage expansion will depend on effective outreach and enrollment efforts. Investing in community health workers, patient navigators and other outreach workers using new funds provided by the federal government can help to enroll newly eligible populations into Medicaid and provide appropriate follow-up.
- Florida’s Medicaid program will need to meet the complex medical needs of newly enrolled patients, particularly poor adults without children.
- Health Insurance Exchanges for individuals and small employers will be required under national reform to provide a broad choice of private insurance plans for moderate- and middle-income people. Participants with incomes up to four times the federal poverty line, or about \$88,000 a year of income for a family of four, would receive federally financed subsidies on a sliding scale related to the size of their incomes. This is a major benefit to middle-class people in Florida.
- Starting up and operating the Exchanges poses a number of implementation and management challenges to which the state must provide timely and careful attention. Florida needs to develop a multi-step plan to prepare for screening applicants to the Exchanges and Medicaid, coordinating a number of state programs, and working with federal agencies on verifications, determining eligibility for subsidies and/or Medicaid enrollment, communicating enrollment information to consumers and health plans, and securely transferring funds.
- A major source of financing for the new law involves reductions in payment increases for various providers and health plans participating in Medicare. There are, however, no cuts in Medicare benefits under the new law. Also, hospitals, medical device manufacturers, pharmaceutical companies and other health-care providers and plans will experience new assessments under the law. Those costs, however, will be mitigated by the increase in paying patients as a result of the new coverage. People enrolled in Medicare will see the “doughnut hole,” or coverage gap in the middle of their prescription drug coverage, filled over the course of the next decade.
- National health reform includes many new funding opportunities for states and health-care providers. These include substantial federal support for community health centers. The new law includes many grant opportunities related to improving the way health care is delivered and financed, with the goal of enhancing quality of care and patient safety, along with reducing the growth in total spending.

INTRODUCTION & PURPOSE

Regardless of the different political positions on the new national health reform law enacted last year, the reality is that Medicaid costs will increase – with or without this legislation – and more than 4 million uninsured Floridians are placing a financial strain on the state’s health-care system. One thing that is certain is that Florida needs to prepare for changes to help improve the quality of health care rendered and reduce costs. Recognizing differences in preferences and philosophies about health reform, we believe that the new law presents opportunities for the state to enhance the availability of medical care to millions of its residents, while bringing in a substantial amount of federal funding to pay for the vast majority of new Medicaid spending.

This report charts a course that Florida should consider if it is to reap the greatest returns on its investments in the health sector. It highlights the most important features of the national Affordable Care Act (ACA)¹ and presents its potential benefits to Floridians while recognizing the key challenges presented by it.

The law also contains provisions aimed at improving the quality of health care, enhancing patient safety, and managing costs more effectively. ***If these goals are fulfilled, the vast majority of patients and taxpayers will benefit.***

Sections of this report show how children, working families, people struggling with serious illnesses, senior citizens, and others will be impacted. In addition, we note how the reforms will be paid for, and what this means for the people of Florida. The report lays out the potential problems and pitfalls in implementing health reform. It assesses the impact of the new law on Florida against the backdrop of the problems in our current system. While there is clearly a cost to Florida to participate in national health reform, there is also a cost to the state of not taking effective actions to implement it.

The report concludes with an action plan for the state. Making health reform work effectively will require a partnership between the state and leaders in the health-care industry, the business and labor communities, and nonprofit organizations.

Key Features of the Law

The new health reform law is projected to provide health coverage to the majority of the uninsured, improve quality of care and patient safety and slow the rate of growth in health-care spending. Nationwide, about half the newly insured, or roughly 16 million poor and near-poor people, would enter Medicaid. Another 16 million uninsured would obtain private health coverage, primarily through state-based insurance exchanges (both of these provisions are explained in more detail below). Insurance market reforms aim to make health insurance affordable to people regardless of their age, gender, or health status. New demonstration programs and other measures are designed to improve quality of care and lower health spending.²

The key features of the law are as follows:

- Medicaid expansion
- State-based health insurance exchanges
- Insurance market reforms
- New funding for community health centers
- Prevention and wellness initiatives
- Support for the health-care work force
- Financing provisions
- Cost control measures
- Quality improvement features
- Employer obligations
- Individual obligations

MEDICAID FOR THE ELDERLY, BLIND OR DISABLED

Instructions: Before completing this form, read all instructions. Use black or blue ink only. Write in a MM/DD/YYYY format (example: April 2, 1958 would be 04/02/1958). If you need more space to provide answers, please use an additional sheet of paper.

Complete pages 1 through 6 and the Medicaid Change Report (Attachment 3), for future use.

If you are completing this application/review for someone else, complete the Authorization of Representative page (Attachment 2), or attach legal documentation authorizing you to be that person's appointed guardian or durable power of attorney for finances. Information provided on this application should be about the applicant, not the representative.

SECTION I – APPLICANT INFORMATION In this section we need you to tell us about yourself.

Name – Applicant (last, first, MI)		Sex	<input type="checkbox"/>
Do you have any names you have previously used such as a married or maiden name? <input type="checkbox"/>			
If yes, what are those names?			
Date of birth	Where were you born (state)	Are you a member of a member?	<input type="checkbox"/>
Social Security Number	*Race or Ethnicity	Are there any minor children in your home?	<input type="checkbox"/>

PROGRESS TO DATE

The first major milestone in ACA was the establishment on June 23, 2010, of state-by-state temporary high-risk pools. These high-risk pools provide affordable health coverage to people with serious medical conditions, or so-called “pre-existing conditions,” at the standard rates that are offered to people without such conditions. These pools are designed as a bridge for people who have been turned down for private insurance, or who have been quoted premiums they cannot afford, until the insurance reforms under ACA are completely phased in during 2014.

States can choose between using an existing high-risk pool, starting one or allowing the federal government to set up such a pool. Eligibility is restricted to people who have been uninsured for six months or more and who have been rejected when applying for insurance or priced out of affordable coverage. Florida elected to let the federal government set up a high-risk pool. Enrollment began on August 1, 2010, and as of November 1, 2010, 1,293 people in Florida were enrolled.

In addition, 146 employers, most of them cities and counties to date, have enrolled in ACA’s Early Retirement Reinsurance Program, which provides financial assistance to employers to help them maintain coverage for early retirees age 55 and older who are not yet eligible for Medicare.³ Further, over 186,000 Florida participants in the Medicare Part D prescription drug program received a one-time, tax-free rebate as the first installment of ACA’s plan to gradually eliminate the “doughnut hole” in Medicare drug coverage. The doughnut hole is a gap in drug coverage after a person has received \$2,840 in prescription drug benefits for the year, including their own 25 percent share of the cost and the insurance plan’s 75 percent contribution, until they reach a “catastrophic” level of prescription drug spending. ACA will gradually eliminate this coverage gap over ten years. It also

provides a 50 percent discount on brand-name drugs that are on the plan’s formulary of approved medications while the Medicare beneficiary is in the gap.



Florida has received a number of grants made available through ACA. **The state received a \$1 million grant from the US Department of Health and Human Services (HHS) to prepare for the development and implementation of the insurance exchanges called for in the law, explained below.**

Other Grants Awarded in Florida:⁴

- \$26.2 million in Therapeutic Discovery Project Program Tax Credits and Grants
- \$6.7 million for the Primary Care Residency Expansion Program
- \$5.4 million in Communities Putting Prevention to Work grant awards
- \$3.4 million for Tribal, Maternal, Infant and Early Childhood Home Visiting Programs
- \$3 million to implement the National Background Check Program for long-term-care workers
- \$2.1 million to strengthen public health infrastructure to improve health outcomes
- \$2.1 million for the Advanced Nursing Education Expansion Program
- \$1.7 million for demonstration projects to address health professions’ workforce needs
- \$1.4 million for Medicare improvements for patients and providers
- \$1.3 million for HIV Prevention and Public Health Fund activities
- \$600,000 to build epidemiology, laboratory and health information systems capacity
- \$600,000 to expand physician’s assistant training
- \$500,000 for Aging and Disability Resource Centers

The implementation of ACA is being challenged in Florida:

- Attorney General Bill McCollum filed a lawsuit contending that the requirement that all Americans obtain health insurance is unconstitutional and challenging ACA's requirement that states expand Medicaid beginning in 2014.⁵ On October 14, 2010, Judge Roger Vinson ruled that this lawsuit may move forward.⁶
- House Speaker Dean Cannon sent a letter to Governor Crist serving notice to all state agencies that they must submit a complete accounting of all ACA-related activities, take an inventory of all activities pertaining to implementing the law, including employee time spent on such activities and expenditures of funds, and ordering that after November 15, 2010, "any new activities related to (PP)ACA should be initiated only after notification and consultation with the Legislature."⁷
- The Florida legislature met in a special session from November 15-17, 2010, with health reform at the top of the agenda. On November 17, the Florida Senate held a hearing on Medicaid. Senator Negron, the chair of the Subcommittee on Health and Human Services Appropriations, stated the following guiding principles and goals:
 - Every Floridian should have a primary care doctor.
 - Medicaid should shift focus from volume of procedures to outcomes.
 - All long-term care options, including home and community-based services, should be available, not just nursing home care.
 - The Agency for Health Care Administration (AHCA) should be transformed into a monitoring agency, not just a "check-writing" agency that "finds fraud after providers have left the program."
 - Managed care in Medicaid needs to go from being promised to being assured, guaranteed through performance bonds and liquidated damages.
 - The state legislature should determine the amount of funds in Medicaid.
 - Physicians participating in Medicaid should receive higher reimbursement and legal protections.
 - Medicaid benefits should be comparable to benefits under other insurance programs.



Many of the above points would garner widespread support. But it should be noted that the principle that "the state legislature should determine the amount of funds in Medicaid" would likely conflict with the fact that Medicaid is an entitlement program. Under current law, state and federal funding may not simply be capped at some level determined by states. If more people become eligible, as has occurred during the deep recession and weak recovery, spending rises to meet this added demand. Of course, states have searched for other ways to hold down spending but they cannot, by themselves, set the level of spending.

It is clear that there will be much debate over such issues as whether the requirement that individuals obtain health coverage (described below) is constitutional and whether various government initiatives to implement ACA should be fully funded. This report does not assess these issues. The intent is to explain the key features of the law, its intended benefits, how it will affect people in Florida, and the major implementation challenges.

Health Reform Provisions Expanding Public and Private Coverage and Reforming Insurance Markets

Three components of the health reform legislation, taken together, comprise the heart of the effort to make health insurance coverage more affordable and accessible: Medicaid expansion, Health Insurance Exchanges, and insurance reforms. These are also features that require the greatest input, planning, and involvement from Florida state government and stakeholders. This section highlights the implications, benefits and challenges of implementing these key provisions in Florida. There are, of course, many other provisions of health reform, and in a following section, we will briefly explain several of those components.

Medicaid expansion

Starting in 2014, all legal residents of Florida will be eligible for Medicaid, regardless of family status, if their incomes are below 133 percent of the federal poverty level (FPL). Single adults in Florida will be eligible for Medicaid in 2014 if their income is below \$14,404. For families of three and four, respectively, eligibility will extend to those with incomes up to \$24,352 and \$29,327.⁸

The federal government will pay the full cost of covering those newly eligible in 2014 through 2016. Florida would pick up 5 percent of the cost of covering those newly eligible for Medicaid in 2017, 6 percent in 2018, 7 percent in 2019, and 10 percent in 2020 and subsequent years. In contrast, for those already enrolled in Medicaid, Florida pays about 44.6 percent of the cost, with about 55.4 percent provided by federal matching payments.⁹ Federal medical assistance percentages, or FMAPs, are calculated each November based on three years of census data that relate each state's per capita income to the national average per capita income. States with relatively lower incomes get higher federal matching payments, and vice versa.

The Benefits of Medicaid Expansion in Florida

Medicaid expansion will have important benefits for Florida.

Improved Health of the Population: Medicaid provides comprehensive health services with modest cost sharing that will, in turn, improve access to vital health screenings and other preventive care services. Moreover, poor and near-poor residents of the states will have access to affordable diagnostic tests, prescription drugs, and visits to specialist physicians. This will also help treat patients with medical problems before they land in the emergency room or the hospital, and help achieve better health outcomes. Early detection of disease will enable more timely treatment and much greater survival rates for people who are diagnosed with cancer, heart disease, high blood pressure and other medical conditions. Children with chronic conditions such as asthma are more likely to get medications and other treatment that help control these conditions, avoiding dangerous flare-ups and costly trips to the emergency room or admissions to hospitals.

Medicaid also covers a wide range of other services that are frequently not covered under private insurance, such as physical, occupational, and speech therapy, school-based clinic services, transportation (e.g. to a doctor's office), and language interpreters, which can help assure that an insurance card actually translates into timely and culturally sensitive access to care.

Medicaid further provides coverage for mental health and substance abuse, and this will offer much-needed services for many of the low-income uninsured who are struggling with one or both of these conditions. This, in turn, will lead to savings as people with severe mental and emotional disorders and/or substance abuse problems gain access to treatment that may reduce the common cycling through overcrowded ERs and in some cases through the criminal justice system. Recent research has shown a clear connection between the lack of health insurance and recidivism. Insurance after release reduces recidivism, drug use, and crime.¹⁰

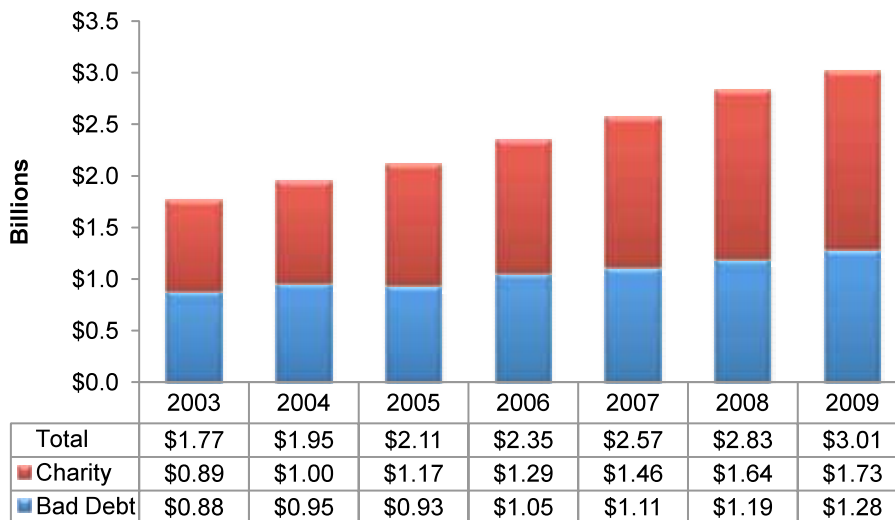
This is another reminder of the “cost of inaction.”

Florida, like other states, piles up costs related to untreated mental illness and substance abuse. The evidence is clear that it makes more financial sense to ensure that patients are treated in appropriate community-based settings rather than permitting the vicious cycle of incarceration and release.

Florida has been working toward providing a medical home to Medicaid beneficiaries, and those newly enrolling in the program can look forward to establishing a regular source of care. A state-wide Task Force report in 2010 called for a “bottom up” approach to building medical homes that solicits feedback from community-based networks and providers on what type of medical homes they can provide to Medicaid recipients. The report recommended that at least one urban area with an academic medical center/medical school and one rural area be included as model sites.¹¹ A medical home has been defined as a “partnership approach with families to provide primary health care that is accessible, family-centered, coordinated, comprehensive, continuous, compassionate, and culturally effective.”¹²

This will help patients manage chronic conditions and avoid flare-ups and complications that lead to serious adverse health outcomes and much higher spending.

Estimated Cost of Uncompensated Care 2003 - 2009



N = 168
Source: AHCA FHURS Data, FY03-FY09

Reduction in Uncompensated Care: The people newly eligible for Medicaid coverage are not the only ones who will benefit. Many physicians and hospitals in Florida are overwhelmed by uncompensated care. The cost of such care provided by Florida hospitals, including bad debt and charity, increased by about 70 percent between 2003 and 2009, as shown in the chart above. Uncompensated care is also 9.1 percent of total hospital costs in Florida, compared with less than 6 percent nationwide.¹³ Hospitals receive Disproportionate Share Hospital (DSH) payments and funds from the Low-Income Pool (LIP). This pool is a capped allotment of \$1 billion per year funded by federal government payments (a little over half of the total) and primarily local funds from counties and hospital taxing districts. This pool was established under a Medicaid waiver approved in 2005, and is designed to assist hospitals and community health centers with uncompensated health care.¹⁴ The chart above shows, however, that uncompensated care provided by Florida hospitals is now over \$3 billion a year, or three times the total of the Low-Income Pool capped amount.

The coverage of many of the uninsured in either Medicaid or the Exchange, discussed below, will reduce this uncompensated care burden. For example, applying the more conservative projections of uninsured gaining coverage should result in at least a one-third reduction in uncompensated care, valued at more than \$1 billion per year.

Indirect savings: There are volumes of research showing that covering the uninsured also provides community-wide benefits.¹⁵ The indirect costs result from the fact that as the uninsured suffer from worse health than those with coverage, their diminished health status affects their school attendance and educational achievement, their productivity in the work place, (related to absences, disability and premature death), their morbidity and their ability to live satisfying and enjoyable lives.¹⁶ The Institute of Medicine (IOM), an independent, nonprofit organization,¹⁷ estimated that 18,000 uninsured adults ages 25 through 64 die each year in the U.S. of illnesses that they would have survived if they had been insured and had received essential care. A subsequent study found that an estimated 137,000 people died from 2000 to 2006 for lack of insurance coverage, including 22,000 in 2006.¹⁸

The Institute of Medicine estimated the “indirect cost” of the uninsured in 2001 as ranging from \$1,645 to \$3,280 per uninsured person per year.¹⁹ Trending forward using the Consumer Price Index, the indirect costs are \$2,020 to \$4,029 per uninsured person in 2010.²⁰

The latest Census Bureau figures show that 4.1 million residents of Florida were uninsured in 2009. *Applying this figure to an updated range of indirect cost per uninsured person, we find that the “indirect cost” of the uninsured in Florida could be in the range of \$8.3 billion to \$16.5 billion per year.²¹ If Florida were able to avoid about half of these indirect costs by covering many of these uninsured residents, this would more than fully offset the cost of this new coverage to the state’s residents and businesses.*

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And this does not count the savings in uncompensated care and other spending on the uninsured, such as when they use state mental health or correctional facilities because their conditions are unmanaged due to a lack of coverage. Nor does it account for savings likely to arise from other parts of ACA, including a number of pilot projects to improve the delivery and financing of health care, which can be converted quickly into law if they prove to be cost-effective.

How Many Will Enroll?

A recent study by the Urban Institute, a nonpartisan economic and social policy research center, estimates that under health reform, approximately 1 million to 1.4 million additional Floridians will enroll in Medicaid by 2019.²² This represents a 35 percent to 50 percent increase in Medicaid enrollment over the 2009 level. This study used two assumptions of Medicaid “take-up”: the lower estimate assumes that 57 percent of the newly eligible uninsured Floridians would actually enroll in Medicaid (similar to CBO assumptions), and the high estimate assumes that 75% of the newly eligible uninsured would enroll as a result of more aggressive outreach.²³

Of these newly enrolled people in Medicaid, the majority — an estimated 0.7 million to 1.1 million — would have been previously uninsured (Table 1).²⁴ Others newly entering Medicaid would be transferring from private coverage, many of them currently struggling to pay their share of the premiums and copayments and/or facing more limited benefits. That is, some of the people newly eligible for Medicaid under ACA but insured privately would switch to Medicaid to reduce their costs and to obtain more comprehensive benefits. Other new Medicaid enrollees would be people who are *currently* eligible for Medicaid (pre-reform) but not enrolled, and who would enroll under reform as a result of enhanced state and federal outreach efforts and/or the requirement to obtain coverage.

Overall, the study’s projections would result in a 44 percent to 70 percent decline in the number of uninsured low-income adults in Florida.

Table 1. Medicaid Expansion in Florida: New Enrollees, by Previous Enrollment Status, in 2019

	Total New Medicaid Enrollees	Previously Uninsured Newly Enrolled	Decline in Uninsured*
Lower Participation	951,622	683,477	44%
Higher Participation	1,376,753	1,073,391	70%

* Uninsured adults with incomes less than 133 percent of the federal poverty line.

Source: Holahan and Headen. Urban Institute. May 2010.



How Much Will Medicaid Expansion Cost Florida?



Without health reform, Florida would expect to spend \$66.3 billion on Medicaid over the 2014-2019 period, with the federal government contributing another \$82.6 billion to Florida Medicaid. Under the ACA, Florida will pay an additional \$1.2 billion over six years based on the lower participation assumption, a 1.8 percent increase in Florida’s costs over the baseline projection. The federal government would spend an additional \$20.1 billion under ACA for Florida Medicaid over 2014-2019, nearly all of it to cover

the newly eligible Medicaid population (see Table 2).

Under the higher-participation assumption, Florida would spend an additional \$2.5 billion during 2014-2019 while the federal government would spend an additional \$24.3 billion.

Thus, under either participation assumption, over this six-year period, the federal government would pick up more than 90 percent of the cost of the newly enrolled Medicaid population, while the state would contribute less than 10 percent of the cost.²⁵

Table 2: Projected Additional State and Federal Cost of People Newly Enrolled in Medicaid as a Result of ACA, 2014-2019 (billions of dollars)

	State Cost	Federal Cost	Total Cost
Lower Participation	\$1.2 5.8% of total	\$20.1 94.2% of total	\$21.3
Higher Participation	\$2.5 9.5% of total	\$24.3 90.5% of total	\$26.8

Source: Holahan and Headen, Urban Institute, May 2010. Figures may differ slightly due to rounding.

Moreover, it is important to recall that a lot of money is being spent on the uninsured today, and this spending should decline as coverage expands under ACA.

The Low Income Pool alone accounts for about \$1 billion in spending, nearly half of which is state funds. Further, insured residents of Florida, and their employers, are paying a portion of the cost of the uninsured today. When Florida Senator Thad Altman asked at the November 18, 2010 Senate hearing how uncompensated care is paid for, Alan Levine, former director of AHCA, stated that “it is cost-shifted to commercial or private payers.”

Of course, finding the funding even for the state’s relatively small share of the cost of Medicaid expansion will be a challenge. Improvements in the state’s budget picture as of late summer 2010 have now given way to much more worrisome projections. The projected deficit for the 2011/2012 period has now risen from about \$1 billion earlier in 2010 to about \$3.5 billion at the end of 2010.

But the figures presented here make a compelling case that Florida would get an enormous return on its investment by drawing in this federal money, particularly in light of savings presented earlier associated with reductions in uncompensated care, the improved health of the population, and the savings associated with more labor force participation and higher productivity.

Strategies for Enhancing Enrollment

Actual take-up of Medicaid coverage by eligible people will depend on how effectively the state can develop partnerships with community-based organizations to conduct outreach and to facilitate enrollment. A number of community-based organizations in Florida have very useful experience in outreach to vulnerable populations. Exhibit 1 illustrates one approach by a community-based organization that targets businesses with low-income employees. Exhibit 2 describes how one federally qualified health center (FQHC) uses Community Health Workers to identify and enroll eligible people into Medicaid and Florida KidCare, as well as link residents to needed services. Other approaches Florida could consider to enhance outreach, enrollment and retention in Medicaid include: “express lane” eligibility, which allows Medicaid to identify, enroll, and recertify residents by relying on eligibility findings from other programs; presumptive eligibility, whereby applicants are provided coverage while their applications are pending; and 12-month continuous coverage, which means that states would redefine the eligibility determination process from a month-to-month basis to an annual basis.

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Exhibit 1

Targeting Businesses for Outreach & Enrollment: The Prosperity Campaign of Miami-Dade

The Prosperity Campaign in Miami-Dade County does not do traditional, door-to-door outreach to the uninsured. It targets businesses that employ low-wage workers to screen for and enroll families into Medicaid and Florida KidCare, as well as link them to other needed services.

“By going to businesses we can reach a large number of people at one time,” said Francoise Penha, Director of The Prosperity Campaign.

As the flagship initiative for Catalyst Miami (formerly known as the Human Services Coalition), the Prosperity Campaign helps lower-wage individuals and families connect to healthcare programs and services, establish financial security through financial and tax guidance, and obtain other needed services to improve their quality of life. The Campaign pioneered an approach that targets companies typically employing low-income and uninsured workers such as hotels, warehouses, and construction sites. Many of these companies offer health coverage to employees, but the worker's share of the premium can be unaffordable, particularly for family coverage. Among small businesses, employers often cannot afford to offer insurance.

Finding that many of the employers are eager to help their workers, the Prosperity Campaign conducts an “Open Enrollment Day” at the worksite, where employees (and their families) can get screened for Medicaid and KidCare, and referred to a federally qualified health center (FQHC) or other clinic, as well as receive assistance on taxes, finances, and other needs. Those deemed eligible for public health coverage are scheduled to come to one of the Campaign's two offices or to one of ten other sites that comprise the Campaign's network, where an enrollment specialist helps them fill out an application and submits it to the state as an ‘authorized partner’ to Medicaid and KidCare.

“We can even track the application, and sometimes get approval the same day,” said Penha. The Campaign has enrolled about 1,600 adults and children into Medicaid and KidCare from July to November 2010, according to Penha.

Other successful outreach strategies include partnering with schools in low-income communities, where Campaign staff attend parent meetings or workshops and stress the importance of not only enrolling their children in KidCare but also maintaining enrollment at recertification time, and linking to a health clinic rather than relying on hospital emergency rooms when a problem exacerbates. The Campaign also partners with the University of Miami Pediatric Mobile Unit, which provides medical care to uninsured children in different neighborhoods; each time campaign staff accompany the Mobile Unit, they enroll multiple families into Medicaid or KidCare. Like the business outreach model, these group-based approaches get better ‘bang for the buck.’

For more information, contact Francoise Penha, Director, Prosperity Campaign, Catalyst Miami, 305-576-5001, see www.prosperitycampaign.org/



Exhibit 2

Community Health Workers Enroll and Assist Hard-to-Reach Populations



Community Health Workers (CHWs) from Community Health of South Florida, Inc. (CHI) work neighborhood-by-neighborhood to enroll eligible residents in Medicaid and Florida KidCare, and help residents gain access to health-care services. They partner with schools and day care centers to identify families with uninsured children from birth to age 18; they visit flea markets and stores, arrange health fairs, and attend community activities. Sometimes they sit outside a small store or business with a table and chair and laptop, and screen customers going in and out; often the store manager asks the CHW to come back again, viewing their activity as an extra service to their clientele.

The CHWs screen the families for Medicaid and Florida KidCare eligibility, help those eligible to apply, submit the application electronically, follow up to ensure successful enrollment, and address obstacles that arise.

But the CHWs' job goes beyond enrollment in health coverage. They help the family select a CHI clinic as their medical home, make appointments, and later check on whether the individual or family showed up for their appointments. If an appointment is missed, the CHWs follow up with a phone call, a letter, and a home visit. They try to address whatever barriers keep the family from obtaining needed care. They also help families apply for medication assistance programs, and refer them to other needed services such as behavioral health, dental care, or disease management, as needed.

For more information, contact Hermine Pollard, Vice President for Satellite Services, CHI, HPollard@hcnetwork.org. CHI is a federally qualified health center (FQHC) that operates seven clinics offering primary and behavioral health services, and twenty-seven school based programs in South Florida.

Key Challenges

The anticipated Medicaid expansion will also pose a number of challenges, problems, and limitations. These must be addressed during the planning and multi-phased implementation period.

Assuring an Adequate Number of Physicians and Other Providers to Meet the Expanded Medicaid Population

A paramount challenge is to develop an adequate network of physicians, particularly primary care doctors, nurses and allied medical professionals, to serve the expanded Medicaid population. But this task is harder if health-care providers are not paid adequately for serving Medicaid beneficiaries. Medicaid fees are lower in Florida than in the nation as a whole. For all health services, Medicaid reimbursement averages 63 percent of Medicare payments in Florida; for primary care services, Medicaid reimbursement averages only 55 percent of Medicare rates.²⁶ Of course, even Medicare payments are below commercial insurance reimbursement.

The combination of the unusually large proportion of senior citizens (65+) in Florida (16.5 percent of Florida's population versus 12.4 percent nationally²⁷) and the sharp increase in the number of people in Medicaid translates to an increased demand for care pressing upon a limited supply of care providers. In a well-functioning market, this "supply bottleneck" should lead first to an increase in payments to providers, to attract more of them to the medical professions or to the areas of shortages, followed by an increase in supply. But state budget pressures and competing demands could make it very difficult to increase Medicaid payment rates.

Florida should identify ways to redeploy some of the savings from managed care models or other sources into higher payment rates for providers serving the Medicaid system, particularly physicians and nurses. The state can participate in Medicaid demonstration grants under ACA, described below.

In addition to addressing the shortfall of physicians and nurses, Florida is challenged to assure adequate numbers of dentists and dental hygienists, pharmacists, social workers, nutritionists, public health workers, community health workers and other professionals to meet the needs of a growing, aging, population with expanded access to insurance.

The bottom line is that Florida faces an important challenge to first, assure an adequate *number* of qualified professionals to address the large number of new Medicaid enrollees, and second, an appropriate *configuration* of these professionals. Team-based care, featuring a mix of medical and social service personnel, is essential to providing a full range of services to this new population.

Preparing to Meet the Needs of Patients With Chronic Illnesses

Large numbers of poor and near-poor non-elderly adults will be entering Medicaid for the first time, presenting a complex profile of health needs. The majority will be adults without dependent children, many of whom are between 45 and 64 years of age, with conditions such as diabetes, asthma, hypertension, chronic obstructive pulmonary disease, mental illness, and substance abuse. Many will have two or more of these chronic conditions. Some will be in bankruptcy, and some will be homeless.

A recent study by the Center for Health Care Strategies, Inc. indicates that adults without dependent children reported significantly poorer health status than those with dependent children across physical health, mental health, and disability domains. More than a third of low-income adults without dependent children reported that a disability prevented them from working, versus 11 percent of adults with children at home. Adults without children also had more than twice as many inpatient admissions, twice as many emergency room visits, three times as many mental health/substance abuse-related visits, and 30 percent more evaluation and management visits.²⁸

A study by the Kaiser Commission on Medicaid and the Uninsured found that low-income adults without dependent children frequently have limited English proficiency, lower education levels, and literacy issues that can make completing the enrollment process difficult. Latinos and other non-native populations may face language and cultural issues that can serve as enrollment barriers.²⁹ These issues are also barriers to effective and efficient utilization of the health care system. Exhibit 3 illustrates a community-based organization's "Natural Helpers- Community Health Worker" model for engaging hard-to-reach populations.



Exhibit 3

Natural Helper/Community Health Worker & ConnectFamilies Care Coordination Model

'ConnectFamilies,' a not-for-profit community partnership serving neighborhoods in Miami-Dade, FL, has pioneered a care coordination team model that links families to a wide range of social and health services. Eight Natural Helper/Community Health Workers team up with Care Coordinators at some of ConnectFamilies' nearly 50 partner organizations to provide a bridge for families in need of both formal services and informal hand-holding and support.

"Natural helpers" – women and men living in the neighborhood – receive expanded Community Health Worker (CHW) training developed by the Collins Center to equip them to provide outreach, education, information, advocacy and support services to families.

"These families face many challenges. The Natural Helpers/CHWs provide ongoing coaching and support along the way allowing for the removal of barriers and linking families to services and their community," said Betty Alonso, Director of Programs.

Families who request assistance or who are identified as needing help and approached by a Natural Helper/CHW are assessed for a range of needs. Uninsured family members may be eligible for Medicaid, Florida KidCare, or another health program, so the Natural Helper/CHW helps the family fill out the paperwork, refers them to a partner community organization that can enroll them, and helps address enrollment complications that arise.

As a member of a Care Coordination team, the Natural Helper/CHW helps connect families to a medical home at a local community health center or clinic, and encourages families to seek and obtain needed care. They make home visits, place phone calls, and may accompany a family to an appointment. Moreover, the CHWs are essential to providing information and assistance about preventive health care practices that keep people healthy and reduce the number of emergency clinic or hospital visits.

With ACA's Medicaid expansion down the road, the Natural Helper/CHW and Care Coordinator team model could play an instrumental role in outreach, enrollment, and access to appropriate health care services. "The Care Coordination Teams will be retrained on the new eligibility guidelines, and will be critical in getting the word out," said Myriam L. Monsalve Serna, Director of Community Engagement.

For further information, contact Myriam L. Monsalve Serna, Director of Community Engagement, T; 786. 222.1061, E: myriam@connectfamilies.org or Betty Alonso, Director of Programs, The Miami Foundation (f.k.a. Dade Community Foundation), managing partner of ConnectFamilies, T: 305.371.2711, E: balonso@miamifoundation.org



HMO Benefits Summary

Types of Coverage

This Benefit Summary is intended only to highlight your Benefits and should not be relied upon to fully determine coverage. This benefit plan may not cover all of your health care expenses. **More complete descriptions of Benefits and the terms under which they are provided are contained in the Certificate of Coverage that you will receive upon enrolling in the Plan.**

If this Benefit Summary conflicts in any way with the Contract issued to your employer, the Contract shall prevail.

Terms that are capitalized in the Benefit Summary are defined in the Certificate of Coverage.

Benefits are payable for Covered Health Services provided by or under the direction of your Network physician.

Prescription is required for certain services.

Emergency only

Network Benefits / Copayment Amounts
Annual Deductible: No Annual Deductible

Out-of-Pocket Maximum: \$1,500 per Covered Person per calendar year, not to exceed for all Covered Persons in a family. Copayments for some Covered Health Services will be based on the Out-of-Pocket Maximum as specified in Section 1 of the COC.

Maximum Contract Benefit: No Maximum Policy Benefit.

Ground Transportation: No Copayment

Air Transportation: 0% of Eligible Expenses

Sections 8, 11, 12 and 13

to be completed before follow-up treatment

Health Insurance Exchanges

Another key element of health reform involves the establishment of Health Insurance Exchanges. These exchanges are intended to give people with moderate incomes who are ineligible for public programs the opportunity to choose among a number of private health insurance plans, with federal premium subsidies that are scaled to household incomes.

Nationwide, approximately the same number of uninsured people attaining Medicaid coverage is expected to be newly insured through Insurance Exchanges. If that holds in Florida, about 0.7 million to 1.1 million uninsured Floridians would be newly insured through an Exchange.³⁰

States will be called upon to create an “American Health Benefits Exchange” for individuals and a “Small Business Health Options (SHOP) Exchange” for small businesses with up to 100 employees.³¹ States may form multi-state Exchanges with neighboring states, form a single Exchange for the state, or allow more than one Exchange to operate as long as each one serves a distinct geographic area. Or, they may let the federal government establish and administer Exchanges for their state. Access to the Exchange is restricted to U.S. citizens and lawfully present immigrants who are not incarcerated. The Exchanges will create four benefit categories of health plans (bronze, silver, gold, platinum) plus a separate catastrophic plan, to be offered in both the Exchanges and the small-group and individual markets.³²

To be eligible³³ for these federal subsidies, which will take the form of federal income tax credits, people must have incomes within the range of 133 percent to 400 percent of the federal poverty line (FPL). ACA also establishes limits on the amount of out-of-pocket costs for people in this income range. For example, if a family had an income in the range of 100-150 percent of the

FPL, their insurance plan would cover 94 percent of the full value of plan benefits; this proportion would decline to 85 percent of plan value for households with incomes in the 150-200 percent of the FPL range; 73 percent for those in the 200-250 percent range; and 70 percent of plan value for those with incomes between 250 percent and 400 percent of the FPL.

Major Issues

Several major design issues and decisions will need to be addressed in order to prepare for the implementation of the Exchanges.

- **Set up state-based Exchanges or let the federal government set them up:** As noted above, states must either demonstrate to the federal government by 2013 that their Exchanges are on track to be ready to serve consumers by the start of 2014, or indicate that they do not want to go through this process, in which case the federal government will do it and operate the Exchanges. At the present time, most states seem to want to try to do this in their own way, concerned that a federal set-up might not reflect their own orientation, political climate, etc. ***The federal government has made grants to the states to assist them in their planning for this implementation.***
- **Governance:** An important issue for Florida is whether the Exchange should be housed in an existing state government agency, versus being established outside of state government. Options for the latter include establishing a new nonprofit organization to operate the Exchange, or a quasi-governmental authority. Most states are likely to set up Exchanges outside of existing state agencies.

- **State-only Exchanges or multi-state:** States have the option of participating in a multi-state Exchange instead of running their own.
- **One Exchange for individuals or more:** This issue involves whether a single Exchange or more than one Exchange should be set up. Should there be a statewide Exchange or a series of non-overlapping regional Exchanges?
- **Whether to merge markets:** A related issue is whether to merge the individual market with the small-group market or leave them separate.
- **Functions of the Exchange:** Another important open question is whether the Exchange should primarily function only as a clearinghouse or a “farmers’ market,” featuring web portals and side-by-side comparisons, as well as enrollment, or take on additional functions of an organized purchaser. Even under a “basic” approach, states will have to certify plans as qualified (e.g. being assured that plans have an adequate provider network), approve exemptions for reasons such as religious objections, set up a “navigator” function to assist people in selecting plans, and provide some type of consumer support, such as through a hotline. Florida will have to interface with at least two federal agencies, the Social Security Administration or INS, to determine citizen status and residency; and the IRS to determine last year’s income. States will also have to determine family size, which together with income, will determine eligibility for subsidies. Care will have to be taken to assure that privacy is not breached in this process.
- **More optional roles and functions of an “organized purchaser”:** Additional functions that could improve the value and quality of care offered through the exchange, include:
 - Developing quality metrics and implementing rewards or penalties based on performance;
 - Education and outreach;
 - Screening and early intervention, chronic care management;
 - Active purchasing, limiting the number of plans that can participate, based on cost and quality considerations.³⁴
- **Integrating Exchange, Medicaid, CHIP enrollment:** An additional challenge is how best to integrate Medicaid, private insurance, and Exchange activities, as required by ACA, and how to promote an interoperable and seamless system of intake, assignment and enrollment. An Exchange will likely require software that can link various health and human service systems along with developing connections with insurance companies. There will be a need for common, or at least consistent, protocols for sharing enrollment and eligibility information among the various parties participating in the Exchange and with Medicaid.
- **Enabling Legislation:** There will be various legislative and regulatory requirements for delineating responsibilities related to the Exchange. In some areas, regulatory decisions based on existing federal and state statutes will be sufficient while in other areas new state legislative authority may be required.
- **Whether to preserve the external market:** Another issue is whether to preserve the “external market” for individual coverage rather than requiring the sale of all non-group coverage through the Exchange. Most states are likely to retain the existing non-group, or so-called “individual” market outside of the Exchanges.
- **Whether to allow insurers to operate only regionally:** Frequently, health insurers will operate in some counties of a state but not others. At issue is whether Florida would want to permit carriers participating in Exchanges to continue this practice, or require them to provide statewide offerings.³⁵
- **Self-sustaining funding:** The federal government and the State will help with the initial funding of the Exchanges, but there will be a need to make them self-funding without resorting to government funds after a phase-in period. This will require some types of user fees on Qualified Health Plans operating in the Exchange, consumers, or both. There will be a need to determine how much funding is required for ongoing operations, as well as an assessment of alternative revenue streams from both purchasers and providers of insurance.

Benefits to Florida

Exchanges hold the promise of offering multiple choices of affordable health plans to a large number of Florida residents who are either currently uninsured or under-insured. Many residents of Florida are in a financial situation where they will not qualify for Medicaid, are not old enough for Medicare, and yet cannot afford private insurance. Families with incomes of \$40,000, \$50,000, or \$60,000 a year will typically fit this profile. These families usually have one or even two workers in the household, but frequently the employees do not work for an organization that offers health insurance. Even if the employer does offer insurance, many employees are excluded because they work part-time, have not been with the company long enough to qualify, or cannot afford their share of the premium.

A typical scenario is a family with an income of \$53,500 a year, the current median family income in Florida, in which a family earner works for a company that does not offer health insurance.³⁶ Family coverage would likely cost \$12,000 to \$14,000 per year,³⁷ representing about one-fourth of the family's pre-tax income. It is not realistic to think that such a family could afford to buy family coverage.

Under the Exchange, this family would receive a federal subsidy that would substantially lower the premium, which would likely bring it to an affordable level. The family would get a choice of several plans, and could select one that best fits its needs. Florida would not have to contribute any portion of this subsidy cost.



Key Challenges

Establishing health insurance Exchanges will require Florida state government to play a role in the commercial insurance market that goes well beyond running the Medicaid and CHIP programs. The state will need assistance from experts in private health insurance issues and challenges. It will also have to figure out how to make smooth connections between the public programs and the Exchange. One approach is to set up a “single point of entry” with screening to determine whether people are eligible for Medicaid, CHIP for their children, or the Exchange.

Another important challenge involves determining a household's income and then ascertaining the amount of subsidy for which the household is eligible. Then the Exchange would need to obtain the subsidy from the federal government, join it with the household's own contribution to the premium, and direct the total premium contribution to the health plan that the household has selected. This will require close cooperation between the federal government and the state, and no doubt development of a secure system for electronically transferring funds.

Thus, states will need to develop a multi-stage process beginning with initial screening of individuals; determining current enrollment in programs, verifying citizenship, residency, income, and family size; determining eligibility for both public programs and subsidies for people going into the Exchanges; sending eligibility information to other programs; and sending enrollment information to the plans.

Then, on the health plan side of the market, the state must determine whether plans are qualified and whether they are in compliance with “medical loss ratio” requirements (described below), and engage in ongoing monitoring of plan rate increases and performance.

Taken together, these responsibilities represent a “heavy lift” and will require considerable planning and inter-agency coordination.

Finally, an important challenge is to avoid “adverse risk selection” against the Exchange. Risk selection occurs when one insurer attracts a group of consumers who are more costly to serve than those enrolled with another insurer. Risk selection will be greatly reduced but not eliminated by insurance market reforms under ACA. Although plans may not deny coverage to sicker people, or price them out of affordable health coverage, they may compete in other ways. Moreover, insurers with a “better brand” or broader network of physicians may attract patients with more complex health needs, even within the same age brackets. Risk adjustment measures the burden or risk of ill health covered by competing insurers, and then adjusts for it by providing additional payments to insurers with a higher risk burden and assessing fees on insurers with lower risk profiles.³⁸

Florida should begin to develop a risk-adjustment system as part of its preparation for implementing Health Insurance Exchanges.

Insurance Market Reforms

ACA establishes a series of reforms in the insurance market designed to bring premiums within reach of all purchasers, regardless of their demographic and health characteristics. The key provisions that were set to be in force as of September 23, 2010, are:

- There will be no lifetime limits on the dollar value of coverage, and restrictions on annual dollar limits on coverage;
- Young adult children may stay on their parents' policies until age 26;
- There will be no pre-existing condition exclusions for children;
- Insurers are prohibited from rescinding coverage (canceling retroactively) except in cases of fraud or intentional misrepresentation.³⁹
- Reforms scheduled to be implemented in January 2011, intended to give consumers better value for their insurance premiums, include:
 - Requiring insurance companies to publicly report how they spend premium dollars, specifying how much goes toward actual medical care, activities to improve health care and administrative expenses such as marketing, advertising, underwriting, executive salaries and bonuses;
 - Insurance companies in the individual and small group markets that spend less than 80 percent of premium dollars, and insurance companies in the large group market that spend less than 85 percent of premium dollars, on medical care and quality improvement activities must provide rebates to their enrollees, beginning in 2012;
 - Allowing states to request from the federal government an adjustment if requiring insurers in its individual market to meet the 80 percent “medical loss ratio” standard is likely to destabilize the individual market resulting in fewer choices for consumers.
 - Establishing a process for reviewing increases in health plan premiums and requiring plans to justify premium increases. States would report on premium trends and recommend whether certain plans should be excluded from the Exchange based on unjustified premium increases.

Reforms scheduled to be in place by 2014 include:

- Guaranteed issue and renewability: no one can be denied coverage or renewal of coverage;
- Insurers prohibited from varying premiums based on health status or gender;
- New limits on age rating: insurers may charge older people more than younger people, but the oldest consumers cannot be charged a premium that is more than three times the premium charged to the youngest consumers.
- Prohibit insurers from placing annual limits on the dollar value of coverage.⁴⁰

Benefits to Florida

The new insurance market reforms will benefit many residents of Florida who have been either denied insurance coverage or priced out of the market. For example:

- The parents of a young child in Florida with a serious disability can obtain health coverage at an affordable price that does not restrict coverage for “pre-existing conditions,” which of course, are vital needs of this disabled child.
- A young adult in Florida who finishes college and would normally be dropped from his or her parents' coverage at age 23 would have the option of remaining on such a policy until age 26.
- Cancer patients in Florida in the middle of chemotherapy and radiation therapy would no longer see their health insurance suddenly cancelled or discontinued retroactively because they accidentally answered one question incorrectly on their insurance application years earlier.
- A 60-year old Florida worker who loses a job that provides employer group health coverage could now have a more affordable option to purchase coverage until he or she is able to get group coverage again or reaches the age of eligibility for Medicare.
- An accident victim spending weeks in a hospital and months in recuperation in a skilled nursing facility would not find that his or her benefits were exhausted because of hitting the “maximum” just at the time of greatest need.



Key Challenges

The insurance market reforms may pose a number of challenges. For example, as the counter-weight to reducing premiums for older workers when age differences in premiums are compressed to three-to-one, premiums for younger workers are likely to rise. This may cause more of them to pay the fine of \$95 in the first year, and eventually \$695 per year rather than buy health coverage.

Some observers are concerned that the provision outlawing policy rescissions due to unintentional misrepresentation on an insurance application, may effectively give a green light to consumers to intentionally fail to disclose their medical conditions or other pertinent information, as intent is difficult to prove. This concern will be less relevant beginning in 2014, when insurers will not be able to reject applicants or vary premiums due to prior or existing health conditions.

Moreover, there is a lot of work involved in setting up all of the new regulations, and also in ongoing compliance reviews. For example, determining if insurers are actually complying with the medical loss ratio requirements will involve complex reviews of costs and accounting regimes. Setting up processes for determining if insurers' rate increases are "reasonable" and justifiable could get the government close to price controls.

Opportunities to Draw in New Funds Through Grants and Demonstrations



ACA provides states with a number of federal funding opportunities. Some of these new initiatives represent federal assistance for the health care safety net; some provide new resources for public health and prevention; and others represent the chance to participate in innovative pilot or demonstration projects designed to improve the delivery and financing of health care and achieve better health outcomes at a lower cost.

An important feature of ACA involves the provision of \$11 billion over five years in new federal support for community health centers and school-based health centers. Florida has 44 federally qualified health centers operating in nearly 300 locations. A medical homes model, as described earlier, is frequently featured in these community health centers and can help reduce the estimated \$1 billion or more in avoidable emergency room visits experienced in Florida in one year alone.⁴¹

Florida should develop a plan to compete for a share of this new federal funding.

Appendix A provides a menu of opportunities for Florida to consider. It is not meant to be an exhaustive list of all of the provisions of the law, but rather a selection of some of the most pertinent and promising programs and opportunities.

There are a number of pathways that Florida could follow to participate in innovative demonstration and pilot programs aimed at improving health care delivery and the health of the population. If Florida could successfully compete for and implement some of these grants, not only would more funding be brought into the state, but the health care delivery system could become more efficient, safer, and more effective. This would benefit all the residents of Florida.

Employer and Individual Obligations

ACA imposes certain obligations on employers and individuals regarding contributing to health care. These are illustrated in the following text box:

Employer Obligations

- Employers with *50 or fewer employees* are not required to offer health insurance or make any contribution to the government to help finance subsidies. These small firms are now eligible for a federal tax credit covering up to 30 percent of their health insurance premium contributions, and as noted earlier, companies with up to 100 employees will be able to use the Small Business Health Options (SHOP) Exchange beginning in 2014.
- Employers with *more than 50 employees* are also not mandated to offer health insurance, but they are *required* to pay an assessment per worker if they do not offer coverage and at least one of their employees gets a subsidy through the Exchange. The first 30 of their workers are exempt from this assessment. For the additional workers, the fee is assessed if at least one worker in the firm gets a federal tax credit to use as premium assistance inside the Exchange. The company's assessment is a fee of \$2,000 per full-time employee.
- Employers who are already offering health insurance and have some of their employees going to the Exchange (instead of enrolling in the company's plan) and getting a federal subsidy would pay the lesser of \$3,000 for each employee receiving a premium credit or \$2,000 for each full-time employee.
- Employers with more than 200 workers who offer coverage must automatically enroll employees into their health insurance plans unless the workers specifically opt out.

Individual Obligations

- Beginning in 2014, U.S. citizens and legal residents are required to have qualifying health coverage. As noted earlier, the Florida Attorney General is challenging this provision in litigation working its way through the court system.
- Those who do not comply are subject to the following penalties: \$95 in 2014; \$325 in 2015; and \$695 in 2016 for the flat fee, or 1 percent of taxable income in 2014, 2 percent in 2015, and 2.5 percent in 2016, whichever is higher. After 2016, the penalty will be adjusted according to the cost of living.
- Exemptions will be granted for hardship, for religious objections, and for American Indians and other groups.⁴²



Financing

ACA relies on a variety of sources of financing to fully fund the expanded coverage, subsidies and other benefits under the law. The main sources of financing involve changes to Medicare and fees or tax increases. ***It is important to stress that the law does not cut Medicare benefits.*** In fact, the nearly 3.2 million seniors in Florida no longer have to make a co-payment for preventive services such as mammography and colonoscopies, and they no longer pay extra for regular check-ups. ***The Medicare financing provisions involve changes in formulas for updating/increasing payments to a wide range of provider groups that serve the program, reductions in payments to managed care plans, and a new board recommending cost containment measures.***

Medicare Savings

The following savings are anticipated from various measures designed to slow the growth of Medicare spending. These main features are as follows:

- Reduce the annual “market basket updates” for inpatient hospital, home health, skilled nursing facility, hospice, and other Medicare providers, and adjust for productivity. This means that annual Medicare payment increases will be smaller than would otherwise occur.

- Restructure Medicare payments to Medicare Advantage (MA) plans, which are managed care plans serving about one of four people enrolled in Medicare. The adjustments would have the overall effect of lowering payments to MA plans, which many observers believed were higher than the payments under the fee-for-service system (critics of these cuts note that the higher payments could be at least partly justified by extra benefits that these plans provide). Plans will by no means be treated all alike. For example, there will be substantial bonuses paid to MA plans receiving high quality scores on Medicare’s current 5-Star rating system. The overall rate reductions will be phased in over a three-to six-year period.
- Establish an Independent Payment Advisory Board to submit legislative proposals containing recommendations to reduce the per capita growth of Medicare spending if it exceeds a target growth rate.⁴³

Fees and Tax Changes

Financing also relies on selected tax increases. The major provisions are:

- Increase the Medicare Part A tax rate on wages by 0.9 percentage points (from 1.45 percent to 2.35 percent on earnings over \$200,000 for individual taxpayers and \$250,000 for married couples filing jointly), and impose a 3.8 percent tax on unearned income for these higher-income taxpayers (effective January 1, 2013).
- Impose an excise tax on insurers of employer-sponsored health plans with aggregate values exceeding \$10,200 for individual coverage and \$27,500 for family coverage, effective January 1, 2018. This so-called “Cadillac tax” will be adjusted to allow higher thresholds of benefit value above which the tax on plans is triggered, for retired people 55-64 years old and for workers in high-risk professions.
- Limit the amount of contributions to flexible spending accounts for medical expenses to \$2,500 per year, updated annually for inflation, as of January 1, 2013.
- Impose new annual fees on pharmaceutical manufacturers, medical device manufacturers, and health insurers, along with a 10 percent fee on indoor tanning services. These fees have varying starting dates, from 2012 to 2014, except for the tax on tanning salons, which began in 2010.
- Impose fees or penalties on individuals and firms with more than 50 workers that do not comply with the obligations to obtain or offer insurance, as described above.

The financing mechanisms in ACA were designed to avoid cutting benefits under public programs and to insulate, to the extent possible, the great majority of taxpayers from an increase in taxes. *The explicit tax increases noted above will affect about 2 percent of households nationwide,⁴⁴ and this is likely to be the case, approximately, in Florida. For example, if a family in Florida has an income of \$300,000, and it gains net investment income of \$20,000 in a given year, it will pay an additional \$1,210 in income and payroll taxes.⁴⁵ A family with an income of \$230,000 a year will not be subject to either form of new taxation.*





Summary and Action Steps for Florida

In summary, the new health care legislation holds the promise of many benefits for the residents of Florida. These would take the form of a healthier population, potentially lower premiums and cost-savings as a result of reductions in uncompensated care, a healthier work force, greater use of health information technology, and the bargaining power of Exchanges with private health plans, among other factors.

The state would have to spend some new money to help achieve these results, but the federal government would be putting in at least \$10 in new funding over the decade for each \$1 of new money from Florida for the Medicaid expansion. The subsidies for the Exchanges are paid entirely by the federal government.

The highest-income taxpayers in the state would experience an increase in taxes and many health care providers and insurers would pay new fees to help finance the benefits associated with subsidized coverage for lower-income and middle-income residents of Florida.

SUMMARY

Action Steps for Florida

The following recommended action steps are designed to help Florida prepare for the implementation of health reform. They are designed to maximize the potential benefits of the new law, and avoid, to the extent possible, the potential pitfalls and problems.

- **Florida will experience important direct and indirect benefits to covering the uninsured that will ultimately more than justify the state's relatively small share of the total cost of doing so. Therefore, the state should start planning now for the two key measures that will provide this coverage: Medicaid expansion and the Insurance Exchanges.**
 - Florida should develop a multi-faceted and innovative approach to outreach and enrollment as it prepares for the Medicaid expansion beginning in 2014. This should include auto-enrollment; 12-month continuous eligibility, at least for children; simplified enrollment procedures and a concerted effort to work with community-based organizations and community health centers to identify eligible people and help them enroll.
 - The Florida legislature seems headed toward moving nearly all Medicaid enrollees into some form of managed care. The intent is to feature timely access to primary and preventive care, disease management and integrated delivery systems while containing state Medicaid costs. To achieve this vision in the manner that is most beneficial to all patients, the state will need to move beyond county-level pilots to a new statewide plan. This will be required if the state is to hold onto federal support for the Low Income Pool. The state should also build in protections for people with very serious medical conditions and developmental disabilities, and assure that managed care organizations provide such people with the full range of services they require. Lastly, as seen with other Medicaid managed care pilots in Florida, the state should be careful with capitated payments to providers where it is hard to distinguish whether people were served appropriately. With managed care, one size does not fit all.
 - Florida should assess the range and incidence of medical conditions of the poor and near-poor adult population without dependent children, and develop systems for managing their needs. For example, when higher-risk patients are discharged from the hospital, e.g. people with diseases such as congestive heart failure or chronic obstructive pulmonary disease, a nurse practitioner could conduct a follow-up visit to the home, or at least make periodic telephone contact with the patients to alert them to danger signals, check on their conditions, and make suggestions where appropriate for seeing a physician. The development of individualized care plans for such high-risk patients is effective. And women with high-risk pregnancies should be given special attention and regular monitoring.⁴⁶
 - Florida should begin preparations as soon as possible for building Health Insurance Exchanges. A plan is needed to develop a seamless system that screens people and directs them to either a public program such as Medicaid or CHIP, or to the Exchange, depending upon their circumstances. Initial focus should be on how to establish web portals for consumer “shopping” to select a health plan, income determinations, and the interface with federal agencies needed to ascertain eligibility and the size of subsidies for which individuals and families qualify. A risk-adjustment mechanism will also be needed.
 - Florida should seriously consider making the Exchanges active “organized purchasers” with clear accountability among health plans for both cost and quality of care. The state should try to align its new care management approach to Medicaid with its own employee benefit program, CHIP, and the Exchanges so that it can drive improvements in the quality, safety, and efficiency of health care throughout Florida. For example, the state could develop a consistent set of quality indicators and quality reporting requirements for metrics related to diabetes (e.g. hemoglobin A1C tests), asthma, and hypertension for use in Medicaid, the Exchanges, and state employee benefit plans.
 - **Insurance market reforms constitute a critically important complement to the Medicaid expansions and the Exchanges. Thus, the legislature should move quickly in 2011 to provide the Insurance Department as well as the Agency for Healthcare Administration (AHCA) with the authority they need to implement the insurance market reforms that are a key feature of health reform.**
 - **Florida should carefully and systematically review the menu of opportunities for new grants, contracts, and demonstration programs available under health reforms, and begin planning now to participate in some of these opportunities.**
- This report highlights a number of possibilities, with a special focus on grants that might help the state reform the delivery and payment system under Medicaid, a clear state objective. Many of the new demonstration programs and grant opportunities, however, go well beyond Medicaid and hold the promise of making health care safer and more effective for all residents of the state. Of particular interest is the new \$11 billion funding for assisting community health centers. A number of other grants are designed to improve the quality of care and patient safety, and this could benefit all residents of the state.
- All changes will require resources as will continuing on the same trajectory. This report's aim has been to point to potential options and resources that will benefit all Floridians while reducing costs to the state.

APPENDIX A: FUNDING OPPORTUNITIES FOR FLORIDA UNDER ACA

- **New funding for community health centers:** the new law provides \$11 billion nationally over five years to support community health centers and school-based clinics. This money can be used to help centers extend their hours of operation, hire new physicians and nurses, add new services, conduct needed repairs, and modernize facilities. This funding is available beginning in 2011.
- **Pilot project for community health centers to assess individualized wellness plans:** Directs the Secretary to establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan designed to reduce risk factors for preventable conditions identified by a comprehensive risk factor assessment (Section 4206).
- **Enhanced federal match to provide health homes for chronically ill patients:** Given the interest and direction in Florida's Medicaid program of providing a managed care arrangement for all enrollees, this opportunity might be of particular interest. States with an approved Medicaid State Plan Amendment will receive a 90 percent federal match for two years for Health Home services for Medicaid beneficiaries with chronic conditions.⁴⁷ The Health Home "expands on the traditional medical home model to build linkages to other community and social supports, and to enhance coordination of medical and behavioral health care."⁴⁸ May begin January 1, 2011 (Section 2703).
- **Establish a Medicaid Quality Measurement Program:** HHS will identify and publish a recommended core set of adult health quality measures for Medicaid-eligible adults. HHS will then establish a quality measurement program and appropriate funds under grants and contracts (Section 2701).
- **Medicaid Global Payment System Demonstration Project:** Up to five states will be selected by HHS to participate in a pilot project to shift Medicaid payments to safety net hospital systems from fee-for-service to a global capitated payment model. This means that such hospitals would be the hub of a network of providers, including physicians, who would receive a fixed amount of funding to cover a wide array of services ranging from diagnosis and pre-hospital treatment through the hospital stay and for some period after hospital discharge. Providers would share risks with Medicaid but also be rewarded for lowering the total cost of the episode of care (Section 2705).
- **Medicaid Bundled Payment demonstration:** Medicaid would offer a set of "bundled payments" for episodes of health care including hospital care and selected physician services that occur before, during, and after the hospital stay. Up to eight states can receive these demonstration project awards for this program, which runs from 2012 through 2016 (Section 2704).
- **Pediatric ACO Demonstration:** Up to five state Medicaid programs will be selected to work with children's hospitals and other pediatric providers on the development of "accountable care organizations," or ACOs. The ACOs could receive incentive payments based on demonstrating quality improvements and cost reductions. Providers would participate for at least three years (Section 2704).⁴⁹
- **Grants for workplace wellness:** HHS will be making grants to employers with fewer than 100 workers who provide access to comprehensive workplace wellness programs. This includes health awareness, adopting healthy behaviors and healthy workplace environments (Section 10408).
- **Grants for community-based diabetes prevention programs:** This program is targeted to assisting adults at high risk for diabetes to eliminate the preventable burden of diabetes (Section 10501).
- **Demonstration to provide access to affordable care:** Establishes a three-year demonstration program in up to 10 states providing access to comprehensive health-care services to the uninsured at reduced fees. Awards up to \$2 million each to nonprofit, public/private partnerships (Section 10504).
- **Medical Malpractice Demonstration:** States may receive five-year federal grants to develop medical malpractice reforms allowing for alternative ways to resolve disputes and reduce medical errors (Section 10607).
- **Integrating quality improvement and patient safety into clinical education:** Medical schools and other health training schools may apply for support in developing and implementing academic curricula to integrate quality and patient safety improvements into the clinical education of health professionals (Section 3508).⁵⁰
- **Prevention and Public Health Fund:** This will be a major new \$15 billion investment in public health and prevention. Includes prevention research, health screenings, Community Transformation grants⁵¹, and immunization programs (Section 4002).

SOURCES

¹The Affordable Care Act encompasses both the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act of 2010, which amended PPACA. <http://docs.house.gov/energycommerce/ppacacon.pdf>.

²For a summary of the key provisions of the law, see <http://www.kff.org/healthreform/upload/8061.pdf>.

³http://www.healthcare.gov/news/factsheets/pre-existing_condition_insurance_enrollment.html

⁴<http://www.healthcare.gov/center/states/fl.html>

⁵State of Florida, by and through Bill McCollum, et al. v. United States Department of Health and Human Services, et al. Case No. 3:10-cv-91-RV/EMT. United States District Court for the Northern District of Florida Pensacola Division.

⁶[http://myfloridalegal.com/webfiles.nsf/WF/CRUE-8A8REM/\\$file/Order+on+MTD+%5BDE+79%5D.pdf](http://myfloridalegal.com/webfiles.nsf/WF/CRUE-8A8REM/$file/Order+on+MTD+%5BDE+79%5D.pdf)

⁷Letter from Speaker-Designate Dean Cannon to the Honorable Charlie Crist. October 19, 2010. p. 2.

⁸These numbers are based on the federal poverty line in 2010. As that is adjusted between now and 2014, the actual dollar figures will rise slightly. Further, the 133 percent of FPL limit refers to "net income," after allowing for a 5 percent "income disregard," meaning that the cutoff for eligibility using gross income is really 138 percent of the FPL.

⁹Currently, the federal government is paying an enhanced Federal Medical Assistance Percentage (FMAP) of 67.6 percent under the American Recovery and Reinvestment Act (ARRA), but that rate will be stepped down during the first half of 2011 and return to 55.4 percent in July 2011.

¹⁰Daniels J, Crum M, Ramaswamy M, Freudenberg N. Creating REAL MEN: Description of an Intervention to Reduce Drug Use, HIV risk, and Rearrest Among Young Men Returning to Urban Communities From Jail. *Health Promot Pract*. 2009.

¹¹AHCA. "Medicaid Medical Home Task Force Report: Recommendations for Designing and Implementing a Medical Home Pilot Project for Florida Medicaid." February 2010. p.1.

¹²Sia, C, Tonniges T, Osterhus E, and Taba S. "History of the Medical Home Concept." *Pediatrics* Vol. 113, No. 5. May 2004. May 2004: 1473-1478.

¹³American Hospital Association Trend Watch Chart Book, 2010. AHCA FHURS Data, FY 2003-FY 2009.

¹⁴http://www.fdhc.state.fl.us/Medicaid/medicaid_reform/lip/lip.shtml

¹⁵See, for example. Institute of Medicine. *Coverage Matters: Insurance and Health Care*. Washington, D.C. National Academy Press. 2001; Hadley J., "Sicker and Poorer: The Consequences of Being Uninsured (available at www.kff.org/content/2002/20020510) Medical Care Research and Review (Supplement to Vol. 60, No.2, June 2003); Hadley J and J Holahan. "How Much Care Do the Uninsured Use and Who Pays for It? Health Affairs web exclusive, Feb. 12, 2003 Hidden Costs, Values Lost: Uninsurance in America, Institute of Medicine, June 2003. <http://www.iom.edu/-/media/Files/Report%20Files/2003/Hidden-Costs-Value-Lost-Uninsurance-in-America/Uninsured5FINAL.pdf>

¹⁶Ibid. and Jack A. Meyer and Jack Hadley. "Mapping Health Spending and Insurance Coverage in Connecticut." Report Prepared for the Universal Health Care Foundation of Connecticut. February 2006.

¹⁷The Institute of Medicine (IOM) is a non-governmental entity that is part of the United States National Academies. Using volunteer scientists and other experts, and a rigorous peer-review process, the IOM provides independent guidance and analysis concerning health and science policy for policy-makers, the private sector, and the public. See <http://iom.edu/>

¹⁸Stan Dorn. "Uninsured and Dying Because of It: Updating the Institute of Medicine Analysis on the Impact of Uninsurance on Mortality." Urban Institute. January 8, 2008.

¹⁹The IOM calculated the average annual discounted value of lost health over time as a result of lacking health insurance.

²⁰This is a conservative estimate that uses the CPI to update the cost, rather than a measure of health care inflation.

²¹HMA estimates using IOM findings.

²²John Holahan and Irene Headen. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL." Urban Institute. May 2010.

²³The model assumes lower Medicaid participation rates both among newly eligible individuals who have private coverage, and among people currently eligible but not enrolled in Medicaid and uninsured.

²⁴Holahan and Headen. *Supra*. pp. 41, 45.

²⁵Holahan and Headen. *Supra*. pp. 39-46. If we look just at the cost of covering those newly eligible for Medicaid, the federal government will cover 96% of the cost over the 2014-2019 period, meaning that Florida would receive \$25 in new federal funding for each new state dollar. The estimate above is lower because people previously eligible but not enrolled will newly participate under ACA, and the state only gets the regular match on this group.

²⁶Stephen Zuckerman, Aimee Williams, and Karen Stockley. "Trends in Medicaid Fees, 2003-2008." Health Affairs web exclusive. Vol. 28, No. 3. P. w 517.

²⁷www.statehealthfacts.org

²⁸Center for Health Care Strategies. "Covering Low-Income Childless Adults in Medicaid: Experiences from Selected States." August 2010. pp. 4-5.

²⁹Kaiser Commission on Medicaid and the Uninsured. "Expanding Medicaid to Low-Income Childless Adults under Health Reform: Key Lessons from State Experiences." July 2010. p. 7.

³⁰CBO estimated that about 16 million people would be newly insured through Medicaid enrollment and another 16 million would be newly insured through Insurance Exchanges. <http://www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf>.

³¹Beginning in 2017 firms with 100 employees or more may purchase coverage through the SHOP Exchange.

³²Kaiser Family Foundation. Focus on Health Reform: Summary of New Health Reform Law. pp. 4-5.

³³These tax credits are refundable, meaning that a household gets the full value of the credit even if it has no federal tax liability to offset, and advanceable, meaning that the household gets the credits right away instead of having to wait to file an income tax return the following year.

³⁴Exchange and Insurance Markets Workgroup. "Report to the Health Care Reform Coordinating Council. State of Maryland." October 31, 2010.

³⁵Maryland Exchange and Insurance Market's Workgroup. *Supra*.

³⁶<http://www.census.gov/hhes/www/income/statemedfaminc.html>

³⁷The national average premium for family coverage is \$13,770 (Kaiser/HRET annual survey). <http://ehbs.kff.org/pdf/2010/8086.pdf>.

³⁸Jon Kingsdale and John Bertko. "Insurance Exchanges Under Health Reform: Six Design Issues for The States." *Health Affairs* June 2010. 29:6:1158-1163.

³⁹A "rescission" is a cancellation or discontinuance of coverage that has a retroactive effect. A cancellation or discontinuation of coverage is not a rescission if it only has a prospective effect, or the retroactive effect is attributable to a failure to timely pay required premiums or contributions. Under prior law, rescissions may have been permissible if an individual made a misrepresentation of a material fact, even if the misrepresentation was not intentional or made knowingly. Under the new standard, plans and issuers cannot rescind coverage unless an individual was involved in fraud or intentional misrepresentation.' (<http://www.healthcarelawandpolicy.com/>).

⁴⁰Kaiser Family Foundation. Focus on Health Reform. *Supra*. pp. 6-7.

⁴¹Florida Association of Community Health Centers.

⁴²Kaiser Family Foundation. *Supra*.

⁴³Kaiser Family Foundation. Focus on Health Reform. *Supra*.

⁴⁴Census data shows that 1.93 percent of households had incomes greater than \$250,000 in 2006. (U.S. Census Bureau. 2006. Economic Survey, income data. Retrieved 8-28-2007.

⁴⁵This family would pay an extra \$450 in Medicare payroll taxes (0.9 percent of the \$50,000 of earned income over \$250,000) and an extra \$760 in federal income taxes (3.8 percent of the \$20,000 in net investment income), for a total of \$1,210 in extra taxes for the year.

⁴⁶Jack Meyer and Barbara Smith. "Chronic Care Management: Evidence of Predictable Savings." Health Management Associates. November 2008.

⁴⁷The individual may have two chronic illnesses, one chronic illness and risk factors for another, or a serious and persistent mental health condition.

⁴⁸CMS November 16, 2010 Guidance to Medicaid Directors re: Health Homes for Enrollees with Chronic Conditions, SMDL#10-024 ACA#12. p. 4.

⁴⁹University of Massachusetts, Center for Health Law and Economics. "Funding Opportunities in the Affordable Care Act: Pilot Programs, Demonstrations Projects, and Grants.

⁵⁰University of Massachusetts, Center for Law and Economics. *Supra*.

⁵¹Community Transformation grants are defined in the ACA as, "competitive grants to state and local governmental agencies and community-based organizations for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming, with not less than 20 percent of such grants being awarded to rural and frontier areas." (Section 4201).



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