Self-Insurance Estimating Conference
State Employees' Group Health Self-Insurance Trust Fund
December 12, 2012
Executive Summary

The outlook for the State Employees' Health Insurance Trust Fund has been revised to reflect recent fund experience and updated forecasts for price and utilization trends. The outlook in the short run is more positive: for 2012-13 the projected ending balance has been increased by $15.1 million from $241.6 million to $256.7 million, and for 2013-14 the projected ending balance has been increased by $23.9 million from $148.0 million to $171.9 million. The outlook for subsequent years shows that expenses will exceed revenues by an amount that generates a negative cash flow of $262.7 million in 2014-15 and $468.0 million in 2015-16.

Impacting all areas of the forecast are changes to the enrollment forecast resulting from recent experience and open enrollment for January 2013. Lower than expected new open enrollment subscribers and reductions in the employee population in the July through November period combined to result in lower employee enrollment projections than in the previous forecast. Enrollment for Medicare members and early retirees has also been reduced, while COBRA enrollment has been slightly increased. Overall enrollment is projected to decline by 1.7% in 2012-13 over 2011-12, decline minimally in 2013-14, and increase slightly in both 2014-15 and 2015-16. There is also a continuing shift in enrollment among active employees from the PPO plans to the HMO plans.

On the revenue side, the forecast for premiums is lower due to lower projected enrollment. The premium reduction is offset somewhat by higher than previously projected amounts for Investment Interest, PPO TPA refunds, HMO TPA refunds, and PPO Medicare Part D Subsidy. However, in general, revenues are lower due to the lower enrollment.

On the expense side, PPO expenses are generally lower than in the previous forecast, due to lower than projected claims experience for the first few months of 2012-13 as well as lower projected enrollment. Additionally, the PPO prescription drug trend was reduced from the previous forecast, which along with lower enrollment results in lower projected PPO prescription drug costs. Similarly, self-insured HMO prescription drug claims are lower than in the previous forecast. However, HMO medical claims are higher than in the previous forecast as a result of higher than expected claims for the first few months of 2012-13. HMO premiums are lower due to enrollment changes. There is no change from the previous forecast for other expenses.

Reports on the Financial Outlook prepared from December 2010 through June 2012 all included estimates of the impact of the Patient Protection and Affordable Care Act (PPACA) on the Trust Fund. Beginning with the previous (August 2012) report, the impact of PPACA is being treated differently to mirror the treatment used by the Social Services Estimating Conference for Medicaid and KidCare. In this forecast as well as the August 2012 forecast, the impacts of the provisions of PPACA that have already been implemented by the Program are included in the affected revenue and expense line items of each year's outlook. The impacts to the Program of the provisions of PPACA that will occur in the future have been removed from the outlook and are now described in a separate report titled *Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act*.

In the separate forecast document for PPACA, the estimated number of OPS employees has been increased based on new survey data. Additionally the number of individuals opting out of State offered coverage has been reduced. The additional costs to the State Health Insurance Program from PPACA are reflected in the line titled "Total Expenses" on page 7 of the referenced report. They are:

	August 2012 Forecast	December 2012 Forecast	Difference
2012-13	$0.38 million	$0.38 million	$0.0 million
2013-14	$48.82 million	$59.79 million	$10.97 million
2014-15	$117.55 million	$137.27 million	$19.72 million
2015-16	$127.55 million	$155.09 million	$27.54 million

These additional costs would be borne by a combination of the participating employers and the members covered by the Plans.

Impact on the
State Health Insurance Program
of the Patient Protection and Affordable Care Act

Adopted December 12, 2012 by the
Self-Insurance Estimating Conference

Prepared by: Florida Department of Management Services
Division of State Group Insurance

EXECUTIVE SUMMARY

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. PPACA has many components, including new reporting mandates, taxes and fees, and major structural changes such as insurance reforms, employer and individual mandates, and insurance exchanges phasing in over many years. Every employer-sponsored health plan, including the State Group Insurance Program, will be affected.

The Division of State Group Insurance contracted with a consultant (Mercer) in 2010 to estimate the annual financial impact of PPACA. The results of the consultant's analysis, published on September 1, 2010, were included as an appendix to subsequent State Employee's Group Health Insurance Trust Fund estimating conference documents, adjusted as necessary, and rolled up into single lines in the revenues and expense categories for reporting purposes. The original estimates have been revised over time by subsequent conferences based on revised assumptions and information. In the August 2012 conference, the impacts of PPACA began being reported separately from the Report on the Financial Outlook of the State Employees' Group Health Self-Insurance Trust Fund.

The major health care reform provisions with potential employer impact that have been implemented, or are in the process of being implemented, for the Program, include:

- Elimination of overall lifetime plan maximums;
- Removal of annual limits for essential health benefits;
- Elimination of pre-existing condition exclusions for children under age 19;
- Patient-centered outcome research institute fees (phased in at $1 to $2 per participant); and
- Extended coverage for employees' adult children to age 26 without regard to dependency.

Major changes, effective January 1, 2014, include:

- Imposition of pass-through fees relating to the pharmaceutical industry; 2.3% excise tax on medical devices; and reinsurance, risk corridors, and risk adjustment;
- Elimination of all pre-existing condition limitations;
- "Shared responsibility" provisions requiring employers to offer affordable coverage meeting minimum standards to full-time workers (30 or more hours per week) or face potential penalties; and
- Individual mandate to maintain health coverage or face a penalty.

It is important to note that federal regulations implementing PPACA have not been finalized. For example, the Mercer report referenced Health Insurance Industry Fees effective 2014, now identified by The Centers for Medicare and Medicaid Services, Department of Health and Human Services (HHS) as Transitional Reinsurance, Risk Corridors, and Risk Adjustment Programs. The Transitional Reinsurance Program is applicable to the State Group Insurance Program, however the others are not. This is a temporary program, in place from 2014 to 2016, and the primary purpose of the program is to help stabilize premiums in the individual health insurance marketplace. The total amount to be collected under the program is projected to be $25 billion over three years. HHS has recently released proposed preliminary guidance for determining enrollment and associated costs, however final guidance is slated for release in 2013. Impacts to the State Employees' Group Health Program will need to be determined at that time.

In some instances, implementation of reforms may require changes to state law for compliance or to avoid significant penalties. For example, current law prohibits employees in the Other Personal Services (OPS) category from being covered by the State Group Insurance Program. However, this prohibition subjects the State to significant penalties (potentially exceeding $318 million annually). This analysis assumes that such employees, meeting hours of work requirements, would be covered. This report reflects the changes to the financial impact forecasted in the August 2012, due to increased OPS enrollment.

This report has been revised to reflect updated OPS and Opt Out data and projected costs associated with implementation of the Individual Mandates with federal subsidies for these two groups. There is a substantial increase in reported OPS enrollment, up from 3,864 OPS workers forecasted in August 2012, to 6,291 OPS workers reported for this analysis. The number of Opt Outs has decreased from 14,897 to 13,723.

These enrollment changes have had the following impacts to previously forecasted revenues: Fiscal Year 2013-14 revenues increased from $27.04M to $37.02, up $9.98M; FY 2014-15 revenues increased from $57.24M to $73.46, up $16.22M; and for FY 2015-16 revenues increase from $65M to $80.6M, up $15.6M, for a total revenue increase of $41.8M for the FY 2013-14 through FY 2015-16 periods.

The fiscal impacts to previously forecasted expenses due to the changes in OPS and Opt Outs are: Fiscal Year 2013-14 expenses increased from $48.82M to $59.79M, up $10.97M; FY 2014-15 expenses of $117.55M increased to $137.27M, up $19.72M; and, for FY 2015-16 expenses of $127.55M increased to $155.09M, up $27.54M, for a total expense increase of $58.23M for FY 2013-15 through FY 2015-16 periods.

SUMMARY OF PPACA REFORMS WITH A FISCAL IMPACT ON THE STATE EMPLOYEES' HEALTH INSURANCE PROGRAM (PROGRAM)

1. **Early Retiree Reinsurance Program (ERRP) – Interim Final Regulations Effective on June 1, 2010**

   - **Effective June 2010**
   - **No** estimated fiscal impact to Trust Fund (Estimated fiscal impact modified by Division of State Group Insurance to reflect that federal money provided for this purpose has been depleted prior to the state receiving any requested reimbursements.)

   Provides reimbursement to participating employment-based plans for a portion of the cost of health benefits for early retirees and their spouses, surviving spouses and dependents.

   - 80% Reimbursement for certain claims between $15,000 and $90,000 (with those amounts being indexed for plan years starting on or after October 1, 2011).
   - Claims must be for participants ages 55-64 who are not Medicare eligible.
   - Payments must be used to lower plan costs (i.e. offsetting future premium increases for all members).

2. **No lifetime dollar maximum**

   - **Effective January 1, 2011**
   - Actual costs are embedded in medical and pharmacy claims reported in FY 2011-12 and subsequent years. As a result, specific costs cannot be separately identified for this estimate and are not included.

   Plans cannot impose any lifetime dollar limits on benefits.

   - Plans may place lifetime limits per beneficiary on specific covered benefits other than "essential health benefits," if the limits are otherwise permitted by federal or state law.
   - **Essential health benefits** include items and services in the below listed categories:
     - ambulatory patient services; emergency services; hospital, maternity and newborn care; mental health and substance use disorders, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services; chronic disease management; and pediatric services, including oral and vision care.

3. **Restricted annual dollar limits**

   - **Effective January 1, 2011**
   - **No** estimated fiscal impact as minimum requirements are already met by the Program.

   All insured and self-insured group health plans will face new rules on annual dollar limits. For plan years subsequent to 2011, "restricted" or no annual dollar limits may apply to "essential health benefits" (discussed below).

   - The maximum annual dollar limit that may be imposed on essential health benefits are:
     - $750,000 for the plan year beginning on or after September 23, 2010 but before September 23, 2011.

- $1,250,000 for the plan year beginning on or after September 23, 2011 but before September 23, 2012.
- $2,000,000 for the plan year beginning on or after September 23, 2012 but before January 1, 2014.
- No annual dollar limits permitted for plan years on or after January 1, 2014.

- Plans may impose annual per-beneficiary limits on non-essential benefits.

4. Elimination of preexisting condition for subscribers or dependents under 19 – Interim Final Regulations Issued on June 28, 2010

- **Effective January 1, 2011**
- Actual costs were incurred as part of medical and pharmacy claims in FY 2011-12 and are indeterminable as pertains to PPACA. Costs for FY 2012-13 through FY 2014-15 are based on the FY 2011-12 actual and are also indeterminable.

Before 2014, insured and self-insured plans cannot impose preexisting condition exclusions for subscribers and dependents under age 19.

- Until 2014, employers may continue to adopt or retain preexisting condition exclusions for participants ages 19 and older.
- A general ban is effective for all members for plan years starting in 2014. See #8 below.

5. Patient-centered outcome research institute fees

- **Effective October 1, 2012 for the next plan year.**
- Annual estimated fiscal impact for the Program – **$750 thousand**.

- State of Florida Employees' Group Health Insurance Program - Beginning January 1, 2012, $1 per participant in 1st year.
- $2 in subsequent years, from 2013 thru 2019 (sunset after 2019).

6. Other pass-through fees included

- **Effective January 1, 2014**
- Annual estimated fiscal impact for the Program – **$42.82 million**.

Fees include pharmaceutical industry fees; 2.3% excise tax on medical devices, and reinsurance, risk corridors, and risk adjustment.

7. Extension of coverage for all adult children until age 26 – Interim Final Regulations Issued on July 12, 2010

- **Effective January 1, 2011**
- Actual costs were embedded in medical and pharmacy claims in FY 2011-12 and subsequent years. As a result, specific costs cannot be separately identified for this estimate and are not included.

Applies to fully-insured and self-insured group health plans providing dependent coverage.

- Coverage available until the child's 26th birthday.
- The mandate applies regardless of the typical criteria for dependent status under the tax law, such as whether the adult child resides with the covered employee or is the employee's tax dependent, a full- or part-time student, or married or unmarried.
- Plans may extend coverage beyond the child's 26th birthday – for example, until the end of the plan year in which the child turns 26. However, plans will not have to extend coverage to an adult child's dependents.
- No special-enrollment period required; eligible dependents need not be enrolled until the plan's next open enrollment.

8. Eliminate all preexisting condition limitations – Interim Final Regulations Issued on July 30, 2010

- **Effective January 1, 2014**
- Annual estimated fiscal impact for the Program –**$4.3 million**.

Preexisting condition limitation exclusion applies to all plan participants regardless of age as of January 1, 2014. See #4 above.

9. Free-choice vouchers (FCVs) – Repealed by Congress

- **Effective January 1, 2014**
- **No** estimated fiscal impact to the Program.

10. Shared responsibility "free rider surcharge'

- **Effective January 1, 2014**
- **No** estimated direct fiscal impact to the Program. .

Individuals who fail to maintain coverage will face a penalty (lesser of these amounts):

- National average premium for the year, or the greater of
- 1% AGI or $95 in 2014; 2% AGI or $325 in 2015; 2.5% AGI or $695 in 2016; indexed thereafter.

11. Medicaid expansion and migration to Exchange

- **Effective January 1, 2014**
- There will be no direct fiscal impact to the Program unless the state elects to expand the current Medicaid Program to include the optional enhancements. The optional enhancements would expand the current Medicaid Program to cover persons up to 138% of the Federal Poverty Level (FPL) beginning in 2014.

Medicaid expanded to up to 133% of Federal Poverty Level (FPL), effective 2014 when the State-exchanges come online.

12. Individual mandate with federal subsidies

- **Effective January 1, 2014**
- Total estimated fiscal impact for the Program – See item #12 on the Summary of Fiscal Impacts to the State Group Insurance Program for details.

- Large employers (those employing 50 or more) are required to offer health coverage to all "full-time" employees (i.e., persons who annually work an average of 30 hours or more per week).
- Employer penalty for failing to offer health coverage for all such "full-time" employees = $2,000 per year, per employee as to all employees, if one or more employees enroll in an exchange and receives a premium credit.
- Subsidies available to anyone on an exchange plan with household income 133-400% FPL (person cannot be Medicaid eligible).
- Income level must be verifiable for the two years prior to the current calendar year of coverage (example, eligibility for affordability assistance for 2016 is based on household income for 2014).
- Assistance in the form of premium credits will be provided for exchange-participants on a sliding scale based on household income. Premium credits will be paid directly to the insurer; individuals will be required to pay insurers any remaining premium amount.
- Employer penalties = $3,000 per year for each employee enrolled in the exchange and receiving a subsidy, if employee is offered coverage which is unaffordable (i.e., cost exceeds 9.5% of the employee's household income) or if the offered coverage fails to cover a minimum of 60% of covered health care expenses. Capped at $2,000 per FTE.
- Employers with more than 200 full-time employees must automatically enroll new full-time employees in a plan (and continue enrollment of current employees). (The implementation date is subject to the adoption of required federal regulations.)

In most instances, these impacts will be borne by the State Employee Health Insurance Trust Fund. In some instances, the fiscal impacts may be borne by other funding sources or participating employers, as determined by the Legislature.

State Health Insurance Program | **State of Florida DSGI**

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	FY 2012-13 Aug '12	FY 2012-13 Dec '12	FY 2012-13 Diff	FY 2013-14 Aug '12	FY 2013-14 Dec '12	FY 2013-14 Diff	FY 2014-15 Aug '12	FY 2014-15 Dec '12	FY 2014-15 Diff	FY 2015-16 [2] Aug '12	FY 2015-16 [2] Dec '12	FY 2015-16 [2] Diff
1. Early retiree medical reinsurance		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*											
2. No lifetime dollar maximum	Jan 2011	**Net**	*ALREADY EMBEDDED*											
3. Restricted annual dollar limits		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*											
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	**Net**	*ALREADY EMBEDDED*											
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	-	-	-	-
		E	0.38	0.38	-	0.75	0.75	-	0.75	0.75	-	0.75	0.75	-
		Net	**(0.38)**	**(0.38)**	**-**	**(0.75)**	**(0.75)**	**-**	**(0.75)**	**(0.75)**	**-**	**(0.75)**	**(0.75)**	**-**
6. Other pass-through fees include:														
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-	-	-	-	-	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	E	-	-	-	20.41	20.41	-	42.82	42.82	-	42.82	42.82	-
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	**Net**	**-**	**-**	**-**	**(20.41)**	**(20.41)**	**-**	**(42.82)**	**(42.82)**	**-**	**(42.82)**	**(42.82)**	**-**
7. Extension of coverage for all adult children until age 26	Jan 2011	**Net**	*ALREADY EMBEDDED*											
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	-	-	-	-
		E	-	-	-	2.03	2.03	-	4.30	4.30	-	4.30	4.30	-
		Net	**-**	**-**	**-**	**(2.03)**	**(2.03)**	**-**	**(4.30)**	**(4.30)**	**-**	**(4.30)**	**(4.30)**	**-**
9. Free choice vouchers		**Net**	*REPEALED BY CONGRESS*											
10. Shared responsibility "free rider surcharge"		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*											
11. Medicaid Expansion and migration into Exchange		**Net**	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*											
12. Individual Mandate with federal subsidies	Jan 2014													
Opt-Outs [3]		R	-	-	-	10.88	10.01	(0.87)	29.54	27.16	(2.38)	37.30	34.30	(3.00)
Agency and Universities OPS [4][5][6]		R	-	-	-	16.16	27.01	10.85	27.70	46.30	18.60	27.70	46.30	18.60
Opt-Outs [3]		E	-	-	-	9.04	8.31	(0.73)	29.32	26.98	(2.34)	42.60	39.22	(3.38)
Agency and Universities OPS [4][5][6]		E	-	-	-	16.97	28.67	11.70	39.98	62.04	22.06	36.70	67.62	30.92
		Net	**-**	**-**	**-**	**1.03**	**0.04**	**(0.99)**	**(12.06)**	**(15.56)**	**(3.50)**	**(14.30)**	**(26.24)**	**(11.94)**
TOTAL REVENUES [7]			-	-	-	27.04	37.02	9.98	57.24	73.46	16.22	65.00	80.60	15.60
TOTAL EXPENSES			0.38	0.38	-	48.82	59.79	10.97	117.55	137.27	19.72	127.55	155.09	27.54
NET TOTAL [8]			**(0.38)**	**(0.38)**	**-**	**(21.78)**	**(22.77)**	**(0.99)**	**(60.31)**	**(63.81)**	**(3.50)**	**(62.55)**	**(74.49)**	**(11.94)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program **State of Florida DSGI**

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)
(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	FY 2012-13 Total	FY 2013-14 Total	FY 2014-15 Total	FY 2015-16 Total [2]
1. Early retiree medical reinsurance		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
2. No lifetime dollar maximum	Jan 2011	**Net**	*ALREADY EMBEDDED*			
3. Restricted annual dollar limits		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	**Net**	*ALREADY EMBEDDED*			
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-
		E	0.38	0.75	0.75	0.75
		Net	**(0.38)**	**(0.75)**	**(0.75)**	**(0.75)**
6. Other pass-through fees include:						
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	E	-	20.41	42.82	42.82
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	**Net**	**-**	**(20.41)**	**(42.82)**	**(42.82)**
7. Extension of coverage for all adult children until age 26	Jan 2011	**Net**	*ALREADY EMBEDDED*			
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-
		E	-	2.03	4.30	4.30
		Net	**-**	**(2.03)**	**(4.30)**	**(4.30)**
9. Free choice vouchers		**Net**	*REPEALED BY CONGRESS*			
10. Shared responsibility "free rider surcharge"		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*			
11. Medicaid Expansion and migration into Exchange		**Net**	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*			
12. Individual Mandate with federal subsidies	Jan 2014					
Opt-Outs [3]		R	-	10.01	27.16	34.30
Agency and Universities OPS [4][5][6]		R	-	27.01	46.30	46.30
Opt-Outs [3]		E	-	8.31	26.98	39.22
Agency and Universities OPS [4][5][6]		E	-	28.67	62.04	67.62
		Net	**-**	**0.04**	**(15.56)**	**(26.24)**
TOTAL REVENUES [7]			0.00	37.02	73.46	80.60
TOTAL EXPENSES			0.38	59.79	137.27	155.09
NET TOTAL [8]			**(0.38)**	**(22.77)**	**(63.81)**	**(74.49)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program **State of Florida DSGI**

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	Estimated Annual Fiscal Impact FY 2012-13 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2012-13 Total
1. Early retiree medical reinsurance		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
2. No lifetime dollar maximum	Jan 2011	Net	*ALREADY EMBEDDED*								
3. Restricted annual dollar limits		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	Net	*ALREADY EMBEDDED*								
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	0.18	-	0.20	0.38	**0.38**
		Net	-	-	-	-	(0.18)	-	(0.20)	(0.38)	**(0.38)**
6. Other pass-through fees include:											
Pharmaceutical industry fees	Jan 2011	R	*IMPACT WILL NOT OCCUR UNTIL 2013-14*								
2.3% excise tax on medical devices	Jan 2013	E									
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	**Net**									
7. Extension of coverage for all adult children until age 26	Jan 2011	Net	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	*IMPACT WILL NOT OCCUR UNTIL 2013-14*								
		E									
		Net									
9. Free choice vouchers		Net	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		Net	PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR								
12. Individual Mandate with federal subsidies	Jan 2014										
Opt-Outs [3]		R	*IMPACT WILL NOT OCCUR UNTIL 2013-14*								
Agency and Universities OPS [4][5][6]		R									
Opt-Outs [3]		E									
Agency and Universities OPS [4][5][6]		E									
		Net									
TOTAL REVENUES [7]			**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL EXPENSES			**-**	**-**	**-**	**-**	**0.18**	**-**	**0.20**	**0.38**	**0.38**
NET TOTAL [8]			**-**	**-**	**-**	**-**	**(0.18)**	**-**	**(0.20)**	**(0.38)**	**(0.38)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program **State of Florida DSGI**

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	Estimated Annual Fiscal Impact FY 2013-14 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2013-14 Total
1. Early retiree medical reinsurance		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
2. No lifetime dollar maximum	Jan 2011	**Net**	*ALREADY EMBEDDED*								
3. Restricted annual dollar limits		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	**Net**	*ALREADY EMBEDDED*								
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	**-**
		E	-	-	-	-	0.34	-	0.41	0.75	**0.75**
		Net	-	-	-	-	(0.34)	-	(0.41)	(0.75)	**(0.75)**
6. Other pass-through fees include:											
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-	-	-	-	-	**-**
2.3% excise tax on medical devices	Jan 2013	E	-	-	-	-	7.25	1.87	11.29	20.41	**20.41**
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	**Net**	-	-	-	-	(7.25)	(1.87)	(11.29)	(20.41)	**(20.41)**
7. Extension of coverage for all adult children until age 26	Jan 2011	**Net**	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	**-**
		E	-	-	-	-	0.69	0.21	1.13	2.03	**2.03**
		Net	-	-	-	-	(0.69)	(0.21)	(1.13)	(2.03)	**(2.03)**
9. Free choice vouchers		**Net**	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		**Net**	PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR								
12. Individual Mandate with federal subsidies	Jan 2014										
Opt-Outs [3]		R	-	-	-	-	-	-	-	10.01	**10.01**
Agency and Universities OPS [4][5][6]		R	-	-	-	-	-	-	-	27.01	**27.01**
Opt-Outs [3]		E	-	-	-	-	-	-	-	8.31	**8.31**
Agency and Universities OPS [4][5][6]		E	-	-	-	-	-	-	-	28.67	**28.67**
		Net	-	-	-	-	-	-	-	0.04	**0.04**
TOTAL REVENUES [7]			**-**	**-**	**-**	**-**	**-**	**-**	**-**	**37.02**	**37.02**
TOTAL EXPENSES			**-**	**-**	**-**	**-**	**8.10**	**2.08**	**12.63**	**59.79**	**59.79**
NET TOTAL [8]			**-**	**-**	**-**	**-**	**(8.10)**	**(2.08)**	**(12.63)**	**(22.77)**	**(22.77)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family covera ge if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Re venues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respectiv e fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other part icipating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insu rance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Sin gle OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the Decemb er 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimat ed 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and a re therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have covera ge from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenue s and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program **State of Florida DSGI**

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	Estimated Annual Fiscal Impact FY 2014-15 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2014-15 Total
1. Early retiree medical reinsurance		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
2. No lifetime dollar maximum	Jan 2011	Net	*ALREADY EMBEDDED*								
3. Restricted annual dollar limits		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	Net	*ALREADY EMBEDDED*								
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	-
		E	-	-	-	-	0.33	-	0.42	0.75	**0.75**
		Net	-	-	-	-	(0.33)	-	(0.42)	(0.75)	**(0.75)**
6. Other pass-through fees include:											
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-	-	-	-	-	-
2.3% excise tax on medical devices	Jan 2013	E	7.38	1.90	11.49	20.77	7.83	2.02	12.20	22.05	**42.82**
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	Net	(7.38)	(1.90)	(11.49)	(20.77)	(7.83)	(2.02)	(12.20)	(22.05)	**(42.82)**
7. Extension of coverage for all adult children until age 26	Jan 2011	Net	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	-
		E	0.71	0.22	1.16	2.09	0.75	0.23	1.23	2.21	**4.30**
		Net	(0.71)	(0.22)	(1.16)	(2.09)	(0.75)	(0.23)	(1.23)	(2.21)	**(4.30)**
9. Free choice vouchers		Net	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		Net	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		Net	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*								
12. Individual Mandate with federal subsidies	Jan 2014										
Opt-Outs [3]		R	-	-	-	13.58	-	-	-	13.58	**27.16**
Agency and Universities OPS [4][5][6]		R	-	-	-	23.15	-	-	-	23.15	**46.30**
Opt-Outs [3]		E	-	-	-	13.49	-	-	-	13.49	**26.98**
Agency and Universities OPS [4][5][6]		E	-	-	-	31.02	-	-	-	31.02	**62.04**
		Net	-	-	-	(7.78)	-	-	-	(7.78)	**(15.56)**
TOTAL REVENUES [7]			**-**	**-**	**-**	**36.73**	**-**	**-**	**-**	**36.73**	**73.46**
TOTAL EXPENSES			**8.09**	**2.12**	**12.65**	**67.37**	**9.09**	**2.25**	**14.05**	**69.90**	**137.27**
NET TOTAL [8]			**(8.09)**	**(2.12)**	**(12.65)**	**(30.64)**	**(9.09)**	**(2.25)**	**(14.05)**	**(33.17)**	**(63.81)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

State Health Insurance Program **State of Florida DSGI**

Summary of Fiscal Impact to Forecast of Federal Patient Protection Affordable Care Act (PPACA)

(In Millions)

Reform	Effective Date	Revenue(R) Expense (E) Net [1]	Estimated Annual Fiscal Impact FY 2015-16 July-December Medical	Drugs	HMO	Total	January-June Medical	Drugs	HMO	Total	FY 2015-16 Total
1. Early retiree medical reinsurance		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
2. No lifetime dollar maximum	Jan 2011	**Net**	*ALREADY EMBEDDED*								
3. Restricted annual dollar limits		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
4. Eliminate preexisting condition limitations for dependent children under 19	Jan 2011	**Net**	*ALREADY EMBEDDED*								
5. Patient-centered outcomes research institute fees ($1 per participant in first year, $2 in 2nd year, assumes 3rd year is same as 2nd year)	Jan 2012	R	-	-	-	-	-	-	-	-	**-**
		E	-	-	-	-	0.33	-	0.42	0.75	**0.75**
		Net	-	-	-	-	(0.33)	-	(0.42)	(0.75)	**(0.75)**
6. Other pass-through fees include:											
Pharmaceutical industry fees	Jan 2011	R	-	-	-	-	-	-	-	-	**-**
2.3% excise tax on medical devices	Jan 2013	E	7.38	1.90	11.49	20.77	7.83	2.02	12.20	22.05	**42.82**
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	**Net**	(7.38)	(1.90)	(11.49)	(20.77)	(7.83)	(2.02)	(12.20)	(22.05)	**(42.82)**
7. Extension of coverage for all adult children until age 26	Jan 2011	**Net**	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	**-**
		E	0.71	0.22	1.16	2.09	0.75	0.23	1.23	2.21	**4.30**
		Net	(0.71)	(0.22)	(1.16)	(2.09)	(0.75)	(0.23)	(1.23)	(2.21)	**(4.30)**
9. Free choice vouchers		**Net**	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		**Net**	*PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR*								
12. Individual Mandate with federal subsidies	Jan 2014										
Opt-Outs [3]		R	-	-	-	17.15	-	-	-	17.15	**34.30**
Agency and Universities OPS [4][5][6]		R	-	-	-	23.15	-	-	-	23.15	**46.30**
Opt-Outs [3]		E	-	-	-	19.61	-	-	-	19.61	**39.22**
Agency and Universities OPS [4][5][6]		E	-	-	-	33.81	-	-	-	33.81	**67.62**
		Net	-	-	-	(13.12)	-	-	-	(13.12)	**(26.24)**
TOTAL REVENUES [7]			**-**	**-**	**-**	**40.30**	**-**	**-**	**-**	**40.30**	**80.60**
TOTAL EXPENSES			**8.09**	**2.12**	**12.65**	**76.28**	**9.09**	**2.25**	**14.05**	**78.81**	**155.09**
NET TOTAL [8]			**(8.09)**	**(2.12)**	**(12.65)**	**(35.98)**	**(9.09)**	**(2.25)**	**(14.05)**	**(38.51)**	**(74.49)**

(1) "Net" is defined as Revenue less Expense.

(2) Projected revenues and expenses for Items 1 - 11 of FY 2014-15 are used for FY 2015-16 as the original report by Mercer Consultants did not include projections for FY 2015-16. Revenues and expenses for Item 12 of FY 2015-16 are projected using the analysis described in Notes 3 and 5.

(3) As of November 1, 2012, 13,723 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the November 2012 Single and Family ratios of 38.8% and 61.2%, respectively, it is projected that 5,325 will qualify for single coverage and 8,398 will qualify for family coverage if they elect to enter the Plan. It is projected that 20% of the Opt-Outs will elect to enter the Plan with 10% entering on January 1, 2014, and the remaining 10% on January 1, 2015. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying 50% of Single enrollment by $4,114.18 (7-months premium), 50% of Single enrollment by $7,052.88 (12-months premium), 50% of Family enrollment by $9,303.98 (7-months premium), and 50% of Family enrollment by $15,949.68 (12-months premium). Expenses for FY 2013-14 are determined by multiplying the Opt-Out enrollment by $6,055.84 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,105.53 (12-months claims expense) and 50% of Opt-Out enrollment by $6,552.77 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(4) Current law prohibits participation in the State Group Insurance Program, if law is not amended, the state and other participating employers could be subject to penalties exceeding $318 million annually.

(5) As of November 1, 2012, there are an estimated 2,198 State Agency OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 58% are Single (21.34% are under 30 years old) and 42% are Married. It is projected that 50% of the Married OPS will elect to enter the Plan on January 1, 2014, 50% of the Single OPS Under 30 Years Old will elect to enter the Plan on January 1, 2014, and all of the Single OPS Over 30 Years Old will elect to enter the Plan on January 1, 2014. Revenues for FY 2013-14 are determined by multiplying Single enrollment by $4,114.18 (7-months premium) and Family enrollment by $9,303.98 (7-months premium). For FY 2014-15, revenues are determined by multiplying Single enrollment by $7,052.88 (12-months premium) and Family enrollment by $15,949.68 (12-months premium). Expenses are determined by multiplying the OPS enrollment by $6,055.84 (6-months claims expense) for FY 2013-14 and $13,105.53 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the December 2012 Conference.

(6) The State University System of Florida Board of Governors has indicated that as of November 1, 2012, there are an estimated 7,465 State University System OPS employees who work an annual average of 30 hours or more per week. Of these, 1,844 were reported as having other health coverage and are therefore removed from the Board of Governor's count. Additionally, it is assumed that 25% (320) of Faculty OPS and 15% (585) of Administrative OPS have coverage from other sources and are also removed from the Board of Governor's count. Assumptions pertaining to Single and Married percentages, as well as calculations for Revenues and Expenses, are the same as for State Agency OPS, as noted in (5) above.

(7) Revenues are derived largely from state-paid premiums. The funding methodology determined by the Legislature will establish the cost to the participating employers.

(8) The "net total" simply shows the shortfalls resulting from projected revenues being less than projected expenses.

University OPS

University	Total Number of OPS employees averaging more than 30 hours per week	Number that are students with teaching or research assistantships	Number that currently have university-required health care	Number in faculty or teaching positions	Typical Administrative / Other	OPS Contractors	Other student assistants
FAMU	198	0	0	22	176		
FAU	426	0	0	154	272		
FGCU	17	2	0	0	15		
FIU	264	0	Unknown	24	123		
FSU	1400	44	47	54	1119		
NCF	19	0	0	0	19		
UCF	381	47	Unknown	53	263	18	
UF	2948	note below	note below	138	1026		
UNF	168	0	0	19	127		22
USF	1515	67	38	761	687		
UWF	129	5	0	53	71		
Total SUS	7,465	165	85	1,278	3,898	18	22

Informtion updated 12/7/2012 via SUS data request.

UF knows the number of students w/ teaching or reseasrch assistantships, but cannot provide GA's that meet the 30 hour rule, as they are appointed .25 FTE.
UF can provide total GA numbers: 4,459 GA appointments. Of this number, 3,913 are enrolled in the Gator Grad Care, which is the health plan offered to this group.
There are also 1,759 Clinical Post Docs, Postdoctoral Associates, and Residents appointed greater than 30 hours and enrolled in health insurance. They are included in the 2,948 reported above.

- Clinical post docs: 76
- Postdoctoral Associates: 578
- Residents/Housestaff : 1,105

NOTE: For purposes of projecting financial impacts of extending health coverage to State University OPS , the 1,759 University of Florida Clinical Post Docs, Postdoctoral Associates, and Residents noted above, and the 85 identified as having university-required health coverage, are not included in the projections. Additionally, 25% (320) of Faculty OPS and 15% (585) of Administrative OPS are assumed to have coverage from other sources and are also not included in the projections.