Self-Insurance Estimating Conference
State Employees' Group Health Self-Insurance Trust Fund
Last conference held: August 20, 2012
Executive Summary

The outlook for the State Employees' Health Insurance Trust Fund has been revised to take into account 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 $114.9 million from $126.7 million to $241.6 million, and for 2013-14 the projected ending balance has been increased by $200.7 million from ($52.7) million to $148.0 million. The outlook for subsequent years shows that expenses will exceed revenues by an amount that generates a negative cash flow of $276.6 million in 2014-15 and $484.1 million in 2015-16.

Impacting all areas of the forecast are changes to the enrollment forecast arising from recent experience. Projected enrollment has been reduced slightly throughout the forecast period due to continued reductions in enrollment among active employees. Enrollment for Medicare members and early retirees has also been reduced. Overall enrollment is projected to decline by 0.9% in 2012-13 over 2011-12, and then to decline minimally over the three remaining years of the forecast period. There is also a marginal shift in enrollment among active employees from the HMO plans to the PPO plans, consistent with the June 2012 enrollment figures.

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 (2012-13 only), PPO TPA refunds, HMO PBM rebates, and the HMO Medicare Part D Subsidy, but 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 2011-12 as well as slightly lower enrollment. Additionally, the PPO prescription drug trend was reduced from the previous forecast. Similarly, self-insured HMO medical claims are lower than in the previous forecast. However, HMO prescription drug claims are higher than in the previous forecast as a result of both higher claims in 2011-12 and a higher trend factor. HMO premiums are lower due to enrollment changes. Overall there was a very slight increase in other expenses.

The removal of the prospective Patient Protection and Affordable Care Act (PPACA) revenues and expenditures from this outlook positively benefited the ending cash balance by removing net losses in the latter years. Reports on the Financial Outlook prepared from December 2010 through June 2012 all included estimates of the impact of PPACA on the Program. In the current 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 the new 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*. Moreover, the methodology for developing the estimates has been refined to reflect the conference's understanding of the latest federal guidance on implementation.

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:

- 2012-13 $0.38 million
- 2013-14 $48.82 million
- 2014-15 $117.55 million
- 2015-16 $127.55 million

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

State Employees' Group Health Self-Insurance Trust Fund

Report on the Financial Outlook

For the Fiscal Years Ending June 30, 2012 through June 30, 2016

Adopted August 20, 2012 by the
Self-Insurance Estimating Conference

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

EXECUTIVE SUMMARY

The Division of State Group Insurance has prepared a financial outlook for the State Employees' Group Health Self-Insurance Trust Fund (the Trust Fund) for the fiscal years (FY) ending June 30, 2012 through June 30, 2016, to aid in state planning and budgeting in accordance with Section 216.136(9), *Florida Statutes.* The outlook has been prepared using cash basis methods and modeling and is based on the healthcare benefit and funding designs of current law and current administration.

The Post-Session Outlook presented on June 20, 2012, reported and recognized the fiscal impact resulting from the 2012 General Appropriations Act (Section 8) providing premium increases effective December 2012 for certain Medicare participants, and May 2013 for all other enrollees.

This Outlook uses the June 2012 Post-Session Outlook as the base and reports and recognizes the fiscal impact of the following activities to Trust Fund:

1. Monthly enrollment activity from January 2012 through June 2012.
2. Actual enrollment as of June 30, 2012.
3. FY 2011-12 actual revenue and expense results.
4. FY 2011-12 cash flow activity through June 2012.

A substantial reduction in expenses is contributing to a healthier cash balance during the forecast period. Favorable improvement in the cash position is attributable to a slowing of medical healthcare costs in the self-insured Preferred Provider Organization (PPO) plans and realization of the fiscal impact of the new Health Maintenance Organization (HMO) contracts effective January 1, 2012. The Trust Fund is expected to remain solvent through 2013-14. The actual ending cash balance for FY 2011-12 increased from $227.0 million to $313.9 million, an increase of $86.9 million; the estimated operating gain increased from $29.2 million to $116.1 million. The projected ending cash balance for FY 2012-13 increased from $126.7 million to $241.6 million, an increase of $114.9 million; the estimated operating loss decreased from $100.3 million to $72.3 million, a decrease of $28.0 million. The projected ending cash balance for FY 2013-14 increased from a deficit of $52.7 million to a surplus of $148.0 million, an increase of $200.7 million; the estimated operating loss decreased from $179.4 million to $93.6 million.

If there are no changes to benefit attributes, covered services, premium rates, or other plan factors, the Trust Fund is projected to go from a cash surplus of $241.6 million in FY 2012-13 to a projected ending cash deficit of $128.6 million in FY 2014-15; projected revenue will fall short in meeting health plan cost growth by $276.6 million.

Following is a summary of the outlook from FY 2011-12 through FY 2015-16.

Financial Outlook (Dollars in Millions)	FY 2011-12 Actual	FY 2012-13 Estimate	FY 2013-14 Estimate	FY 2014-15 Estimate	FY 2015-16 Estimate
Beginning Cash Balance	$ 197.8	313.9	241.6	148.0	0.0
Revenues	1,903.4	1,896.8	1,984.0	1,969.6	1,959.8
Expenses	1,787.3	1,969.1	2,077.6	2,246.2	2,443.9
Operating Gain/(Loss)	116.1	(72.3)	(93.6)	(276.6)	(484.1)
Ending Cash Balance	$ 313.9	241.6	148.0	(128.6)	(484.1)

Note: Assumes no carry forward of negative cash balance from prior year beginning FY 2015-16**.**

The cash position of the Trust Fund improved from the previous outlook through the forecast period for all years; however revenues are projected to continue to fall short of expenses for all years. Revised projections are primarily due to an increased ending cash balance recognized in actual results for FY 2011-12, resulting from significantly lower than projected expenses in medical claims and marginal decreases in enrollment. The removal of the prospective PPACA revenues and expenditures from this outlook positively benefited the ending cash balance by removing net losses in the latter years. (See, "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act" report.)

Enrollment patterns suggest decreased projections in Insurance Premiums, PPO Medical Costs, and PPO Prescription drug costs. Minimal decreases in HMO administrative services only (ASO) fees as well as increases in HMO Prescription drug costs are also reflected in this forecast, as compared with previous projections. Projected

non-premium revenue shows minimal changes to the forecast period. Also reflected in this forecast are minimal decreases in Medicare Part D Subsidy projections, resulting from reduced enrollment.

Marginal projected declines in enrollment, as well as projected recurring growth in expenses through the forecast period with relatively stable revenues will cause significant deterioration of the cash position in FY 2014-15 and FY 2015-16. Attention to the cash position will be required in order to maintain sufficient cash balances for operations.

Growth Trends

The declining employee membership trend and other economic influences continue to impact utilization patterns and costs for the state. The medical growth rate for the forecast period is 9.0%. The assumed growth rate falls within the expected industry range of 5.4% to 10.0%.

Prescription drugs are vital to preventing and treating illness and in helping to avoid more costly medical problems. The main factors driving changes in prescription drug costs are: (1) utilization, (2) price changes, and (3) changes in the types of drugs used. The prescription drug market continues to provide opportunities for the dispensing of generic drugs. The offering of new and more expensive biotech and specialty drugs counterbalances the trend towards the utilization of less expensive generic drugs.

The overall prescription drug cost trend rate for PPO has been reduced from 8.9% to 8.3% for the forecast period due primarily to the reduced utilization and trending of lower actual than expected costs. The overall prescription drug cost trend rate for HMO has been increased from 8.6% to 10.3% due to higher than projected drug costs. The assumed growth rate is above the industry range of 6.9% to 9.6%, due primarily to resetting the base for actual claims experience.

The main factors driving changes in prescription drug spending are: (1) membership demographics, (2) utilization, (3) price changes, and (4) changes in the types of drugs used. FY 2011-12 actual PPO pharmacy expenses were significantly lower than projections, while HMO pharmacy expenses were significantly higher than projections. The net pharmacy costs combined exceeded projections significantly, and projections have been adjusted based on actual results, including six months of actual HMO pharmacy experience.

Following is a summary of the trends used in the previous projections and those used for the development of this outlook.

	January 2012		August 2012	
	Trend	Industry Range	Trend	Industry Range
PPO Medical Claims	9.0%	5.4% - 11.7%	9.0%	5.4% - 10.0%
HMO Medical Claims	9.0%		9.0%	
PPO Prescription Drug Claims	8.9%	6.5% - 11.3%	8.3%	6.9% - 9.6%
HMO Prescription Drug Claims	9.6%		10.3%	
HMO Premium Payments	9.0%	9.2% - 10.6%	9.0%	7.8% - 9.9%

* Survey data for Calendar Years 2011 and 2012.

It is noteworthy that the current contract with the PPO Third Party Administrator (TPA) expires on December 31, 2014. Assumptions and projected growth rates used for the forecast could be directly impacted by the results of the procurement of the PPO TPA contract.

Enrollment

Impacting all areas of the forecast are changes to the enrollment forecast, due to recent trends. Overall projected enrollment has been reduced slightly throughout the forecast period, due to continued reductions in enrollment among active employees. Overall enrollment is projected to decline by 0.6% for all years included in this forecast.

June 2012 enrollment totals reflect a marginal shift in active employee enrollment from the HMO plans to the PPO plans resulting in an annual decrease in the HMO enrollment of approximately 870 contracts, or -1.1%, and an annual increase in the PPO enrollment of approximately contracts 98, or 0.2%.

Enrollment patterns for FY 2012-13 through FY 2015-16 reflect a decreasing trend of enrollment in all coverage categories, except Medicare which increases at an annual rate of 503 contracts per year. Total plan enrollment projections result in an annual decrease of 475 contracts per year.

Subscriber migration and new hire election patterns indicate continuing change in the enrollment distribution between the PPO plans and the HMO plans. FY 2012-13 total enrollment distribution is projected at 51.4% in the PPO plans and 48.6% in the HMO plans. However, active employee enrollment is projected at 44.1% in the PPO plans and 55.9% in the HMO plans, during the same period.

Approximately 1,603 subscribers (1,517 active employees) are currently enrolled in a High Deductible Health Plan (0.8% of total enrollment). Approximately 878 of those active employees, or 64.2%, are participating in the integrated state-sponsored Health Savings Account offering.

Federal Patient Protection and Affordable Care Act (PPACA)

During 2010, a consultant was retained to forecast the fiscal impact to the trust fund of new federal mandates required by the Patient Protection and Affordable Care Act (PPACA). Estimates were presented in prior outlooks as a single line in both the Revenue and Expense categories, with supporting detail in appendices 1 and 2 of the Financial Outlooks. The consultant's estimates have been revised over time using more current staffing data and revised assumptions for some of the federal mandates.

Reports on the Financial Outlook prepared from December 2010 through June 2012 included estimates of the impact of PPACA on the Program. In this Report, the impact of PPACA is being treated differently. The new approach, described below, conforms the treatment of the impacts of PPACA on the Program to the treatment used by the Social Services Estimating Conference for Medicaid and KidCare.

Those impacts 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 that will occur in the future have been removed from the Outlook and are now described in a separate report titled the Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act.

One future PPACA impact that should be highlighted is the treatment of employees paid from Other Personnel Services (OPS). Current state law specifically excludes OPS employees from participating in the Program. However, under PPACA the state will be required to extend health insurance coverage to all its full time employees (those working 30 hours or more per week) or be subject to a penalty. Assuming that some OPS employees meet the definition of full time employees under the federal law, the state will be assessed a penalty of approximately $312.6 million annually if these OPS employees cannot participate in the Program. This estimated penalty has been calculated at $2,000 for each full time employee of the entities participating in the Program. In lieu of paying the federal penalty, the state may decide to allow OPS employees that are considered full time employees under PPACA to participate in the Program. This change would result in increased premiums and increased expenses for the plan. The total expense to the trust fund associated with including OPS personnel, in the first full year of implementation, would be slightly less than $40 million.

In a number of areas, federal regulations implementing PPACA have not been finalized. Therefore, it will be necessary to continually monitor developments to ensure that the impacts on the Trust Fund are fully understood and decisions can be made accordingly.

The removal of the prospective PPACA revenues and expenditures from this outlook positively benefited the ending cash balance by removing net losses in the latter years. (See, "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act" report.)

Exhibits

The exhibits that follow provide more in-depth information about projected enrollment, expected health care cost growth, cash positions and comparisons to the previous outlook.

STATE EMPLOYEES' GROUP HEALTH SELF-INSURANCE TRUST FUND

Exhibit I

Financial Outlook by Fiscal Year

Highlights of Changes to Forecast - Conference July 2012 Compared to June 2012

(In Millions)

	FY 2011-12			FY 2012-13			FY 2013-14			FY 2014-15			FY 2015-16		
	June '12	Aug '12	Diff.	June '12	Aug '12	Diff.	June '12	Aug '12	Diff.	June '12	Aug '12	Diff.	June '12	Aug '12	Diff.
BEGINNING CASH BALANCE	$ 197.8	$ 197.8	$ -	$ 227.0	$ 313.9	$ 86.9	$ 126.7	$ 241.6	$ 114.9	$ 0.0	$ 148.0	$ 148.0	$ 0.0	$ 0.0	$ -
REVENUES:															
Insurance Premiums	$ 1,811.2	$ 1,825.1	$ 13.9	$ 1,820.0	$ 1,809.2	$ (10.8)	$ 1,914.0	$ 1,902.5	$ (11.5)	$ 1,905.1	$ 1,895.0	$ (10.1)	$ 1,897.9	$ 1,887.8	$ (10.1)
Investment Interest	4.2	4.7	0.5	3.5	5.5	2.0	-	3.9	3.9	-	-	-	-	-	-
PPO-TPA Refunds	10.6	11.9	1.3	7.2	9.3	2.1	7.2	9.3	2.1	7.2	9.3	2.1	7.2	9.3	2.1
PPO-PBM Rebates	23.0	24.2	1.2	27.5	23.4	(4.1)	24.9	17.6	(7.3)	21.7	14.8	(6.9)	20.2	13.2	(7.0)
HMO-PBM Rebates	-	-	-	7.0	9.8	2.8	7.5	9.2	1.7	8.2	8.3	0.1	9.1	7.7	(1.4)
Pretax Trust Fund Transfer	18.0	19.0	1.0	18.0	19.0	1.0	18.0	19.0	1.0	18.0	19.0	1.0	18.0	19.0	1.0
PPO-Medicare Part D Subsidy	19.3	15.7	(3.6)	20.6	19.6	(1.0)	22.5	21.5	(1.0)	23.2	22.2	(1.0)	22.8	21.8	(1.0)
HMO-Medicare Part D Subsidy	-	0.3	0.3	-	1.0	1.0	-	1.0	1.0	-	1.0	1.0	-	1.0	1.0
Other Revenues	-	2.5	2.5	-	-	-	-	-	-	-	-	-	-	-	-
PPACA	-	-	-	-	-	-	104.0	-	(104.0)	211.1	-	(211.1)	211.1	-	(211.1)
TOTAL REVENUES	$ 1,886.3	$ 1,903.4	$ 17.1	$ 1,903.8	$ 1,896.8	$ (7.0)	$ 2,098.1	$ 1,984.0	$ (114.1)	$ 2,194.5	$ 1,969.6	$ (224.9)	$ 2,186.3	$ 1,959.8	$ (226.5)
TOTAL CASH AVAILABLE	$ 2,084.1	$ 2,101.2	$ 17.1	$ 2,130.8	$ 2,210.7	$ 79.9	$ 2,224.8	$ 2,225.6	$ 0.8	$ 2,194.5	$ 2,117.6	$ (76.9)	$ 2,186.3	$ 1,959.8	$ (226.5)
EXPENSES:															
PPO Plan	$ 940.6	$ 881.0	$ (59.6)	$ 999.1	$ 943.0	$ (56.1)	$ 1,069.7	$ 1,006.0	$ (63.7)	$ 1,147.1	$ 1,069.1	$ (78.0)	$ 1,229.1	$ 1,147.9	$ (81.2)
HMO Plan	919.4	897.9	(21.5)	980.6	1,016.4	35.8	1028.4	1062.5	34.1	1133.3	1168.0	34.7	1,248.9	1,286.9	38.0
HSA Deposits	1.6	1.7	0.1	1.6	1.6	-	1.6	1.6	-	1.6	1.6	-	1.6	1.6	-
Operating Costs & Admin Assessme	2.6	2.2	(0.4)	2.6	3.6	1.0	2.6	3.0	0.4	2.6	3.0	0.4	2.6	3.0	0.4
Premium Refunds	3.5	4.4	0.9	3.5	4.4	0.9	3.5	4.4	0.9	3.5	4.4	0.9	3.5	4.4	0.9
Other Expenses	0.1	0.1	-	0.1	0.1	-	0.1	0.1	-	0.1	0.1	-	0.1	0.1	-
PPACA	(10.7)	-	10.7	16.6	-	(16.6)	171.6	-	(171.6)	339.2	-	(339.2)	339.2	-	(339.2)
TOTAL EXPENSES	$ 1,857.1	$ 1,787.3	$ (69.8)	$ 2,004.1	$ 1,969.1	$ (35.0)	$ 2,277.5	$ 2,077.6	$ (199.9)	$ 2,627.4	$ 2,246.2	$ (381.2)	$ 2,825.0	$ 2,443.9	$ (381.1)
EXCESS OF REV. OVER EXP.	$ 29.2	$ 116.1	$ 86.9	$ (100.3)	$ (72.3)	$ 28.0	$ (179.4)	$ (93.6)	$ 85.8	$ (432.9)	$ (276.6)	$ 156.3	$ (638.7)	$ (484.1)	$ 154.6
ENDING CASH BALANCE	**$ 227.0**	**$ 313.9**	**$ 86.9**	**$ 126.7**	**$ 241.6**	**$ 114.9**	**$ (52.7)**	**$ 148.0**	**$ 200.7**	**$ (432.9)**	**$ (128.6)**	**$ 304.3**	**$ (638.7)**	**$ (484.1)**	**$ 154.6**
ADDITONAL INFORMATION															
Total Unreported Claims Liability	**$ 115.2**	**$ 123.9**	**$ 8.7**	**$ 120.6**	**$ 139.3**	**$ 18.7**	**$ 126.5**	**$ 142.2**	**$ 15.7**	**$ 132.8**	**$ 150.6**	**$ 17.8**	**$ 139.9**	**$ 166.4**	**$ 26.5**

Revenue and Expense categories have been collapsed to present the highlights of changes to forecast.
Exhibits II through XII present detail forecast information per fiscal year.

Highlights of Changes to Forecast

- Inclusion of actual enrollment through June 2012
- Inclusion of actual cash flow activity through June 2012
- Correction to Medicare rates for Calendar Year 2013
- Removal of PPACA revenues and expenses from the Report on the Financial Outlook

Exhibit II

Financial Outlook by Fiscal Year [1] (In Millions)

		FY 2011-12 Actual	FY 2012-13 Estimate	FY 2013-14 Estimate	FY 2014-15 Estimate	FY 2015-16 Estimate
BEGINNING CASH BALANCE		$ 197.8	$ 313.9	$ 241.6	$ 148.0	$ 0.0 [2]
REVENUES:						
Insurance Premiums:						
Employer		$ 1,446.0	$ 1,430.6	$ 1,511.7	$ 1,502.0	$ 1,492.3
Employee		165.3	163.4	162.5	161.5	160.6
HSA Contributions [3]		1.7	1.6	1.6	1.6	1.6
COBRA		6.0	6.1	6.4	6.4	6.4
Early Retiree		63.0	61.6	64.9	64.8	64.7
Medicare		143.1	145.9	155.4	158.7	162.2
Investment Interest		4.7	5.5	3.9	0.0	0.0
PPO-TPA Refunds		11.9	9.3	9.3	9.3	9.3
PPO-PBM Rebates [4]		24.2	23.4	17.6	14.8	13.2
HMO-PBM Rebates [5]		0.0	9.8	9.2	8.3	7.7
Pretax Trust Fund Transfer		19.0	19.0	19.0	19.0	19.0
PPO-Medicare Part D Subsidy		15.7	19.6	21.5	22.2	21.8
HMO-Medicare Part D Subsidy		0.3	1.0	1.0	1.0	1.0
Other Revenues		2.5	0.0	0.0	0.0	0.0
PPACA		0.0	0.0	0.0	0.0	0.0
TOTAL REVENUES		$ 1,903.4	$ 1,896.8	$ 1,984.0	$ 1,969.6	$ 1,959.8
TOTAL CASH AVAILABLE		$ 2,101.2	$ 2,210.7	$ 2,225.6	$ 2,117.6	$ 1,959.8
EXPENSES:						
State PPO Plan: [6]						
Medical Claims		$ 600.7	$ 643.9	$ 692.8	$ 745.2	$ 801.5
ASO Fee		19.4	19.2	19.0	18.7	18.5
Prescription Drug Claims [4]		260.7	279.7	294.0	305.0	327.7
PBM Claims Administration		0.2	0.2	0.2	0.2	0.2
HMO Plan: [5][7]						
Premium Payments		626.3	264.5	285.7	315.1	347.5
Medical Claims		190.4	520.6	574.5	634.0	699.6
Risk Reserve [8]		0.0	44.8	N/A	N/A	N/A
ASO Fee		11.2	29.7	32.1	34.1	36.4
Prescription Drug Claims [4]		70.0	156.8	170.2	184.8	203.4
HSA Deposits [3]		1.7	1.6	1.6	1.6	1.6
Operating Costs & Admin Assessment		2.2	3.6	3.0	3.0	3.0
Premium Refunds		4.4	4.4	4.4	4.4	4.4
Other Expenses		0.1	0.1	0.1	0.1	0.1
PPACA		0.0	0.0	0.0	0.0	0.0
TOTAL EXPENSES		$ 1,787.3	$ 1,969.1	$ 2,077.6	$ 2,246.2	$ 2,443.9
EXCESS OF REVENUES OVER EXPENSES		$ 116.1	$ (72.3)	$ (93.6)	$ (276.6)	$ (484.1)
ENDING CASH BALANCE [9]		**$ 313.9**	**$ 241.6**	**$ 148.0**	**$ (128.6)**	**$ (484.1)**
ADDITONAL INFORMATION						
Total Unreported Claims Liability [10]		$ 123.9	$ 139.3	$ 142.2	$ 150.6	$ 166.4
Average Enrollment by Plan	PPO Standard	88,470	86,912	85,769	84,626	83,493
	PPO HIHP	1,083	1,162	1,162	1,162	1,162
	HMO Standard	83,005	82,863	83,906	84,959	86,014
	HMO HIHP	452	441	441	441	441
	Total	173,010	171,378	171,278	171,188	171,110
Average Enrollment by Coverage Type	Active Standard	134,609	132,612	131,993	131,374	130,755
	Active HIHP	1,452	1,517	1,517	1,517	1,517
	COBRA	674	675	675	675	675
	Early Retiree	7,671	7,477	7,490	7,513	7,548
	Medicare	28,604	29,097	29,603	30,109	30,615
	Total	173,010	171,378	171,278	171,188	171,110

[1] Actual results may differ from projected values with increasing likelihood of variance in future periods.

[2] Assumes no carry forward of negative ending cash balance from prior year.

[3] Contributions approximate a split between employer and employee of 42% and 58%, respectively.

[4] Includes estimated fiscal impact of new PBM contract effective January 1, 2012.

[5] Includes estimated fiscal impact of new HMO contracts effective January 1, 2012.

[6] PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.00M.

[7] Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.

[8] Established by Principals of the Revenue Estimating Conference for HMO medical and prescription drug claims. Calculated for Fiscal Year 2012-13 at 6.5% of total estimated HMO claim costs.

[9] Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.

[10] Includes estimated PPO Plan and Self-Insured HMO Plans Incurred but not Reported (IBNR) claims and outstanding drafts.

Exhibit III

Financial Outlook - Fiscal Year 2011-12 (In Millions)

		(A) June '12	(B) Aug '12	(B) - (A) Difference
BEGINNING CASH BALANCE		$ 197.8	$ 197.8	$ 0.0
REVENUES:				
Insurance Premiums:				
Employer		$ 1,431.4	$ 1,446.0	$ 14.6
Employee		165.3	165.3	0.0
HSA Contributions [1]		1.6	1.7	0.1
COBRA		6.2	6.0	(0.2)
Early Retiree		63.5	63.0	(0.5)
Medicare		143.2	143.1	(0.1)
Investment Interest		4.2	4.7	0.5
PPO-TPA Refunds		10.6	11.9	1.3
PPO-PBM Rebates		23.0	24.2	1.2
HMO-PBM Rebates [2][3]		0.0	0.0	0.0
Pretax Trust Fund Transfer		18.0	19.0	1.0
PPO Medicare Part D Subsidy		19.3	15.7	(3.6)
HMO Medicare Part D Subsidy		0.0	0.3	0.3
Other Revenues		0.0	2.5	2.5
PPACA		0.0	0.0	0.0
TOTAL REVENUES		$ 1,886.3	$ 1,903.4	$ 17.1
TOTAL CASH AVAILABLE		$ 2,084.1	$ 2,101.2	$ 17.1
EXPENSES:				
State PPO Plan: [4]				
Medical Claims		$ 631.5	$ 600.7	$ (30.8)
ASO Fee		19.4	19.4	0.0
Prescription Drug Claims [3]		289.5	260.7	(28.8)
PBM Claims Administration [3]		0.2	0.2	0.0
HMO Plan: [2][5]				
Premium Payments		626.3	626.3	0.0
Medical Claims		199.9	190.4	(9.5)
Risk Reserve [6]		22.3	0.0	(22.3)
ASO Fee		14.3	11.2	(3.1)
Prescription Drug Claims [3]		56.6	70.0	13.4
HSA Deposits [1]		1.6	1.7	0.1
Operating Costs & Admin Assessment		2.6	2.2	(0.4)
Premium Refunds		3.5	4.4	0.9
Other Expenses		0.1	0.1	0.0
PPACA		(10.7)	0.0	10.7
TOTAL EXPENSES		$ 1,857.1	$ 1,787.3	$ (69.8)
EXCESS OF REVENUES OVER EXPENSES		$ 29.2	$ 116.1	$ 86.9
ENDING CASH BALANCE [7]		**$ 227.0**	**$ 313.9**	**$ 86.9**
ADDITONAL INFORMATION				
Total Unreported PPO Plan Claims Liability [8]		$ 64.5	$ 62.6	$ (1.9)
Total Unreported HMO Plan Claims Liability [9]		50.7	57.5	6.8
Total Unreported PBM Claims Liability [10]		n/a	3.8	3.8
Total Unreported Claims Liability		$ 115.2	$ 123.9	$ 8.7
Average Enrollment by Plan	PPO Standard	88,391	88,470	79
	PPO HIHP	1,067	1,083	16
	HMO Standard	83,197	83,005	(192)
	HMO HIHP	450	452	2
	Total	173,105	173,010	(95)
Average Enrollment by Coverage Type	Active Standard	134,636	134,609	(27)
	Active HIHP	1,432	1,452	20
	COBRA	691	674	(17)
	Early Retiree	7,704	7,671	(33)
	Medicare	28,642	28,604	(38)
	Total	173,105	173,010	(95)

[1] Contributions approximate a split between employer and employee of 42% and 58%, respectively.

[2] Includes estimated fiscal impact of new HMO contracts effective January 1, 2012.

[3] Includes estimated fiscal impact of new PBM contract effective January 1, 2012.

[4] PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.

[5] Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.

[6] Actual expenses recognized in medical claims, pharmacy claims, and ASO fees.

[7] Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.

[8] Includes estimated PPO Incurred but not Reported (IBNR) claims of $55.6M and outstanding drafts of $7.0M.

[9] Includes estimated HMO IBNR medical claims and outstanding drafts.

[10] Includes estimated PPO and HMO IBNR Rx claims.

Exhibit IV
Financial Outlook - Fiscal Year 2012-13 (In Millions)

		(A) June '12	(B) Aug '12	(B) - (A) Difference
BEGINNING CASH BALANCE		$ 227.0	$ 313.9	$ 86.9
REVENUES:				
Insurance Premiums:				
Employer		$ 1,438.0	$ 1,430.6	$ (7.4)
Employee		163.9	163.4	(0.5)
HSA Contributions [1]		1.6	1.6	0.0
COBRA		6.3	6.1	(0.2)
Early Retiree		63.6	61.6	(2.0)
Medicare		146.6	145.9	(0.7)
Investment Interest		3.5	5.5	2.0
PPO-TPA Refunds		7.2	9.3	2.1
PPO-PBM Rebates [2]		27.5	23.4	(4.1)
HMO-PBM Rebates [2][3]		7.0	9.8	2.8
Pretax Trust Fund Transfer		18.0	19.0	1.0
PPO Medicare Part D Subsidy		20.6	19.6	(1.0)
HMO Medicare Part D Subsidy		0.0	1.0	1.0
Other Revenues		0.0	0.0	0.0
PPACA		0.0	0.0	0.0
TOTAL REVENUES		$ 1,903.8	$ 1,896.8	$ (7.0)
TOTAL CASH AVAILABLE		$ 2,130.8	$ 2,210.7	$ 79.9
EXPENSES:				
State PPO Plan: [4]				
Medical Claims		$ 678.6	$ 643.9	$ (34.7)
ASO Fee		19.1	19.2	0.1
Prescription Drug Claims [2]		301.2	279.7	(21.5)
PBM Claims Administration [2]		0.2	0.2	0.0
HMO Plan: [3][5]				
Premium Payments		266.6	264.5	(2.1)
Medical Claims		520.6	520.6	0.0
Risk Reserve [6]		42.1	44.8	2.7
ASO Fee		30.2	29.7	(0.5)
Prescription Drug Claims [2]		121.1	156.8	35.7
HSA Deposits [1]		1.6	1.6	0.0
Operating Costs & Admin Assessment		2.6	3.6	1.0
Premium Refunds		3.5	4.4	0.9
Other Expenses		0.1	0.1	0.0
PPACA		16.6	0.0 [7]	(16.6)
TOTAL EXPENSES		$ 2,004.1	$ 1,969.1	$ (35.0)
EXCESS OF REVENUES OVER EXPENSES		$ (100.3)	$ (72.3)	$ 28.0
ENDING CASH BALANCE [8]		**$ 126.7**	**$ 241.6**	**$ 114.9**
ADDITONAL INFORMATION				
Total Unreported PPO Plan Claims Liability [9]		$ 64.5	$ 62.6	$ (1.9)
Total Unreported HMO Plan Claims Liability [10]		56.1	68.0	11.9
Total Unreported PBM Claims Liability [11]		n/a	8.7	8.7
Total Unreported Claims Liability		$ 120.6	$ 139.3	$ 18.7
Average Enrollment by Plan	PPO Standard	87,083	86,912	(171)
	PPO HIHP	1,111	1,162	51
	HMO Standard	83,805	82,863	(942)
	HMO HIHP	429	441	12
	Total	172,428	171,378	(1,050)
Average Enrollment by Coverage Type	Active Standard	133,450	132,612	(838)
	Active HIHP	1,451	1,517	66
	COBRA	699	675	(24)
	Early Retiree	7,657	7,477	(180)
	Medicare	29,171	29,097	(74)
	Total	172,428	171,378	(1,050)

[1] Contributions approximate a split between employer and employee of 42% and 58%, respectively.

[2] Includes estimated fiscal impact of new PBM contract effective January 1, 2012.

[3] Includes estimated fiscal impact of new HMO contracts effective January 1, 2012.

[4] PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.

[5] Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.

[6] Established by Principals of the Revenue Estimating Conference for HMO medical and prescription drug claims. Calculated at 6.5% of total estimated HMO claim costs.

[7] PPACA impact moved to the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act" report.

[8] Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.

[9] Includes estimated PPO Incurred but not Reported (IBNR) claims of $55.6M and outstanding drafts of $7.0M.

[10] Includes estimated HMO IBNR medical claims and outstanding drafts.

[11] Includes estimated PPO and HMO IBNR Rx claims.

Exhibit V

Financial Outlook - Fiscal Year 2013-14 (In Millions)

		(A) June '12	(B) Aug '12	(B) - (A) Difference
BEGINNING CASH BALANCE		$ 126.7	$ 241.6	$ 114.9
REVENUES:				
Insurance Premiums:				
Employer		$ 1,519.5	$ 1,511.7	$ (7.8)
Employee		163.0	162.5	(0.5)
HSA Contributions [1]		1.6	1.6	0.0
COBRA		6.6	6.4	(0.2)
Early Retiree		67.1	64.9	(2.2)
Medicare		156.2	155.4	(0.8)
Investment Interest		0.0	3.9	3.9
PPO-TPA Refunds		7.2	9.3	2.1
PPO-PBM Rebates [2]		24.9	17.6	(7.3)
HMO-PBM Rebates [2][3]		7.5	9.2	1.7
Pretax Trust Fund Transfer		18.0	19.0	1.0
PPO Medicare Part D Subsidy		22.5	21.5	(1.0)
HMO Medicare Part D Subsidy		0.0	1.0	1.0
Other Revenues		0.0	0.0	0.0
PPACA		104.0	0.0 [4]	(104.0)
TOTAL REVENUES		$ 2,098.1	$ 1,984.0	$ (114.1)
TOTAL CASH AVAILABLE		$ 2,224.8	$ 2,225.6	$ 0.8
EXPENSES:				
State PPO Plan: [5]				
Medical Claims		$ 730.0	$ 692.8	$ (37.2)
ASO Fee		18.9	19.0	0.1
Prescription Drug Claims [2]		320.6	294.0	(26.6)
PBM Claims Administration [2]		0.2	0.2	0.0
HMO Plan: [3][6]				
Premium Payments		288.0	285.7	(2.3)
Medical Claims		575.6	574.5	(1.1)
ASO Fee		32.6	32.1	(0.5)
Prescription Drug Claims [2]		132.2	170.2	38.0
HSA Deposits [1]		1.6	1.6	0.0
Operating Costs & Admin Assessment		2.6	3.0	0.4
Premium Refunds		3.5	4.4	0.9
Other Expenses		0.1	0.1	0.0
PPACA		171.6	0.0 [4]	(171.6)
TOTAL EXPENSES		$ 2,277.5	$ 2,077.6	$ (199.9)
EXCESS OF REVENUES OVER EXPENSES		$ (179.4)	$ (93.6)	$ 85.8
ENDING CASH BALANCE [7]		**$ (52.7)**	**$ 148.0**	**$ 200.7**
ADDITONAL INFORMATION				
Total Unreported PPO Plan Claims Liability [8]		$ 64.5	$ 62.6	$ (1.9)
Total Unreported HMO Plan Claims Liability [9]		62.0	70.3	8.3
Total Unreported PBM Claims Liability [10]		n/a	9.3	9.3
Total Unreported Claims Liability		$ 126.5	$ 142.2	$ 15.7
Average Enrollment by Plan	PPO Standard	85,940	85,769	(171)
	PPO HIHP	1,111	1,162	51
	HMO Standard	84,850	83,906	(944)
	HMO HIHP	429	441	12
	Total	172,330	171,278	(1,052)
Average Enrollment by Coverage Type	Active Standard	132,831	131,993	(838)
	Active HIHP	1,451	1,517	66
	COBRA	699	675	(24)
	Early Retiree	7,672	7,490	(182)
	Medicare	29,677	29,603	(74)
	Total	172,330	171,278	(1,052)

[1] Contributions approximate a split between employer and employee of 42% and 58%, respectively.

[2] Includes estimated fiscal impact of new PBM contract effective January 1, 2012.

[3] Includes estimated fiscal impact of new HMO contracts effective January 1, 2012.

[4] PPACA impact moved to the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act" report.

[5] PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.

[6] Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.

[7] Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.

[8] Includes estimated PPO Incurred but not Reported (IBNR) claims of $55.6M and outstanding drafts of $7.0M.

[9] Includes estimated HMO IBNR medical claims and outstanding drafts.

[10] Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VI

Financial Outlook - Fiscal Year 2014-15 (In Millions)

		(A) June '12	(B) Aug '12	(B) - (A) Difference
BEGINNING CASH BALANCE		$ 0.0 [1]	$ 148.0	$ 148.0
REVENUES:				
Insurance Premiums:				
Employer		$ 1,509.8	$ 1,502.0	$ (7.8)
Employee		162.0	161.5	(0.5)
HSA Contributions [2]		1.6	1.6	0.0
COBRA		6.6	6.4	(0.2)
Early Retiree		66.9	64.8	(2.1)
Medicare		158.2	158.7	0.5
Investment Interest		0.0	0.0	0.0
PPO-TPA Refunds		7.2	9.3	2.1
PPO-PBM Rebates [3][4]		21.7	14.8	(6.9)
HMO-PBM Rebates		8.2	8.3	0.1
Pretax Trust Fund Transfer		18.0	19.0	1.0
PPO Medicare Part D Subsidy		23.2	22.2	(1.0)
HMO Medicare Part D Subsidy		0.0	1.0	1.0
Other Revenues		0.0	0.0	0.0
PPACA		211.1	0.0 [5]	(211.1)
TOTAL REVENUES		$ 2,194.5	$ 1,969.6	$ (224.9)
TOTAL CASH AVAILABLE		$ 2,194.5	$ 2,117.6	$ (76.9)
EXPENSES:				
State PPO Plan: [6]				
Medical Claims		$ 785.3	$ 745.2	$ (40.1)
ASO Fee		18.7	18.7	0.0
Prescription Drug Claims [3]		342.9	305.0	(37.9)
PBM Claims Administration [3]		0.2	0.2	0.0
HMO Plan: [4][7]				
Premium Payments		317.7	315.1	(2.6)
Medical Claims		635.1	634.0	(1.1)
ASO Fee		34.7	34.1	(0.6)
Prescription Drug Claims [3]		145.8	184.8	39.0
HSA Deposits [2]		1.6	1.6	0.0
Operating Costs & Admin Assessment		2.6	3.0	0.4
Premium Refunds		3.5	4.4	0.9
Other Expenses		0.1	0.1	0.0
PPACA		339.2	0.0 [5]	(339.2)
TOTAL EXPENSES		$ 2,627.4	$ 2,246.2	$ (381.2)
EXCESS OF REVENUES OVER EXPENSES		$ (432.9)	$ (276.6)	$ 156.3
ENDING CASH BALANCE [8]		**$ (432.9)**	**$ (128.6)**	**$ 304.3**
ADDITONAL INFORMATION				
Total Unreported PPO Plan Claims Liability [9]		$ 64.5	$ 62.6	$ (1.9)
Total Unreported HMO Plan Claims Liability [10]		68.3	78.2	9.9
Total Unreported PBM Claims Liability [11]		n/a	9.8	9.8
Total Unreported Claims Liability		$ 132.8	$ 150.6	$ 17.8
Average Enrollment by Plan	PPO Standard	84,797	84,626	(171)
	PPO HIHP	1,111	1,162	51
	HMO Standard	85,904	84,959	(945)
	HMO HIHP	429	441	12
	Total	172,241	171,188	(1,053)
Average Enrollment by Coverage Type	Active Standard	132,212	131,374	(838)
	Active HIHP	1,451	1,517	66
	COBRA	699	675	(24)
	Early Retiree	7,696	7,513	(183)
	Medicare	30,183	30,109	(74)
	Total	172,241	171,188	(1,053)

[1] Assumes no carry forward of negative ending cash balance from prior year.

[2] Contributions approximate a split between employer and employee of 42% and 58%, respectively.

[3] Includes estimated fiscal impact of new PBM contract effective January 1, 2012.

[4] Includes estimated fiscal impact of new HMO contracts effective January 1, 2012.

[5] PPACA impact moved to the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act" report.

[6] PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.

[7] Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.

[8] Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.

[9] Includes estimated PPO Incurred but not Reported (IBNR) claims of $55.6M and outstanding drafts of $7.0M.

[10] Includes estimated HMO IBNR medical claims and outstanding drafts.

[11] Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VII

Financial Outlook - Fiscal Year 2015-16 (In Millions)

		(A) June '12	(B) Aug '12	(B) - (A) Difference
BEGINNING CASH BALANCE		$ 0.0 [1]	$ 0.0 [1]	$ 0.0
REVENUES:				
Insurance Premiums:				
Employer		$ 1,500.1	$ 1,492.3	$ (7.8)
Employee		161.1	160.6	(0.5)
HSA Contributions [2]		1.6	1.6	0.0
COBRA		6.6	6.4	(0.2)
Early Retiree		66.8	64.7	(2.1)
Medicare		161.7	162.2	0.5
Investment Interest		0.0	0.0	0.0
PPO-TPA Refunds		7.2	9.3	2.1
PPO-PBM Rebates [3][4]		20.2	13.2	(7.0)
HMO-PBM Rebates		9.1	7.7	(1.4)
Pretax Trust Fund Transfer		18.0	19.0	1.0
PPO Medicare Part D Subsidy		22.8	21.8	(1.0)
HMO Medicare Part D Subsidy		0.0	1.0	1.0
Other Revenues		0.0	0.0	0.0
PPACA		211.1	0.0 [5]	(211.1)
TOTAL REVENUES		$ 2,186.3	$ 1,959.8	$ (226.5)
TOTAL CASH AVAILABLE		$ 2,186.3	$ 1,959.8	$ (226.5)
EXPENSES:				
State PPO Plan: [6]				
Medical Claims		$ 844.7	$ 801.5	$ (43.2)
ASO Fee		18.5	18.5	0.0
Prescription Drug Claims [3]		365.7	327.7	(38.0)
PBM Claims Administration [3]		0.2	0.2	0.0
HMO Plan: [4][7]				
Premium Payments		350.3	347.5	(2.8)
Medical Claims		700.8	699.6	(1.2)
ASO Fee		36.9	36.4	(0.5)
Prescription Drug Claims [3]		160.9	203.4	42.5
HSA Deposits [2]		1.6	1.6	0.0
Operating Costs & Admin Assessment		2.6	3.0	0.4
Premium Refunds		3.5	4.4	0.9
Other Expenses		0.1	0.1	0.0
PPACA		339.2	0.0 [5]	(339.2)
TOTAL EXPENSES		$ 2,825.0	$ 2,443.9	$ (381.1)
EXCESS OF REVENUES OVER EXPENSES		$ (638.7)	$ (484.1)	$ 154.6
ENDING CASH BALANCE [8]		**$ (638.7)**	**$ (484.1)**	**$ 154.6**
ADDITONAL INFORMATION				
Total Unreported PPO Plan Claims Liability [9]		$ 70.0	$ 62.6	$ (7.4)
Total Unreported HMO Plan Claims Liability [10]		70.0	93.1	23.2
Total Unreported PBM Claims Liability [11]		n/a	10.7	10.7
Total Unreported Claims Liability		$ 139.9	$ 166.4	$ 26.5
Average Enrollment by Plan	PPO Standard	83,661	83,493	(168)
	PPO HIHP	1,111	1,162	51
	HMO Standard	86,960	86,014	(946)
	HMO HIHP	429	441	12
	Total	172,161	171,110	(1,051)
Average Enrollment by Coverage Type	Active Standard	131,593	130,755	(838)
	Active HIHP	1,451	1,517	66
	COBRA	699	675	(24)
	Early Retiree	7,729	7,548	(181)
	Medicare	30,689	30,615	(74)
	Total	172,161	171,110	(1,051)

[1] Assumes no carry forward of negative ending cash balance from prior year.

[2] Contributions approximate a split between employer and employee of 42% and 58%, respectively.

[3] Includes estimated fiscal impact of new PBM contract effective January 1, 2012.

[4] Includes estimated fiscal impact of new HMO contracts effective January 1, 2012.

[5] PPACA impact moved to the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act" report.

[6] PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.

[7] Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.

[8] Includes $36.5M held in accounts outside of the Trust Fund at the Dept. of Financial Services, Division of Treasury, for the purpose of paying medical claims.

[9] Includes estimated PPO Incurred but not Reported (IBNR) claims of $55.6M and outstanding drafts of $7.0M.

[10] Includes estimated HMO IBNR medical claims and outstanding drafts.

[11] Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VIII

Comparison of Financial Outlooks

Fiscal Year 2011-12

(In Millions)

$ 227.0 Previous Ending Cash Balance Forecast [1]

17.1 Increase in Revenue Forecast
- 13.9 - Net increase in Insurance Premiums
  - (0.9) - Decrease in employer and enrollee Insurance Premiums due to lower actual enrollment from 173,105 to 173,010 and category shifts
  - 14.8 - An accounting transaction reduced FY 2010-11 and increased FY 2011-12 insurance premiums in the amount of $14.8M for a net impact of $0.0
- 0.5 - Increase in Investment Interest due to a higher actual than projected cash balance
- 1.3 - Increase in PPO-TPA Refunds due to nonrecurring activity
- 1.2 - Increase in PPO-PBM Rebates due to higher actual Rx claim costs
- 1.0 - Increase in Pretax Trust Fund Transfers due to higher actual than projected revenues
- (3.6) - Decrease in PPO-Medicare Part D Subsidy due to timing of receipt of subsidy payments
- 0.3 - Increase in HMO-Medicare Part D Subsidy due to shift to self insured HMO models
- 2.5 - Increase in Other Revenue due to legal settlement from previous PBM manager

(69.8) Decrease in Expense Forecast

(59.6) Decrease in State PPO Plan
- (30.8) - Decrease in Medical Claims
  - (31.5) - Decrease due to lower actual than projected claims experience through June 2012
  - 0.7 - Increase due to an increase in actual enrollment from 89,458 to 89,553 and category shifts
- (28.8) - Decrease in Prescription Drug Claims
  - (29.1) - Decrease due to lower actual than projected paid claims experience through June 2012
  - 0.3 - Increase due to actual higher than projected enrollment and category shifts

(21.5) Decrease in HMO Plan
- (9.5) - Decrease in Medical Claims
  - (8.6) - Decrease due to lower actual than projected claims experience through June 2012
  - (0.9) - Decrease due to a decrease in actual enrollment from 86,647 to 83,457 and category shifts
- (22.3) - Decrease in Risk Reserve due to lower than anticipated HMO medical claims
- (3.1) - Decrease in ASO Fee due to lower actual than projected Fiscal Year enrollment
- 13.4 - Increase in Prescription Drug Claims
  - 13.7 - Increase due to higher actual than projected paid claims experience
  - (0.3) - Decrease due to lower actual than projected enrollment and category shifts

11.3 Increase in Other Expense Categories
- 0.1 - Increase in HSA Deposits due to higher actual than projected activity
- (0.4) - Decrease in Operating Costs and Administrative Assessments due to lower actual than projected activity
- 0.9 - Increase in Premium Refunds due to higher actual than projected activity
- 10.7 - Increase in PPACA due to a decrease in projected $25.7M in Early Retiree Reinsurance Program collections and realization of other PPACA expenses projected at $15.0M in incurred medical and Rx claims

$ 313.9 Ending Cash Balance

[1] Self Insurance Estimating Conference held in June 2012.

Exhibit IX
Comparison of Financial Outlooks
Fiscal Year 2012-13
(In Millions)

$ 126.7 Previous Ending Cash Balance Forecast [1]

86.9 Increase in Beginning Cash Balance Forecast

(7.0) Decrease in Revenue Forecast

(10.8) - Net decrease in Insurance Premiums

0.4 - Increase due to premium rates effective May 2013 for June 2013 coverage

(11.2) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 172,428 to 171,378 and category shifts

2.0 - Increase in Investment Interest due to an increase in projected cash balance

2.1 - Increase in PPO-TPA Refunds due to higher actual base for FY 11-12

(4.1) - Decrease in PPO-PBM Rebates due to lower projected Rx claim costs

2.8 - Increase in HMO-PBM Rebates due to an increase in the projected HMO Rx claim costs

1.0 - Increase in Pretax Trust Fund Transfer due to higher actual FY 11-12 transfer

(1.0) - Decrease in PPO-Medicare Part D Subsidy due to category shifts

1.0 - Increase in HMO-Medicare Part D Subsidy due to shift to self insured HMO models

(35.0) Decrease in Expense Forecast

(56.1) Decrease in State PPO Plan

(34.7) - Decrease in Medical Claims

(0.9) - Decrease due to a decrease in projected enrollment from 88,194 to 88,074 and category shifts

(33.8) - Decrease due to lower actual base for FY 2011-12

0.1 - Increase in ASO Fee due to an increase in adjustment factor based on actual experience

(21.5) - Decrease in Prescription Drug Claims

(0.6) - Decrease due to lower projected enrollment and category shifts

(20.9) - Decrease due to lower actual base for FY 2011-12 and lower trend

35.8 Increase in HMO Plan

(2.1) - Decrease in Premium Payments due to a decrease in projected enrollment from 84,234 to 83,304 and category shifts

- - Decrease in Medical Claims

(5.7) - Decrease due to a decrease in projected enrollment

5.7 - Increase due to higher actual base for FY 2011-12

2.7 - Increase in Risk Reserve due to an increase in projected Rx claims

(0.5) - Decrease in ASO Fee due to a decrease in projected enrollment

35.7 - Increase in Prescription Drug Claims

(1.3) - Decrease due to lower projected enrollment

37.0 - Increase due to higher actual base for FY 2011-12 and higher trend

(14.7) Decrease in Other Expense Categories

1.0 - Increase in Operating Costs and Administrative Assessments due to acquisition of Health Insurance Management Information System (HIMIS)

0.9 - Increase in Premium Refunds due to higher base for FY 2011-12

(16.6) - Decrease in PPACA due to reporting of fiscal impact in the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act"

$ 241.6 Ending Cash Balance

[1] Self Insurance Estimating Conference held in June 2012.

Exhibit X
Comparison of Financial Outlooks
Fiscal Year 2013-14
(In Millions)

$ (52.7) Previous Ending Cash Balance Forecast [1]

114.9 Increase in Beginning Cash Balance Forecast

(114.1) Decrease in Revenue Forecast

- (11.5) Net decrease in Insurance Premiums
  - 0.3 Increase due to premium rates effective May 2013 for June 2013 coverage
  - (11.8) Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 172,330 to 171,278 and category shifts
- 3.9 Increase in Investment Interest due to an increase in projected cash balance
- 2.1 Increase in PPO-TPA Refunds due to higher actual base for FY 11-12
- (7.3) Decrease in PPO-PBM Rebates due to lower projected Rx claim costs
- 1.7 Increase in HMO-PBM Rebates due to an increase in projected Rx claim costs
- 1.0 Increase in Pretax Trust Fund Transfer due to higher actual FY 11-12 transfer
- (1.0) Decrease in PPO-Medicare Part D Subsidy due to category shifts
- 1.0 Increase in HMO-Medicare Part D Subsidy due to shift to self insured HMO models
- (104.0) Decrease in PPACA due to reporting of fiscal impact in the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act"

(199.9) Decrease in Expense Forecast

- (63.7) Decrease in State PPO Plan
  - (37.2) Decrease in Medical Claims
    - (1.0) Decrease due to a decrease in projected enrollment from 87,051 to 86,931 and category shifts
    - (36.2) Decrease due to lower actual base for FY 2011-12
  - 0.1 Increase in ASO Fee due to an increase in adjustment factor based on actual experience
  - (26.6) Decrease in Prescription Drug Claims
    - (1.1) Decrease due to lower projected enrollment
    - (25.5) Decrease due to lower actual Rx claim costs for FY 11-12 and lower trend
- 34.1 Increase in HMO Plan
  - (2.3) Decrease in Premium Payments due to a decrease in projected enrollment from 85,279 to 84,347 and category shifts
  - (1.1) Decrease in Medical Claims
    - (6.3) Decrease due to lower projected enrollment
    - 5.2 Increase due to higher actual base for FY 2011-12
  - (0.5) Decrease in ASO Fee due to a decrease in projected enrollment
  - 38.0 Increase in Prescription Drug Claims
    - (1.4) Decrease due to lower projected enrollment
    - 39.4 Increase due to higher actual base for FY 2011-12 and higher trend
- (170.3) Decrease in Other Expense Categories
  - 0.4 Increase in Operating Costs and Administrative Assessments due to acquisition of Health Insurance Management Information System (HIMIS)
  - 0.9 Increase in Premium Refunds due to higher base for FY 2011-12
  - (171.6) Decrease in PPACA due to reporting of fiscal impact in the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act"

148.0 Ending Cash Balance

[1] Self Insurance Estimating Conference held in June 2012.

Exhibit XI
Comparison of Financial Outlooks
Fiscal Year 2014-15
(In Millions)

$ (432.9) Previous Ending Cash Balance Forecast [1]

148.0 Increase in Beginning Cash Balance Forecast

(224.9) Decrease in Revenue Forecast

- (10.1) Net decrease in Insurance Premiums
  - 1.7 Increase due to premium rates effective May 2013 for June 2013 coverage
  - (11.8) Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 172,241 to 171,188 and category shifts
- 2.1 Increase in PPO-TPA Refunds due to higher actual base for FY 11-12
- (6.9) Decrease in PPO-PBM Rebates due to lower projected Rx claim costs
- 0.1 Increase in HMO-PBM Rebates due to an increase in projected Rx claim costs
- 1.0 Increase in Pretax Trust Fund Transfer due to higher actual FY 11-12 transfer
- (1.0) Decrease in PPO-Medicare Part D Subsidy due to category shifts
- 1.0 Increase in HMO-Medicare Part D Subsidy due to shift to self insured HMO models
- (211.1) Decrease in PPACA due to reporting of fiscal impact in the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act"

(381.2) Decrease in Expense Forecast

(78.0) Decrease in State PPO Plan

- (40.1) Decrease in Medical Claims
  - (1.1) Decrease due to a decrease in projected enrollment from 85,908 to 85,788 and category shifts
  - (39.0) Decrease due to lower actual base for FY 2011-12
- (37.9) Decrease in Prescription Drug Claims
  - (1.6) Decrease due to lower projected enrollment
  - (36.3) Decrease due to lower actual Rx claim costs for FY 11-12 and lower trend

34.7 Increase in HMO Plan

- (2.6) Decrease in Premium Payments due to a decrease in projected enrollment from 86,333 to 85,400 and category shifts
- (1.1) Decrease in Medical Claims
  - (6.9) Decrease due to lower projected enrollment
  - 5.8 Increase due to higher actual base for FY 2011-12
- (0.6) Decrease in HMO Plan ASO Fee due to a decrease in projected enrollment
- 39.0 Increase in HMO Plan Prescription Drug Claims
  - (1.6) Decrease due to lower projected enrollment
  - 40.6 Increase due to higher actual base for FY 2011-12 and higher trend

(337.9) Decrease in Other Expense Categories

- 0.4 Increase in Operating Costs and Administrative Assessments due to acquisition of Health Insurance Management Information System (HIMIS)
- 0.9 Increase in Premium Refunds due to higher base for FY 2011-12
- (339.2) Decrease in PPACA due to reporting of fiscal impact in the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act"

(128.6) Ending Cash Balance

[1] Self Insurance Estimating Conference held in June 2012.

Exhibit XII
Comparison of Financial Outlooks
Fiscal Year 2015-16
(In Millions)

$ (638.7) Previous Ending Cash Balance Forecast [1]

(226.5) Decrease in Revenue Forecast
- (10.1) - Net decrease in Insurance Premiums
  - 1.7 - Increase due to premium rates effective May 2013 for June 2013 coverage
  - (11.8) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 172,161 to 171,110 and category shifts
- 2.1 - Increase in PPO-TPA Refunds due to higher actual base for FY 11-12
- (7.0) - Decrease in PPO-PBM Rebates due to lower projected Rx claim costs
- (1.4) - Decrease in HMO-PBM Rebates due to lower projected Rx claim costs
- 1.0 - Increase in Pretax Trust Fund Transfer due to higher actual FY 11-12 transfer
- (1.0) - Decrease in PPO-Medicare Part D Subsidy due to category shifts
- 1.0 - Increase in HMO-Medicare Part D Subsidy due to shift to self insured HMO models
- (211.1) - Decrease in PPACA due to reporting of fiscal impact in the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act"

(381.1) Decrease in Expense Forecast

(81.2) Decrease in State PPO Plan
- (43.2) - Decrease in Medical Claims
  - (1.2) - Decrease due to a decrease in projected enrollment from 84,772 to 84,655 and category shifts
  - (42.0) - Decrease due to lower actual base for FY 2011-12
- (38.0) - Decrease in Prescription Drug Claims
  - (2.2) - Decrease due to lower projected enrollment
  - (35.8) - Decrease due to lower actual Rx claim costs for FY 11-12 and lower trend

38.0 Increase in HMO Plan
- (2.8) - Decrease in Payments due to a decrease in projected enrollment from 87,389 to 86,455 and category shifts
- (1.2) - Decrease in Medical Claims
  - (7.5) - Decrease due to lower projected enrollment
  - 6.3 - Increase due to higher actual base for FY 2011-12
- (0.5) - Decrease in HMO Plan ASO Fee due to a decrease in projected enrollment
- 42.5 - Increase in HMO Plan Prescription Drug Claims
  - (1.7) - Decrease due to lower projected enrollment
  - 44.2 - Increase due to higher actual base for FY 2011-12 and higher trend

(337.9) Decrease in Other Expense Categories
- 0.4 - Increase in Operating Costs and Administrative Assessments due to acquisition of Health Insurance Management Information System (HIMIS)
- 0.9 - Increase in Premium Refunds due to higher base for FY 2011-12
- (339.2) - Decrease in PPACA due to reporting of fiscal impact in the "Impact on the State Health Insurance Program of the Patient Protection and Affordable Care Act"

(484.1) Ending Cash Balance

[1] Self Insurance Estimating Conference held in June 2012.

Premium Rate Table

Effective December 2011 for January 2012 Coverage

(Premium rate change ONLY for CHP and FHCP Medicare Participants)

Subscriber Category / Contribution Cycle		Coverage Type	PPO/HMO Standard			PPO/HMO HIHP		
			Employer	Enrollee	Total	Employer [7]	Enrollee	Total
Career Service	Monthly Full -Time Employees [1]	Single	499.80	50.00	549.80	499.80	15.00	514.80
		Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
		Spouse	1,213.36	30.00	1,243.36	1,097.64	30.00	1,127.64
	Bi-Weekly Full -Time Employees [1]	Single	249.90	25.00	274.90	249.90	7.50	257.40
		Family	531.67	90.00	621.67	531.67	32.15	563.82
		Spouse	606.68	15.00	621.68	548.82	15.00	563.82
"Payalls"	Monthly Full -Time Employees [1,2]	Single	541.46	8.34	549.80	506.46	8.34	514.80
		Family	1,213.34	30.00	1,243.34	1,097.64	30.00	1,127.64
	Bi-Weekly Full -Time Employees [1,2]	Single	270.73	4.17	274.90	253.23	4.17	257.40
		Family	606.67	15.00	621.67	548.82	15.00	563.82
COBRA	Monthly [3]	Single	0.00	560.80	560.80	0.00	482.60	482.60
		Family	0.00	1,268.21	1,268.21	0.00	1,065.20	1,065.20
Early Retirees	Monthly	Single	0.00	549.80	549.80	0.00	473.14	473.14
		Family	0.00	1,243.34	1,243.34	0.00	1,044.31	1,044.31
Overage Dependents		Single	0.00	549.80	549.80	0.00	473.14	473.14

Medicare Monthly Premium Rates (Effective January 1, 2012)				
Plan Name	Plan Type	Medicare I One Eligible [4]	Medicare II One Under/Over [5]	Medicare III Both Eligible [6]
Self-Insured PPO/HMO Plans	Standard	305.82	881.80	611.64
	HIHP	230.52	722.16	461.04
Capital Health Plan [8]	Standard	266.00	895.49	532.00
	HIHP	244.69	810.36	489.38
Florida Health Care Plan [8]	Standard	45.50	644.84	91.00
	HIHP	45.50	534.54	91.00

Notes:

(1) Premium contribution for Part-Time Employees is to be calculated as follows:
Step 1. State Contribution x FTE% = Calculated State Contribution
Step 2. Total Contribution - Calculated State Contribution = Employee Contribution

(2) "Payalls" - Includes executive, legislative and judicial branch agencies for employees with enhanced benefits, excluding Spouse Program participants.

(3) Includes an additional 2% for administrative costs as permitted by federal regulations.

(4) Single coverage for participant eligible for Medicare Parts A and B.

(5) Family coverage for two or more participants, if at least one participant is eligible for Medicare Parts A and B.

(6) Family coverage for two participants and both are eligible for Medicare Parts A and B.

(7) The employer monthly HSA contribution of $41.66/single ($500 annually) and $83.33/family ($1,000 annually) is included in the listed employer rates.

(8) Medicare eligible members who enroll with either CHP or FHCP must also enroll in a Medicare Advantage Prescription Drug ("MAPD") plan with CHP or FHCP for an additional premium.

Premium Rate Table

Effective December 2012 for January 2013 Coverage

(Premium rate change ONLY for CHP and FHCP Medicare Participants)

Subscriber Category / Contribution Cycle		Coverage Type	PPO/HMO Standard			PPO/HMO HIHP		
			Employer	Enrollee	Total	Employer [4]	Enrollee	Total
Career Service	Monthly Full -Time Employees [1]	Single	499.80	50.00	549.80	499.80	15.00	514.80
		Family	1,063.34	180.00	1,243.34	1,063.34	64.30	1,127.64
		Spouse	1,213.36	30.00	1,243.36	1,097.64	30.00	1,127.64
	Bi-Weekly Full -Time Employees [1]	Single	249.90	25.00	274.90	249.90	7.50	257.40
		Family	531.67	90.00	621.67	531.67	32.15	563.82
		Spouse	606.68	15.00	621.68	548.82	15.00	563.82
"Payalls"	Monthly Full -Time Employees [1,2]	Single	541.46	8.34	549.80	506.46	8.34	514.80
		Family	1,213.34	30.00	1,243.34	1,097.64	30.00	1,127.64
	Bi-Weekly Full -Time Employees [1,2]	Single	270.73	4.17	274.90	253.23	4.17	257.40
		Family	606.67	15.00	621.67	548.82	15.00	563.82
COBRA	Monthly [3]	Single	0.00	560.80	560.80	0.00	482.60	482.60
		Family	0.00	1,268.21	1,268.21	0.00	1,065.20	1,065.20
Early Retirees	Monthly	Single	0.00	549.80	549.80	0.00	473.14	473.14
		Family	0.00	1,243.34	1,243.34	0.00	1,044.31	1,044.31
Overage Dependents		Single	0.00	549.80	549.80	0.00	473.14	473.14

Medicare Monthly Premium Rates (Premium rate change effective December 1, 2012 for CHP and FHCP only)				
Plan Name	Plan Type	Medicare I One Eligible [5]	Medicare II One Under/Over [6]	Medicare III Both Eligible [7]
Self-Insured PPO / HMO [8]	Standard	305.82	881.80	611.64
	HIHP	230.52	722.16	461.04
Capital Health Plan [9]	Standard	268.00	921.83	536.00
	HIHP	259.98	853.57	519.96
Florida Health Care Plan [9]	Standard	45.50	696.39	91.00
	HIHP	45.50	576.60	91.00

Notes:

(1) Premium contribution for Part-Time Employees is to be calculated as follows:
Step 1. State Contribution x FTE% = Calculated State Contribution
Step 2. Total Contribution - Calculated State Contribution = Employee Contribution

(2) "Payalls" - Includes executive, legislative and judicial branch agencies for employees with enhanced benefits, excluding Spouse Program participants.

(3) Includes an additional 2% for administrative costs as permitted by federal regulations.

(4) The employer monthly HSA contribution of $41.66/single ($500 annually) and $83.33/family ($1,000 annually) is included in the listed employer rates.

(5) Single coverage for participant eligible for Medicare Parts A and B.

(6) Family coverage for two or more participants, if at least one participant is eligible for Medicare Parts A and B.

(7) Family coverage for two participants and both are eligible for Medicare Parts A and B.

(8) Premium rates for Medicare participants enrolled in a Self-Insured HMO plan may differ from what is presented.

(9) Medicare eligible members who enroll with either CHP or FHCP must also enroll in a Medicare Advantage Prescription Drug ("MAPD") plan with CHP or FHCP.

Premium Rate Table

Effective May 2013 for June 2013 Coverage

(Premium rate change for all participants EXCEPT CHP and FHCP Medicare)

Subscriber Category / Contribution Cycle		Coverage Type	PPO/HMO Standard			PPO/HMO HIHP		
			Employer	Enrollee	Total	Employer [4]	Enrollee	Total
Career Service	Monthly Full -Time Employees [1]	Single	537.74	50.00	587.74	537.74	15.00	552.74
		Family	1,149.14	180.00	1,329.14	1,149.14	64.30	1,213.44
		Spouse	1,299.16	30.00	1,329.16	1,183.44	30.00	1,213.44
	Bi-Weekly Full -Time Employees [1]	Single	268.87	25.00	293.87	268.87	7.50	276.37
		Family	574.57	90.00	664.57	574.57	32.15	606.72
		Spouse	649.58	15.00	664.58	591.72	15.00	606.72
"Payalls"	Monthly Full -Time Employees [1,2]	Single	579.40	8.34	587.74	544.40	8.34	552.74
		Family	1,299.14	30.00	1,329.14	1,183.44	30.00	1,213.44
	Bi-Weekly Full -Time Employees [1,2]	Single	289.70	4.17	293.87	272.20	4.17	276.37
		Family	649.57	15.00	664.57	591.72	15.00	606.72
COBRA	Monthly [3]	Single	0.00	599.49	599.49	0.00	521.30	521.30
		Family	0.00	1,355.72	1,355.72	0.00	1,152.71	1,152.71
Early Retirees	Monthly	Single	0.00	587.74	587.74	0.00	511.08	511.08
		Family	0.00	1,329.14	1,329.14	0.00	1,130.11	1,130.11
Overage Dependents		Single	0.00	587.74	587.74	0.00	511.08	511.08

Medicare Monthly Premium Rates (Premium rate change effective May 1, 2013 for PPO only)				
Plan Name	Plan Type	Medicare I One Eligible [5]	Medicare II One Under/Over [6]	Medicare III Both Eligible [7]
Self-Insured PPO / HMO [8]	Standard	326.92	942.64	653.84
	HIHP	246.43	771.99	492.85
Capital Health Plan [9]	Standard	268.00	921.83	536.00
	HIHP	259.98	853.57	519.96
Florida Health Care Plan [9]	Standard	45.50	696.39	91.00
	HIHP	45.50	576.60	91.00

Notes:

(1) Premium contribution for Part-Time Employees is to be calculated as follows:
Step 1. State Contribution x FTE% = Calculated State Contribution
Step 2. Total Contribution - Calculated State Contribution = Employee Contribution

(2) "Payalls" - Includes executive, legislative and judicial branch agencies for employees with enhanced benefits, excluding Spouse Program participants.

(3) Includes an additional 2% for administrative costs as permitted by federal regulations.

(4) The employer monthly HSA contribution of $41.66/single ($500 annually) and $83.33/family ($1,000 annually) is included in the listed employer rates.

(5) Single coverage for participant eligible for Medicare Parts A and B.

(6) Family coverage for two or more participants, if at least one participant is eligible for Medicare Parts A and B.

(7) Family coverage for two participants and both are eligible for Medicare Parts A and B.

(8) Premium rates for Medicare participants enrolled in a Self-Insured HMO plan may differ from what is presented.

(9) Medicare eligible members who enroll with either CHP or FHCP must also enroll in a Medicare Advantage Prescription Drug ("MAPD") plan with CHP or FHCP.

Exhibit XIII

Abbreviations / Description of Terms

Accrual Basis	…….	Accounting method in which transactions are recorded when the order is made, the item is delivered, or the services occur, regardless of when the money is actually received or paid. Income is recorded when the sale occurs, and expenses are recorded when goods or services are received.
ASO	…….	Administrative Services Only
Cash Basis	…….	Accounting method in which income is not recorded until cash, check or electronic payment is actually received, and expenses are not recorded until they are actually paid.
Carve-Out	…….	Health insurance benefits that are separated from a contract and paid and administered under a different vendor/arrangement.
COBRA	…….	Consolidated Omnibus Budget Reconciliation Act
DSGI	…….	Division of State Group Insurance
FTE	…….	Full Time Equivalency
FY	…….	Fiscal Year (July 1 through June 30)
HIHP	…….	Health Investor Health Plan (i.e., High Deductible Health Plan)
HMO	…….	Health Maintenance Organization
HSA	…….	Health Savings Account
IBNR	…….	Incurred but not Reported Claims – The IBNR claims liability reflect the estimated total amount owed by the trust fund for valid medical claims incurred by self-insured plan members but not yet reported/submitted by providers to the state's TPA.
Fully-Insured Plan	…….	A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all incurred administrative costs.
Medicare Advantage Prescription Drug (MAPD) Plan	…….	A type of Medicare health plan offered by a private company that contracts with Medicare to provide beneficiaries with all Medicare Part A (hospital coverage), Part B (doctors' services, outpatient care, home health services, some preventive services, and other medical services) and Part D (prescription drugs) benefits. MAPDs include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans.
Medicare Part D Subsidy	…….	A federal program passed as part of the Medicare Modernization Act (MMA) in 2003 to subsidize the costs of prescription drugs for Medicare beneficiaries in the United States. By being the primary payer for Medicare eligible subscribers drug claims, the state receives 28 percent of covered charges (net of rebates) between $310 and $6,300 for each Medicare-eligible participant.
Outstanding Drafts	…….	Represent drafts (checks) that have been issued by the PPO plan TPA but have not been presented to the bank account for payment.
N/A	…….	Not applicable.
PBM	…….	Pharmacy Benefits Manager
PPACA	…….	Patient Protection and Affordable Care Act signed into law on March 23, 2010, known as the Federal Health Care Reform
PPO	…….	Preferred Provider Organization
Self-Insured Plan	…….	A plan offered by employers who directly assume the major cost of health insurance for their employees. Some self-insured employers contract with insurance carriers or third party administrators for claims processing and other administrative services; other self-insured plans are self-administered. All types of plans (Conventional Indemnity, Preferred Provider Organizations, Exclusive Provider Organizations, Health Maintenance Organizations, Point of Service, and Physician Hospital Organizations) can be financed on a self-insured basis. Employers may offer both self-insured and fully insured plans to their employees.
TPA	…….	Third Party Administrator

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

Adopted August 20, 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. The 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 the 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.

For purposes of this conference, the impacts of PPACA for fiscal years 2012-13 to 2015-16 are reported separately from the Report on the Financial Outlook of the State Employees' Group Health Self-Insurance Trust Fund. This analysis addresses the potential fiscal impacts on the State Health Insurance Program (the Program) resulting from the implementation of the various provisions of PPACA.

The major health care reform provisions with potential employer impact that have already 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 $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 pharmaceutical industry fees, 2.3% excise tax on medical devices and health insurance industry fees;
- 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.

In some instances, implementation 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 $312 million annually). This analysis assumes that such employees, meeting hours of work requirements, would be covered.

It is important to note that federal regulations implementing PPACA have not been finalized. As a result, assumptions made in this analysis may change as more direction is provided.

The additional costs to the Program from PPACA are reflected in the line titled "TOTAL EXPENSE" in the accompanying tables. They are:

- Fiscal Year 2012 – 2013 $0.38 million
- Fiscal Year 2013 – 2014 $48.82 million
- Fiscal Year 2014 – 2015 $117.55 million
- Fiscal Year 2015 – 2016 $127.55 million

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

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 health insurance industry fees.

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 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
Health Insurance Industry fees	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*			
12. Individual Mandate with federal subsidies	Jan 2014					
Opt-Outs [3]		R	-	10.88	29.54	37.30
Agency and Universities OPS [4][5]		R	-	16.16	27.70	27.70
Opt-Outs [3]		E	-	9.04	29.32	42.60
Agency and Universities OPS [4][5]		E	-	16.97	39.98	36.70
		Net	**-**	**1.03**	**(12.06)**	**(14.30)**
TOTAL REVENUES [6]			0.00	27.04	57.24	65.00
TOTAL EXPENSES			0.38	48.82	117.55	127.55
NET TOTAL [7]			**(0.38)**	**(21.78)**	**(60.31)**	**(62.55)**

(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 August 1, 2012, 14,897 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the FY 2011-12 Single and Family ratios of 38.5% and 61.5%, respectively, it is projected that 5,735 will qualify for single coverage and 9,162 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 $6,065.00 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,121.20 (12-months claims expense) and 50% of Opt-Out enrollment by $6,560.60 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the August 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 $312 million annually.

(5) As of August 1, 2012, there are an estimated 3,864 OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 57.58% are Single (25.45% are under 30 years old) and 42.42% 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 $6,065.00 (6-months claims expense) for FY 2013-14 and $13,121.20 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the August 2012 Conference.

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

(7) 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									
Health Insurance Industry fees	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]		R									
Opt-Outs [3]		E									
Agency and Universities OPS [4][5]		E									
		Net									
TOTAL REVENUES [6]			**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**	**-**
TOTAL EXPENSES			**-**	**-**	**-**	**-**	**0.18**	**-**	**0.20**	**0.38**	**0.38**
NET TOTAL [7]			**-**	**-**	**-**	**-**	**(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 August 1, 2012, 14,897 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the FY 2011-12 Single and Family ratios of 38.5% and 61.5%, respectively, it is projected that 5,735 will qualify for single coverage and 9,162 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 $6,065.00 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,121.20 (12-months claims expense) and 50% of Opt-Out enrollment by $6,560.60 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the August 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 $312 million annually.

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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**
Health Insurance Industry fees	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	-	-	-	-	-	-	-	10.88	**10.88**
Agency and Universities OPS [4][5]		R	-	-	-	-	-	-	-	16.16	**16.16**
Opt-Outs [3]		E	-	-	-	-	-	-	-	9.04	**9.04**
Agency and Universities OPS [4][5]		E	-	-	-	-	-	-	-	16.97	**16.97**
		Net	-	-	-	-	-	-	-	1.03	**1.03**
TOTAL REVENUES [6]			**-**	**-**	**-**	**-**	**-**	**-**	**-**	**27.04**	**27.04**
TOTAL EXPENSES			**-**	**-**	**-**	**-**	**8.10**	**2.08**	**12.63**	**48.82**	**48.82**
NET TOTAL [7]			**-**	**-**	**-**	**-**	**(8.10)**	**(2.08)**	**(12.63)**	**(21.78)**	**(21.78)**

(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 August 1, 2012, 14,897 eligible individuals have opted-out ("Opt-Outs") of the Health Insurance Plan. Using the FY 2011-12 Single and Family ratios of 38.5% and 61.5%, respectively, it is projected that 5,735 will qualify for single coverage and 9,162 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 $6,065.00 (6-months claims expense). For FY 2014-15, expenses are determined by multiplying 50% of Opt-Out enrollment by $13,121.20 (12-months claims expense) and 50% of Opt-Out enrollment by $6,560.60 (6-months claims expense). These amounts are the Program Cost per Contract for the respective fiscal year computed for the August 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 $312 million annually.

(5) As of August 1, 2012, there are an estimated 3,864 OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 57.58% are Single (25.45% are under 30 years old) and 42.42% 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 $6,065.00 (6-months claims expense) for FY 2013-14 and $13,121.20 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the August 2012 Conference.

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

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**
Health Insurance Industry fees	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	-	-	-	14.77	-	-	-	14.77	**29.54**
Agency and Universities OPS [4][5]		R	-	-	-	13.85	-	-	-	13.85	**27.70**
Opt-Outs [3]		E	-	-	-	14.66	-	-	-	14.66	**29.32**
Agency and Universities OPS [4][5]		E	-	-	-	19.99	-	-	-	19.99	**39.98**
		Net	-	-	-	(6.03)	-	-	-	(6.03)	**(12.06)**
TOTAL REVENUES [6]			**-**	**-**	**-**	**28.62**	**-**	**-**	**-**	**28.62**	**57.24**
TOTAL EXPENSES			**8.09**	**2.12**	**12.65**	**57.51**	**9.09**	**2.25**	**14.05**	**60.04**	**117.55**
NET TOTAL [7]			**(8.09)**	**(2.12)**	**(12.65)**	**(28.89)**	**(9.09)**	**(2.25)**	**(14.05)**	**(31.42)**	**(60.31)**

(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.

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(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 $312 million annually.

(5) As of August 1, 2012, there are an estimated 3,864 OPS employees not covered under the State's Health Insurance Plan who work an annual average of 30 hours or more per week. 57.58% are Single (25.45% are under 30 years old) and 42.42% 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 $6,065.00 (6-months claims expense) for FY 2013-14 and $13,121.20 (12-months claims expense) for FY 2014-15. These amounts are the Program Cost per Contract for the respective fiscal year computed for the August 2012 Conference.

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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**
Health Insurance Industry fees	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	-	-	-	18.65	-	-	-	18.65	**37.30**
Agency and Universities OPS [4][5]		R	-	-	-	13.85	-	-	-	13.85	**27.70**
Opt-Outs [3]		E	-	-	-	21.30	-	-	-	21.30	**42.60**
Agency and Universities OPS [4][5]		E	-	-	-	18.35	-	-	-	18.35	**36.70**
		Net	-	-	-	(7.15)	-	-	-	(7.15)	**(14.30)**
TOTAL REVENUES [6]			**-**	**-**	**-**	**32.50**	**-**	**-**	**-**	**32.50**	**65.00**
TOTAL EXPENSES			**8.09**	**2.12**	**12.65**	**62.51**	**9.09**	**2.25**	**14.05**	**65.04**	**127.55**
NET TOTAL [7]			**(8.09)**	**(2.12)**	**(12.65)**	**(30.01)**	**(9.09)**	**(2.25)**	**(14.05)**	**(32.54)**	**(62.55)**

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