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

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

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

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

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

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

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

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

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

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 December 12, 2012 by the
Self-Insurance Estimating Conference

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

EXECUTIVE SUMMARY

The Florida Division of State Group Insurance (the Division) prepared a financial Outlook for the State Employees' Group Health Self-Insurance Trust Fund (the Trust Fund) for the fiscal years ending June 30, 2012, through June 30, 2016 to assist in the State's planning and budgeting in accordance with Section 216.136(9), *Florida Statutes.* The Division prepared the Outlook using cash basis methods and modeling based on the healthcare benefit and funding design currently in place.

The August 2012 Outlook reported and recognized the fiscal impact of the activities listed below:

1. Monthly enrollment 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.

This Outlook used the August 2012 financial outlook as its base and reports and recognizes the fiscal impact of the following activities to Trust Fund:

1. Actual enrollment through November 2012.
2. Actual cash flow through September 2012.
3. Open Enrollment results for Plan Year 2013.
4. Enrollment model revisions.

This Outlook is improved from the prior Outlook presented in August 2012, with increases in ending cash balances for FY 2012-13 and FY 2013-14, as well as reductions in previously projected deficits for FY 2014-15 and FY 2015-16. The increases are due to recognition of monthly enrollment activity through November 2012 and Open Enrollment results for plan year 2013; refined enrollment projection methods; updated revenue and expenditure activity through September 2012; and allocation of the net increase of HMO medical and RX expenses to the Risk Reserve. The Trust Fund is expected to remain solvent through FY 2013-14. The projected ending cash balance for FY 2012-13 increased from $241.6 million to $256.7 million; the estimated operating loss decreased from $72.3 million to $57.2 million. For FY 2013-14 the ending cash balance increased from $148 million to $171.9 million; the estimated operating loss decreased from $93.6 million to $84.8 million. The projected ending cash balance for FY 2014-15 decreased from a projected deficit of $128.6 million to a deficit of $90.8 million.

If there are no changes to benefit attributes, covered services, premium rates, or other plan factors, the Trust Fund is projected to have a cash surplus of $256.7 million in FY 2012-13 and a projected ending cash deficit of $90.8 million in FY 2014-15. Projected revenue will fall short in meeting growth in health plan expenses by $262.7 million in FY 2014-15.

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

Financial Outlook	FY 2011-12	FY 2012-13	FY 2013-14	FY 2014-15	FY 2015-16
(Dollars in Millions)	Actual	Estimate	Estimate	Estimate	Estimate
Beginning Cash Balance	$ 197.8	$ 313.9	$ 256.7	$ 171.9	$ 0.0
Revenues	$ 1,903.4	$ 1,885.2	$ 1,972.6	$ 1,969.5	$ 1,975.3
Expenses	$ 1,787.3	$ 1,942.4	$ 2,057.4	$ 2,232.2	$ 2,443.3
Operating Gan/(Loss)	$ 116.1	$ (57.2)	$ (84.8)	$ (262.7)	$ (468.0)
Ending Cash Balance	$ 313.9	$ 256.7	$ 171.9	$ (90.8)	$ (468.0)

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

Enrollment

Open Enrollment (OE) results for 2013 show a decreased trend in movement from the PPO plans to the HMO plans within the active employee population. PPO plans enrollment decreased by an annual average over the past five years of 1,065 contracts. HMO plans enrollment increased by an annual average of 2,525 contracts over the same period. For 2013, OE reflects a decrease of enrollment in the PPO plan of 779 active contracts and an increase of 2,096 active HMO contracts. The change in new contracts decreased from a five year annual average of 1,460 to 1,317 in 2013.

Lower than previously projected new OE subscribers and a decrease in the employee population from July through November 2012 resulted in adjustments to enrollment projections for the forecast period. Total subscriber enrollment is projected to decrease at an annual average of 0.3 percent through the forecast period. The affected revenue and expense components of the Outlook have been adjusted accordingly to consider the decrease in enrollment provided in previous projections.

Fiscal Year 2012-13 total enrollment distribution is projected at 51.4 percent in the PPO plans and 48.6 percent in the HMO plans. However, active employee enrollment is projected at 44 percent in the PPO plans and 56 percent in the HMO plans, during the same period.

As of November 2012, approximately 1,671 subscribers (1,582 active employees) were currently enrolled in a High Deductible Health Plan (0.986 percent of total enrollment). Approximately 1,049 of those active employees, or 66.3 percent, were participating in the integrated state-sponsored Health Savings Account offering.

In January 2013, approximately 1,678 subscribers (1,586 active employees) will be enrolled in a High Deductible Health Plan (0.983 percent of total enrollment). Approximately 1,085 of those active employees, or 68.4 percent, will be participating in the integrated state-sponsored Health Savings Account offering

Growth Trends

This forecast reflects a moderate reduction in PPO medical expenses over the forecasted period, and an increase in HMO medical claims is forecasted. Additionally, pharmacy costs for both the PPO and HMO have been marginally reduced. These changes are primarily due to updated claims experience through September 2012, as well as changes to updated enrollment projections and enrollment shifts from the PPO to HMO plans.

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 forecasted period is held consistent with the previous forecast at 9.0% for both PPO and HMO. The assumed growth rate falls within the expected industry range of 5.4% to 10.0%.

The forecasted trend rate for prescription drug costs has been reduced from 8.3% to 8.1% for the PPO plan and from 10.3% to 10% for the HMO. The assumed growth rates are within the industry range of 5.3% to 10.5%. The primary drivers impacting the differences in the forecasted trend rates are due to (1) member demographics, (2) utilization and (3) drug mix. Generic dispensing rates are higher among the PPO population, whereas more costly specialty drugs account for a higher percentage of overall drug spend in the HMO population

The increase in premium rates for the two fully-insured HMO vendors continues at 9.0 percent. The assumed growth rate is slightly lower than the expected industry range of 3.5 to 9.2 percent for traditional HMO offerings. For plan year 2013, all counties in Florida will have at least one HMO plan offering. The PPO standard and high deductible health plans remain available worldwide.

Increases in forecasted third party administrator refunds reflected in this Outlook are due primarily to the updates of actuals through September 2012, including the realization of refunds being received under the new self-insured HMO contracts.

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

	August 2012		December 2012 *	
	Trend	Industry Range	Trend	Industry Range
PPO Medical Claims	9.0%	5.4% - 10.0%	9.0%	4.0% - 11.0%
HMO Medical Claims	9.0%		9.0%	
PPO Prescription Drug Claims	8.3%	6.9% - 9.6%	8.1%	5.3% - 10.5%
HMO Prescription Drug Claims	10.3%		10.0%	
HMO Premium Payments	9.0%	7.8% - 9.9%	9.0%	3.5% - 9.2%

* Survey data for Calendar Years 2012 and 2013.

Federal Patient Protection and Affordable Care Act (PPACA)

Reports on the Financial Outlook prepared from December 2010 through June 2012 included estimates of the impact of PPACA on the Program. In the August 2012 Financial Outlook, the impact of PPACA was treated differently with the new approach conforming 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 were 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.

Exhibits

The exhibits that follow provide more in-depth information about the projections, estimated 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 December 2012 Compared to August 2012

(In Millions)

	FY 2011-12			FY 2012-13			FY 2013-14			FY 2014-15			FY 2015-16		
	Aug '12	Dec '12	Diff.	Aug '12	Dec '12	Diff.	Aug '12	Dec '12	Diff.	Aug '12	Dec '12	Diff.	Aug '12	Dec '12	Diff.
BEGINNING CASH BALANCE	$ 197.8	$ 197.8	$ -	$ 313.9	$ 313.9	$ -	$ 241.6	$ 256.7	$ 15.1	$ 148.0	$ 171.9	$ 23.9	$ 0.0	$ 0.0	$ -
REVENUES:															
Insurance Premiums	$ 1,825.1	$ 1,825.1	$ -	$ 1,809.2	$ 1,791.7	$ (17.5)	$ 1,902.5	$ 1,887.7	$ (14.8)	$ 1,895.0	$ 1,891.6	$ (3.4)	$ 1,887.8	$ 1,898.7	$ 10.9
Investment Interest	4.7	4.7	-	5.5	5.6	0.1	3.9	4.2	0.3	-	-	-	-	-	-
PPO-TPA Refunds	11.9	11.9	-	9.3	10.9	1.6	9.3	9.3	-	9.3	9.3	-	9.3	9.3	-
PPO-PBM Rebates	24.2	24.2	-	23.4	23.4	-	17.6	17.5	(0.1)	14.8	14.7	(0.1)	13.2	13.1	(0.1)
HMO-TPA Refunds	-	-	-	-	2.9	2.9	-	2.9	2.9	-	2.9	2.9	-	2.9	2.9
PPO-Medicare Part D Subsidy	15.7	15.7	-	19.6	20.9	1.3	21.5	21.8	0.3	22.2	22.7	0.5	21.8	23.6	1.8
TOTAL REVENUES	$ 1,903.4	$ 1,903.4	$ -	$ 1,896.8	$ 1,885.2	$ (11.6)	$ 1,984.0	$ 1,972.6	$ (11.4)	$ 1,969.6	$ 1,969.5	$ (0.1)	$ 1,959.8	$ 1,975.3	$ 15.5
TOTAL CASH AVAILABLE	$ 2,101.2	$ 2,101.2	$ -	$ 2,210.7	$ 2,199.1	$ (11.6)	$ 2,225.6	$ 2,229.3	$ 3.7	$ 2,117.6	$ 2,141.4	$ 23.8	$ 1,959.8	$ 1,975.3	$ 15.5
EXPENSES:															
PPO Plan	$ 881.0	$ 881.0	$ -	$ 943.0	$ 927.3	$ (15.7)	$ 1,006.0	$ 984.3	$ (21.7)	$ 1,069.1	$ 1,044.8	$ (24.3)	$ 1,147.9	$ 1,122.3	$ (25.6)
HMO Plan	897.9	897.9	-	1,016.4	1,005.4	(11.0)	1062.5	1064.0	1.5	1168.0	1178.3	10.3	1,286.9	1,311.9	25.0
TOTAL EXPENSES	$ 1,787.3	$ 1,787.3	$ -	$ 1,969.1	$ 1,942.4	$ (26.7)	$ 2,077.6	$ 2,057.4	$ (20.2)	$ 2,246.2	$ 2,232.2	$ (14.0)	$ 2,443.9	$ 2,443.3	$ (0.6)
EXCESS OF REV. OVER EXP.	$ 116.1	$ 116.1	$ -	$ (72.3)	$ (57.2)	$ 15.1	$ (93.6)	$ (84.8)	$ 8.8	$ (276.6)	$ (262.7)	$ 13.9	$ (484.1)	$ (468.0)	$ 16.1
ENDING CASH BALANCE	**$ 313.9**	**$ 313.9**	**$ -**	**$ 241.6**	**$ 256.7**	**$ 15.1**	**$ 148.0**	**$ 171.9**	**$ 23.9**	**$ (128.6)**	**$ (90.8)**	**$ 37.8**	**$ (484.1)**	**$ (468.0)**	**$ 16.1**
ADDITONAL INFORMATION															
Total Unreported Claims Liability	**$ 123.9**	**$ 123.9**	**$ -**	**$ 139.3**	**$ 131.0**	**$ (8.3)**	**$ 142.2**	**$ 133.3**	**$ (8.9)**	**$ 150.6**	**$ 141.2**	**$ (9.4)**	**$ 166.4**	**$ 156.4**	**$ (10.0)**

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

1) Inclusion of actual enrollment through November 2012
2) Inclusion of Open Enrollment results for Plan Year 2013
3) Inclusion of actual cash flow activity through September 2012
4) Update to Medicare rates for Self-Insured HMOs
5) Update to calculation of Risk reserve for HMO Medical and Rx claims

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	$ 256.7	$ 171.9	$ 0.0 [2]
REVENUES:						
Insurance Premiums:						
Employer		$ 1,446.0	$ 1,414.0	$ 1,496.5	$ 1,497.0	$ 1,500.3
Employee		165.3	161.6	161.5	161.9	162.6
HSA Contributions [3]		1.7	1.6	1.6	1.6	1.6
COBRA		6.0	6.3	6.7	6.7	6.7
Early Retiree		63.0	61.3	64.3	63.6	62.8
Medicare		143.1	146.9	157.1	160.8	164.7
Investment Interest		4.7	5.6	4.2	0.0	0.0
PPO-TPA Refunds		11.9	10.9	9.3	9.3	9.3
PPO-PBM Rebates		24.2	23.4	17.5	14.7	13.1
HMO-TPA Refunds		0.0	2.9	2.9	2.9	2.9
HMO-PBM Rebates		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	20.9	21.8	22.7	23.6
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
TOTAL REVENUES		$ 1,903.4	$ 1,885.2	$ 1,972.6	$ 1,969.5	$ 1,975.3
TOTAL CASH AVAILABLE		$ 2,101.2	$ 2,199.1	$ 2,229.3	$ 2,141.4	$ 1,975.3
EXPENSES:						
State PPO Plan: [4]						
Medical Claims		$ 600.7	$ 631.7	$ 676.3	$ 726.8	$ 782.0
ASO Fee		19.4	19.1	18.8	18.5	18.2
Prescription Drug Claims		260.7	276.3	289.0	299.3	321.9
PBM Claims Administration		0.2	0.2	0.2	0.2	0.2
HMO Plan: [5]						
Premium Payments		626.3	260.9	282.9	314.4	349.8
Medical Claims		190.4	525.3	581.8	646.7	719.7
Risk Reserve [6]		0.0	35.9	N/A	N/A	N/A
ASO Fee		11.2	29.4	31.8	34.1	36.7
Prescription Drug Claims		70.0	153.9	167.5	183.1	205.7
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
TOTAL EXPENSES		$ 1,787.3	$ 1,942.4	$ 2,057.4	$ 2,232.2	$ 2,443.3
EXCESS OF REVENUES OVER EXPENSES		$ 116.1	$ (57.2)	$ (84.8)	$ (262.7)	$ (468.0)
ENDING CASH BALANCE [7]		**$ 313.9**	**$ 256.7**	**$ 171.9**	**$ (90.8)**	**$ (468.0)**
ADDITONAL INFORMATION						
Total Unreported Claims Liability [8]		$ 123.9	$ 131.0	$ 133.3	$ 141.2	$ 156.4
Average Enrollment by Plan	PPO Standard	88,470	86,200	84,642	83,435	82,347
	PPO HIHP	1,083	1,200	1,207	1,207	1,207
	HMO Standard	83,005	82,241	83,556	85,219	87,000
	HMO HIHP	452	459	464	464	464
	Total	173,010	170,100	169,869	170,325	171,018
Average Enrollment by Coverage Type	Active Standard	134,609	131,248	130,771	131,110	131,736
	Active HIHP	1,452	1,570	1,582	1,582	1,582
	COBRA	674	695	695	695	695
	Early Retiree	7,671	7,404	7,345	7,278	7,189
	Medicare	28,604	29,183	29,476	29,660	29,816
	Total	173,010	170,100	169,869	170,325	171,018

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) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.00M.
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 for Fiscal Year 2012-13 at 6.5% of total estimated HMO claim costs. Per approval of Principals for December 12, 2012 Conference, the calculated amount of the Risk Reserve is reduced by the net increase in HMO Medical and Rx claims from the previous Estimating Conference.
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 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) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE	$ 197.8	$ 197.8	$ 0.0
REVENUES:			
Insurance Premiums:			
Employer	$ 1,446.0	$ 1,446.0	$ 0.0
Employee	165.3	165.3	0.0
HSA Contributions [1]	1.7	1.7	0.0
COBRA	6.0	6.0	0.0
Early Retiree	63.0	63.0	0.0
Medicare	143.1	143.1	0.0
Investment Interest	4.7	4.7	0.0
PPO-TPA Refunds	11.9	11.9	0.0
PPO-PBM Rebates	24.2	24.2	0.0
HMO-PBM Rebates	0.0	0.0	0.0
Pretax Trust Fund Transfer	19.0	19.0	0.0
PPO Medicare Part D Subsidy	15.7	15.7	0.0
HMO Medicare Part D Subsidy	0.3	0.3	0.0
Other Revenues	2.5	2.5	0.0
TOTAL REVENUES	$ 1,903.4	$ 1,903.4	$ 0.0
TOTAL CASH AVAILABLE	$ 2,101.2	$ 2,101.2	$ 0.0
EXPENSES:			
State PPO Plan: [2]			
Medical Claims	$ 600.7	$ 600.7	$ 0.0
ASO Fee	19.4	19.4	0.0
Prescription Drug Claims	260.7	260.7	0.0
PBM Claims Administration	0.2	0.2	0.0
HMO Plan: [3]			
Premium Payments	626.3	626.3	0.0
Medical Claims	190.4	190.4	0.0
Risk Reserve [4]	0.0	0.0	0.0
ASO Fee	11.2	11.2	0.0
Prescription Drug Claims	70.0	70.0	0.0
HSA Deposits [1]	1.7	1.7	0.0
Operating Costs & Admin Assessment	2.2	2.2	0.0
Premium Refunds	4.4	4.4	0.0
Other Expenses	0.1	0.1	0.0
TOTAL EXPENSES	$ 1,787.3	$ 1,787.3	$ 0.0
EXCESS OF REVENUES OVER EXPENSES	$ 116.1	$ 116.1	$ 0.0
ENDING CASH BALANCE [5]	**$ 313.9**	**$ 313.9**	**$ 0.0**
ADDITONAL INFORMATION			
Total Unreported PPO Plan Claims Liability [6]	$ 62.6	$ 62.6	$ 0.0
Total Unreported HMO Plan Claims Liability [7]	57.5	57.5	0.0
Total Unreported PBM Claims Liability [8]	3.8	3.8	0.0
Total Unreported Claims Liability	$ 123.9	$ 123.9	$ 0.0

Average Enrollment by Plan	PPO Standard	88,470	88,470	0
	PPO HIHP	1,083	1,083	0
	HMO Standard	83,005	83,005	0
	HMO HIHP	452	452	0
	Total	173,010	173,010	0
Average Enrollment by Coverage Type	Active Standard	134,609	134,609	0
	Active HIHP	1,452	1,452	0
	COBRA	674	674	0
	Early Retiree	7,671	7,671	0
	Medicare	28,604	28,604	0
	Total	173,010	173,010	0

1) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
2) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
3) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
4) Actual expenses recognized in medical claims, pharmacy claims, and ASO fees.
5) 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.
6) Includes estimated PPO Incurred but not Reported (IBNR) claims of $55.6M and outstanding drafts of $7.0M.
7) Includes estimated HMO IBNR medical claims and outstanding drafts.
8) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit IV

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

		(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE		$ 313.9	$ 313.9	$ 0.0
REVENUES:				
Insurance Premiums:				
Employer		$ 1,430.6	$ 1,414.0	$ (16.6)
Employee		163.4	161.6	(1.8)
HSA Contributions [1]		1.6	1.6	0.0
COBRA		6.1	6.3	0.2
Early Retiree		61.6	61.3	(0.3)
Medicare		145.9	146.9	1.0
Investment Interest		5.5	5.6	0.1
PPO-TPA Refunds		9.3	10.9	1.6
PPO-PBM Rebates		23.4	23.4	0.0
HMO-TPA Refunds		0.0	2.9	2.9
HMO-PBM Rebates		9.8	9.8	0.0
Pretax Trust Fund Transfer		19.0	19.0	0.0
PPO Medicare Part D Subsidy		19.6	20.9	1.3
HMO Medicare Part D Subsidy		1.0	1.0	0.0
Other Revenues		0.0	0.0	0.0
TOTAL REVENUES		$ 1,896.8	$ 1,885.2	$ (11.6)
TOTAL CASH AVAILABLE		$ 2,210.7	$ 2,199.1	$ (11.6)
EXPENSES:				
State PPO Plan: [2]				
Medical Claims		$ 643.9	$ 631.7	$ (12.2)
ASO Fee		19.2	19.1	(0.1)
Prescription Drug Claims		279.7	276.3	(3.4)
PBM Claims Administration		0.2	0.2	0.0
HMO Plan: [3]				
Premium Payments		264.5	260.9	(3.6)
Medical Claims		520.6	525.3	4.7
Risk Reserve [4]		44.8	35.9	(8.9)
ASO Fee		29.7	29.4	(0.3)
Prescription Drug Claims		156.8	153.9	(2.9)
HSA Deposits [1]		1.6	1.6	0.0
Operating Costs & Admin Assessment		3.6	3.6	0.0
Premium Refunds		4.4	4.4	0.0
Other Expenses		0.1	0.1	0.0
TOTAL EXPENSES		$ 1,969.1	$ 1,942.4	$ (26.7)
EXCESS OF REVENUES OVER EXPENSES		$ (72.3)	$ (57.2)	$ 15.1
ENDING CASH BALANCE [5]		**$ 241.6**	**$ 256.7**	**$ 15.1**
ADDITONAL INFORMATION				
Total Unreported PPO Plan Claims Liability [6]		$ 62.6	$ 57.3	$ (5.3)
Total Unreported HMO Plan Claims Liability [7]		68.0	65.1	(2.9)
Total Unreported PBM Claims Liability [8]		8.7	8.6	(0.1)
Total Unreported Claims Liability		$ 139.3	$ 131.0	$ (8.3)
Average Enrollment by Plan	PPO Standard	86,912	86,200	(712)
	PPO HIHP	1,162	1,200	38
	HMO Standard	82,863	82,241	(622)
	HMO HIHP	441	459	18
	Total	171,378	170,100	(1,278)
Average Enrollment by Coverage Type	Active Standard	132,612	131,248	(1,364)
	Active HIHP	1,517	1,570	53
	COBRA	675	695	20
	Early Retiree	7,477	7,404	(73)
	Medicare	29,097	29,183	86
	Total	171,378	170,100	(1,278)

1) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
2) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
3) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
4) Established by Principals of the Revenue Estimating Conference for Fiscal Years 2011-12 and 2012-13 for HMO medical and prescription drug claims. Calculated at 6.5% of total estimated HMO claim costs. Per approval of Principals for December 12, 2012 Conference, the calculated amount of the Risk Reserve is reduced by the net increase of $8.9M in HMO Medical and Rx claims from the previous Estimating Conference. See Page 12 for details on the increase in HMO Medical and Rx claims.
5) 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.
6) Includes estimated PPO Incurred but not Reported (IBNR) claims of $50.3M and outstanding drafts of $7.0M.
7) Includes estimated HMO IBNR medical claims and outstanding drafts.
8) Includes estimated PPO and HMO IBNR Rx claims.

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

		(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE		$ 241.6	$ 256.7	$ 15.1
REVENUES:				
Insurance Premiums:				
Employer		$ 1,511.7	$ 1,496.5	$ (15.2)
Employee		162.5	161.5	(1.0)
HSA Contributions [1]		1.6	1.6	0.0
COBRA		6.4	6.7	0.3
Early Retiree		64.9	64.3	(0.6)
Medicare		155.4	157.1	1.7
Investment Interest		3.9	4.2	0.3
PPO-TPA Refunds		9.3	9.3	0.0
PPO-PBM Rebates		17.6	17.5	(0.1)
HMO-TPA Refunds		0.0	2.9	2.9
HMO-PBM Rebates		9.2	9.2	0.0
Pretax Trust Fund Transfer		19.0	19.0	0.0
PPO Medicare Part D Subsidy		21.5	21.8	0.3
HMO Medicare Part D Subsidy		1.0	1.0	0.0
Other Revenues		0.0	0.0	0.0
TOTAL REVENUES		$ 1,984.0	$ 1,972.6	$ (11.4)
TOTAL CASH AVAILABLE		$ 2,225.6	$ 2,229.3	$ 3.7
EXPENSES:				
State PPO Plan: [2]				
Medical Claims		$ 692.8	$ 676.3	$ (16.5)
ASO Fee		19.0	18.8	(0.2)
Prescription Drug Claims		294.0	289.0	(5.0)
PBM Claims Administration		0.2	0.2	0.0
HMO Plan: [3]				
Premium Payments		285.7	282.9	(2.8)
Medical Claims		574.5	581.8	7.3
ASO Fee		32.1	31.8	(0.3)
Prescription Drug Claims		170.2	167.5	(2.7)
HSA Deposits [1]		1.6	1.6	0.0
Operating Costs & Admin Assessment		3.0	3.0	0.0
Premium Refunds		4.4	4.4	0.0
Other Expenses		0.1	0.1	0.0
TOTAL EXPENSES		$ 2,077.6	$ 2,057.4	$ (20.2)
EXCESS OF REVENUES OVER EXPENSES		$ (93.6)	$ (84.8)	$ 8.8
ENDING CASH BALANCE [4]		**$ 148.0**	**$ 171.9**	**$ 23.9**
ADDITONAL INFORMATION				
Total Unreported PPO Plan Claims Liability [5]		$ 62.6	$ 57.3	$ (5.3)
Total Unreported HMO Plan Claims Liability [6]		70.3	66.9	(3.4)
Total Unreported PBM Claims Liability [7]		9.3	9.1	(0.2)
Total Unreported Claims Liability		$ 142.2	$ 133.3	$ (8.9)
Average Enrollment by Plan	PPO Standard	85,769	84,642	(1,127)
	PPO HIHP	1,162	1,207	45
	HMO Standard	83,906	83,556	(350)
	HMO HIHP	441	464	23
	Total	171,278	169,869	(1,409)
Average Enrollment by Coverage Type	Active Standard	131,993	130,771	(1,222)
	Active HIHP	1,517	1,582	65
	COBRA	675	695	20
	Early Retiree	7,490	7,345	(145)
	Medicare	29,603	29,476	(127)
	Total	171,278	169,869	(1,409)

1) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
2) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
3) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
4) 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.
5) Includes estimated PPO Incurred but not Reported (IBNR) claims of $50.3M and outstanding drafts of $7.0M.
6) Includes estimated HMO IBNR medical claims and outstanding drafts.
7) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VI

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

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE	$ 148.0	$ 171.9	$ 23.9
REVENUES:			
Insurance Premiums:			
Employer	$ 1,502.0	$ 1,497.0	$ (5.0)
Employee	161.5	161.9	0.4
HSA Contributions [1]	1.6	1.6	0.0
COBRA	6.4	6.7	0.3
Early Retiree	64.8	63.6	(1.2)
Medicare	158.7	160.8	2.1
Investment Interest	0.0	0.0	0.0
PPO-TPA Refunds	9.3	9.3	0.0
PPO-PBM Rebates	14.8	14.7	(0.1)
HMO-TPA Refunds	0.0	2.9	2.9
HMO-PBM Rebates	8.3	8.3	0.0
Pretax Trust Fund Transfer	19.0	19.0	0.0
PPO Medicare Part D Subsidy	22.2	22.7	0.5
HMO Medicare Part D Subsidy	1.0	1.0	0.0
Other Revenues	0.0	0.0	0.0
TOTAL REVENUES	$ 1,969.6	$ 1,969.5	$ (0.1)
TOTAL CASH AVAILABLE	$ 2,117.6	$ 2,141.4	$ 23.8
EXPENSES:			
State PPO Plan: [2]			
Medical Claims	$ 745.2	$ 726.8	$ (18.4)
ASO Fee	18.7	18.5	(0.2)
Prescription Drug Claims	305.0	299.3	(5.7)
PBM Claims Administration	0.2	0.2	0.0
HMO Plan: [3]			
Premium Payments	315.1	314.4	(0.7)
Medical Claims	634.0	646.7	12.7
ASO Fee	34.1	34.1	0.0
Prescription Drug Claims	184.8	183.1	(1.7)
HSA Deposits [1]	1.6	1.6	0.0
Operating Costs & Admin Assessment	3.0	3.0	0.0
Premium Refunds	4.4	4.4	0.0
Other Expenses	0.1	0.1	0.0
TOTAL EXPENSES	$ 2,246.2	$ 2,232.2	$ (14.0)
EXCESS OF REVENUES OVER EXPENSES	$ (276.6)	$ (262.7)	$ 13.9
ENDING CASH BALANCE [4]	**$ (128.6)**	**$ (90.8)**	**$ 37.8**
ADDITONAL INFORMATION			
Total Unreported PPO Plan Claims Liability [5]	$ 62.6	$ 57.3	$ (5.3)
Total Unreported HMO Plan Claims Liability [6]	78.2	74.3	(3.9)
Total Unreported PBM Claims Liability [7]	9.8	9.6	(0.2)
Total Unreported Claims Liability	$ 150.6	$ 141.2	$ (9.4)
Average Enrollment by Plan — PPO Standard	84,626	83,435	(1,191)
PPO HIHP	1,162	1,207	45
HMO Standard	84,959	85,219	260
HMO HIHP	441	464	23
Total	171,188	170,325	(863)
Average Enrollment by Coverage Type — Active Standard	131,374	131,110	(264)
Active HIHP	1,517	1,582	65
COBRA	675	695	20
Early Retiree	7,513	7,278	(235)
Medicare	30,109	29,660	(449)
Total	171,188	170,325	(863)

1) Contributions approximate a split between employer and employee of 42% and 58%, respectively.
2) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
3) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
4) 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.
5) Includes estimated PPO Incurred but not Reported (IBNR) claims of $50.3M and outstanding drafts of $7.0M.
6) Includes estimated HMO IBNR medical claims and outstanding drafts.
7) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VII

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

	(A) Aug '12	(B) Dec '12	(B) - (A) Difference
BEGINNING CASH BALANCE	$ 0.0 [1]	$ 0.0 [1]	$ 0.0
REVENUES:			
Insurance Premiums:			
Employer	$ 1,492.3	$ 1,500.3	$ 8.0
Employee	160.6	162.6	2.0
HSA Contributions [2]	1.6	1.6	0.0
COBRA	6.4	6.7	0.3
Early Retiree	64.7	62.8	(1.9)
Medicare	162.2	164.7	2.5
Investment Interest	0.0	0.0	0.0
PPO-TPA Refunds	9.3	9.3	0.0
PPO-PBM Rebates	13.2	13.1	(0.1)
HMO-TPA Refunds	0.0	2.9	2.9
HMO-PBM Rebates	7.7	7.7	0.0
Pretax Trust Fund Transfer	19.0	19.0	0.0
PPO Medicare Part D Subsidy	21.8	23.6	1.8
HMO Medicare Part D Subsidy	1.0	1.0	0.0
Other Revenues	0.0	0.0	0.0
TOTAL REVENUES	$ 1,959.8	$ 1,975.3	$ 15.5
TOTAL CASH AVAILABLE	$ 1,959.8	$ 1,975.3	$ 15.5
EXPENSES:			
State PPO Plan: [3]			
Medical Claims	$ 801.5	$ 782.0	$ (19.5)
ASO Fee	18.5	18.2	(0.3)
Prescription Drug Claims	327.7	321.9	(5.8)
PBM Claims Administration	0.2	0.2	0.0
HMO Plan: [4]			
Premium Payments	347.5	349.8	2.3
Medical Claims	699.6	719.7	20.1
ASO Fee	36.4	36.7	0.3
Prescription Drug Claims	203.4	205.7	2.3
HSA Deposits [2]	1.6	1.6	0.0
Operating Costs & Admin Assessment	3.0	3.0	0.0
Premium Refunds	4.4	4.4	0.0
Other Expenses	0.1	0.1	0.0
TOTAL EXPENSES	$ 2,443.9	$ 2,443.3	$ (0.6)
EXCESS OF REVENUES OVER EXPENSES	$ (484.1)	$ (468.0)	$ 16.1
ENDING CASH BALANCE [5]	**$ (484.1)**	**$ (468.0)**	**$ 16.1**
ADDITONAL INFORMATION			
Total Unreported PPO Plan Claims Liability [6]	$ 62.6	$ 57.3	$ (5.3)
Total Unreported HMO Plan Claims Liability [7]	93.1	88.5	(4.6)
Total Unreported PBM Claims Liability [8]	10.7	10.6	(0.1)
Total Unreported Claims Liability	$ 166.4	$ 156.4	$ (10.0)
Average Enrollment by Plan – PPO Standard	83,493	82,347	(1,146)
PPO HIHP	1,162	1,207	45
HMO Standard	86,014	87,000	986
HMO HIHP	441	464	23
Total	171,110	171,018	(92)
Average Enrollment by Coverage Type – Active Standard	130,755	131,736	981
Active HIHP	1,517	1,582	65
COBRA	675	695	20
Early Retiree	7,548	7,189	(359)
Medicare	30,615	29,816	(799)
Total	171,110	171,018	(92)

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) PPO bank services are estimated at approximately $35,000 per year for the projected period, which rounds to $0.0M.
4) Estimated annual HMO PBM claim administration costs are approximately $20,000 and therefore round to $0.0M.
5) 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.
6) Includes estimated PPO Incurred but not Reported (IBNR) claims of $50.3M and outstanding drafts of $7.0M.
7) Includes estimated HMO IBNR medical claims and outstanding drafts.
8) Includes estimated PPO and HMO IBNR Rx claims.

Exhibit VIII
Comparison of Financial Outlooks
Fiscal Year 2011-12
(In Millions)

$	**313.9**	**Previous Ending Cash Balance Forecast** [1]
	-	Increase in Revenue Forecast
	-	Decrease in Expense Forecast
$	**313.9**	**Ending Cash Balance**

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

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

$ 241.6 Previous Ending Cash Balance Forecast [1]

- Increase in Beginning Cash Balance Forecast

(11.6) Decrease in Revenue Forecast

(17.5) - Net decrease in Insurance Premiums

(1.9) - Decrease due to premium rates effective May 2013 for June 2013 coverage

(15.6) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 171,378 to 170,100 and category shifts

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

1.6 - Increase in PPO-TPA Refunds due to higher projected activity

2.9 - Increase in HMO-TPA Refunds due to higher projected activity

1.3 - Increase in PPO-Medicare Part D Subsidy due to higher projected activity

(26.7) Decrease in Expense Forecast

(15.7) Decrease in State PPO Plan

(12.2) - Decrease in Medical Claims

(4.9) - Decrease due to a decrease in projected enrollment from 88,074 to 87,400 and category shifts

(7.3) - Decrease due to lower projected claims experience

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

(3.4) - Decrease in Prescription Drug Claims

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

(1.3) - Decrease due to lower projected claims experience and trend

(11.0) Decrease in HMO Plan

(3.6) - Decrease in Premium Payments due to a decrease in projected enrollment from 30,616 to 30,299 and category shifts

4.7 - Increase in Medical Claims

(5.9) - Decrease due to a decrease in projected enrollment from 53,002 to 52,400

10.6 - Increase due to higher projected claims experience

(8.9) - Decrease in Risk Reserve due to an increase in projected Medical and Rx claims

(0.3) - Decrease in ASO Fees due to a decrease in projected enrollment from 53,002 to 52,400

(2.9) - Decrease in Prescription Drug Claims

(1.2) - Decrease due to a decrease in projected enrollment from 83,304 to 82,699

(1.7) - Decrease due to lower projected claims experience and trend

$ 256.7 Ending Cash Balance

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

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

$ 148.0 Previous Ending Cash Balance Forecast [1]

- 15.1 Increase in Beginning Cash Balance Forecast
- (11.4) Decrease in Revenue Forecast
  - (14.8) - Net decrease in Insurance Premiums
    - 1.5 - Increase due to premium rates effective May 2013 for June 2013 coverage
    - (16.3) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 171,278 to 169,869 and category shifts
  - 0.3 - Increase in Investment Interest due to an increase in projected cash balance
  - (0.1) - Decrease in PPO-PBM Rebates due to a decrease in projected claims experience
  - 2.9 - Increase in HMO-TPA Refunds due to higher projected activity
  - 0.3 - Increase in PPO-Medicare Part D Subsidy due to higher projected activity
- (20.2) Decrease in Expense Forecast
  - (21.7) Decrease in State PPO Plan
    - (16.5) - Decrease in Medical Claims
      - (8.8) - Decrease due to a decrease in projected enrollment from 86,931 to 85,849 and category shifts
      - (7.7) - Decrease due to lower projected claims experience
    - (0.2) - Decrease in ASO Fee due to a decrease in projected enrollment
    - (5.0) - Decrease in Prescription Drug Claims
      - (3.7) - Decrease due to lower projected enrollment
      - (1.3) - Decrease due to lower projected claims experience
  - 1.5 Increase in HMO Plan
    - (2.8) - Decrease in Premium Payments due to a decrease in projected enrollment from 30,989 to 30,784 and category shifts
    - 7.3 - Increase in Medical Claims
      - (4.7) - Decrease due to a decrease in projected enrollment from 53,675 to 53,239
      - 12.0 - Increase due to higher projected claims experience
    - (0.3) - Decrease in ASO Fees due to a decrease in projected enrollment from 53,675 to 53,239
    - (2.7) - Decrease in Prescription Drug Claims
      - (0.7) - Decrease due to a decrease in projected enrollment from 84,347 to 84,023
      - (2.0) - Decrease due to lower projected claims experience and trend

171.9 Ending Cash Balance

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

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

$ (128.6)	**Previous Ending Cash Balance Forecast [1]**
23.9	Increase in Beginning Cash Balance Forecast
(0.1)	Decrease in Revenue Forecast
(3.4)	- Net decrease in Insurance Premiums
3.2	- Increase due to premium rates effective May 2013 for June 2013 coverage
(6.6)	- Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 171,188 to 170,325 and category shifts
(0.1)	- Decrease in PPO-PBM Rebates due to a decrease in projected claims experience
2.9	- Increase in HMO-TPA Refunds due to higher projected activity
0.5	- Increase in PPO-Medicare Part D Subsidy due to higher projected activity
(14.0)	Decrease in Expense Forecast
(24.3)	Decrease in State PPO Plan
(18.4)	- Decrease in Medical Claims
(10.0)	- Decrease due to a decrease in projected enrollment from 85,788 to 84,642 and category shifts
(8.4)	- Decrease due to lower projected claims experience
(0.2)	- Decrease in ASO Fee due to a decrease in projected enrollment
(5.7)	- Decrease in Prescription Drug Claims
(4.1)	- Decrease due to lower projected enrollment
(1.6)	- Decrease due to lower projected claims experience
10.3	Increase in HMO Plan
(0.7)	- Decrease in Premium Payments due to an increase in projected enrollment from 31,366 to 31,393 and category shifts
12.7	- Increase in Medical Claims due to higher projected claims experience
(1.7)	- Decrease in HMO Plan Prescription Drug Claims
0.6	- Increase due to an increase in projected enrollment from 85,400 to 85,686
(2.3)	- Decrease due to lower projected claims experience and trend
(90.8)	**Ending Cash Balance**

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

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

$ (484.1) Previous Ending Cash Balance Forecast [1]

15.5 Increase in Revenue Forecast
- 10.9 - Net increase in Insurance Premiums
  - 5.1 - Increase due to premium rates effective May 2013 for June 2013 coverage
  - (0.2) - Decrease in employer and enrollee Insurance Premiums due to lower projected enrollment from 171,110 to 171,018
  - 6.0 Increase in employer and enrollee Insurance Premiums due to category shifts
- (0.1) - Decrease in PPO-PBM Rebates due to a decrease in projected claims experience
- 2.9 - Increase in HMO-TPA Refunds due to higher projected activity
- 1.8 - Increase in PPO-Medicare Part D Subsidy
  - (0.2) - Decrease due to a decrease in projected enrollment from 84,655 to 83,554 and category shifts
  - 2.0 - Increase due to higher projected activity

(0.6) Decrease in Expense Forecast
- (25.6) Decrease in State PPO Plan
  - (19.5) - Decrease in Medical Claims
    - (10.4) - Decrease due to a decrease in projected enrollment from 84,655 to 83,554 and category shifts
    - (9.1) - Decrease due to lower projected claims experience
  - (0.3) - Decrease in ASO Fee due to a decrease in projected enrollment
  - (5.8) - Decrease in Prescription Drug Claims
    - (4.3) - Decrease due to lower projected enrollment
    - (1.5) - Decrease due to lower projected claims experience
- 25.0 Increase in HMO Plan
  - 2.3 - Increase in Premium Payments
    - 3.2 - Increase due to an increase in projected enrollment from 31,743 to 32,038 and category shifts
    - (0.9) - Decrease due to category shifts
  - 20.1 - Increase in Medical Claims
    - 5.1 - Increase due to an increase in projected enrollment from 55,029 to 55,429
    - 15.0 - Increase due to higher projected claims experience
  - 0.3 - Increase in ASO Fee due to an increase in projected enrollment from 55,029 to 55,429
  - 2.3 - Increase in Prescription Drug Claims
    - 2.3 - Increase in Prescription Drug Claims due to an increase in projected enrollment from 86,455 to 87,467
    - (1.6) - Decrease due to changes in projected claims experience and trend
    - 1.6 - Increase due to correction in projected claims from August 2012 estimating conference

(468.0) Ending Cash Balance

[1] Self Insurance Estimating Conference held in August 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	473.12	473.12
		Family	0.00	1,243.34	1,243.34	0.00	1,044.32	1,044.32
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	48.00	698.89	96.00
	HIHP	48.00	579.10	96.00

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	649.58	15.00	664.58	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	Standard	326.92	942.64	653.84
	HIHP	246.43	771.99	492.85
Capital Health Plan [8]	Standard	268.00	921.83	536.00
	HIHP	259.98	853.57	519.96
Florida Health Care Plan [8]	Standard	48.00	698.89	96.00
	HIHP	48.00	579.10	96.00

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

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

EXECUTIVE SUMMARY

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

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

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

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

Major changes, effective January 1, 2014, include:

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

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

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

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

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

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

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

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

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

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

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

2. **No lifetime dollar maximum**

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

   Plans cannot impose any lifetime dollar limits on benefits.

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

3. **Restricted annual dollar limits**

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

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

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

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

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

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

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

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

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

5. Patient-centered outcome research institute fees

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

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

6. Other pass-through fees included

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

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

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

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

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

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

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

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

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

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

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

10. Shared responsibility "free rider surcharge'

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

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

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

11. Medicaid expansion and migration to Exchange

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

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

12. Individual mandate with federal subsidies

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

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

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

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

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

(In Millions)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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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**
Reinsurance, Risk Corridors, and Risk Adjustment	Jan 2014	**Net**	-	-	-	-	(7.25)	(1.87)	(11.29)	(20.41)	**(20.41)**
7. Extension of coverage for all adult children until age 26	Jan 2011	**Net**	*ALREADY EMBEDDED*								
8. Eliminate all preexisting condition limitations	Jan 2014	R	-	-	-	-	-	-	-	-	**-**
		E	-	-	-	-	0.69	0.21	1.13	2.03	**2.03**
		Net	-	-	-	-	(0.69)	(0.21)	(1.13)	(2.03)	**(2.03)**
9. Free choice vouchers		**Net**	*REPEALED BY CONGRESS*								
10. Shared responsibility "free rider surcharge"		**Net**	*NO ESTIMATED IMPACT ON THE TRUST FUND*								
11. Medicaid Expansion and migration into Exchange		**Net**	PENDING FUTURE ACTION BY THE LEGISLATURE AND GOVERNOR								
12. Individual Mandate with federal subsidies	Jan 2014										
Opt-Outs [3]		R	-	-	-	-	-	-	-	10.01	**10.01**
Agency and Universities OPS [4][5][6]		R	-	-	-	-	-	-	-	27.01	**27.01**
Opt-Outs [3]		E	-	-	-	-	-	-	-	8.31	**8.31**
Agency and Universities OPS [4][5][6]		E	-	-	-	-	-	-	-	28.67	**28.67**
		Net	-	-	-	-	-	-	-	0.04	**0.04**
TOTAL REVENUES [7]			**-**	**-**	**-**	**-**	**-**	**-**	**-**	**37.02**	**37.02**
TOTAL EXPENSES			**-**	**-**	**-**	**-**	**8.10**	**2.08**	**12.63**	**59.79**	**59.79**
NET TOTAL [8]			**-**	**-**	**-**	**-**	**(8.10)**	**(2.08)**	**(12.63)**	**(22.77)**	**(22.77)**

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(In Millions)

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

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University OPS

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

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

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

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

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