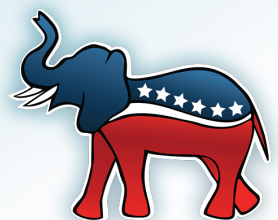


Florida Health Choices *PLUS*⁺

Creating a Stronger Marketplace for
Better Health, More Choice,
and Expanded Coverage

April 2013

By the Florida House Majority Office



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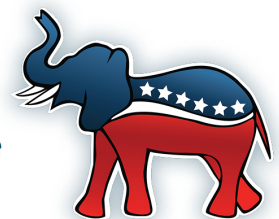


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Executive Summary

7 REASONS MEDICAID EXPANSION IS WRONG FOR FLORIDA PATIENTS AND TAXPAYERS

1. Medicaid is already failing patients

Medicaid patients already suffer from worse health outcomes compared to privately insured patients as a result of poorer access to specialists, longer wait times, and limited access to early screenings and treatments.

2. Medicaid expansion will hurt Florida seniors

ObamaCare cuts to Medicare, an increase in demand for health services if expansion occurs, and an already declining number of physicians accepting new Medicare patients puts Florida seniors at much greater risk if Medicaid is expanded.

3. Ever-increasing Medicaid costs prevent critical investments in education and other priorities

Between 2000 and 2012, Medicaid spending in Florida spiked 160 percent, while the Consumer Price Index grew just 33 percent. Florida is already expected to spend \$270 billion on Medicaid without expansion in the next decade, and as much as \$341 billion if Medicaid expands.

4. There are no reliable projections of taxpayer costs

Differences in assumptions of enrollment and per-person costs yield many widely varying projections of overall costs to taxpayers—ranging from \$3.7 billion to \$19.5 billion.

5. Florida cannot trust the federal government to keep its funding promise

With years of trillion dollar federal deficits, a history of broken funding promises to the states, current and future cost-shifts to the states, and a \$900 billion federal price tag over the next decade make it unlikely the federal government can keep its promise to fund Medicaid expansion costs in Florida or any state.

6. Medicaid expansion is unlikely to reduce charity care and will shift costs to the privately insured

Other states that previously expanded Medicaid did not achieve a reduction in charity care; in most states charity care actually increased. Increased charity care, as well as Medicaid's low reimbursements to providers, resulted in cost-shifts that raised premiums for individuals with private insurance.

7. Medicaid expansion is a flawed approach to reduce the uninsured and will increase government dependency

Expanding Medicaid will permanently increase government dependence among a huge population of individuals, despite the fact that living below the poverty level and living without health insurance are short-term circumstances for the majority of the uninsured.

6 OUTCOMES OF A TRULY PATIENT-CENTERED HEALTH CARE MARKETPLACE

1. An open, fair, transparent and highly competitive market where both the patient and provider care about cost
2. An Amazon of health care that gives patients both an Expedia and a Priceline-style menu of care and coverage choices
3. A reduction in the leading cost driver in health care (chronic care) by empowering patients with tools to better care for themselves
4. An ending to the two-tiered health care system that treats low-income families different than everyone else
5. Protection for Florida patients and taxpayers from excessive federal interference and coercion by minimizing the federal government's role playing doctor and payer
6. A prioritized safety net and reduced poverty through combining government help with reasonable work requirements, always promoting independence

FLORIDA HEALTH CHOICES PLUS: A NEW APPROACH TO HEALTH CARE FOR FLORIDA FAMILIES

Florida Health Choices Plus helps about 115,700 eligible adults living in poverty to:

- Fill the coverage gap created by ObamaCare for parents and certain adults with disabilities
- Get access to health care at the lowest cost possible
- Lift themselves out of poverty through a good paying job

Critical Facts

- Only 1 in 4 uninsured Floridians live in poverty
- 71% of the uninsured are reinsured within 12 months; almost half are reinsured within 4 months
- Half of privately insured low-income adults use just \$500 in health care services; only 1 in 6 use more than \$3,500 in services in a given year
- Just 5% of the uninsured use 68% of all care provided to the uninsured
- 12% of uninsured adults use more than \$2,000 in health care in a given year

New and more affordable coverage options for low-income parents, those with disabilities, and all Florida residents

Individuals	Eligibility Criteria	State/Taxpayer CARE Account contribution (annualized)	Individual Contribution
Parents	22%-100% of poverty, Medicaid ineligible	\$2,000 (\$167/month)	\$25/month
Individuals on SSI with Disabilities	74%-100% of poverty, Medicaid ineligible	\$2,000 (\$167/month)	\$25/month
Individuals	Any Florida resident	N/A	Full cost plus small admin fee

Florida Health Choices Plus fills the coverage gap for low-income parents and certain adults with disabilities ineligible for Medicaid or exchange coverage

- Low-income parents and individuals with disabilities who earn too much to qualify for traditional Medicaid but too little to qualify for coverage through the federal exchange will be eligible for state help to purchase private coverage.

- Florida Health Choices Plus is not an entitlement but a market-based approach to designing a health care safety net that promotes better health, private coverage, personal responsibility, reduced poverty and independence.

Many health coverage options will be available through Florida Health Choices Plus and, for the first time, within reach of these uninsured adults in poverty

- Participants will have a robust choice of plans, including comprehensive coverage options that meet Affordable Care Act standards, lower cost Health Savings Account-eligible plans, basic plans with focused fixed dollar benefits, and short-term plans for less than 12 months of coverage.

New provider-led packages and bundled health services encourage affordable new products and services for participants

- Allowing individuals to personalize their health coverage lets Florida Health Choices Plus support new provider-led options that deliver high value health service packages.

Florida Health Choices Plus will provide choice counseling to low-income adults seeking the best coverage for their specific needs

- Florida Health Choices Plus’ choice counseling ensures low-income adults are educated about their likely health care utilization and possible packages of care and coverage that would work best for them. Its online tools further assist parents with finding the best, most appropriate option given their individual circumstances.

Reasonable work requirements for recipients of taxpayer help (excluding those with disabilities)

Status	Work Requirement
Single parents with a child under age 6	20 hours weekly in core work activities
Other single parent families or two-parent families where one parent is disabled	30 hours weekly with at least 20 hours in core activities
Married teen or teen head of household	Maintain satisfactory attendance at secondary school or equivalent, or participate in education related to employment for at least 20 hours weekly
Two-parent families who do not receive subsidized child care	35 hours weekly (total among both parents) with at least 30 hours in core activities

Required financing of Florida Health Choices Plus

- Based on the actual number of uninsured parents and adults with disabilities in Florida, and assuming a similar take-up rate as those currently in Florida Medicaid, the Florida Health Choices Plus program is projected to have a total annualized cost of \$237 million to serve about 115,700 adults (assuming 79.7% of those eligible enroll), with the cost in FY2014 being an estimated \$12 million, assuming the program begins April 2014.

Part I – 7 Reasons Medicaid Expansion is Wrong for Florida Patients and Taxpayers

#1: Medicaid is already failing patients

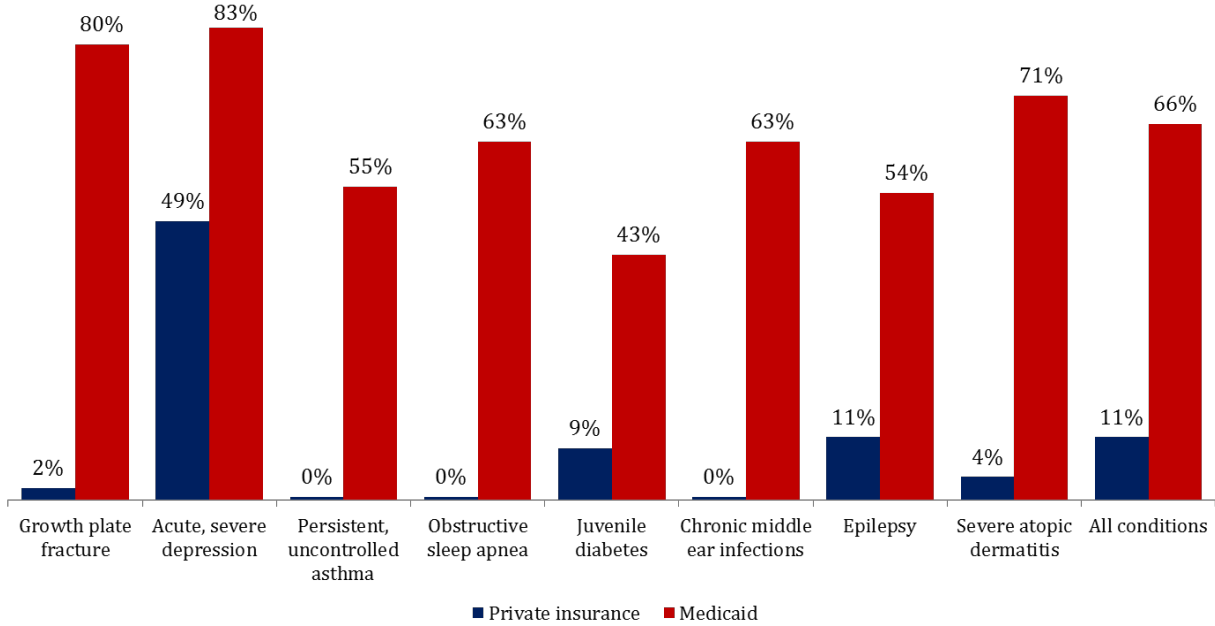
Medicaid patients have been plagued with access and quality problems for decades. Patients frequently suffer health outcomes far worse than patients with private insurance and, in many cases, health outcomes even worse than patients without any insurance at all. These results are unsurprising given the huge access barriers Medicaid patients face.

Today, just 59 percent of Florida doctors are accepting new Medicaid patients.¹ Access barriers to specialty care appear to be even worse. Research published in the *New England Journal of Medicine*, for example, found that children on Medicaid are denied appointments with specialists nearly two-thirds of the time.² Privately insured children, on the other hand, are typically denied appointments just 11 percent of the time.³ For some conditions, the denial rate for Medicaid patients was as high as 83 percent.⁴

Research published in *Pediatrics*, the official journal of the American Academy of Pediatrics, found that children on Medicaid were 23 times more likely to be denied appointments to see head and neck specialty surgeons than children with private insurance.⁵ Similar research in the peer-reviewed journal *Urology* found that children on Medicaid were nearly 14 times more likely to be denied appointments with pediatric urologists than children who are privately insured.⁶

Research studying access to specialists in south Florida found that 86 percent of hip and knee surgeons refused appointments with Medicaid patients, while none refused appointments with patients who are privately insured.⁷ These same access barriers exist even in safety net clinics and community health centers.^{8,9} In fact, clinics in Jacksonville were more willing to see a patient offering to pay just \$20 than they were to see a Medicaid patient.¹⁰

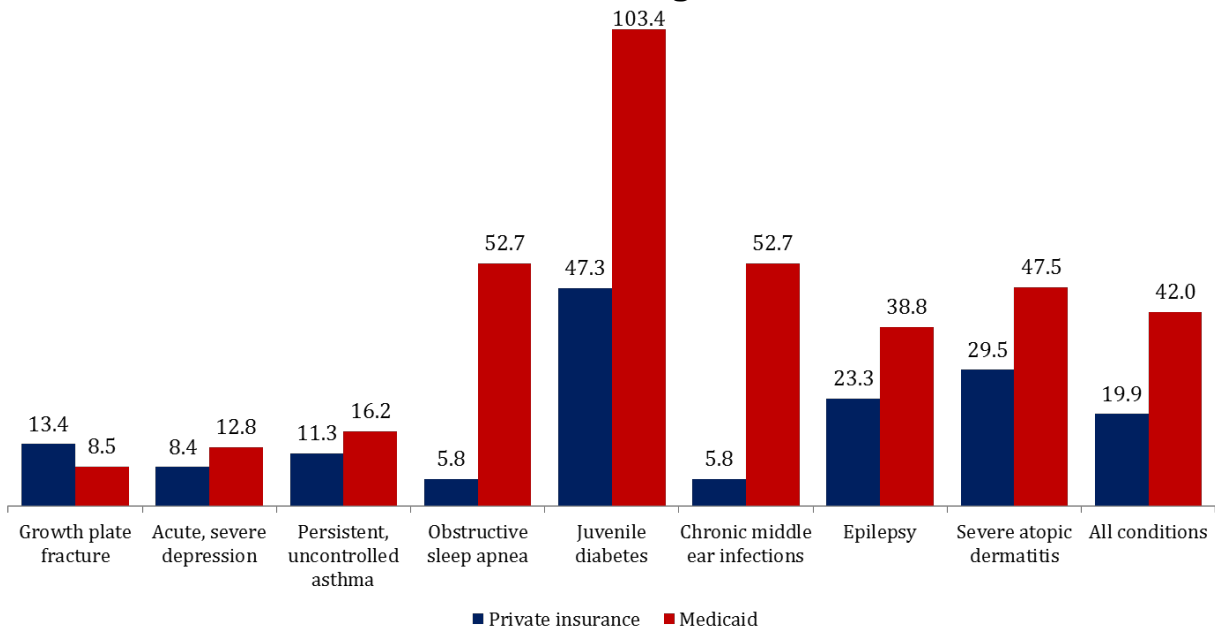
Medicaid Patients are Far More Likely to be Denied an Appointment with a Specialist



Source: Bisgaier and Rhodes

Even when Medicaid patients are finally able to get an appointment, they often wait longer for services.¹¹ To see an endocrinologist, for example, children on Medicaid must wait on average 103 days, more than twice as long as children who are privately insured.¹² For all specialty care, the average wait for Medicaid patients is 22 days longer than for patients with private insurance.¹³ In south Florida, Medicaid patients were diagnosed with torn ACLs four times later than privately insured patients, despite there being no significant difference in how long patients delayed seeking treatment.¹⁴

Medicaid Patients Wait Longer to Receive Care



Source: Bisgaier and Rhodes

These large access barriers force many Medicaid patients to seek non-urgent care from emergency rooms. Research published in the *Journal of the American Medical Association* found that Medicaid patients are six times more likely than privately insured patients to seek treatment of preventable conditions at ERs.¹⁵ In fact, Medicaid patients used emergency rooms in this manner three times as often as the uninsured.¹⁶

While this type of ER use has steadily declined for both uninsured and privately insured patients, it has grown 38 percent for Medicaid patients.¹⁷ In fact, four out of five patients who seek emergency room care on a frequent basis are enrolled in either Medicare or Medicaid.¹⁸

It is no surprise this poor access results in poor health outcomes. Medicaid patients often have much greater mortality risks during common surgeries. According to research published in the *American Journal of Cardiology*, for example, Medicaid patients were three times more likely than privately insured patients to die after heart surgery.¹⁹ They were also substantially more likely to have a major adverse cardiac event within 30 days of discharge.²⁰ Medicaid patients even had higher risks than patients with no insurance.²¹ These greater risks persisted for more than a year after discharge.²² Even after adjusting for age, sex, race, income, location, hospital characteristics, comorbidities and severity of disorders, Medicaid patients still face greater risk of mortality.²³

Research published in the *Journal of the American College of Surgeons* finds similar mortality results following 10 types of heart valve surgery.²⁴ Medicaid patients were also more likely to suffer complications following surgery, including wound, infection and pulmonary complications.²⁵ They face higher rates of complications following other types of common surgeries as well.²⁶ These complications no doubt contribute to Medicaid patients experiencing the longest hospital stays and having the highest treatment costs.^{27,28}

Limited access to early screening and treatment also contributes heavily to poorer health outcomes. Medicaid patients are more likely to be diagnosed with diseases at later, less treatable stages. The odds of a Medicaid patient being diagnosed with late-stage melanoma, for example, is nearly four times greater than for patients who are privately insured.²⁹

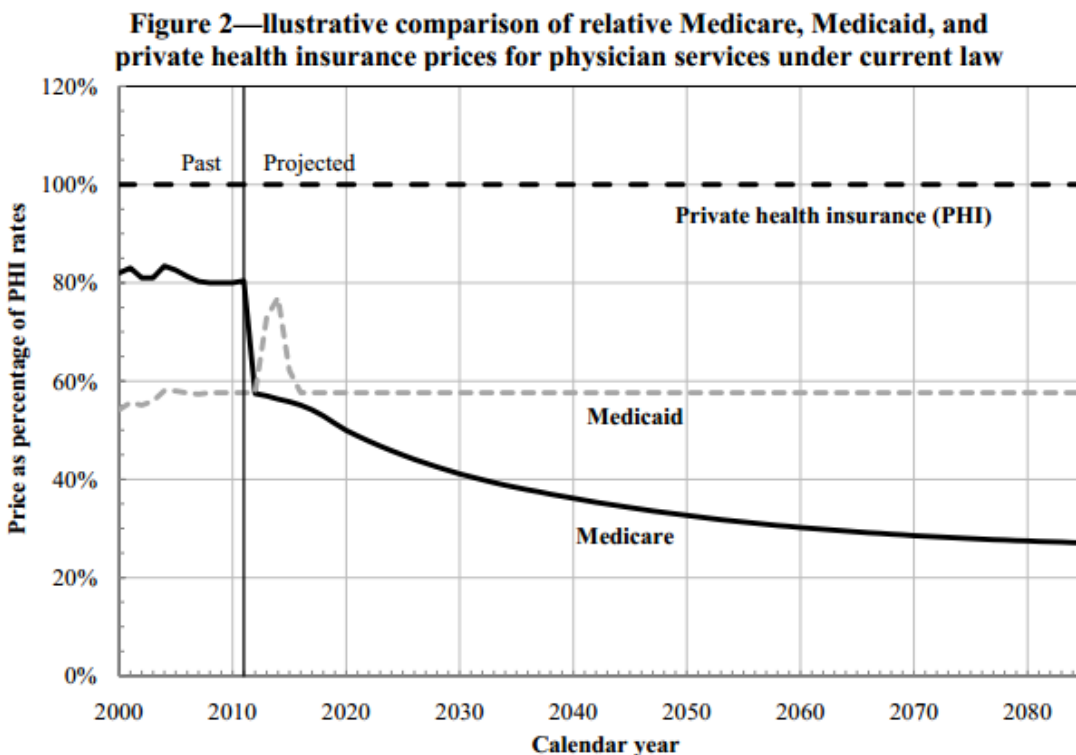
A review of the state's tumor registry data by researchers at the University of South Florida found that 26 percent of Florida Medicaid patients diagnosed with breast cancer died within four years.³⁰ In contrast, just 12 percent of privately insured patients died within that same time.³¹ This higher mortality rate appears to result almost entirely from the fact that Medicaid patients are diagnosed at later, less treatable stages.³² Medicaid patients were 87 percent more likely than privately insured patients to be diagnosed with late-stage breast cancer.³³ Similar disparities exist in late-stage diagnosis for other types of cancer as well.^{34,35}

#2: Medicaid expansion will hurt Florida seniors

More than 3.3 million Floridians residents were enrolled in Medicare in 2010—more than any state except California.³⁶ The Affordable Care Act cuts Medicare spending by \$716 billion over the next decade.³⁷ Florida's share of those cuts exceeds \$44 billion. \$1.7 billion in cuts takes effect in 2014 alone.³⁸

Many of these cuts will heavily target Medicare Advantage beneficiaries. More than 500,000 Florida seniors are expected to be forced out of the Medicare Advantage plans they would have chosen pre-ObamaCare.³⁹ Under current law, the average Medicare Advantage enrollee in Florida could lose up to \$3,203 per year in health benefits because of ObamaCare's Medicare cuts by 2017.⁴⁰

These cuts are expected to deepen over time. Medicare's actuaries predict that, as a result of ObamaCare, Medicare reimbursement rates for doctors will fall to just 27 percent of what private health insurers pay, down from 80 percent in 2009.⁴¹ They further estimate that reimbursement rates for hospitals will fall to 33 percent of what private insurers pay, down from 67 percent in 2009.⁴² Not surprisingly, the actuaries predict that Medicare beneficiaries will "almost certainly face increasingly severe problems with access to care", as more health providers realize they cannot afford to continue participating in Medicare.⁴³

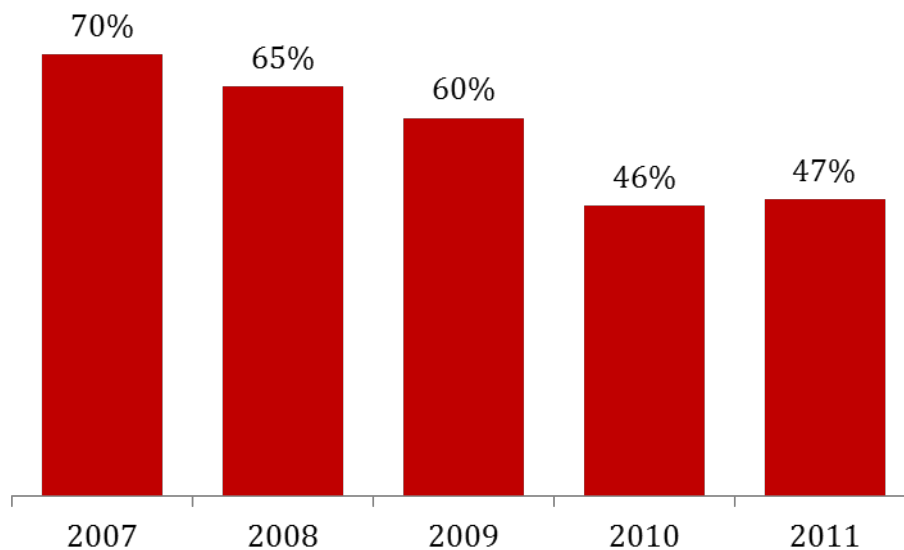


A doctor shortage is expected to make these problems even worse. In 2011, Florida had just 42,302 active physicians providing patient care to its state population of 18.7 million.⁴⁴ Roughly 16,060 of them were primary care physicians.⁴⁵ According to the Florida Department of Health, just two of Florida's 67 counties have no primary care shortage

areas.⁴⁶ This is even more troubling considering the large number of physicians nearing retirement. Only 13.8 percent of Florida doctors are under the age of 40, with more than 28 percent over the age of 60.⁴⁷

Medicaid expansion is expected to drastically increase demand for medical services, but will not substantially increase the supply for those services. Such an increase in demand is certain to increase average wait times and result in fewer physicians accepting new patients. In the years following Massachusetts' coverage expansion, the number of family physicians accepting new patients steadily declined from 70 percent in 2007 to 47 percent in 2011.⁴⁸

The Number of Family Doctors Accepting New Patients Dropped after Massachusetts' Medicaid Expansion



Source: Massachusetts Medical Society

Wait times for family physicians rose from 33 days in 2006 to 52 days in 2007.⁴⁹ Since then, wait times have averaged between 49 and 50 days.⁵⁰ In Boston, the wait time to see a family practice physician is 63 days.⁵¹ This is the longest wait time of any large metropolitan area. For comparison, the average wait time in Miami for the same specialty is just 7 days.⁵² The wait times for most specialists in Boston increased between 2004 and 2009, nearly doubling in some cases.⁵³

Greater demand for services and the resulting longer wait times will likely have the biggest impact on patients with Medicare and Medicaid, which reimburse physicians substantially less than private insurers. Meanwhile, many physicians are already taking steps to limit the number of Medicare patients they see.

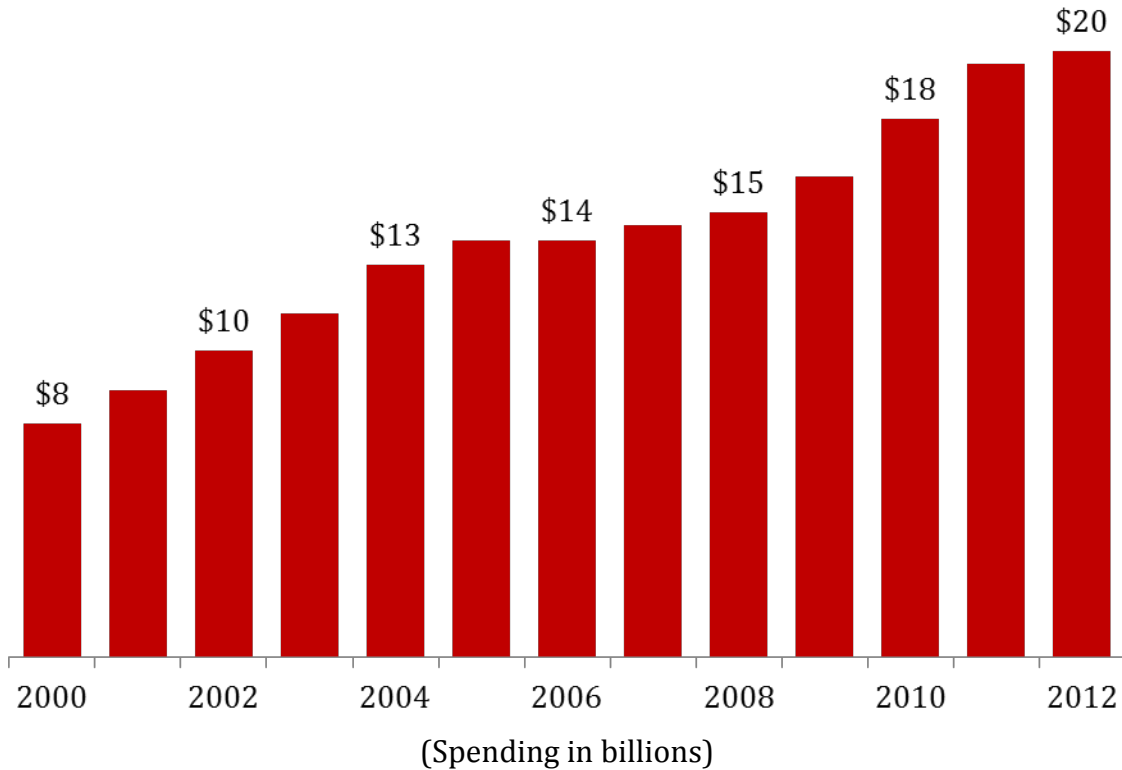
Although only 9 percent of doctors have already stopped accepting Medicare patients, 23 percent report they are placing new or additional limits on Medicare acceptance.⁵⁴ If Medicare fees decrease by 10 percent or more—as required by the Affordable Care Act—nearly a third of doctors report they will impose new and additional limits. 26 percent report they will stop accepting new Medicare patients altogether.⁵⁵

Seniors are also more likely to have complex or chronic conditions that require more frequent care. Roughly 87 percent of seniors have at least one chronic condition and 67 percent have multiple chronic conditions.⁵⁶ Accordingly, the need for routine visits to physicians ensures any supply shortage will disproportionately impact seniors. This means seniors will wait longer, drive farther and generally have a harder time finding a physician who can treat them in a timely manner.

#3: Ever-increasing Medicaid spending prevents critical investments in education and other priorities

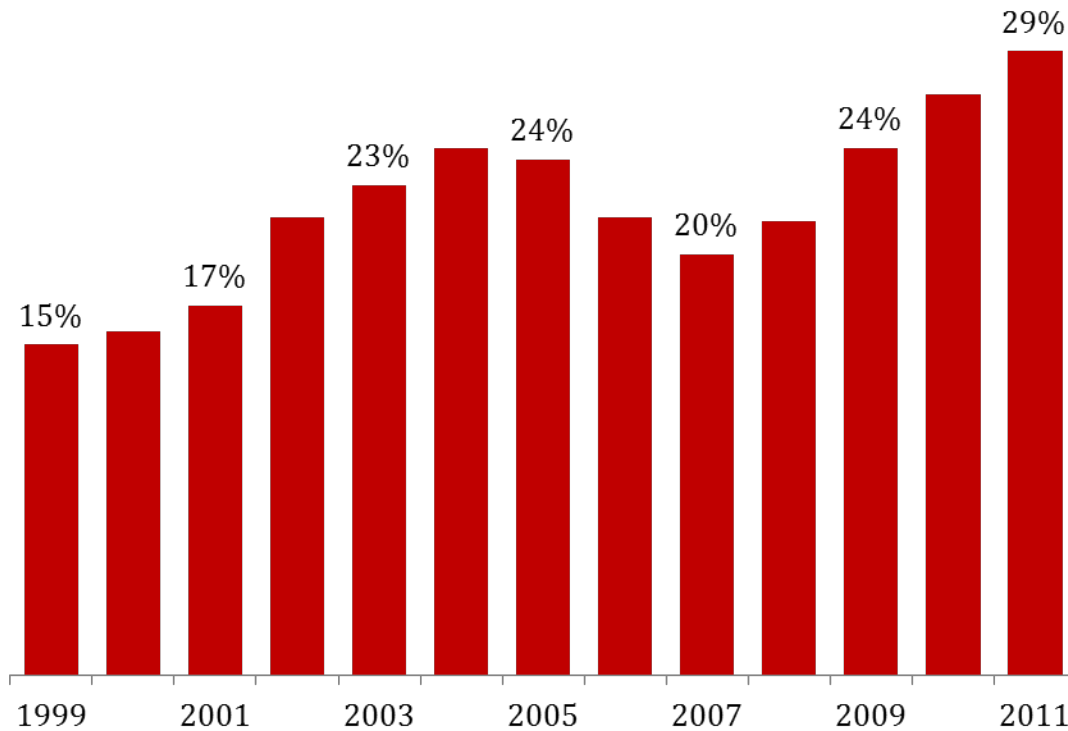
In fiscal year 2000, Florida spent \$7.8 billion on Medicaid.⁵⁷ By fiscal year 2012, this amount had skyrocketed to \$20.2 billion—a shocking 160 percent increase.⁵⁸ Meanwhile, the Consumer Price Index grew only 33 percent over that same time.⁵⁹ As a result, Medicaid spending continues to consume a larger share of the state budget.⁶⁰

Medicaid Spending More Than Doubled During Last Decade



Source: Florida Agency for Health Care Administration

Medicaid Spending is Consuming More of the State's Total Budget



Source: Social Services Estimating Conference

Medicaid spending and enrollment growth will continue in the coming decades. Even without Medicaid expansion, the Affordable Care Act is expected to add at least 357,000 more people to Florida's program.⁶¹ And that assumes that fewer than a quarter of the people who are eligible for Medicaid, but not yet enrolled, will sign up.⁶²

Without expansion, Florida is still expected to spend \$270 billion on its Medicaid program during the next 10 years.⁶³ For comparison, Florida spent just \$154 billion on Medicaid during the past 10 years.⁶⁴ Should Florida choose to expand Medicaid—thus adding another 1.2 to 1.3 million people to the program—total Medicaid spending would rise to \$341 billion during the next ten years.⁶⁵

These enrollment and cost numbers could be even higher if the Affordable Care Act operates as intended. The individual mandate, for example, is expected to increase enrollment among currently eligible individuals. Likewise, health insurance exchanges are required by law to automatically enroll users into Medicaid if they are eligible.⁶⁶ As illustrated above, even minor changes in price, utilization and participation assumptions could make these estimates skyrocket.

This will inevitably shift an increasing amount of resources away from core services to continue funding Medicaid. If the federal government shifts more Medicaid costs to the state, as even President Obama has proposed, this funding crisis will become worse. Scarce education dollars would simply give way to ever-growing Medicaid costs.

#4: There are no reliable projections of taxpayer costs

A number of groups have made projections on the impact of Medicaid expansion in Florida. While they all look at the same policy decision, the projections among these different groups vary dramatically.

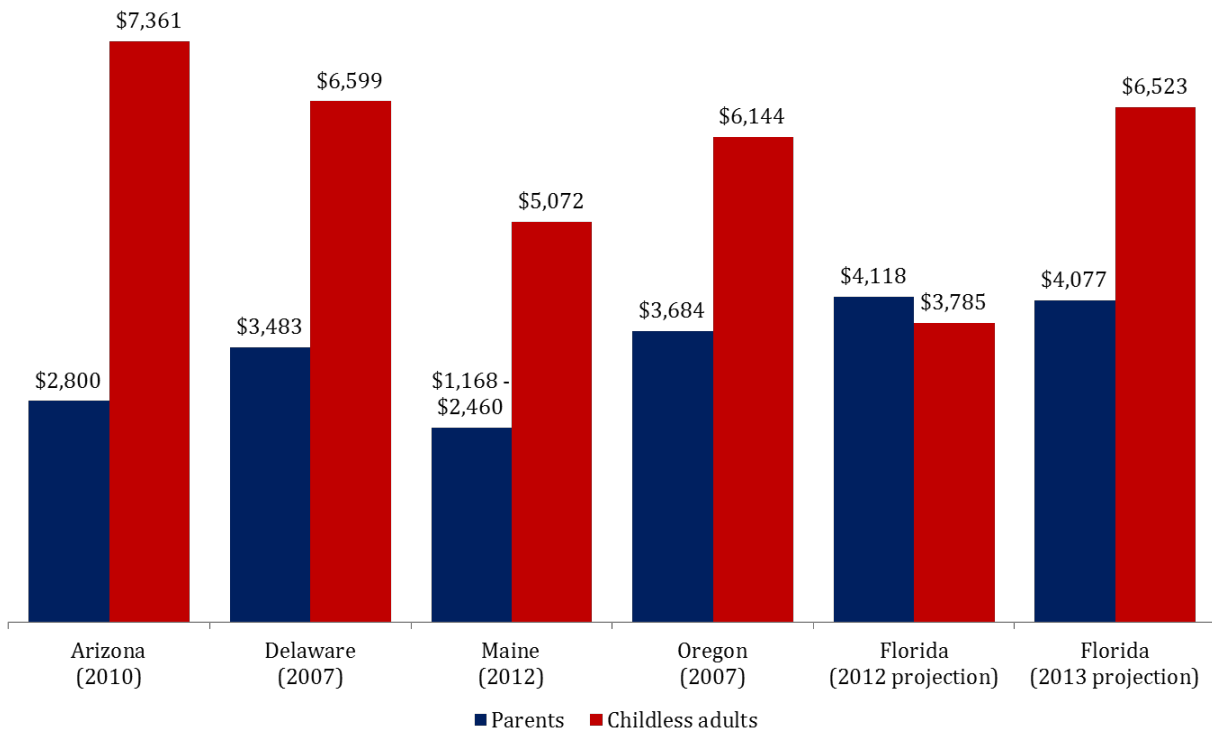
In order to produce accurate cost estimates, one must first know how many people will actually enroll in Medicaid after expansion. However, projected participation rates are hugely different from one study to the next.

Georgetown's Health Policy Institute, for example, predicts that just 57 percent of uninsured Florida residents newly eligible after expansion would actually enroll in Medicaid.⁶⁷ On the other hand, actuaries with the federal Centers for Medicare and Medicaid Services predict a 95 percent participation rate.⁶⁸ The difference between these two estimates is nearly 500,000 individuals.⁶⁹ A third projection by Florida's Social Services Estimating Conference falls in between the two, predicting 80 percent participation.⁷⁰

Studies also vary widely on the projected per-person costs of the expansion population. Some predict covering childless adults will cost roughly the same as covering low-income parents. In its 2012 estimates, however, Florida's Social Services Estimating Conference predicted covering the expansion population of childless adults would be 8 percent cheaper than covering parents.⁷¹

But the states that already expanded Medicaid eligibility to childless adults actually spent much more to cover them than to cover parents. Childless adults have cost between 1.7 and 4.3 times what parents cost in those states.⁷² After the Social Services Estimating Conference's 2012 assumptions were questioned, it revised its 2013 estimates and now predicts childless adults will cost 60 percent more than parents.⁷³

Childless Adults are Much More Expensive to Cover than Low-Income Parents



Source: Foundation for Government Accountability

Even modest differences in assumptions about enrollment rates and per-person costs can have a huge impact on projected overall costs. The annual cost for the Medicaid expansion could run anywhere from \$3.7 billion to \$19.5 billion, even before accounting for any crowd-out effect on private health insurance.⁷⁴

With so many different assumptions and projections made, policymakers have no way of knowing just how Medicaid expansion will impact the state budget and taxpayer costs.

#5: Florida cannot trust the federal government to keep its funding promise

Most supporters of Medicaid expansion insist the federal government will keep its promise to finance the expansion. However, given the current state of federal finances, it would be irresponsible for Florida to embrace expansion without first considering the consequences if that enhanced federal funding eventually stops.

The federal government is already hamstrung by trillion-dollar deficits. During the course of the next decade, Medicaid expansion is expected to add more than \$900 billion in new costs to the federal government's ledger—which is already filled with red ink.⁷⁵

Federal spending at this level is simply unsustainable. Aid to state and local governments is likely to be one of the first targets for cuts. Just as the federal government broke its promise on education funding, it will likely break this promise of permanently enhanced Medicaid funding.

In fact, President Obama already proposed shifting more Medicaid costs onto states in his fiscal year 2013 budget.⁷⁶ Additional cost-shifting onto the states has also played a prominent role in deficit-reduction talks, fiscal cliff negotiations and the debt-ceiling debate.⁷⁷

If Florida expands Medicaid it may not be able to undo that decision, even if the federal government moves forward with added cost-shifts to the states. The federal government would be able to shift more costs to Florida taxpayers and could prohibit state lawmakers from backing out of the expansion. Although expansion is voluntary, there is nothing preventing the federal government from imposing new maintenance of effort requirements on the states that choose to expand, just as they did in 2009 and 2010 to states that voluntarily expanded in the 1990s and 2000s.

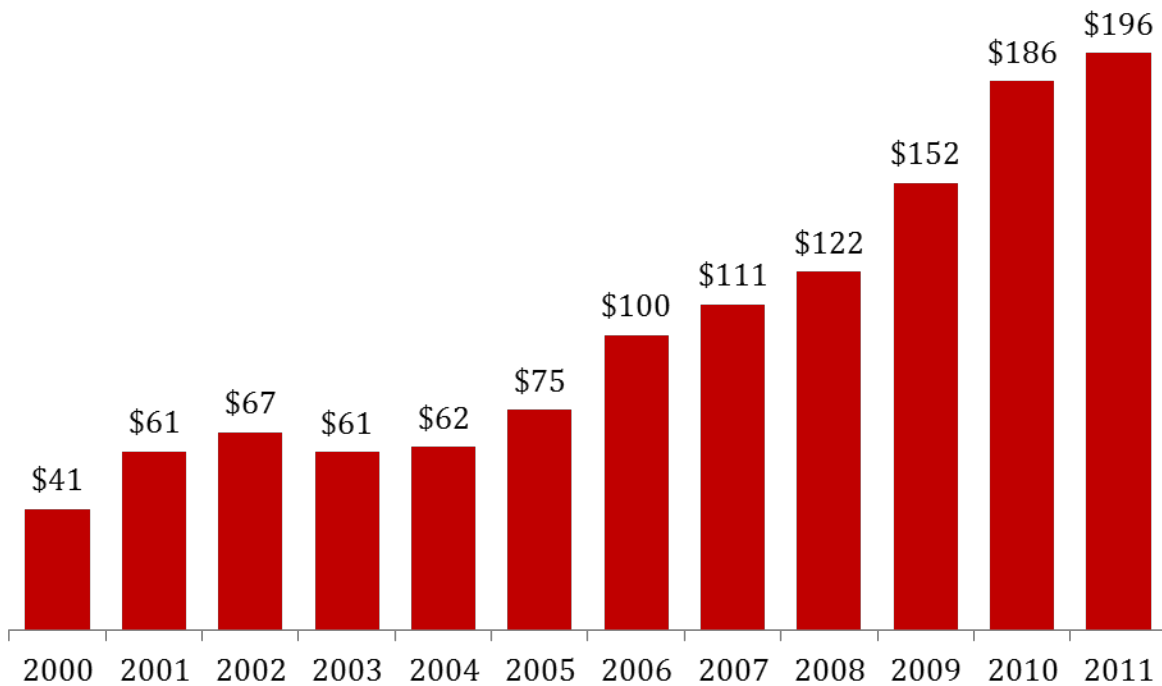
Without certainty the federal government will keep its funding promise, it is too risky for Florida to let Medicaid expand.

#6: Medicaid expansion is unlikely to reduce charity care costs and will further shift costs to the privately insured

Supporters of Medicaid expansion promise it will greatly reduce charity care. Yet this promise was not kept in the states that have already expanded Medicaid eligibility to childless adults.

In 2001, the Maine Hospital Association supported lawmakers' decision to expand Medicaid eligibility as a way to reduce the nearly \$41 million in charity care hospitals provided in 2000. By 2011, however, charity care costs had actually risen to \$196 million per year.⁷⁸

Maine Charity Care, By Year (in millions)



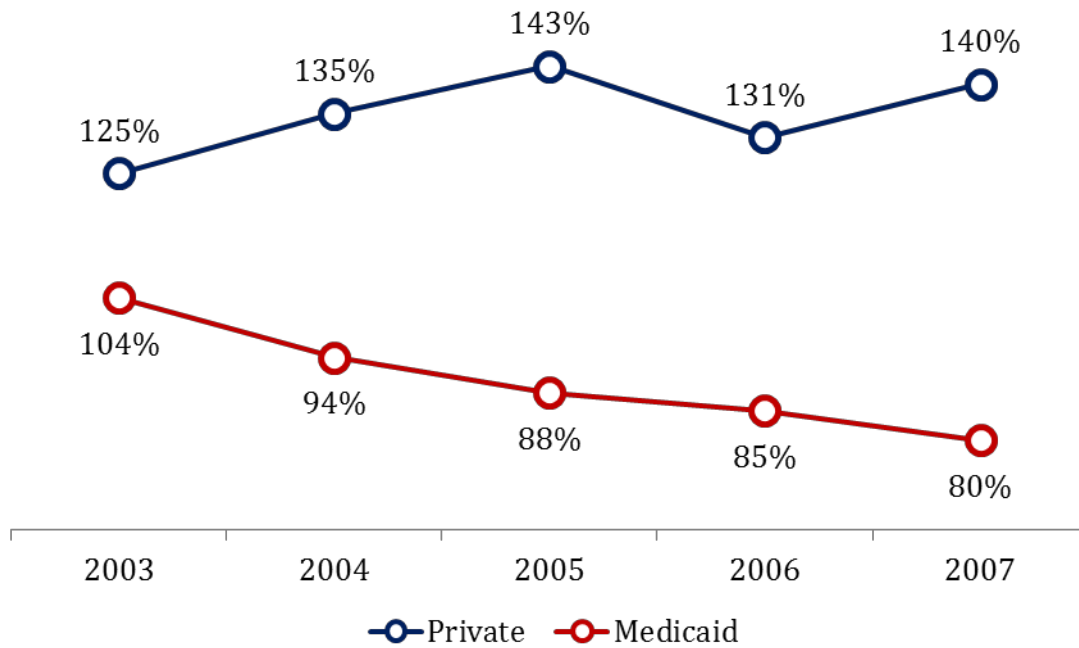
Source: Foundation for Government Accountability

In Arizona, supporters of the expansion argued it was necessary to reduce the cost-shift to privately insured individuals. But Medicaid reimburses doctors so little that the program actually creates a cost-shift of its own.

Hospitals typically measure this as the payment-to-cost ratio, or the total revenue from a type of payer divided by the total expenses related to patients of that type of payer. According to an analysis of hospital claims data, the payment-to-cost ratio for Medicaid declined to 80 percent in 2007, down from 104 percent in 2003.⁷⁹ This means that instead of covering the total cost of care provided, like it was in 2003, Medicaid in 2007 was paying just 80 cents of every dollar it owed to hospitals. The payment-to-cost ratio for private payers, on the other hand, rose to 140 percent in 2007, up from 125 percent in 2003.⁸⁰ The

report also found that the total cost-shift from Medicaid was actually higher than the cost-shift from uncompensated care. Arizona hospitals reported Medicaid's cost-shift as \$407 million in 2007, compared to the \$390 million cost-shift from uncompensated care.⁸¹

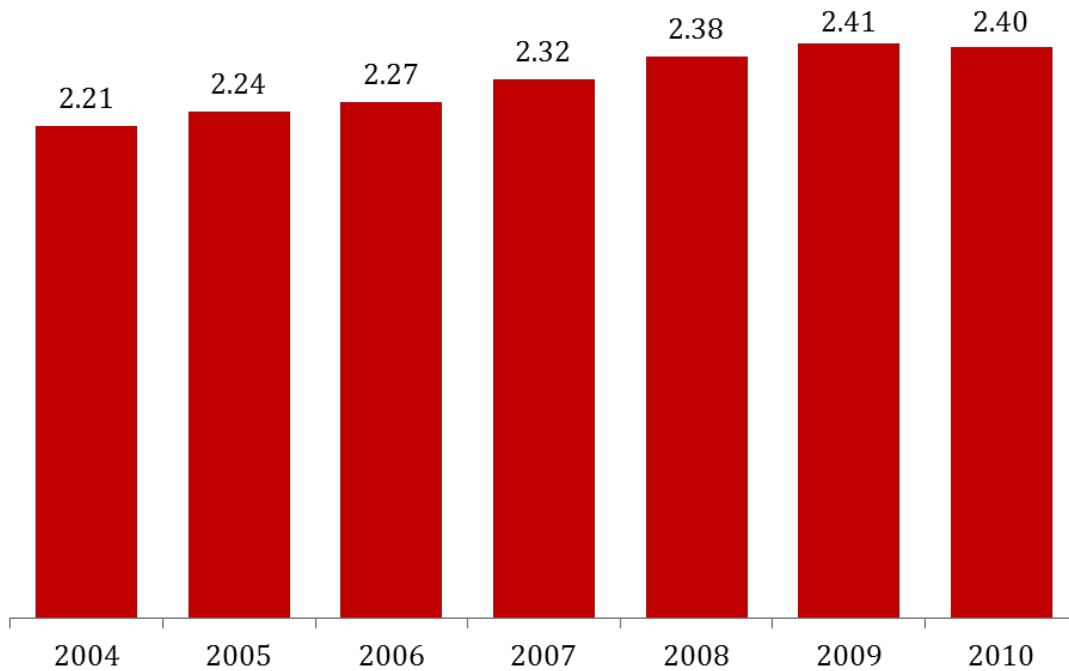
Cost-Shift to Private Insurance Increased after Arizona Expanded Medicaid
(Payment to Cost Ratios by Payer)



Source: Lewin Group

When Massachusetts enacted similar reforms in 2006, it was widely believed increasing coverage would reduce utilization of emergency rooms, particularly for preventable conditions. It was believed that charity care would immediately fall with reductions in unnecessary ER utilization. However, visits to emergency rooms have actually increased by 6 percent since the Massachusetts reforms were enacted.⁸² The use of emergency rooms for non-emergent conditions rose nearly 9 percent over that same time.⁸³ By 2010, just 38 percent of ER visits were for actual emergency conditions that were not preventable.⁸⁴

Emergency Department Utilization Increased after Massachusetts' Reform
(in millions)



Source: Massachusetts Health and Human Services

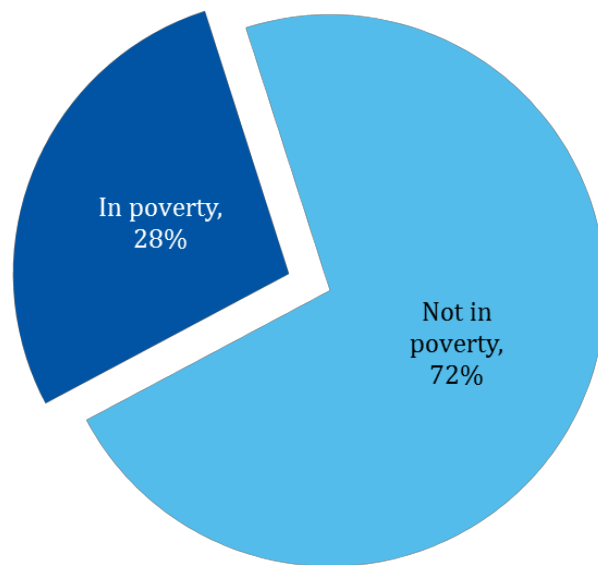
Higher emergency room utilization has led to much higher spending. In 2006, the cost of preventable emergency room visits totaled \$412 million. By 2010, it had increased to \$558 million, a whopping 35 percent higher than it was before the Massachusetts reform.⁸⁵

#7: Medicaid expansion is a flawed approach to reduce the uninsured that will increase dependence on government

For years, policymakers have struggled to solve the problem of Florida's high rate of uninsured. But understanding who the uninsured are is key to a solution. The uninsured population is a diverse and dynamic population. Typically young, healthy and not poor, this population often lacks health insurance for just a short period of time.

In 2011, there were 3.7 million uninsured, non-elderly Florida residents.⁸⁶ The vast majority of this population does not live in poverty. According to the latest Census data, just 28 percent of uninsured Florida residents live in poverty.⁸⁷ In fact, the average uninsured individual has a household income greater than \$51,000.⁸⁸ Accordingly, the vast majority of the uninsured will qualify for free or subsidized private coverage through the Affordable Care Act's health insurance exchanges.⁸⁹

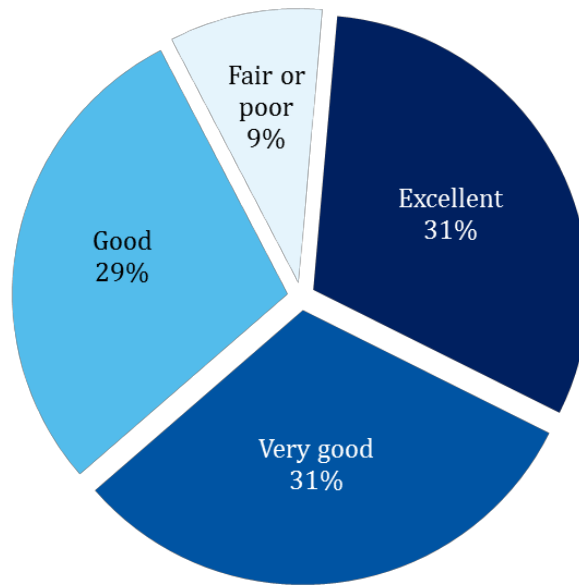
Most Uninsured Florida Residents Do Not Live in Poverty



Source: Census Bureau

Most uninsured Florida residents are younger and in good health. Nearly 64 percent of uninsured adults have no dependent children at home, and 60 percent are single.⁹⁰ More than 91 percent self-report that they are in good or excellent health.⁹¹

Most Uninsured Florida Residents Report They are in Good Health



Source: Census Bureau

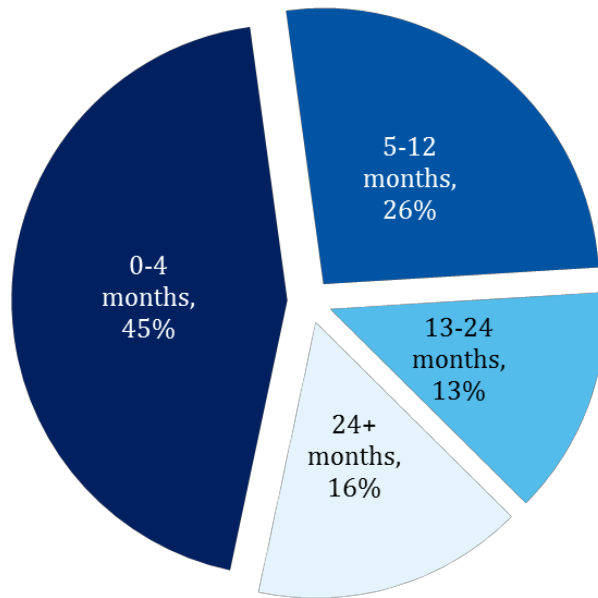
A significant portion of low-income uninsured residents qualify for public insurance programs, but simply chose not to enroll. Although there are more than 500,000 uninsured children in Florida, 62 percent of them live in households with income levels that qualify them for public insurance through Medicaid or KidCare.⁹² A sizeable number of uninsured adults also qualify for Medicaid under current law.⁹³

Lacking health insurance is also typically a temporary circumstance. Nationally, nearly half of all uninsured individuals are reinsured within four months and 70 percent are reinsured within a year.⁹⁴ Fewer than one in six remain uninsured for two or more years.⁹⁵

Accordingly, more than 1.6 million uninsured Florida residents will be reinsured within four months and 2.6 million will be reinsured within a year. Just 586,000 Floridians, or 16 percent of the uninsured population, will remain uninsured for more than two years.

This generally means that the people who are uninsured this year are not the same people who were uninsured last year or the people who will be uninsured next year. These temporary periods of no insurance is largely explained by the general mobility of a modern workforce and tax rules that encourage insurance policies to be tied to jobs, not people.

Most Uninsured Individuals are Reinsured Within a Year

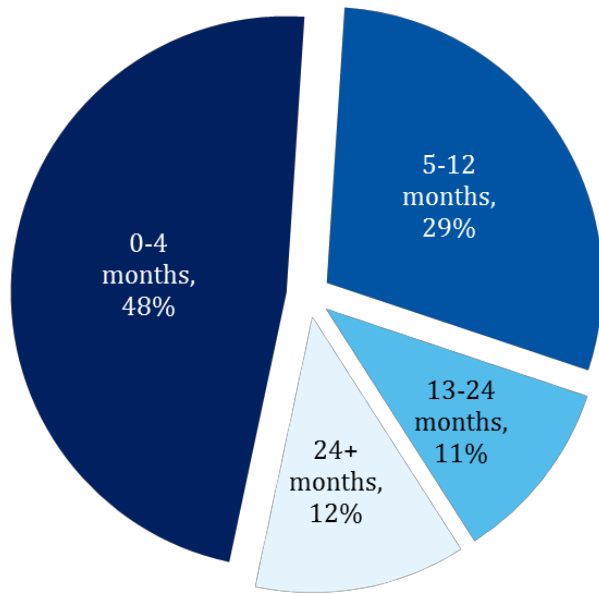


Source: Congressional Budget Office

Living below the poverty level is also typically temporary. While nearly 29 percent of the U.S. population was in poverty for at least 2 months between 2004 and 2006, just 2.8 percent remained in poverty for that entire period.⁹⁶ The average length of time an individual was in poverty was just 4.5 months.⁹⁷ Just one in eight individuals remained in poverty for more than 2 years.⁹⁸

Roughly 1 million Florida residents are both uninsured and in poverty at any given time. But being in poverty and being uninsured are both temporary circumstances, not permanent conditions. Nearly 462,000 of those residents will no longer be in poverty within 4 months and 729,000 will exit poverty within a year. Just 165,000 will remain in poverty for two or more years.

Most Individuals in Poverty Remain There for Only a Short Time



Source: Census Bureau

Part II – 6 Outcomes of a Truly Patient-Centered Health Care Marketplace

ObamaCare’s optional Medicaid expansion is too dangerous a risk for Florida patients and taxpayers, but there is no denying that the needs of Florida families must be addressed.

Florida families need a stronger health care safety net:

- Greater access to health care
- New, affordable, personalized health care and coverage options

6 OUTCOMES OF A TRULY PATIENT-CENTERED HEALTH CARE MARKETPLACE

1. An open, fair, transparent and highly competitive market where both the patient and provider care about cost
2. An Amazon of health care that gives patients both an Expedia and a Priceline-style menu of care and coverage choices
3. A reduction in the leading cost driver in health care (chronic care) by empowering patients with tools to better care for themselves
4. An ending to the two-tiered health care system that treats low-income families different than everyone else
5. Protection for Florida patients and taxpayers from excessive federal interference and coercion by minimizing the federal government’s role playing doctor and payer
6. A prioritized safety net and reduced poverty through combining government help with reasonable work requirements, always promoting independence

Part III – Florida Health Choices Plus: A New Approach to Health Care for Florida Families

Critical Facts – why a targeted, personalized free market approach works best for Florida’s uninsured adults

- **Only 1 in 4 uninsured Floridians live in poverty.**

First, it is critical to understand that only about one in four uninsured Floridians are living in poverty.

Nationally, living both in poverty and without insurance is temporary.

- **71% of the uninsured are reinsured within 12 months; almost half are reinsured within 4 months.**

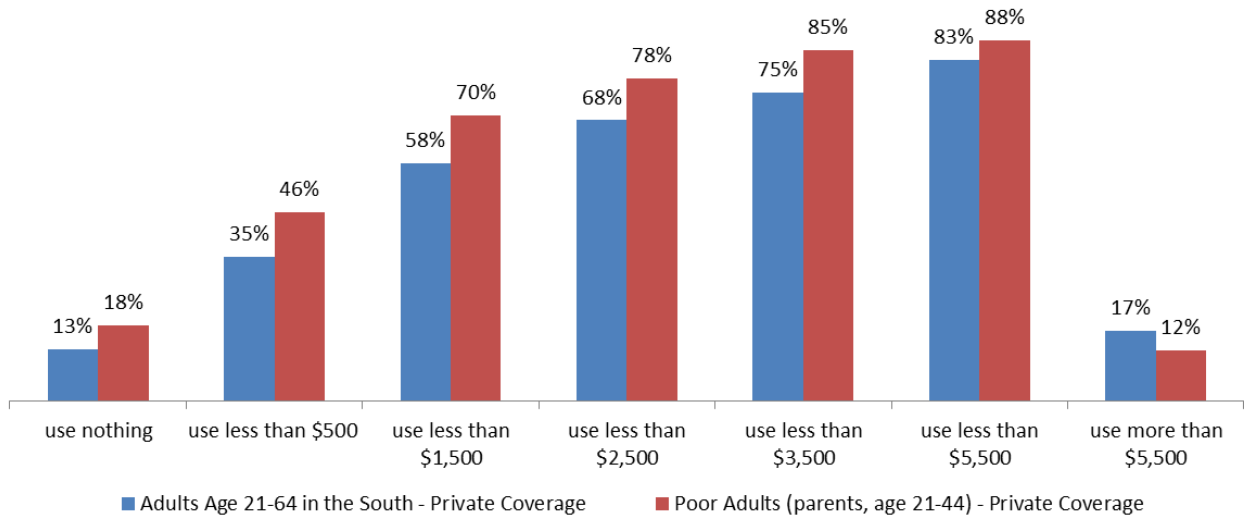
American adults with private coverage, including low-income parents, use only a small amount of health care in a given year. Given that, low-income adults need protection against a catastrophic health event, and access to and help with affording the first few hundred dollars of health care, which is typically lower-cost preventive or primary care.

- **Half of privately insured low-income adults use just \$500 in health care services. Only 1 in 6 use more than \$3,500 in services in a given year.**

Most adults with private insurance are low users of health care. Only a few have catastrophic health events or large health care expenses in any one year.

Half of low-income adults with private coverage use \$500 or less in health care services in a given year. Another quarter use \$500 to \$1,500 of health care and just 15 percent use more than \$3,500 in total health care services (including hospital care, physician care and prescription drugs). This means just 15 percent of low-income adults are moderate health care users, receiving \$1,500 to \$3,500 in health care services in any given year.

How Much Health Care do People Actually Use?



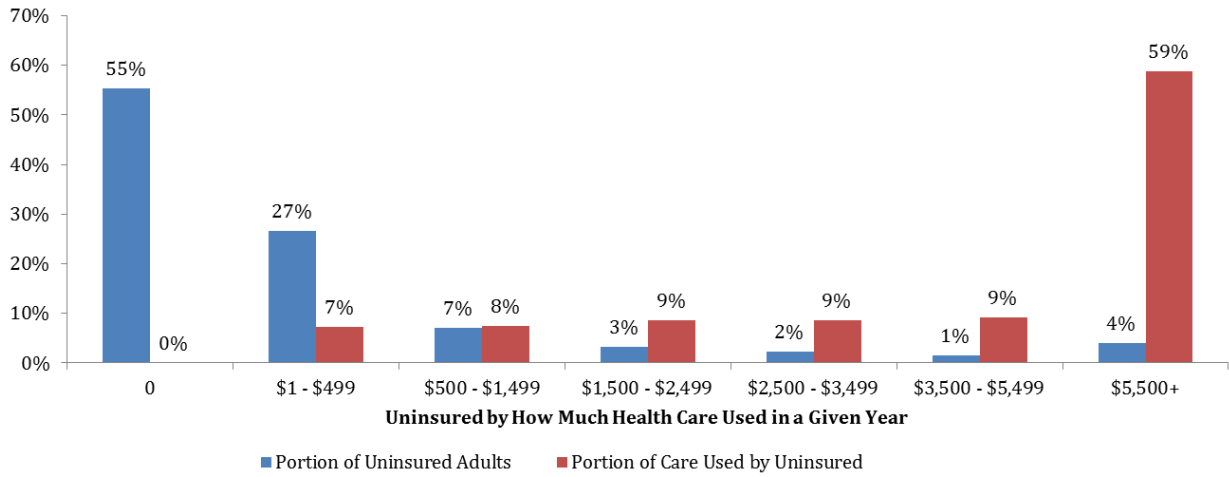
Source: Medical Expenditure Panel Survey

Therefore, the most cost effective, and healthiest, coverage for low-income adults provides access to preventive and primary care, and protection for a catastrophic health event.

- 5% of the uninsured use 68% of all care provided to the uninsured**
 Uninsured individuals with catastrophic health events are driving charity care costs for Florida hospitals. In fact, federal data shows that 5 percent of the uninsured (those using more than \$3,500 in health care services in a given year) use 68% of all care provided to the uninsured.

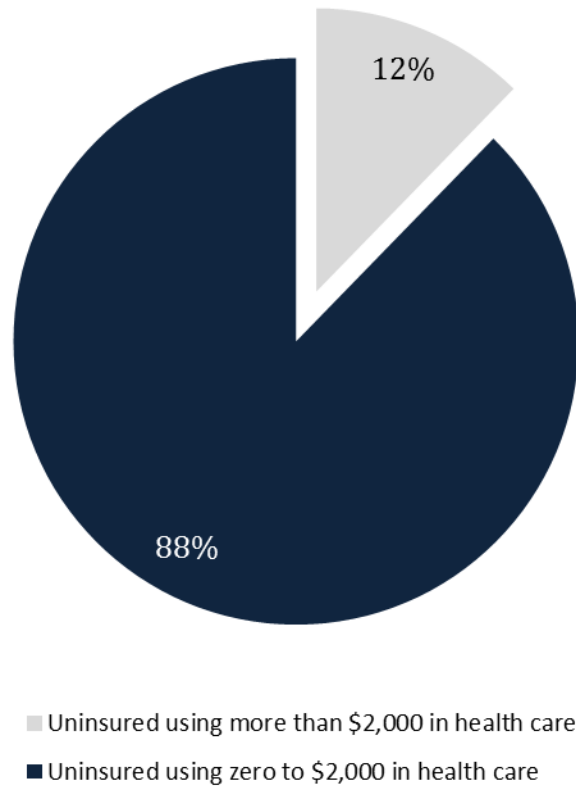
Therefore, providing catastrophic health protection to the uninsured is the most cost effective way to reduce the vast majority of charity care Florida hospitals provide to the uninsured.

Uninsured Adults (21-64 years old) by Health Care Used



Source: Medical Expenditure Panel Survey

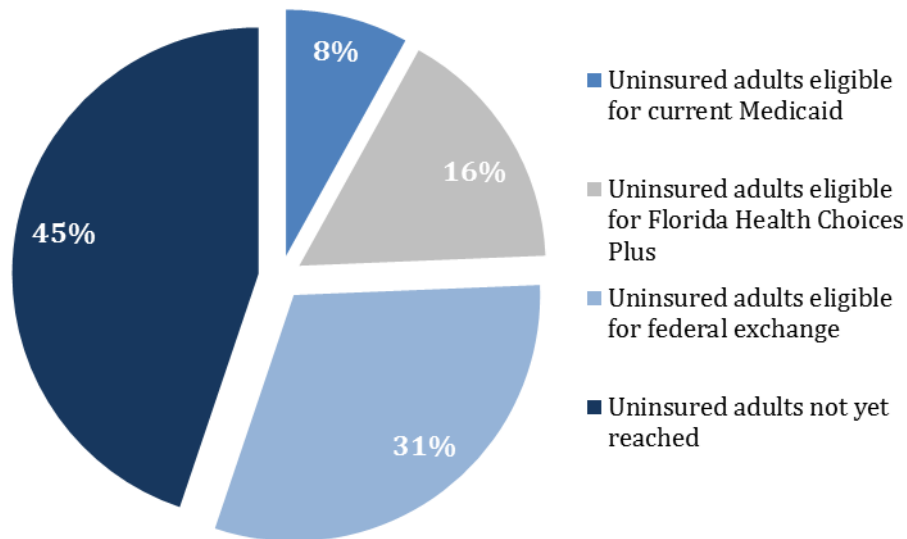
Uninsured Adults (19-64 years) Using More than \$2,000



Source: Medical Expenditure Panel Survey

- **Just 12% of uninsured adults use more than \$2,000 in health care in a given year**
Just one in eight uninsured adults living in the south, ages 19 to 64, use more than \$2,000 in health care services in a given year.

Uninsured Adults (19-64 years) Earning Less than 138 Percent of Poverty

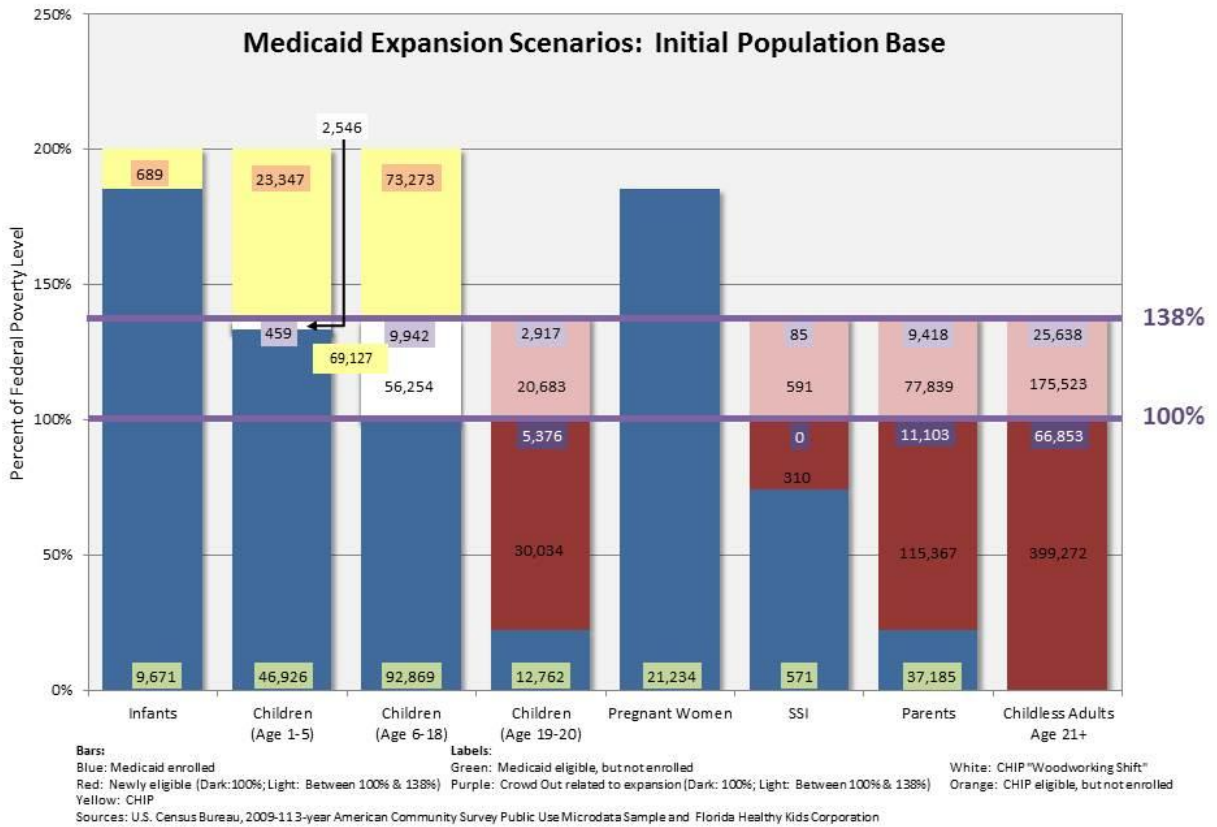


Source: Census Bureau

- **Florida Health Choices Plus reaches 16% of all uninsured adults in Florida earning 138 percent or less of the federal poverty level. Another 8% are eligible for current Florida Medicaid.**

Uninsured Florida Children and Adults

by Demographic, Income Level, Medicaid Eligibility and Exchange Eligibility



Source: Florida House of Representatives' Select Committee on PPACA (number of uninsured reached assumes 79.7% of eligible uninsured enrolling in Medicaid)

New and more affordable coverage options for low-income parents and all Florida residents

Florida Health Choices Plus builds off the infrastructure of Florida Health Choices to achieve patient-centered health reform outcomes. Florida Health Choices Plus empowers individuals who meet certain criteria to build the lowest cost, highest value health coverage package for themselves and their families.

Participants in Florida Health Choices Plus

Individuals	Eligibility Criteria	Taxpayer Contribution to CARE Account (annualized)	Individual Contribution
Parents	22%-100% of poverty, Medicaid ineligible	\$2,000 (\$167/month)	\$25/month
Individuals on SSI with Disabilities	74%-100% of poverty, Medicaid ineligible	\$2,000 (\$167/month)	\$25/month

Newly Eligible Participants in Florida Health Choices

Individuals	Eligibility Criteria	Employer Contribution	Individual Contribution
Individuals	Any Florida resident	N/A	Full cost plus small admin fee
Employees	Employees at any participating Florida employer, large or small (only small employers are currently eligible)	Set by employer (e.g., \$300/month for all employees)	Set by employer, if required at all

Florida Health Choices Plus uses CARE Accounts to fill the coverage and care gap for low-income parents and adults with disabilities ineligible for Medicaid or exchange coverage

Low-income parents and adults with disabilities who earn too much to qualify for traditional Medicaid but too little to qualify for coverage through the federal exchange will be eligible for state help to purchase coverage and care. Each participating adult will have a CARE Account (Contribution Amount for Responsible Expenditures). Each participant will receive \$2,000 a year in their CARE Account.

Eligibility for these low-income adults, whose children under 18 already qualify for Medicaid or KidCare, and these adults with disabilities would be determined by the federal exchange and/or the Florida Department of Children and Families. If it is determined an

adult is not eligible for either Medicaid or the exchange, and that adult meets the other criteria, he or she is referred to Florida Health Choices Plus and notified of their eligibility for state help and available health care and coverage options.

**Income Requirement for Low-Income Parents
Eligible for State Help through a CARE Account Contribution**

Household Size	Income less than, qualify for Medicaid (22% FPL)		Income more than, qualify for exchange (100% FPL)		Income more than, too high for exchange (400% FPL)
2	\$ 3,412		\$ 15,510		\$ 62,040
3	\$ 4,297	Parents in this income range eligible for Florida Health Choices Plus	\$ 19,530	Individuals in this income range eligible for federal exchange	\$ 78,120
4	\$ 5,181		\$ 23,550		\$ 94,200
5	\$ 6,065		\$ 27,570		\$ 110,280
6	\$ 6,950		\$ 31,590		\$ 126,360
7	\$ 7,834		\$ 35,610		\$ 142,440
8	\$ 8,719		\$ 39,630		\$ 158,520

**Income Requirement for Low-Income Adults with Disabilities
Eligible for State Help through a CARE Account Contribution**

Household Size	Income less than, qualify for Medicaid (74% FPL)		Income more than, qualify for exchange (100% FPL)		Income more than, too high for exchange (400% FPL)
1	\$ 8,503		\$ 11,490		\$ 45,960
2	\$ 11,477	Certain adults with disabilities in this income range eligible for Florida Health Choices Plus	\$ 15,510	Individuals in this income range eligible for federal exchange	\$ 62,040
3	\$ 14,452		\$ 19,530		\$ 78,120
4	\$ 17,427		\$ 23,550		\$ 94,200
5	\$ 20,402		\$ 27,570		\$ 110,280
6	\$ 23,377		\$ 31,590		\$ 126,360
7	\$ 26,351		\$ 35,610		\$ 142,440
8	\$ 29,326		\$ 39,630		\$ 158,520

Florida Health Choices will be available to any interested Florida resident or employees of participating Florida employers

Florida Health Choices is available, without a taxpayer-financed CARE Account contribution, to any interested Florida resident. In addition, Florida employers large or small, both for-profit and not-for-profit, will be able to have Florida Health Choices Plus become their health benefit provider. Currently, Florida Health Choices is only available for participating small employers and certain other employers. Employers could determine the amount of their contribution and any employee contribution. Employees would then have access to the same care and coverage options available to low-income parents in Florida Health Choices Plus.

Many health coverage options will be available through Florida Health Choices

By using Florida Health Choices, participants will have a robust choice of plans, including comprehensive coverage options that meet Affordable Care Act standards (platinum, gold, silver and bronze level plans), lower cost Health Savings Account-eligible plans, basic plans with focused fixed dollar benefits, discount cards, and short-term plans for less than 12 months of coverage.

Types of Plans that Could Be Available (illustrative purposes only)

Individual Insurance Plans	Short-Term Insurance Plans
Preventive-Catastrophic Protection #1 <ul style="list-style-type: none"> • 100% preventive, no copay • \$1,500 deductible • 0% coinsurance after deductive 	Short-Term Preventive-Catastrophic Protection #1 <ul style="list-style-type: none"> • 100% preventive, no copay • \$1,500 deductible • 0% coinsurance after deductive • Up to 12 months
Preventive-Catastrophic Protection #2 <ul style="list-style-type: none"> • 100% preventive, no copay • \$2,500 deductible • 0% coinsurance after deductive 	Short-Term Preventive-Catastrophic Protection #2 <ul style="list-style-type: none"> • 100% preventive, no copay • \$2,500 deductible • 0% coinsurance after deductive • Up to 12 months
Preventive-Catastrophic Protection #3 <ul style="list-style-type: none"> • 100% preventive, no copay • \$3,500 deductible • 0% coinsurance after deductive 	Short-Term Preventive-Catastrophic Protection #3 <ul style="list-style-type: none"> • 100% preventive, no copay • \$3,500 deductible • 0% coinsurance after deductive • Up to 12 months
Preventive-Catastrophic Protection #4 <ul style="list-style-type: none"> • 100% preventive, no copay • \$5,000 deductible • 0% coinsurance after deductive 	Short-Term Preventive-Catastrophic Protection #4 <ul style="list-style-type: none"> • 100% preventive, no copay • \$5,000 deductible • 0% coinsurance after deductive • Up to 12 months
Preventive-Catastrophic Protection #5 <ul style="list-style-type: none"> • 100% preventive, no copay • \$6,250 deductible • 0% coinsurance after deductive 	Short-Term Preventive-Catastrophic Protection #5 <ul style="list-style-type: none"> • 100% preventive, no copay • \$10,000 deductible • 0% coinsurance after deductive • Up to 12 months

Unfortunately, due to the impact of ObamaCare on Florida’s individual insurance market as a result of the federal government’s new regulations on individual insurance, it is impossible to say for certain what the individual insurance premiums will be in 2014.

However, the State of Florida will still have regulatory oversight over short-term insurance plans. Given that 71 percent of the uninsured are only without coverage for fewer than 12 months, most participants in Florida Health Choices Plus would likely select these lower cost short-term plans.

Below is a table showing actual premiums for a 35-year-old man or woman in Orlando purchasing a 6-month or 11-month short-term health policy. The average age of an uninsured parent in Florida is 35 years old.

**Sample Short-Term Premiums for Adult Participants in Florida Health Choices Plus
(Orlando rates, based on April 2013 plans)**

Temporary Comprehensive Health Insurance Plan Details				Term of Coverage		
Initial Deductible	Coinsurance	Max Out of Pocket (including deductible)	Drug Coverage?	6 months of Coverage	11 months of Coverage	Per Member Per Month
\$1,000	20%	\$2,000	only inpatient	\$445		\$74
\$1,000	20%	\$3,000	yes	\$778		\$130
\$1,000	50%	\$3,500	only inpatient	\$399		\$67
\$1,000	50%	\$6,000	yes	\$664		\$111
\$1,500	20%	\$3,500	yes	\$662		\$110
\$2,500	0%	\$2,500	yes	\$790		\$132
\$2,500	20%	\$4,500	yes	\$508		\$85
\$2,500	20%	\$6,500	yes		\$1,844	\$168
\$2,500	30%	\$7,500	no		\$1,073	\$98
\$2,500	50%	\$7,500	yes	\$518		\$86
\$3,500	0%	\$3,500	yes	\$754		\$126
\$5,000	20%	\$7,000	yes	\$411		\$68
\$5,000	20%	\$9,000	yes		\$1,484	\$135
\$5,000	30%	\$10,000	no		\$867	\$79
\$5,000	50%	\$7,500	only inpatient	\$251		\$42
\$7,500	20%	\$8,500	only inpatient	\$255		\$42
\$7,500	50%	\$1,000	only inpatient	\$247		\$41
\$10,000	20%	\$12,000	yes	\$343		\$57

Sources: ehealth.com (April 2013 short-term plans for Orlando adults)

New provider-led packages and bundled health services encourage affordable new products and services for participants

Allowing individuals to personalize their health coverage lets Florida Health Choices Plus support new provider-led options that deliver high value health service packages. For example, a local hospital may provide a hospital primary care (an inpatient and outpatient health plan targeting patients in a particular county or region). A physician group or walk-in clinic may offer a preventive health package (i.e. a physical, flu shot and wellness regimen of tests for \$125) at a dramatically reduced rate only made possible with the captured market provided by Florida Health Choices Plus. A dental practice may offer a package of two cleanings and one restorative procedure for \$250.

This approach is similar to Groupon®, which offers deep discounts to a large number of individuals for particular services, including health services. To better understand how this Groupon®-like feature could reduce costs to low-income parents, consider the following actual Groupon® health care deals available in Orlando:

- \$39 for new glasses priced at \$200
- \$35 for a dental cleaning priced at \$218
- \$39 for a dental checkup priced at \$379
- \$29 for a palliative pain treatment priced at \$75
- \$39 for a chiropractic treatment priced at \$194

In addition, hospitals may choose to offer their own package of health services for patients willing to limit their treatment to that hospital and other participating affiliates. For example, Sarasota Memorial Hospital offers such a plan, called Charter Health Plan:⁹⁹

Sarasota Memorial Hospital Charter Health Plan Benefits

Category	Coverage
Deductible / Co-Insurance	\$500/80-20% to \$10,000
Maximum out of pocket (including deductibles)	\$2,500 individual, \$7,500 family
Office Visits – Primary Care Physician	\$20 copay (4 per calendar year)
Office Visits – Specialist	Deductible & Co-Insurance
Wellness Visit	100% up to \$300 maximum
Diagnostics-X-Ray & Lab	Deductible & Co-Insurance
Diagnostics-Complex Imaging	Deductible & Co-Insurance
Outpatient Services/Surgery	Deductible & Co-Insurance
Rehab Services (physical, occupational, and speech therapy)	20% after deductible has been met
Hospitalization	Deductible & Co-Insurance
Emergency Room	\$100 per visit plus Deductible & Co-Insurance
SMH Walk-In Medical Center	\$75 per visit plus Deductible & Co-Insurance
Maternity pre-natal & monitoring	\$35 Copay
Maternity hospitalization	Deductible & Co-Insurance
Behavioral Health Services	\$0 Copay first 4 visits, \$30 Copay for visits 5-20
Prescription – (<i>subject to \$1,200 annual maximum</i>)	\$15 Generic/\$40 Brand
Durable Medical Equipment	20% after deductible has been met
Lifetime Maximum Benefit	\$2,000,000

Source: SMH Charter Health Plan

Sarasota Memorial Hospital Charter Health Plan Sample Premiums

Individual	Premium
Male under age 25	\$90/month
Female age 40-44	\$276/month

Source: SMH Charter Health Plan

Individuals may purchase these packages in addition to more comprehensive coverage. This price transparency and competition allows Florida Health Choices Plus participants to maximize their health care dollars.

Florida Health Choices Plus will provide choice counseling to low-income adults seeking the best coverage for their specific needs

Florida Health Choices Plus’ choice counseling ensures low-income adults are educated about their likely health care utilization. Choice counseling online tools would further assist parents with finding the best, most appropriate option given their individual circumstances. Florida state employees already have these tools available to guide them to the best value health plan among the four MyFlorida plans for state employees (available at: <http://www.myflorida.com/mybenefits/calculator/HPCE.htm>).

Low-income parents can put leftover funds into a Health Savings Account or keep in their CARE Account

Florida Health Choices Plus will allow participants to deposit any remaining funds, after their own contributions and the balance of their taxpayer-financed credit are applied, into a Health Savings Account. These funds can only be applied to IRS-defined health expenses, which include dental services, vision services, and copays for health services. SSI disabled enrollees can also use the funds for Medicare premiums and cost-sharing. Enrollees may choose to keep the remaining funds in their CARE accounts, to purchase additional products and services in the Florida Health Choices marketplace.

By encouraging low-income parents to be prudent consumers of health coverage, Florida Health Choices Plus prepares them for future financial responsibility and independence.

Reasonable work requirements for recipients of taxpayer help

To encourage self-sufficiency and independence, low-income parents receiving taxpayer help must meet a work requirement. This work requirement and related sanctions mirrors the requirement for parents who receive Temporary Cash Assistance (Florida’s Temporary Assistance for Needy Families cash welfare program).

Status	Work Requirement
Single parents with a child under age 6	20 hours weekly in core work activities
Other single parent families or two-parent families where one parent is disabled	30 hours weekly with at least 20 hours in core activities
Married teen or teen head of household	Maintain satisfactory attendance at secondary school or the equivalent, or participate in education related to employment for at least 20 hours weekly
Two-parent families who do not receive subsidized child care	35 hours weekly (total among both parents) with at least 30 hours in core activities ¹⁰⁰

Under Florida's TANF program, the following qualify as work activities:

- Unsubsidized employment
- Subsidized private sector employment
- Subsidized public sector employment
- On-the-job training
- Community service programs
- Work experience
- Job search and job readiness assistance
- Vocational educational training
- Job skills training directly related to employment
- Education directly related to employment
- Satisfactory attendance at a secondary school or in a course of study leading to a graduate equivalency diploma
- Providing childcare services¹⁰¹

On average, a parent on Temporary Cash Assistance receives \$240 a month¹⁰², not significantly more than the \$167 monthly Florida Health Choices Plus credit. Having a similar work requirement is consistent with the overall mission of the Temporary Cash Assistance Program, as signed into law by President Bill Clinton on August 22, 1996:

1. "To provide assistance to needy families with children so that they can live in their own home or the homes of relatives;
2. To end the dependency of needy parents on government benefits through work, job preparation, and marriage;
3. To reduce the incidence of out-of-wedlock pregnancies; and
4. To promote the formation and maintenance of two-parent families."¹⁰³

Scenarios of what Florida Health Choices Plus would provide

Mary is a single 35-year-old mom of two. She selects a \$2,500 deductible plan providing 11 months of coverage for just herself (kids on Medicaid) costing \$1,884

- Receives a \$2,000 taxpayer-funded CARE Contribution
- Pays \$25/month as her personal contribution
- Has \$416 left over in CARE Account to cover out of pocket health care for the year
- Has 46% chance of using less than \$500 in health care in given year
- Best case (has coverage, uses nothing beyond preventive)
 - Has \$116 more in her CARE Account than she paid in
- Likely case (uses \$500 in health care during year)
 - Has all health care expenses except \$84 covered by CARE Account
- Worst case (has coverage and \$250,000 catastrophic health event, less than 1% chance of this happening)
 - Has \$6,384 out of pocket expenses

Maria is a single 35-year-old mom of two who has lost her full-time job and is working very part-time. She selects a \$5,000 deductible plan providing 11 months of coverage for just herself (kids on Medicaid) costing \$867.

- Receives a \$2,000 taxpayer-funded CARE Contribution
- Pays \$25/month as her personal contribution
- Has \$1,433 left over in CARE Account to cover out of pocket health care for the year
- Has 46% chance of using less than \$500 in health care in given year
- Best case (has coverage, uses nothing beyond preventive)
 - Has \$1,133 more in her CARE Account than she paid in
- Likely case (uses \$500 in health care during year)
 - Has all health care expenses covered by CARE Account
- Worst case – (has coverage and \$250,000 catastrophic health event, less than 1% chance of this happening)
 - Has \$8,567 out of pocket expenses(possible charity care to hospital)

Tom is an adult with disabilities earning too much to qualify for Medicaid and too little to qualify for the exchange. As he is on disability, he receives Medicare coverage.

- Receives a \$2,000 taxpayer-funded CARE Contribution
- Pays \$25/month as his personal contribution
- Has \$2,300 in CARE Account to cover Medicare Part B premiums and deductibles and other out of pocket health care for the year
- Can use CARE Account to cover his entire year of Part B premiums (\$1,259 for year)
- Can use CARE Account to cover his entire Part B deductible (\$147 for the year)
- Has \$894 left over in CARE Account to cover other Medicare copays and coinsurance

Required financing of Florida Health Choices Plus

Based on the actual number of uninsured parents and adults with disabilities in Florida, and assuming a similar take-up rate as those currently in Florida Medicaid, the Florida Health Choices Plus program is projected to have a total annualized cost of \$237 million to serve all 145,000 eligible adults (with 115,700 actually enrolling).

This total annual cost projection includes an assumed 2.5 percent administrative cost.

	Adults with Disabilities (19-64 years old, 74-100% of poverty)	Parents (with children under 18, 22-100% of poverty)	Total
Currently uninsured	389	144,752	145,141
Projected Take-Up Rate (79.7% of uninsured, taken from Social Services Estimating Conference)	79.7%	79.7%	
Expected Enrollment	310	115,367	115,677
Annual Credit	\$2,000	\$2,000	
All take credit for full year	\$620,000	\$230,734,000	\$ 231,354,000
Administration (2.5%)	\$15,500	\$5,768,350	\$ 5,783,850
TOTAL Annualized Cost	\$635,500	\$236,502,350	\$ 237,137,850

Below is a table showing the costs by state fiscal year based on Florida Health Choices Plus beginning in April 2014. Enrollment is assumed to phase-in at the same rate as the optional Medicaid expansion would have been, as calculated by the Social Services Estimating Conference.

Year	Total Uninsured	@ 79.7% Take Up	Phase in	Enrolled Uninsured Parents and Eligible Adults with Disabilities	Annual CARE Account Contribution from State	Admin.cost (2.5%)	Total Cost by Year
FY 2014 (begins April 2014)	145,141	115,677	20%	23,135	\$11,567,700	\$289,193	\$11,856,893
FY 2015	147,196	117,315	50%	58,658	\$117,315,389	\$2,932,885	\$120,248,274
FY 2016	149,266	118,965	65%	77,327	\$154,654,685	\$3,866,367	\$158,521,052
FY 2017	151,312	120,596	85%	102,506	\$205,012,876	\$5,125,322	\$210,138,198
FY 2018	153,329	122,203	100%	122,203	\$244,406,903	\$6,110,173	\$250,517,076
FY 2019	155,316	123,787	100%	123,787	\$247,573,195	\$6,189,330	\$253,762,525
FY 2020	157,270	125,344	100%	125,344	\$250,687,903	\$6,267,198	\$256,955,100
FY 2021	159,190	126,875	100%	126,875	\$253,749,089	\$6,343,727	\$260,092,816
FY 2022	161,076	128,377	100%	128,377	\$256,754,910	\$6,418,873	\$263,173,783
FY 2023	162,926	129,852	100%	129,852	\$259,703,497	\$6,492,587	\$266,196,084

Part IV –Ideas to Study to Maximize Florida Health Choices and Build a Better Health Care Marketplace for Everyone

Consider a strategy that allows all state employees to join Florida Health Choices with a state contribution equal to the value of their current health insurance benefit

In future years, Florida state government employees could be allowed to participate in Florida Health Choices using the full value of their taxpayer-financed health benefit, as shown below.

Individuals	Eligibility Criteria	State Contribution (annualized)	Individual Contribution
Full-time state employees	Qualify for family coverage	\$13,800 (based on 2013 value) ¹⁰⁴	If desired
Full-time state employees	Qualify for single coverage	\$6,450 (based on 2013 value)	If desired
Legislators& “Payalls”	Qualify for family and single coverage	\$15,600 family/\$6,950 individual	If desired
Part-time state employees	working at least 30 hours a week	To be determined	If desired

Study allowing health professionals to practice within the full extent of their training

If Florida is going to increase access to care, it must allow health professionals to practice up to the full extent of their training. Florida is one of just two states that do not provide nurse practitioners or physician assistants with prescribing authority.¹⁰⁵ These health professionals are also not permitted to establish practices that are not under the supervision of a physician.¹⁰⁶

By allow these professionals to practice with more independence, within the full extent of their training, Florida can increase its supply of medical care. This should help alleviate the current and looming physician shortages, especially in primary care, the field most commonly served by nurse practitioners and physician assistants.

Studies have consistently shown that expanding the scope of practice for nurse practitioners and physician assistants does not negatively affect patient safety. In fact, research suggests that patients who exclusively visit physician assistants for 30 percent or more of their health care needs actually have fewer visits per year than other patients.¹⁰⁷ Even after controlling for demographics, socioeconomic status, insurance status, health status and medical conditions, these patients had 16 percent fewer medical visits in a given year.¹⁰⁸

The Office of Program Policy Analysis and Government Accountability estimates expanding scope of practice could save more than \$300 million per year statewide.¹⁰⁹ By increasing the supply of lower cost medical care, this is expected to reduce access barriers faced by low-income patients. This would also expand the opportunity for nurse practitioners and physician assistants to donate more charity care through the Volunteer Health Services Program, a program of the Florida Department of Health.

Study petitioning the federal government to request freedom for Florida patients and taxpayers from federal control

Although Florida is best suited to design a program to meet the needs of its poorest citizens, it is hamstrung by federal rules and regulations controlling the state's Medicaid program. If the state is ever to design an innovative, customized program to meet the needs, culture, and values of Florida's unique and diverse population, the state must be emancipated from federal micromanaging.

Below is draft resolution calling for such freedom:

WHEREAS, The Medicaid program was created by Title XIX of the Social Security Act;

WHEREAS, Title XIX allows states to administer the Medicaid program, but only under the supervision of the federal government;

WHEREAS, Federal rules and regulations are not tailored to the unique needs of individual Florida's most vulnerable residents;

WHEREAS, Florida is best suited to make decisions about the design of its Medicaid program based upon the needs, culture and values of its population;

WHEREAS, Florida's most vulnerable population deserves a Medicaid program that is customized to meet its unique needs;

WHEREAS, Florida can provide Medicaid patients meaningful choices in their coverage plans by leveraging the private insurance marketplace through innovative support mechanisms;

WHEREAS, A customized program would increase access to needed care, improve health outcomes and raise patient engagement;

WHEREAS, These reforms can only be achieved with greater flexibility and freedom from the federal government in controlling the Medicaid program;

LET IT BE RESOLVED, The Florida House of Representatives urges the federal government to pass federal funds onto states for Medicaid purposes through a global waiver, thereby giving Florida the flexibility to design its Medicaid program in a way that best suits Florida's population.

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