Prepared Statement of
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before the

Subcommittee on Energy Policy, Health Care and Entitlements and the Subcommittee on Economic Growth, Job Creation, and Regulatory Affairs

Committee on Oversight and Government Reform
U.S. House of Representatives

September 18, 2013

Introduction

Chairman Lankford, Chairman Jordan, Ranking Member Speier, Ranking Member Cartwright, and members of the Committee, thank you for the invitation to testify on "Federal Implementation of Obamacare: Concerns of State Governments." I welcome this opportunity to share with you the challenges Florida has experienced in dealing with the Patient Protection and Affordable Care Act (PPACA).

My name is Matt Hudson and I represent the 80th District in the Florida House of Representatives. I was elected to office in 2007 and I serve as chairman of the Florida House Health Appropriations Subcommittee and vice-chairman of the Florida House Select Committee on PPACA. I also serve as co-chairman of the National Conference of State Legislatures (NCSL) Health Committee and as a member of the NCSL Health Reform Task Force.

State officials across the country have a vested interest in ensuring access to quality, affordable, private health insurance coverage for their citizens. My colleagues in the state of Florida are no different. Currently, 19 percent of Florida's population is uninsured.[1] Between 2008 and 2012, average private-sector employer-based premiums rose by 22 percent, or a compounded average increase of 5.1 percent per year.[2] We have 3.3 million Floridians in our Medicaid program, yet 41 percent of Florida's doctors won't accept new Medicaid patients.[3-4]

These problems existed before PPACA, and we look forward to working with our federal partners to make health coverage more affordable and accessible to all Floridians. Unfortunately, PPACA only makes these problems worse. Today, I'd like to discuss four areas of concern: one, Florida's health workforce shortages; two, the excessive premium increases on Florida's families; three, the haphazard implementation and privacy concerns surrounding health insurance exchanges; and four, PPACA's Medicaid expansion.

PPACA Makes Florida's Health Workforce Shortages Worse

The growth and aging of the U.S. population has increased demand for healthcare services.[5] The implementation of PPACA will substantially add to the demand for healthcare services,

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[1] U.S. Census Bureau, Current Population Survey, U.S. Census Bureau, http://www.census.gov/cps/.

[2] Based on 2008 Medical Expenditure Panel Survey-Insurance Component: Table X.D, U.S. Department of Health and Human Services (2009), http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_10/2008/txd.pdf and Agency for Healthcare Research and Quality, 2012 Medical Expenditure Panel Survey-Insurance Component: Table X.D, U.S. Department of Health and Human Services (2013), http://meps.ahrq.gov/mepsweb/data_stats/summ_tables/insr/state/series_10/2012/txd.pdf.

[3] Florida Agency for Health Care Administration, Florida Medicaid Managed Care [1915(b)] and Medicaid Pilot* (1115) Enrollment Reports As of September 1st, 2013, Florida Agency for Health Care Administration (2013), http://www.fdhc.state.fl.us/MCHQ/Managed_Health_Care/MHMO/docs/MC_ENROLL/RF_NR_SMMC/ENR_Sep2013.xls.

[4] Sandra L. Decker, In 2011 Nearly One-Third Of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help, Health Affairs (2012), http://content.healthaffairs.org/content/31/8/1673.

[5] Maria Schiff, The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care, National Governors Association (2012), http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf and A. N.

especially primary care services.[6] Currently there is an inadequate supply of healthcare practitioners in the U.S. to meet this growing need for healthcare services.

According to the Association of American Medical Colleges, the U.S. faces a shortage of more than 90,000 physicians by 2020 and the shortage will grow to more than 130,000 physicians by 2025.[7] According to the U.S. Bureau of Labor Statistics, the registered nurse workforce is the top occupation in terms of job growth through 2020. The number of employed nurses is expected to grow from approximately 2.74 million in 2010 to 3.45 million in 2020—an increase of 712,000, or 26 percent. Additionally there is a projected need for 495,500 replacements in the nursing workforce, bringing the total number of nursing job openings due to growth and replacements to 1.2 million by 2020.[8]

Florida's demographics, particularly its disproportionately large elder population, mean Florida will experience a greater healthcare workforce shortage than many other states. Florida's aging population currently includes many practicing physicians. Within the next five years, 5,810 (12.97 percent) of Florida's 44,804 active physicians plan to retire, adding to the workforce shortage dilemma.[9] Florida currently has a shortage of primary care physicians and would need 753 doctors just to eliminate the state's 248 primary care crisis areas.[10] The implementation of subsidized health insurance through the exchange, plus a PPACA Medicaid expansion, would generate the need for an additional 50,300 registered nurses to meet the demand for healthcare services in Florida.[11]

These shortages will affect access to health care negatively, both with regard to patient caseloads and price. Practitioners will have larger caseloads. Patients will have to wait longer for care and may have difficulty accessing the care they need. Increased demand for fewer resources leads to higher costs.

States can address healthcare workforce shortages by increasing the matriculation of practitioners in the state, competing for existing workforce resources by encouraging and

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Hofer, J. M. Abraham, and I. Moscovice, Expansion of Coverage Under the Patient Protection and Affordable Care Act and Primary Care Utilization, The Milbank Quarterly (2011), http://www.ncbi.nlm.nih.gov/pubmed/21418313.

[6] Id.

[7] Association of American Medical Colleges, Fixing the Doctor Shortage, Association of American Medical Colleges (2013), https://www.aamc.org/advocacy/campaigns_and_coalitions/fixdocshortage/.

[8] U.S. Department of Labor, Bureau of Labor Statistics, Employment Projections – 2010-20, U.S. Department of Labor, Bureau of Labor Statistics (2012), http://www.bls.gov/news.release/pdf/ecopro.pdf. See also: Robert J. Rossiter, Nursing Shortage Fact Sheet, American Association of Colleges of Nursing (2012), http://www.aacn.nche.edu/media-relations/NrsgShortageFS.pdf.

[9] Florida Department of Health, Physician Workforce Annual Report 2012, Florida Department of Health (2012), http://www.doh.state.fl.us/Workforce/Workforce/Annual_Reports/PhysicianWorkforceAnnualReport2012.pdf.

[10] Florida Department of Health, Presentation by State Surgeon General & Secretary of Health John H. Armstrong, M.D., before the House Select Committee on Patient Protection and Affordable Care Act, February 18, 2013, on file with Florida House Select Committee on PPACA staff.

[11] Florida Center for Nursing, RN and LPN Supply and Demand Forecasts, 2010-2025: Florida's Projected Nursing Shortage in View of the Recession and Healthcare Reform, Florida Center for Nursing (2010), http://www.doh.state.fl.us/Workforce/Workforce/Annual_Reports/PhysicianWorkforceAnnualReport2012.pdf.

removing barriers to migration from other states, and using existing in-state resources as efficiently as possible. Some of the methods to accomplish these goals include dedicating more funds to practitioner education programs, removing regulatory barriers to licensure, creating or expanding licensure reciprocity between states, and expanding scope of practice to ensure all practitioners practice to the greatest extent of their education, training, and experience.

Healthcare workforce regulation is traditionally the purview of state governments, not the federal government. The federal government's attempts to both increase access to care and reduce costs through PPACA will be thwarted by the failure to address workforce problems.

In Florida, the political and policy dialogue surrounding PPACA led us to consider significant changes to the way we produce and utilize health care practitioners as a way to mitigate the existing and looming health care workforce shortages. To that end, the Speaker of the House of Representatives, Will Weatherford, has convened a Select Committee to explore these issues and identify short-term and long-term solutions. We hope to improve Florida's regulatory position compared to other states, invest more wisely in education, and make it easier for health plans and health provider organizations to build networks and recruit practitioners. We want to make sure that Florida is in the best possible position to ensure our citizens have access to the best possible health care workforce.

PPACA Levies Excessive Premium Increases on Florida's Families

PPACA inflicts problems on both the supply and the demand side of health care. We must have a robust and innovative healthcare workforce to meet the health needs of all Floridians. But we also need to make health insurance more affordable so that Floridians can access that care. Contrary to its name, PPACA fails to make health care more affordable and will price increasing numbers of Floridians out of the healthcare marketplace.

Under the new federal health law, individuals are seeing their premiums skyrocket in Florida. There are a number of reasons for this. The law's guaranteed issue requirements, community rating provisions, minimum mandated benefits, age rating restrictions, actuarial value requirements, and new taxes and fees will all drive up the cost of health insurance.[12]

These provisions require insurance companies to accept all applicants, even if they wait until they get sick before applying for coverage, and the insurance companies are now prohibited from charging premiums based upon likely costs. So many individuals in the market today are seeing their premiums go up in order to subsidize others. These provisions also make individuals buy more robust coverage than they currently have, want, or even need. And the new taxes and fees on private insurance are simply being passed along to consumers.

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[12] House of Representatives Select Committee on PPACA, Committee Meeting Notice: January 25, Florida House of Representatives (2013), http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2738&Session=2013&DocumentType=Meeting%20Packets&FileName=PPACA%201-25-13%20ONLINE.pdf.

The Florida Office of Insurance Regulation (OIR) reports that premiums in our small-group market will rise by an average of 5 to 20 percent.[13] In our individual market, the results are even worse. According to OIR, premiums in our individual market are expected to increase by an average of 30 to 40 percent.[14]

Of course, insurance regulation has historically been a state power. As vice-chairman of the Florida House Select Committee on PPACA, I learned that PPACA had taken much of this state role and given it to the federal government without creating the regulatory structure to administer it. We learned that the U.S. Department of Health and Human Services (HHS) planned to leverage state infrastructure and resources to implement the PPACA insurance provisions—particularly state insurance regulatory departments.[15]

When we started the Select Committee meetings in January of 2013, the rules on insurance rating were not finalized. The insurance industry was facing a deadline of May 1, 2013 to submit products to HHS for approval to be sold on the exchange.[16] The rating rules did become final on February 27, 2013.[17] We knew that because of the lateness of the rule we would not know the full impact of PPACA on rates until after the legislative session ended.

Florida has a long history of transparency including extensive public records and open meetings laws—and the Select Committee realized that insurance rates were changing as a result of the actions of the federal government. We wanted Floridians to know and understand the effects of PPACA on their insurance rates. Since the federal government had superseded the role of the state in setting policy affecting insurance rates, we wanted to make sure the public understood that state could do nothing to affect rates.

As a result, the legislature passed Senate Bill 1842, which in part requires insurance companies to provide a one-time notice to policyholders that describes or illustrates the estimated impact of PPACA on monthly premiums.[18] The notice must also be submitted to OIR, which will post a summary of the notices on its website.[19]

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[13] Wences Troncoso, Patient Protection & Affordable Care Act (PPACA) Overview: Post-Legislative Session Update, Florida Office of Insurance Regulation (2013), http://www.floir.com/sitedocuments/PPACAUpdate07302013.pdf.
[14] Id.
[15] Florida House of Representatives, Select Committee on PPACA, Overview of the Patient Protection and Affordable Care Act, January 14, 2013, on file with Florida House Select Committee on PPACA staff.
[16] Wences Trocoso, Patient Protection & Affordable Care Act (PPACA) Overview, Florida Office of Insurance Regulation (2013), http://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2738&Session=2013&DocumentType=Meeting Packets&FileName=PPACA1-25-13 ONLINE.pdf.
[17] U.S. Department of Health and Human Services, Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, Federal Register 78 FR 13405 (2013), https://www.federalregister.gov/articles/2013/02/27/2013-04335/patient-protection-and-affordable-care-act-health-insurance-market-rules-rate-review.
[18] Senate Appropriations Committee and Senate Banking and Insurance Committee, CS/SB 1842, Florida Senate (2013), http://www.flsenate.gov/Session/Bill/2013/1842/BillText/er/PDF.
[19] Id.

The information in the notice must be based on the statewide average premium for the bronze, silver, gold, or platinum level plan, whichever is applicable to the policy, and provide an estimate of specified effects of the following PPACA requirements:[20]

- The dollar amount of the premium attributable to the impact of guaranteed issuance of coverage;

- The dollar amount of the premium attributable to fees, taxes, and assessments;

- For individual policies, the dollar amount of the premium increase or decrease attributable to the combined impact of the age and gender rating requirements of PPACA, shown for specified age brackets for males and females; and

- The dollar amount attributable to the requirement to cover essential health benefits and to meet a required actuarial value, as compared to the statewide average premium for the policy that has the highest enrollment in the individual or small group market, whichever is applicable.

OIR developed the form this summer with input from industry and advocacy groups. In Florida, our citizens will know the true costs of PPACA and will be able to judge for themselves if the costs are worth the value they receive from their new insurance policies.

Haphazard Implementation of PPACA Exchanges Threatens Both Policymaking and Privacy

The Florida Select Committees on PPACA spent a great deal of time learning about our policy options under PPACA, including our choices for the structure and operation of Florida's health insurance exchange. In several areas of PPACA, the federal government made assumptions about the degree of state willingness to participate in implementation. For the members of Florida's Legislature, the decision concerning what kind of exchange would operate in Florida turned on whether there were any meaningful policy choices we could make in a state-based exchange or partnership to tailor the exchange to meet Floridians' unique needs.

We needed information on how the federal government would run the federally-facilitated exchanges (FFEs) in order to evaluate and decide whether Florida would benefit from taking on this role of building and operating an exchange. What policy choices would HHS make? For example:

- Would the FFE be an active purchaser, or an open market?

- Would Florida be one statewide rating area, or divided into many rating areas? If the latter, how many areas and what would they look like?

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[20] Florida Office of Insurance Regulation, Notice of Premium Impact Template, Florida Office of Insurance Regulation (2013), http://www.floir.com/siteDocuments/NoticeofPremiumImpactsTemplate.xlsx.

- Will the FFE have an outreach program, and what will it look like?

- What is the process for transitioning from a FFE to a state-based exchange?

- What are the procedural and technical requirements for connecting to the federal data hub?

However, federal timelines and a lack of information made the legislative process difficult. The federal deadline for a state to notify HHS that it planned to have a state-based exchange was originally November 16, 2012, and was extended to December 14, 2012.[21] The notice deadline for a partnership exchange election was February 15, 2013.[22]

We were being forced to make this important decision before the federal government had addressed these and many other questions in either rules or guidance. Prior to the deadlines for declaring which exchange model Florida would pursue, the Speaker of the House of Representatives and the Senate President submitted a joint letter to HHS detailing a list of questions they believed needed to be answered in order for the Florida Legislature to make an informed decision.[23] They received a response in January—after the notice deadline for a state-based exchange—which contained no answers to any of the questions.[24]

In an attempt to get answers to some of our questions, the legislature invited Center for Consumer Information and Insurance Oversight (CCIIO) staff to attend a committee meeting and discuss exchanges with the members of the Select Committees.[25] Over a period of weeks of communication, Select Committee staff first was advised that CCIIO does not have a travel budget so no one from CCIIO could attend in person.[26] Later they were told CCIIO officials are not allowed to meet officially with state legislatures; rather, they are permitted only talk informally and not in public.[27] This created understandable problems given our open

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[21] Kathleen Sebelius, Letter to The Honorable Bob McDonnell and The Honorable Bobby Jindal, U.S. Department of Health and Human Services (2012), accessed at http://healthreformgpsdev.forumone.com/resources/sebelius-grant-rga-request-for-more-time-to-decide-on-a-state-run-exchange/.

[22] Id.

[23] Don Gaetz and Will Weatherford, Letter to The Honorable Kathleen Sebelius, Florida Legislature, November 15, 2012, on file with Florida House Select Committee on PPACA staff.

[24] Gary Cohen, Letter to The Honorable Don Gaetz and The Honorable Will Weatherford, U.S. Department of Health and Human Services, January 14, 2013, on file with Florida House Select Committee on PPACA staff.

[25] E-mail from staff of the U.S. Department of Health and Human Services to staff of the Florida House of Representatives Select Committee on PPACA, December 17, 2012, on file with Florida House Select Committee on PPACA staff.

[26] E-mail from staff of the U.S. Department of Health and Human Services to staff of the Florida House of Representatives Select Committee on PPACA, January 2, 2013, on file with Florida House Select Committee on PPACA staff.

[27] E-mails from staff of the U.S. Department of Health and Human Services to staff of the Florida House of Representatives Select Committee on PPACA, January 28, 2013, January 29, 2013, and January 30, 2013, on file with Florida House Select Committee on PPACA staff.

government laws, so we were not able to schedule the meeting. The February partnership deadline passed without any answers.

The final rule for the FFEs came out in late March of this year, in the middle of Florida's legislative session and long after the deadlines for deciding on FFE alternatives. While the substance of the rules happened to affirm Florida's policy decision to have a federally-facilitated exchange, the federal timeline made a more thoughtful, informed decision process impossible, further damaging a federal-state relationship already stressed by PPACA's assumptions about states' willingness to participate.

The federal government's haphazard implementation of exchanges affected Florida's ability to craft sound public policy. And now our most vulnerable Floridians will be impacted, thanks to the exchange navigator program that lacks meaningful privacy protections.

These exchanges—and the people helping run the exchanges—will be handling all kinds of personal information of consumers. Consumers will be handing over Social Security numbers, dates of birth, addresses, employment information, tax return information, and much more, not just for the applicants themselves, but for their entire families.[28] This is more than enough personal information for consumers to have their identities stolen.

We wanted to know who would be handling this information. Would the people handling this information receive background checks? If not, how can we be sure the people collecting this information haven't committed identity theft in the past? Would the data be secure once collected? Would the federal government be able to protect this personal information against security breaches that we see time and again?

Florida takes the safety of its citizens' private information very seriously. I want to thank Florida's Attorney General, Pam Bondi, for joining with 12 other attorneys general in a letter to HHS Secretary Kathleen Sebelius expressing concern about the failure to adequately protect the privacy of citizens seeking to enroll in the new exchanges.[29]

During the legislative session, we wanted to protect the private information of Floridians. We didn't want to pass overly burdensome or duplicate regulation on the navigators. Additionally, PPACA placed constraints on a state's ability to regulate navigators by requiring that state

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[28] Health Insurance Marketplace, Application for Health Coverage & Help Paying Costs, U.S. Department of Health and Human Services (2013), http://cdn.insuranceexchangehq.com/wp-content/uploads/2013/05/ObamaCare-Application-Form-Family-AttachmentC_042913.pdf.

[29] Patrick Morrisey et al., A Communication from the States of West Virginia, Alabama, Florida, Georgia, Kansas, Louisiana, Michigan, Montana, Nebraska, North Dakota, Oklahoma, South Carolina, and Texas Regarding Data Privacy Risks Posed by Programs Assisting Consumers with Enrollment in Health Insurance Through the New Exchanges, State of West Virginia, Office of the Attorney General (2013), accessed at http://myfloridalegal.com/webfiles.nsf/WF/JMEE-9AKRP2/$file/HHSLetter.pdf.

regulation may not "prevent the application of a provision of PPACA."[30] It is unclear and uncertain what requirements a state can place on navigators.

We passed a law in Florida that required the registration of navigators which included background screenings, disqualifications for certain crimes, and penalties for improper actions.[31]

During session, the navigator grants had not been awarded, the navigator rules had not been finalized, and the navigator training had not been announced. We didn't know, and frankly didn't expect, how little training and oversight the navigators received—or we would have passed an even more rigorous law in Florida.

PPACA itself only refers to "navigators." And Florida passed registration requirements for navigators. Now we find out that HHS has also created certified application assisters, certified application organizations, and Champions for Coverage—all of which appear to be expected to perform the same activates as navigators but with even less oversight.

PPACA's Medicaid Expansion Will Lead to Poor Care and Cost Overruns

The federal government has exerted great pressure on our state to expand Medicaid eligibility. Despite the fact that our Medicaid reform pilot had been widely hailed as a decided success, our request to implement those reforms statewide sat on the desk at the Centers for Medicare & Medicaid Services (CMS) for nearly two years. We submitted our request to implement those reforms statewide in August 2011, but didn't gain final approval until June 2013.[32-33]

Were our reforms held hostage to pressure us into expanding Medicaid? After all, HHS is continuing to push Medicaid expansion in our state.[34] Fundamentally, I believe the Medicaid expansion is a flawed approach to reduce the number of uninsured residents in Florida.

Rather than temporary assistance targeted to our most vulnerable residents, the optional Medicaid expansion would have created a new entitlement for able-bodied, working age adults without children.[35] This group has never been considered categorically needy and doesn't

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[30] Senate Banking and Insurance Committee, Bill Summary for CS/SB 1842, Florida Senate (2013), http://www.flsenate.gov/PublishedContent/Session/2013/BillSummary/Banking_BI1842bi_1842.pdf.

[31] Supra Note 18.

[32] Florida Agency for Health Care Administration, Statewide Managed Medical Assistance Program 1115 Research and Demonstration Waiver, Florida Agency for Health Care Administration (2011), http://www.fdhc.state.fl.us/Medicaid/statewide_mc/pdf/mma/Amendment_1_1115_Medicaid_Reform_Waiver_08012011.pdf.

[33] Centers for Medicare and Medicaid Services, Managed Medical Assistance Program Approval Letter, U.S. Department of Health and Human Services (2013), http://www.fdhc.state.fl.us/Medicaid/statewide_mc/pdf/mma/06-14-2013_Appproval_Letter.pdf.

[34] Daniel Chang and Kathleen McGrory, Feds to Florida: Not Too Late for Medicaid Expansion, Miami Herald (2013), http://www.miamiherald.com/2013/07/24/3519595/feds-to-florida-not-too-late-for.html.

[35] According to the Urban Institute, nearly 83 percent of the uninsured individuals made eligible by the expansion are working-age adults with no disabilities and no dependent children. The remaining 17 percent are working-age

qualify for other types of welfare, including the Temporary Assistance for Needy Families program's cash assistance.[36]

Across the nation, Medicaid programs already face major problems. Access to care is limited and outcomes are poor.[37-38] The only randomized, controlled trial of Medicaid ever conducted found no improvements in health when compared to the uninsured.[39]

We're already facing a provider shortage, both inside and outside of the Medicaid program. There is nothing in PPACA to significantly and permanently increase the number of providers. Expanding Medicaid to more than a million new individuals would undoubtedly make access problems worse. And those who would suffer most would be our most vulnerable residents, including our elderly population and those with disabilities. They would be forced to compete with able-bodied adults for a limited number of appointments.

But even if Medicaid were an efficient program, state lawmakers face another huge problem—we have no idea how much it would really cost. In Florida, we heard testimony on what happened in other states that had already expanded Medicaid to this group of people.[40-41]

We learned that in Arizona, enrollment was nearly three times what was expected and that costs were four times what was expected.[42] We learned within two years of Maine expanding Medicaid, nearly twice as many people signed up as the state thought were even eligible and uninsured.[43] We learned that in state after state that expanded, this new eligibility category cost far more than policymakers expected.[44]

We received plenty of cost estimates. But they were all highly sensitive to a number of assumptions—illustrating the general lack of experience and multitude of unknowns inherent in

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parents with no disabilities. See, for example, Genevieve M. Kenney, Opting In to the Medicaid Expansion Under the ACA: Who Are the Uninsured Adults Who Could Gain Health Insurance Coverage?, Urban Institute (2012), http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[36] Gene Falk, The Temporary Assistance for Needy Families (TANF) Block Grant: A Primer on TANF Financing and Federal Requirements, Congressional Research Service (2013), http://www.fas.org/sgp/crs/misc/RL32748.pdf.

[37] Supra note 4.

[38] Kevin D. Dayaratna, Studies Show: Medicaid Patients Have Worse Access and Outcomes than Privately Insured, The Heritage Foundation (2012), http://thf_media.s3.amazonaws.com/2012/pdf/bg2740.pdf.

[39] Katherine Baicker et al., The Oregon Experiment—Effects of Medicaid on Clinical Outcomes, New England Journal of Medicine (2013), http://www.nejm.org/doi/full/10.1056/NEJMsa1212321.

[40] Senate Select Committee on PPACA, Committee Meeting Expanded Agenda: February 11, Florida Senate (2013), http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2026.pdf.

[41] House of Representatives Select Committee on PPACA, Committee Meeting Notice: February 18, Florida House (2013), http://www.myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2738&Session=2013&DocumentType=Meeting%20Packets&FileName=PPACA%202-18-13-ONLINE.pdf.

[42] Id.

[43] Supra note 41.

[44] Supra note 42.

expanding Medicaid to such a large and unfamiliar population.[45] As we got more information over time, the projected costs of Florida's Medicaid expansion skyrocketed. Our official estimates on the total ten-year cost of expanding Medicaid went from less than $30 billion, as reported to us at a February 2013 committee hearing, to nearly $55 billion less than one month later—based on more realistic figures pulled from reports from CMS, Mathematica, and other states' Medicaid programs.[46-47] Florida's share of these costs more than doubled to $3.5 billion, up from the earlier $1.4 billion estimate.[48]

Even without expansion, Medicaid spending is crowding out funding for state priorities like education. More than 30 percent of our state budget goes to Medicaid.[49] A little over a decade ago, it was half that.[50] Expanding Medicaid would crowd-out even more of our resources. And even worse, it would prioritize our Medicaid resources on able-bodied, working-age adults, rather than on the most vulnerable.

All this assumes, of course, that the federal government is going to keep its funding promises. The federal government is already nearly $17 trillion in debt.[51] That's expected to grow to more than $26 trillion during the next decade.[52] Can the federal government afford to keep this promise? It couldn't afford to keep its promises to states on special education funding.[53] Or on the funding promised to states when we borrowed with Build America Bonds.[54] How many broken promises do we need to be on the losing end of before we recognize that grand promises such as this one are inherently suspect?

Florida decided not opt-in to the Affordable Care Act's voluntary expansion of Medicaid. That doesn't mean we won't be affected by the law. The law is still expected to add more than $82 billion in costs to our Medicaid system during the next decade.[55]

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[45] Jonathan Ingram, The Uncertainty of Medicaid Expansion, Foundation for Government Accountability (2013), http://www.floridafga.org/wp-content/uploads/1FINAL-The-Uncertainty-of-Medicaid-Expansion.pdf.
[46] Supra note 42.
[47] Senate Select Committee on PPACA, Committee Meeting Expanded Agenda: March 11, Florida Senate (2013), http://www.flsenate.gov/PublishedContent/Committees/2012-2014/SPPA/MeetingRecords/MeetingPacket_2102.pdf.
[48] Id.
[49] Brian Sigritz, State Expenditure Report: 2011, National Association of State Budget Officers (2012), http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf.
[50] Nick Samuels et al., State Expenditure Report: 2000, National Association of State Budget Officers (2001), http://www.nasbo.org/sites/default/files/ER_2000.pdf.
[51] Bureau of the Public Debt, The Debt to the Penny and Who Holds It, U.S. Department of the Treasury (2013), http://www.treasurydirect.gov/NP/debt/current.
[52] Douglas W. Elmendorf, The Budget and Economic Outlook: Fiscal Years 2013 to 2023, Congressional Budget Office (2013), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf.
[53] Jonathan Ingram, Medicaid in Ohio: The Choice is Clear, Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/06/Medicaid-in-Ohio-The-Choice-is-Clear.pdf.
[54] Id.
[55] John Holahan, The Cost and Coverage Implications of the ACA Medicaid Expansion:

CONCLUSION

Thank you, Chairman Lankford and Chairman Jordan, for giving me the opportunity to share Florida's challenges with PPACA implementation. I share your goal of making quality, affordable, private health coverage accessible for all Americans—and I look forward to working with you to accomplish that goal outside of the constraints of the federal health law.

National and State-by-State Analysis, Kaiser Commission on Medicaid and the Uninsured (2012), http://www.urban.org/UploadedPDF/412707-The-Cost-and-Coverage-Implications-of-the-ACA-Medicaid-Expansion.pdf.