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Mismanaging Medicaid Managed Care: Senate Proposal Goes Further, Risks Even More Than Problematic Predecessors

The proposal for overhauling Florida Medicaid released through the Senate Budget Committee on Health and Human Services Appropriations[1] calls for building on and expanding key aspects of the flawed Medicaid Reform (Reform) Pilot. It also borrows from the House's more expansive 2010 proposal to turn most Medicaid-related decisions entirely over to managed care plans.

Although the Senate bill includes a number of improvements over earlier proposals, it also expands many problematic elements of the current Reform experiment, while adding several new features of serious concern. Indeed, securing federal approval to continue and markedly expand on the broad flexibility given to Florida via the current Medicaid Reform (federal "Section 1115" research and demonstration) waiver is the linchpin to the Senate proposal. Yet none of the potentially beneficial measures introduced in the Senate bill require use of the Section 1115 waiver mechanism.

Waivers are primarily needed in this case to reduce or limit benefits. One specific feature of the bill – installation of a hard cap on total Medicaid spending – likely makes the Senate proposal one of the biggest threats to Medicaid recipients ever seriously debated in the legislature.

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However, aside from the bill's threat to effectively withdraw from the Medicaid program if approval is not forthcoming by December 1, 2011, there is little reason to expect that federal approval is a possibility. Granting Florida such extreme flexibility to undermine Medicaid is likely even beyond the (federal) Centers for Medicare and Medicaid Services' ability to grant. Only Congress has the authority to alter the fundamental nature of Medicaid, and congressional debate is already underway. In the meantime, codifying a threat to forgo at least $12 billion a year in federal funding in exchange for the right to run an inadequate state-only program that places countless vulnerable recipients and high-paying jobs at-risk is unsound public policy.

1. Expansion of Medicaid Managed Care: The Tip of the Iceberg

The larger implications of the Senate bill, including some differences from earlier proposals to overhaul

Medicaid, are outlined below.

A. Dramatic Expansion of Mandatory Enrollment in Managed Care Plans

Currently, about two-thirds of Florida Medicaid recipients are enrolled either in MediPass (a form of primary care case management in which patient care is coordinated by a primary care physician) or in a managed care plan such as a Medicaid HMO.[2] (The rest are in some form of "fee for service" Medicaid and are currently exempt or excluded from participation in managed care.) In the five-county Reform Pilot, however, MediPass has been virtually eliminated. All recipients in the pilot counties who are not exempt or excluded *must* enroll in a managed care plan.

Given their track record of poor performance in Florida, forcing additional vulnerable groups in 62 additional counties (including rural areas) into Medicaid HMOs is problematic.

Under the proposed Senate bill, a stronger version of the Reform Pilot or its successor to the Reform Pilot would begin the process of statewide expansion as of December 2011. Most Medicaid recipients would be required to enroll in a Medicaid managed care plan by December 2012, with recipients in need of long-term care services enrolled by December 2013. However, recipients with developmental disabilities, current nursing home residents, patients with catastrophic medical expenses ("Medically Needy") and children with complex and continuous medical needs would be excluded.

Although the Senate bill specifies that Medicaid managed care plans need not be limited to Medicaid HMOs, HMOs will clearly capture the majority of market share. Any form of managed care plan would need to operate like an HMO, however, accepting a capitated (fixed) payment per enrollee and assuming the financial risk for managing those enrollees' care. A complete and abrupt shift to a system in which care delivery is purchased on a capitated basis could create serious problems for recipients with the greatest health care needs, especially if payment levels become increasingly inadequate to cover the cost of care.

Given their track record of poor performance[3] in Florida, forcing additional vulnerable groups in 62 additional counties (including rural areas) into Medicaid HMOs is problematic. That track record includes the largest Medicaid fraud case in Florida history, a revolving door of plans entering and exiting the market, and almost five years without the patient encounter (service use) data needed to assess changes in access. The short timetable allotted for the transition also presents cause for concern.

The Senate bill also includes a number of features that would exacerbate the flaws in the Reform experiment. For example, most recipients would be required to pay $10 monthly premiums, a severe financial and logistical barrier for extremely low-income recipients who already lack sufficient income to meet their basic needs. Additionally, recipients with access to job-based health insurance would be required to enroll in that coverage in lieu of Medicaid, even if it is inadequate to meet their needs or a bad value.

B. Significant Flexibility, Limited Accountability and Transparency

Medicaid Reform is more than just mandatory enrollment in managed care plans. In the Reform Pilot each plan is given the flexibility to vary benefit levels and amounts. There would no longer be a guaranteed benefit package upon which recipients can depend. Plans are required, however, to provide a benefit package equivalent in value to traditional Medicaid. The package must also include at least the same *types* of benefits available in traditional Medicaid. Nevertheless, the unprecedented flexibility given to plans, together with a lack of accountability and transparency, has resulted in delayed and denied access to care. Concerns with for-profit Medicaid HMOs and the impact of their primary allegiance to shareholders – who expect a financial return on their investment – have persisted throughout the five-year Pilot.

Particularly because plans are required to produce savings for the state, a clear understanding of the source of those "savings" is essential. In the case of for-profit HMOs, these savings are distinct from and must be generated in addition to the profits they are required to produce for their shareholders.

The Senate proposal incorporates provisions allowing the same abuses of flexibility found in both Medicaid Reform and the 2010 House bill. Of particular concern is the minimal requirement placed on plans that benefits must merely be "sufficient" to meet the needs of "most" enrollees, with the state put in charge of determining whether each plan's benefits are sufficient.

These different benefit packages (and different preferred drug lists) have to date in Reform increased complexity and confusion in plan choice and system navigation while yielding little in the way of optional new benefits. Furthermore, patient encounter (i.e., service use) data still has yet to be used to assess the impact of this flexibility on access to and quality of care. Particularly because plans are required to produce savings for the state, a clear understanding of the source of those "savings" is essential. In the case of for-profit HMOs, these savings are distinct from and must be generated *in addition to* the profits they are required to produce for their shareholders.

Like the 2010 House bill, the Senate bill would use a form of competitive bidding in which plans would negotiate the specific terms of their state contracts behind closed doors. However, instead of dividing the state into 6 regions, the Senate calls for 19 regions. This would intensify confusion and concerns about accountability and transparency, as an HMO might be allowed to operate differently in different regions.

Although the bill would hold plans accountable for actions that harm recipients, it does little to help the recipients who are harmed.

Although the Senate bill includes several improvements that would increase accountability above what was included in the 2010 House bill, it is still extremely vague in many areas. It also lacks safeguards to protect recipients if unforeseen difficulties push back the timeline, as has occurred repeatedly in the past. In addition, although the bill would hold *plans* accountable for actions that harm recipients, it does little to help the *recipients* who are harmed.

C. Hard Spending Cap and Continuously Adjustable Coverage

In addition to exacerbating existing problems, the Senate bill includes a new feature that likely renders it a bigger threat than any Medicaid overhaul considered previously. Specifically, it includes a provision intended to override every other measure protecting Medicaid coverage. A hard cap (i.e., arbitrary limit that cannot be exceeded) on total Medicaid spending would be imposed by the legislature each year, trumping all other considerations, including the harm done to vulnerable recipients as a result. Currently, by contrast, when it appears that Medicaid spending will exceed appropriations (e.g., due to increased enrollment resulting from a lingering recession), the budget must be amended to include the necessary revenue.

> ***With an arbitrary hard cap squeezing tighter every session, however, "optional" benefits could quickly disappear. Even "mandatory" benefit levels could and likely would be reduced.***

The Senate bill requires plans to *start* with the same goal of offering benefits at "sufficient" levels. Plans would at least be required to cover the "mandatory" *types* of services required by federal law. Benefits as well as eligibility could quickly erode from there, however. If the Legislature believes that adequate funding is available, plan payment rates could also include funds to cover so-called "optional" services (i.e., services that states are not absolutely required to provide under federal law). However, these services in fact include essential benefits such as prescription drugs and dentures. With an arbitrary hard cap squeezing tighter every session, however, "optional" benefits could quickly disappear. Even "mandatory" benefit levels could and likely would be reduced. In addition, recipients who under current federal law must remain Medicaid-eligible could supposedly lose that eligibility; the bill purports to authorize numerous violations of the "Maintenance of Effort" included in the Patient Protection and Affordable Care Act.[4]

2. Potential Impact of Medicaid Spending Cap on Recipients: One Scenario

To understand how installing such a spending cap might affect Florida Medicaid, it may be helpful to consider what its impact would have been if it had been in effect during a recent year. In this example (2008-09), the hypothetical budget reductions are triggered by actual updates to Medicaid spending projections issued by legislative economists through the Social Services Estimating Conference.

In the FY 2008-09 (July 2008–June 2009) state budget, the legislature provided total appropriations (state and federal) of $15.39 billion for Medicaid, of which $4.38 billion was state general revenue (GR).[5] By November 2008, however, the GR appropriated was projected to fall $145 million short of the amount needed to fund Medicaid for the full year.[6] By February 2009, the GR shortfall had increased by another $147 million.[7]

Had the Senate bill had been in effect at that time, remedial steps would have been necessary to cut this $292 million in GR from the Medicaid budget by June 30, 2009,[8] in order to remain within budgeted amounts. On an annualized basis, this would have equated to reducing GR spending by $731 million. Because this GR is combined with other non-state revenue sources to draw down an even greater amount of federal funding, the annualized *total* Medicaid cuts needed would have exceeded $1.66 billion. The procedures outlined in the Senate bill would have required that the reductions be achieved as follows:

Steps 1 and 2:
First, after squeezing any available cuts from an underfunded administrative budget, so-called "optional" though nevertheless critical services would have been slated for cuts. Elimination of all of the optional services that are targeted almost every year (adult dentures, hearing aids, etc.) would have done little to close the gap.

Elimination of more expensive optional services would have been virtually impossible. For example, although prescription drugs are a costly optional service, access to medications cannot be stripped from some groups and not others under federal law. Rather, they would need to be eliminated almost across-the-board, a life-threatening and exceedingly expensive proposition, given the mounting consequences of leaving treatable conditions untreated. (One exception, although ultimately a form of directly shifting costs to Floridians with insurance coverage and other payors, would be the elimination of any number of services in the Medically Needy program that provides short-term coverage for people with catastrophic medical expenses. In fact, eliminating all benefits with the exception of physician services for non-pregnant, adult Medically Needy recipients *already* is included in the Senate bill.)

Finally, the chaos associated with these (and any other) reductions cannot be ignored. For example, the service reductions would affect managed care plans as well, with allowances made for mid-year changes in plan payment rates, followed by requirements that plans attempt to inform their members and providers of the changes in coverage.

Step 3:
The Senate bill would have next required cancellation of coverage for so-called "optional" eligibility groups. Even if such eligibility restrictions were permissible, which they are not as a result of the passage of the federal Patient Protection and Affordable Care Act, these groups account for only about 6 percent of all Florida Medicaid recipients. They include some children and pregnant women just above the poverty line, certain vulnerable elderly and disabled recipients with incomes between 74 percent and 88 percent of the poverty level, the Medically Needy and a few other smaller groups.[9] For example, if this step had been taken, a pregnant woman with monthly income of $1,400 would have lost her eligibility in the midst of receiving essential prenatal care. Yet even terminating the eligibility of *all* of these "optional" recipients would have yielded somewhere between a third and a half of the total savings demanded by the cap.[10]

Step 4:
Reductions in provider reimbursement rates would have followed next. Rate reductions have already been constant fixtures in the budget development process over the last several years. Furthermore, provider reimbursement rates in Florida Medicaid are already recognized as chronically inadequate. In this example, a special legislative session immediately preceded the February 2009 forecast, and a total of $191 million in rate reductions had just been approved.[11] It is doubtful that significant additional rate cuts could have been achieved without threatening the integrity of the system and the services it provides.

Step 5:
Although the total amount of cuts that could have been secured through the preceding four steps is difficult to estimate with precision, it is clear that a gap would have remained. This would have left as a final option reductions in the amount, duration and scope of the most basic services for the most vulnerable groups of

recipients. Although the state would seemingly have been limited in the ways in which it could cut, the Senate bill, expanding on the current Medicaid Reform experiment, gives managed care plans much more power to make these decisions. Most harmfully, however, the cap would supposedly trump even the vague requirement in Reform that those benefits be sufficient to meet the needs of most recipients. That is an idea that is foreign to the Medicaid program.

3. Longer-Term Potential Impact of Medicaid Spending Cap

As the example demonstrates, setting an arbitrary cap that fails to consider real implications would have disastrous consequences. Furthermore, the adverse impacts would quickly compound over time.

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First, the cap would have a strong carry-over effect, with the service reductions/eliminations and eligibility restrictions imposed built into the baseline for the following budget year. In the current example, suppose for the sake of illustration that the legislature determined that the maximum acceptable rate of growth in the Medicaid budget was 3% per year. This would have limited total (federal and state) Medicaid spending for 2009-10 to $15.90 billion, $2.05 billion less than the actual appropriation of $17.95 billion.[12] Cutting $2 billion from an already decimated Medicaid system would have made it impossible to provide even the remaining services to the remaining recipients at any level that could reasonably meet their needs, fatally compromising the program.

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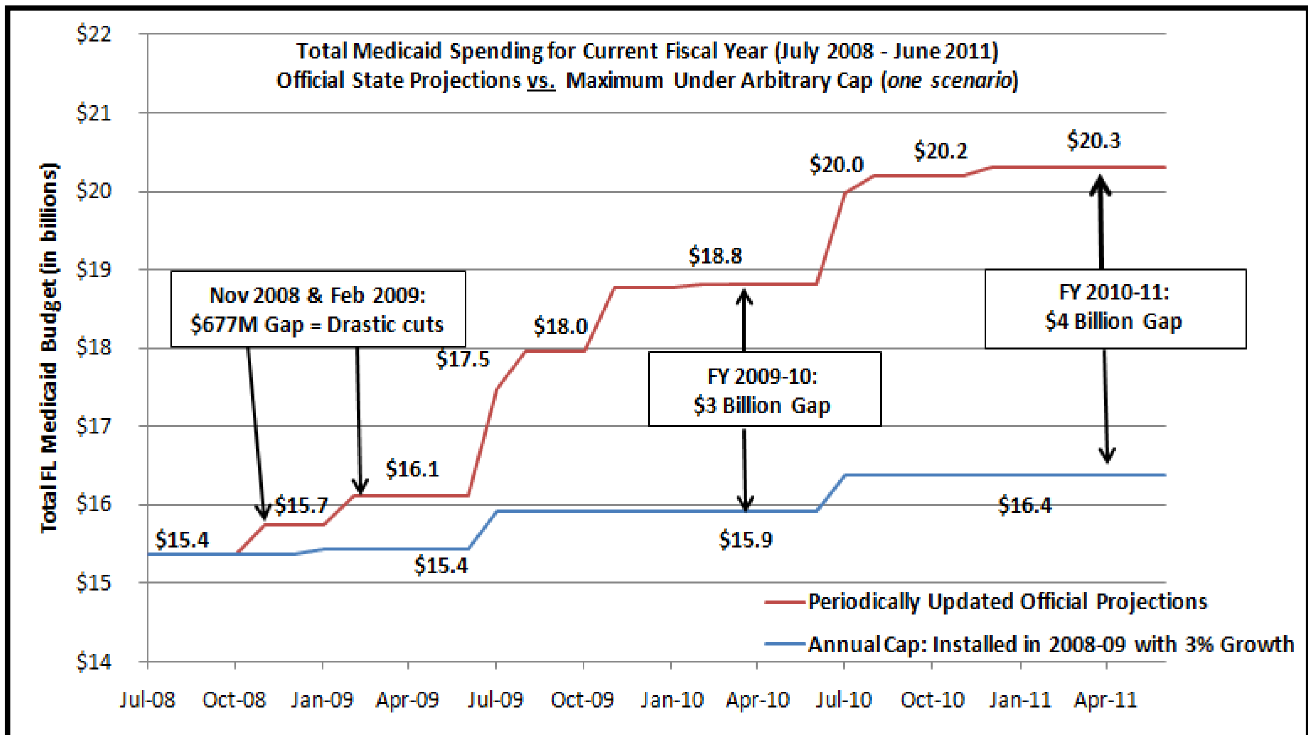
By 2010-11, the capped budget of $16.38 billion would have fallen a massive $3.81 billion below the actual amount appropriated. Consequently, what would remain of Medicaid under a cap would no longer be recognizable as Medicaid in very short order. The figure below depicts how placement of the cap would have quickly unraveled Florida Medicaid in this scenario, endangering countless recipients and ignoring numerous Medicaid laws and protections in the process.



It is important to note that the extent to which annual growth in the Medicaid budget would be permitted is *not* specified in the Senate proposal and in fact could vary year to year at the discretion of the legislature. A 3 percent growth rate seems a realistic placeholder, however. Furthermore, the magnitude of the cuts necessary to remain below the cap was especially pronounced during this period, because the size of the Medicaid rolls grew so markedly during the height of the recession. Such significant mid-year increases in Medicaid spending would be far less likely to occur during periods of economic stability.

4. Potential Economic Impact of Medicaid Spending Cap

The broader impact of such a cap on the economy would be equally severe. Using reasonable estimates generated using the "Medicaid Calculator" developed by Families USA[13], the Senate proposal, along with the assumption of a 3 percent growth rate, would have cost Florida more than $5 billion in federal matching funds, more than 45,000 jobs and more than $9 billion in total economic impact during the first three years (July 2008 – June 2011) alone. Going forward, the losses would compound geometrically.

If the Senate bill had been in effect, a Medicaid Calculator estimates, it would have cost more than $5 billion in federal matching funds, more than 45,000 jobs, and more than $9 billion in total economic impact over the three years.

Finally, the bill includes the threat that Florida would effectively "opt out" of the Medicaid program if the federal Centers for Medicare and Medicaid Services (CMS) declines to approve Florida's request for dramatically expanded powers and flexibility via new or expanded waivers by this December. In an attempt to increase the pressure on CMS to approve requests that it likely lacks the authority to grant, the bill requires that the state first attempt to continue to draw down federal funding while simultaneously implementing the senate bill in violation of federal law. If that attempt proved unsuccessful, the state would drop Medicaid and

drastically scale back its efforts, providing partial coverage to a portion of Medicaid recipients without federal funding. In addition to the immediate threat of irreversible harm done to recipients, opting out of the Medicaid program would cost Florida more than 200,000 mostly private sector jobs and $125 billion in economic activity by the end of the decade.[14]

Key Provisions and Features of the Senate Bill (Including Brief Comparison with 2011 House Bill)

Immediately prior to publication of this brief, the House Health and Human Services Committee released its 2011 version of a statewide Medicaid managed care expansion proposal (Proposed Committee Bills HHSC 2011-01 and HHSC 2011-02).[15] The House and Senate proposals take a similar overall approach, including competitive bidding to select plans to serve regions of the state and expanding on the Medicaid Reform experiment. There are a number of significant differences between them, however, and the new House version even differs in a few key ways from its 2010 predecessor.

Most importantly, the House bill does not call for the imposition of a hard cap on Medicaid spending or threaten withdrawal from the federal Medicaid partnership like the Senate bill. The House bill includes a number of unique shortcomings, however. A broad summary of the of the Senate bill, potentially helpful and potentially harmful, as well as a brief comparison with the House is found in the table below.

General Features of 2011 Senate Medicaid Managed Care Expansion Bill (with Brief House Comparison)

Subject	How Senate Bill Could Protect or Improve Medicaid	How Senate Bill Could Threaten or Undermine Medicaid	How 2011 House Bill Compares/Contrasts with Senate Bill
Expansion of Managed Care	*(see next column)* Excludes from expanded managed care experiment: -recipients with developmental disabilities - current nursing home residents - children with complex and continuous medical needs (Also excludes recipients who receive limited or short-term services and who therefore are impossible to serve profitably through managed care: medically needy, family planning, breast & cervical cancer treatment, emergency care for undocumented immigrants)	Builds on and expands problematic 5-county Medicaid Reform experiment Requires that most Medicaid recipients be enrolled in a Medicaid HMO or other plan required to operate like an HMO by December 2012 Requires that most recipients who need long-term care services to be enrolled in a managed care plan by December 2013 Virtually eliminates MediPass (primary care case management) as an effective alternative to HMO-style managed care Expands flexibility and increases power given to managed care plans, in particular allowing each plan to set its own benefit package as long as the state agrees that it is "sufficient" Extends Reform experiment to many rural areas with no history of managed care representation Extends Reform experiment to require participation by more vulnerable groups (for example, "dually eligible" Medicare recipients, children in foster care) Threatens to compromise the health care safety net by effectively withdrawing Florida from the Medicaid program if federal approval of the state's requests for waivers from a wide array rules and protections is not approved by December	Builds on and expands problematic 5-county Medicaid Reform experiment statewide, in a manner generally similar to the Senate bill, except: Requires that *virtually all* Medicaid recipients – *including* all recipients with long-term care needs or *developmental disabilities* - be enrolled in a Medicaid HMO or other plan *eventually* required to operate like an HMO Long-term care recipients transition into managed care *earlier* (2012-13). Most Medicaid recipients transition in 2013-14. DD recipients transition in 2015-16. Excludes *only* the recipients who receive limited or short-term services who cannot be served profitably through managed care *Fully* eliminates MediPass, even if plan options are unavailable Does *not* include threat to withdraw Florida from the

		2011	Medicaid program
Extreme Cost Containment Measures (Beyond Expansion of Managed Care)		Anticipates placement of an annual hard cap (i.e., arbitrary limit) on total Medicaid spending that trumps all other considerations Anticipates reduction, rationing and even elimination of benefits, eligibility and/or provider payment rates in order to control costs, regardless of the reason for cost increases or the potential impact on recipients Requires that state agencies propose and the Legislative Budget Commission (rather than the full Legislature) approve cuts in benefits, eligibility or provider rates needed to make up any Medicaid budget shortfall identified during the year	House .does not include, though it is important to note that statewide expansion of capitated managed care is itself intended to be a primary form of cost containment
Accountability in Medicaid Managed Care	Adds and/or strengthens plan accountability measures in a variety of areas and increases consequences for poor plan performance or non-compliance Establishes Medical Loss Ratio requirements (MLR): Requires Medicaid managed care plans to achieve a minimum MLR of 90% (i.e., requires that plans spend at least 90% of Medicaid payments on patient care) or pay funds back to the state Increases behavioral health-specific MLR requirement from 80% to 90% (and makes it effective statewide) and increases MLR requirement in Healthy Kids component of Florida KidCare from 85% to 90% Requires plans to post a surety bond to ensure payment to state if plans withdraw	Fails to provide protections for recipients in the event of poor plan performance or plan non-compliance Fails to provide safeguards in the event that implementation does not proceed as planned or timelines are pushed back Fails to correct many longstanding problems in the Reform Pilot	Includes some plan accountability measures and imposes some consequences for poor plan performance or non-compliance, but overall in a weaker manner than does the Senate bill. However, the House bill includes some measures not in the Senate bill as well. Provides fewer or weaker consumer protections, safeguards or contingency plans than even the Senate bill Instead of MLR requirements, provides for less useful "achieved savings rebates" that kick in more quickly, but do not adequately contain plan administrative expenses and do not focus on spending on patient care Instead of requiring a surety bond, requires plans to pay all transition costs <u>and</u> may impose

	from a region, are sanctioned for non-compliance, fail to provide patient encounter data, etc. (The bond amount may be insufficient, however.)		*potentially* significant fine. However, includes weaker *future* consequences for withdrawing plans
Procurement of Managed Care	Uses competitive bidding process to select plans to operate in a region based on quality and capacity considerations, rather than allowing a potentially unlimited number of lower-quality plan options	Uses a form of competitive bidding that allows negotiation with plans behind closed doors, eliminating basic transparency in the benefit-setting process Sets stage for plans to operate differently in different regions, adding to the already complex and confusing plan choice process in Reform	Generally similar to Senate bill (although fewer regions)
Relationship to Private Insurance Coverage		Eliminates access to Medicaid benefits for recipients with access to coverage through a job, expanding the failed "opt-out" component of Reform into a "force-out" to private insurance Instead redirects Medicaid funding that would have been used to pay a Medicaid managed care plan to pay premiums for the job-based coverage, regardless of the adequacy or value of the coverage offered	Continues and expands "opt-out" to private insurance component but does not "force-out" like Senate bill
Provider-Related Provisions Impacting Care and Access to Care	Increases reimbursement rate for primary care physicians to 100% of Medicare rates, effective January 2013 (paid for by the Affordable Care Act)	Fails to address the larger crisis of inadequate provider reimbursement, which will likely be exacerbated by the establishment of a spending cap Extends "sovereign immunity" protection from liability reserved for agents of the state to all Medicaid providers, relegating Medicaid recipients to "second tier" status, without addressing any of the root causes of the practice of defensive medicine	Includes general requirement that plans contract with certain "essential providers" which will strengthen provider networks Requires plans to contract with Healthy Start Coalitions to improve care for pregnant women and infants
Recipient-Related Provisions	Formally recognizes Down syndrome as a developmental disability	Requires all Medicaid recipients (except those elderly and disabled patients who turn virtually all money over to institutions) to pay $10 monthly premiums. Allows cancellation of coverage if premium is not paid	Continues choice counseling as recognized tool essential to plan selection and system navigation, though some problems

Impacting Care and Access to Care	Requires all plans to achieve an EPDST screening rate of at least 80% enrolled for all children enrolled at least 8 months Coordinates eligibility determination processes for School Breakfast and School Lunch programs and KidCare program	Increases charge for a non-emergency visit to an emergency room from $15 to $100, regardless of any access problems that prompted the visit Eliminates guaranteed availability of choice counseling services to help navigate complex plan choice process (enrollment broker presumably still in place) Requires "good faith" participation by recipients in weight loss, smoking cessation or substance abuse treatment programs when appropriate, with unspecified penalties for non-compliance Tightens "good cause" standard allowing recipients to disenroll from a plan in the event of problems accessing care	uncorrected Requires that non-emergency transportation be arranged through statewide contract with Transportation Disadvantaged system, where Senate bill allows each plan to make own arrangements Includes EPSDT screening rate requirement but also tightens good cause standard as in Senate bill
Fundamental Program Changes		Limits services available to non-pregnant adults under the Medically Needy program to physician services only, eliminating inpatient hospital care, medications, etc Allows placement of limits on total enrollment in long-term managed care, not merely on individual home- and community-based waiver programs	Requires that Medically Needy recipients enroll in managed care plans and pay a monthly premium equal to their "share of cost" (an extremely stringent requirement)

Endnotes

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[1] The proposed Senate bill is posted at http://www.flsenate.gov/usercontent/committees/2010-2012/medicaid/billdraft23427.pdf.
[2] Florida Agency for Health Care Administration (AHCA), Comprehensive Medicaid Managed Care Enrollment Report, February 2011.
[3] See, e.g., Florida CHAIN, Detailed Accounting of Persistent and Systemic Failings of Florida's 1115 Waiver and Associated Pilot Program, July 2010.
[4] The Maintenance of Effort requirement in PPACA generally prevents states from tightening or restricting Medicaid eligibility requirements beyond the criteria in place as of passage in March 2010.
[5] Florida Legislature, Office of Economic and Demographic Research (EDR), Social Services Estimating Conference (SSEC), Executive Summary, July 2008, p. 1.
[6] EDR, SSEC, Executive Summary, November 2008, p. 1.
[7] EDR, SSEC, Executive Summary, February 2009, p. 1.
[8] The bill requires each individual agency to notify the SSEC and propose remedial action if its projected Medicaid spending would exceed its allocation of Medicaid appropriations. Most Medicaid funding is allocated to AHCA, however.
[9] See Florida Center for Fiscal and Economic Policy (FCFEP), Out of Options: Cutting Optional Services Would Hurt More Than Help, February 2011, p. 7.
[10] See, e.g., AHCA, Estimated Expenditures by Mandatory and Optional Service and Eligibility Group, June 2009
[11] EDR, SSEC, 2009A Session Action, February 2009, pp. 1-2.
[12] EDR SSEC, Changes to the Forecast, August 2009, p. 2.
[13] For additional information regarding the Families USA Medicaid Calculator and its underlying methodology, see FCFEP, Unhealthy Choices: Flawed Medicaid Proposal Would Kill Florida Jobs, January 2011
[14] FCFEP, Unhealthy Choices, p. 6.
[15] The proposed House bills are posted at http://www.myfloridahouse.gov/Sections/Documents/Publications.aspx?PublicationType=Committees&DocumentType=PCBs

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