



White Paper on the Patient Protection and Affordable Care Act & Its Implications for Florida Philanthropy

University of Florida

*Commissioned by
Florida
Philanthropic
Network & Its
Health Funders
Group*

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Florida Philanthropic Network is pleased to present this “White Paper on the Patient Protection and Affordable Care Act & Its Implications for Florida Philanthropy.” The paper is intended to provide an independent, nonpartisan overview of the Patient Protection and Affordable Care Act (ACA), to discuss key implications for ACA implementation in Florida, and to identify possible roles for Florida philanthropy to play in the ACA’s implementation in the state.

FPN commissioned Dr. R. Paul Duncan at the University of Florida to lead the development of this paper. A nationally prominent health services researcher, Dr. Duncan currently serves as Director of the Florida Center for Medicaid and the Uninsured, and is Professor and Chair of the Department of Health Services Research, Management and Policy in the College of Public Health and Health Professions. He wrote this paper with his colleagues Allyson G. Hall, PhD and Lilliana L. Bell, MHA. We thank them for their excellent work and their dedication to this project.

FPN led this project on behalf of our Health Funders Group (HFG), which is comprised of FPN members who share an interest in supporting health issues, organizations, and needs in Florida. We would like to thank past HFG Co-Chairs Kerry Diaz of the Quantum Foundation and Jane Soltis of the Eckerd Family Foundation for their leadership of the HFG during the development of the paper. We’d also like to thank the Quantum Foundation for providing financial support for this project.

This paper demonstrates how philanthropy can play a vital role as an independent provider of research and knowledge to inform important policy issues for our state. It also demonstrates Florida Philanthropic Network’s ongoing commitment to promote philanthropy, foster collaboration and advance public policy to improve the quality of life for all Floridians.

Sincerely



David Biemesderfer
President & CEO



About Florida Philanthropic Network

Florida Philanthropic Network is a statewide association of more than 100 grantmakers working to build philanthropy to build a better Florida. FPN's members in Florida hold over \$6.5 billion in assets and invest over \$430 million annually to improve the quality of life for our citizens. Our members share a commitment to promoting philanthropy, fostering collaboration and advancing public policy *by Florida, in Florida*.

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Executive Summary

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act (ACA) into law. Whether viewed positively or negatively, the law is commonly seen as the signature domestic policy initiative of President Obama's first term in office. The law and its immediate consequences are likely to touch the lives of virtually every American. This paper describes and identifies key elements of the law and provides consideration of the potential role that might be played by philanthropy in the complex set of processes by which the law is being implemented.

For purposes of this paper, we identify eight areas of the law that have captured considerable attention and discussion (Table 1). Many of these are closely tied to the ACA's emphasis on the central policy objective of dramatically reducing the number of Americans who are without health insurance.

Table 1: Key Elements of the Affordable Care Act

Key Elements of the Affordable Care Act	Description
The individual mandate	Requirement that most Americans carry health insurance with "minimum essential coverage" or potentially face a penalty for noncompliance.
The role and obligations of employers	No formal mandate. However, companies with more than 50 employees will be assessed \$2,000 per employee (excluding the first 30 employees) if health insurance is not provided or at least one employee obtains premium credits through the Exchange.
Medicaid expansion	States have the option to expand their Medicaid programs to include individuals up to 138% of the federal poverty level. The federal government provides 100% of the costs for the expansion for populations through 2016; this declines incrementally to 90% in 2020 and subsequent years. At this point, it is unclear whether Florida will expand Medicaid eligibility.
The Exchanges	States and the federal government will establish marketplaces where individuals and small businesses can purchase insurance.
New rules for insurance companies	New regulations will limit the ability of insurance companies to deny coverage for any reason, including health status, or for charging more based on health status or gender.
New approaches to health-care delivery	Recognizes the importance of cost and quality to health-care delivery and emphasizes new approaches in the form of public health initiatives, information technology advancements, and more. For example, Accountable Care Organizations are groups of doctors, hospitals, and other providers who provide coordinated care to Medicare patients.

Key Elements of the Affordable Care Act	Description
Capacity and systems issues	Addresses the need for more providers by increasing the number of primary care physician programs, increasing the number of loan repayment programs for primary care providers, and increasing and incentivizing the use of primary care non-physician practitioners like physician assistants and nurse practitioners.
Costs and sources of funding	Will cost about \$1.3 trillion over 10 years and will be funded through slight increases in already established taxes as well as new taxes and fees.

(The Henry J. Kaiser Family Foundation, 2012)

There are opportunities for philanthropic organizations, including foundations, to play important roles in the developing implementation processes associated with the ACA. In fact, there is every reason to anticipate that implementation will include subtleties and unexpected twists and turns, with great variation from one community to the next and from state to state. Foundations, especially those with strong community ties, are likely to be a key resource. Foundation-supported projects could include: (1) educating the general public, policymakers, and other key stakeholders on the provisions of the law and regulatory and implementation activities as they unfold; (2) programmatic interventions and direct service activities relevant to aspects of the law, including patient education, navigating changing elements of health insurance and health care, and obtaining benefits; and (3) needs assessments and evaluations of specific elements of the law.

Educating the General Public and Key Stakeholders. The health-care reform law is complex and will profoundly impact health-care delivery in this country. Yet the public, including policymakers and the key stakeholders, lack knowledge about specific reform elements and their potential impacts. Philanthropic activities in Florida could focus on engaging in educational activities.

Programmatic Interventions. Local/regional philanthropic organizations could work towards developing programs and interventions that complement and support the implementation of the ACA. One example is the need for navigational support to help consumers obtain the services they need (e.g., selection of health plans under the Exchanges, or Medicare Part D plans).

Needs Assessments and Evaluations. If implemented as envisioned, the ACA will improve financial access to health care, mental health, and long-term care services. The impact of this legislation on existing delivery infrastructure is unclear. To facilitate planning and redesign of the delivery system, a critical assessment of the health, mental health, and long-term care workforce and access points is warranted. Local/regional philanthropic organizations could focus on conducting such assessments and disseminating the findings to appropriate partners and stakeholders.

Introduction

On March 23, 2010, President Barack Obama signed the Patient Protection and Affordable Care Act into law. Whether viewed positively or negatively, the law is commonly seen as the signature domestic policy initiative of President Obama's first term in office. The law and its immediate consequences are likely to touch the lives of virtually every American. However, key elements of the law are unknown to many and poorly understood by others.

It is quite common for widespread understanding of newly passed laws to emerge gradually as key elements are implemented and experienced by the citizenry. According to The Henry J. Kaiser Family Foundation (2013f) April 2013 Health Tracking Poll, 40% of individuals surveyed were unaware of the current status of the health reform law and 40% indicated that conversations with friends and family were their source of information about the law. The current low level of understanding is in part a result of the sheer length and complexity of the law's many components, including the multi-year implementation process. It also seems likely that the level of controversy surrounding the law has generated a high and sustained level of emotion that may be impeding thoughtful consideration of its objectives, its actual content, and its likely implications.

This paper first describes the underlying policy issues that the Affordable Care Act (ACA) is intended to address. It then identifies and outlines several key elements of the law as the means by which the policy objectives are to be pursued. The third section of the paper discusses issues of particular salience in Florida in greater detail. The paper concludes with a brief consideration of the potential role that might be played by philanthropy in the complex set of processes by which the law is being implemented.

The paper is explicitly intended to be non-partisan and non-ideological. It attempts to describe the ACA in a tone that is neutral to both the underlying philosophy and the specific content of the law. Primary sources of information are selected in part as a reflection of their independence from particular points of view.

This paper was written during the first half of 2013. The gradual implementation of the law is now in the third year of a process that is envisioned as extending over a 12-year period with clearly defined steps. It is simply impossible to predict with certainty how that process will unfold. Furthermore, it is now clear that implementation of the law will vary considerably among the 50 states. The focus of this paper is Florida, where policy conversations about the law and its implementation remain active at the time of writing.

Section 1: Underlying Policy Issues of the Patient Protection and Affordable Care Act

The fundamental policy issues in the delivery of health-care services, in the context of western developed nations, have not changed dramatically in the past century. Furthermore, these policy issues are not likely to be fully resolved in the near future. The pursuit of an optimal balance in assuring **access** to high **quality** care at an acceptable **cost** undergirds almost all serious health policy conversations. Historically, there has been some concern that too much emphasis on any of these elements will have negative consequences for the other(s). In the United States, these policy issues are compounded by an even more basic philosophical ambiguity about the degree to which health and health care are considered public versus private goods, and hence the optimal degree to which government should be involved in their delivery or financing.

Spanning a full century from Theodore Roosevelt's presidency in the early 1900s through that of William J. Clinton's in the late 1990s, our society considered and, in some instances, enacted various health policy initiatives to address one, or even two, of the fundamental issues. For example, Medicare, Medicaid, and favorable tax status for private, employer-sponsored health insurance were established to improve access; prospective payment was added to Medicare as a cost intervention; and the Children's Health Insurance Program was created and subsequently re-authorized to improve access (Goodridge & Arnquist, 2010). Many other reforms were proposed over the years, and the common characteristic of those that were enacted has been a relatively narrow focus. All attempts to pursue comprehensive reform failed, including major proposals from Presidents Franklin D. Roosevelt, Harry S. Truman, Lyndon B. Johnson, Richard M. Nixon, and William J. Clinton (Goodridge & Arnquist, 2010).

During the first few years of the 21st century, issues in all three of the basic areas became especially apparent simultaneously (The Huffington Post, 2012). Ongoing concerns about access to needed care reached a crucial point as the number of Americans without health insurance exceeded 50 million (United States Census Bureau, 2012c). Ever-increasing costs finally crossed a threshold of urgent concern for employers, who play a major role in the purchase of private group insurance. Furthermore, repeated analyses indicated that despite our number one ranking in health-care expenditures, the United States consistently ranked on average in the middle teens among western nations in health and health-care outcomes, raising serious concern about the quality of care being delivered (Schoen et al., 2009). This was the context in which a newly elected president with same-party majorities in both houses of Congress perceived an opportunity for substantial reform and began the steps toward that objective.

While health care had been the subject of some conversation during the presidential campaign of 2008, it was not the main focus. Few analysts expected a major health-care initiative during the first term, in part because the lessons of history were clear regarding the extreme difficulty of health-care reform. Furthermore, the foreign policy issues surrounding two wars, coupled with the overwhelming economic concerns and housing crisis on the domestic policy side, were expected to place (and keep) health care on a back burner. But the somewhat unexpected circumstance of 60 Senators in the Democratic caucus opened the window of opportunity (Iglehart, 2009b; Oberlander, 2009). Furthermore, it was increasingly recognized that health care was a significant component of the nation's economy, and that a failure to move on health-care issues might actually impede economic recovery. In February 2009, the American Recovery

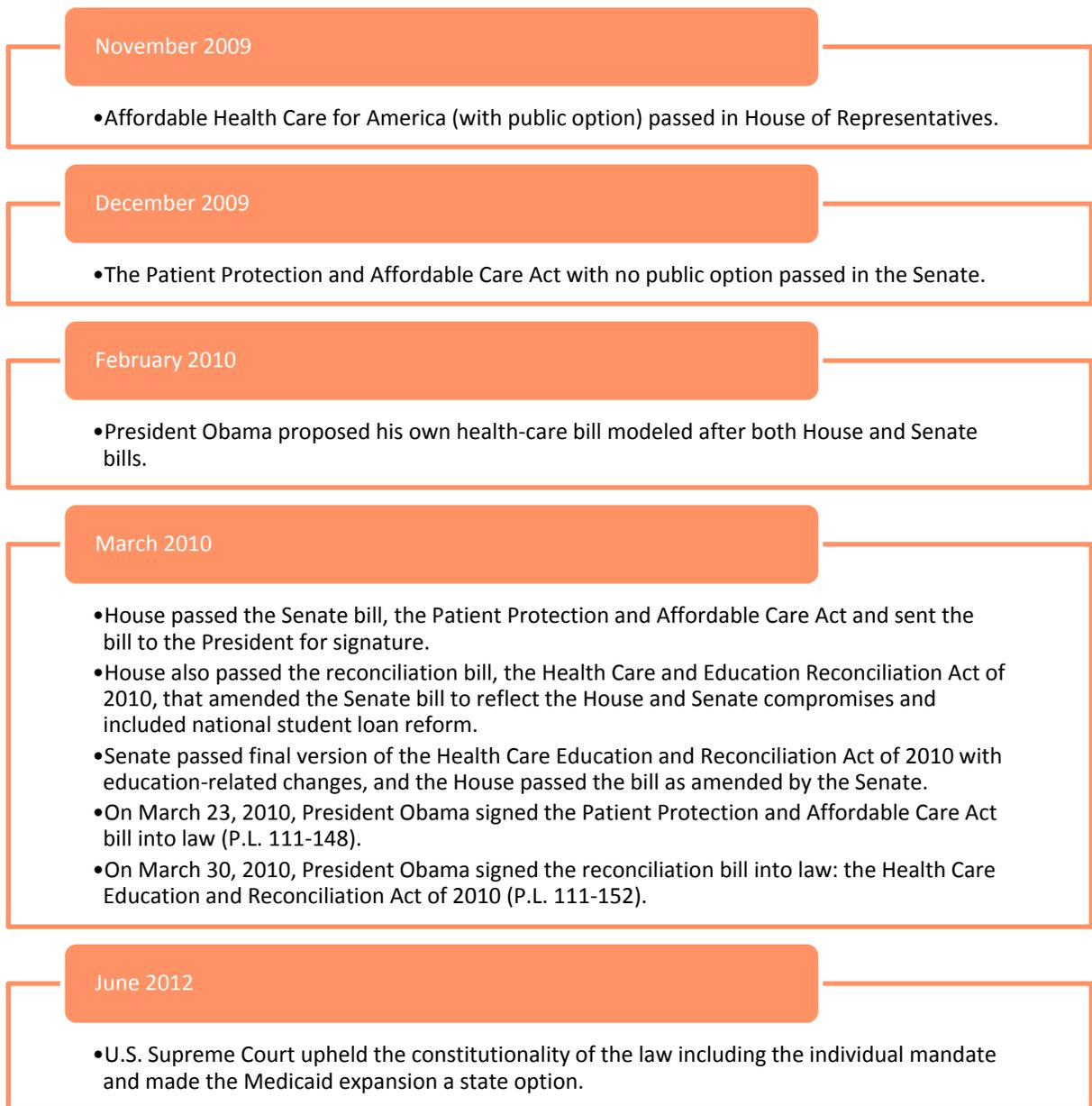
and Reform Act of 2009 (ARRA, also known as the “Stimulus” bill) was passed in an effort to speed economic recovery through tax benefits, contracts, grants and loans, and entitlements (Steinbrook, 2009). It contained significant federal investments in health and health care including \$99 billion to Medicaid and Medicare and \$11.6 billion to the Centers for Disease Control & Prevention, Indian Health Service, Food & Nutrition Service, and the National Institutes of Health, to improve health and the delivery of health-care services (Recovery Accountability and Transparency Board, 2012).

In March 2009, President Obama took the first steps toward a formal health-care reform initiative by convening a White House forum with key health reform stakeholders and promising legislative action by the end of the year. A month later, the “Office of Health Care Reform” was established within the executive branch to coordinate efforts in the health-care arena (Dunham, 2010; Fox, 2009). Over the next several months, staff and members, including three Democratic and three Republican finance committee members, participated in committee assignments, fact-finding hearings, and related processes to develop health reform bills in both houses of Congress (Iglehart, 2009a; The United States Senate Committee on Finance, n.d.).

After a complex legislative process (Figure 1), on March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act bill into law (P.L. 111-148). Then, on March 30, 2010, President Obama signed the reconciliation bill into law: the Health Care Education and Reconciliation Act of 2010 (P.L. 111-152) (The Washington Post, 2012). Together, both laws have come to be commonly referred to as the Affordable Care Act (ACA), the Health Care Reform Law, or sometimes as “Obamacare.”¹

¹ This paper avoids using the term “Obamacare” because it implies the existence of a federal program of benefits, processes, and procedures that simply does not exist. The ACA augments and supports existing programs but does not create a new set of federal activities that could be characterized as a program.

Figure 1: Legislative History of the ACA



(Dunham, 2010; Goodridge & Arnquist, 2010; Herszenhorn & Pear, 2010; The United States Senate Committee on Finance, n.d.; The Washington Post, 2012).

Indeed, the challenges to creating, passing, and ultimately reconciling the House and Senate proposals were numerous and tumultuous. The steps included contentious negotiations about the public plan option, government subsidies, financing the reforms, coverage of abortion services, Tea Party efforts to oppose any increases in taxes or the role of government, coverage for undocumented residents, tort reform, and many other issues. There were uncounted compromises and trial balloons, reflecting the widely diverse hopes and expectations of key stakeholders and the passionate pursuit of their own interests by hundreds of advocacy organizations. The volume and complexity of the law are inevitable consequences of the

connectedness of the many aspects of American health care, its important impacts throughout our society and economy, and the strong advocacy of many interested participants.

Even as supporters of health-care reform celebrated the formal passage of the ACA, it was with clear understanding that opponents would make every effort to repeal the law (Herszenhorn & Pear, 2010). In addition, questions about the constitutionality of the law emerged, and, within minutes after President Obama signed the reconciliation bill into law, a group of 13 states led by Florida filed a lawsuit in the U.S. District Court in Pensacola, FL, against the U.S. Department of Health and Human Services, the U.S. Department of Treasury, and the U.S. Department of Labor raising constitutional questions (Meale, 2010). By June 2010, 20 states had filed lawsuits asserting that the health-care reform law was unconstitutional primarily because it requires individuals to purchase health insurance or pay a tax penalty (National Conference of State Legislatures, 2013).

In deference to the importance of the questions raised and the number of states participating, the U.S. Supreme Court facilitated a somewhat accelerated review process. Once the case reached the Court, over five and a half hours were allocated for oral argument over three days starting on March 26, 2012, an unprecedented amount of time compared to the usual 60 minutes given to most Supreme Court cases. The first day revolved around the legality of the case itself, the second day around the constitutionality of the individual mandate, and finally, on the third day, the severability of the individual mandate and whether the rest of the law could remain intact or be thrown out completely.

The Court's decision was released at the end of its annual term on June 28, 2012, and it was unequivocal in upholding the overall constitutionality of the law, including the specific question of the individual mandate (The New York Times, 2013). It expressed constitutional concern about the coercive method of enforcement for the portion of the law that effectively required states to expand their Medicaid programs, or risk losing all federal matching support for Medicaid. But in raising this issue, the court all but pointed out the obvious remedy, that the federal government could not constitutionally withhold prior Medicaid commitments from states that chose not to participate in expanding their Medicaid programs. And indeed, numerous states, including Florida, continue to debate whether or not and how they might expand their Medicaid programs, without fear that the current federal dollars supporting the program might be withheld.

There have also been various legal appeals on specific parts of the law since the Supreme Court's decisions. As of April 2013, 70 bills in 29 states, including Florida, have been filed to challenge, oppose, or amend various elements of the law (National Conference of State Legislatures, 2013). While it is theoretically possible that some of these claims could reach the Supreme Court, it seems likely that the constitutionality question is now settled and the ACA is now part of our nation's legal structure.

Section 2: Key Elements of the Affordable Care Act

Identifying and summarizing the key elements of this large and complex law can only be described as a formidable task. For purposes of this paper, we identify eight areas of the law that have captured considerable attention and discussion (Table 2). Many of these are closely tied to the ACA’s emphasis on the central policy objective of dramatically reducing the number of Americans who are without health insurance. Other significant elements of the law are identified briefly in Table 3, but are not discussed in detail.

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The individual mandate	Requirement that most Americans carry health insurance with “minimum essential coverage” or potentially face a penalty for noncompliance.
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Medicaid expansion	States have the option to expand their Medicaid programs to include individuals up to 138% of the federal poverty level. The federal government provides 100% of the costs for the expansion for populations through 2016; this declines incrementally to 90% in 2020 and subsequent years. At this point, it is unclear whether Florida will expand Medicaid eligibility.
The Exchanges	States and the federal government will establish marketplaces where individuals and small businesses can purchase insurance.
New rules for insurance companies	New regulations will limit the ability of insurance companies to deny coverage for any reason, including health status, or for charging more based on health status or gender.
New approaches to health-care delivery	Recognizes the importance of cost and quality to health-care delivery and emphasizes new approaches in the form of public health initiatives, information technology advancements, and more. For example, Accountable Care Organizations are groups of doctors, hospitals, and other providers who provide coordinated care to Medicare patients.
Capacity and systems issues	Addresses the need for more providers by increasing the number of primary care physician programs, increasing the number of

Key Elements of the Affordable Care Act	Description
	loan repayment programs for primary care providers, and increasing and incentivizing the use of primary care non-physician practitioners like physician assistants and nurse practitioners.
Costs and sources of funding	Will cost about \$1.3 trillion over 10 years and will be funded through slight increases in already established taxes as well as new taxes and fees.

(The Henry J. Kaiser Family Foundation, 2012)

The Individual Mandate

The ACA requires that all United States citizens and lawful residents have health insurance coverage. Often likened to state requirements that all licensed automobiles have insurance coverage, the law provides for great latitude as to the specific source from which the required insurance might be obtained and a considerable range of the specific insurance product features and coverage that might be deemed credible for purposes of meeting the obligation. There is a mechanism in place to provide relief for existing, private, employer-sponsored insurance that might not achieve quite the level of coverage envisioned for the mandate; there is an exemption from the mandate for certain religious precepts; and while the requirement does include foreign-born residents and naturalized citizens, it does not apply to undocumented residents. However, the principle that as part of the common good, all Americans are expected to obtain and maintain health insurance coverage is evident. The objectives of the mandate are clear. It is intended to improve financial access to health care by the step of increasing the number of people with the means (insurance) required to obtain care and ultimately to improve access to care for all Americans by reducing the costs of care to be borne by individual patients, their families, their employers, and their insurance companies. It is anticipated that the newly insured will have improved financial access to health care (Eibner & Price, 2012). Furthermore, it is expected that reducing the number of uninsured people will ultimately reduce the amount of uncompensated health care currently being delivered to uninsured patients and hence, reduce the burden of those uncompensated care costs—costs that are currently being borne by insured people, their employers, the providers of care, and taxpayers (Buettgens & Carroll, 2012).

Despite the insurance mandate, there are some who are exempt, including undocumented residents, members of Indian tribes, incarcerated persons, members of a religion which opposes accepting benefits of a health insurance policy, individuals whose family income is below the threshold required to file a tax return, and those who would have to pay more than 8% of their income for health insurance (Mulvey & Chaikand, 2012). Furthermore, individuals who provide proof of being insured for 12 months through any combination of Medicare, Medicaid, the Children’s Health Insurance Program, Tricare (the military health care program), and an employer plan; any insurance that provides 60% of an enrollee’s medical costs (bronze level); or a grandfathered health plan are all deemed to have met the requirements for insurance and do not pay a penalty (Mulvey & Chaikand, 2012).

As the mandate expects everyone, except those who are exempt, to be insured, individuals who choose not to follow the law will be “penalized” through the tax code. The range of penalties

for non-insurance is based on the number of adults and children in a household and total income by year. For example, in 2014, the penalty will be \$95 per adult and \$47.50 per child up to a maximum of \$285 per family or 1% of family income, whichever is greater. In 2015, and beyond, the penalty per adult and child, maximum per family, and percentage of family income increases, although it is capped at a maximum of \$2,085 per family and 2.5% of family income (Mulvey & Chaikand, 2012).

The law establishes a threshold of affordability and provides financial support of varying amounts to assist individuals of various income levels in the purchase of private health insurance. For individuals who meet specific eligibility criteria, the ACA provides two types of subsidies for health insurance, including premium subsidies and cost-sharing assistance. Specific eligibility criteria include being a citizen or legal resident, being enrolled in an Exchange, having a household income below 400% of the federal poverty level (FPL) (below \$45,960 for an individual and below \$94,200 for a family of four in 2013), and not being eligible for any other type of coverage (Hagan, Stoll, & Bailey, 2013). Beginning in 2014, individuals and families who purchase health insurance through the Exchanges will be eligible for premium assistance tax credits paid monthly by the government directly to the insurer (Hagan et al., 2013). Since the amount of tax credits provided is based on a sliding scale, individuals with lower incomes will be eligible for more credits. It is estimated that 1.7 million Floridians will become eligible for tax credits starting in 2014, including 87% of working families, 34% of young adults, and 15% of those over age 55 (Hagan et al., 2013). The ACA also establishes cost sharing reductions for out-of-pocket costs (deductibles, copayments, and co-insurance) for individuals and families of modest means, particularly those with income under 250% FPL (below \$28,725 for an individual and below \$58,875 for a family) (Hagan et al., 2013).

Despite the individual mandate, some may choose to not purchase insurance and simply accept the penalties. Due to individuals' choice of not purchasing insurance coupled with exemptions, such as the exclusion of undocumented residents in the law's purview, it is expected that a significant number of uninsured people will continue to impact the health-care system.

The Role and Obligations of Employers

In an attempt to implement the individual mandate, policies were developed to address the various means by which the obligation can be met. The single most common means by which insured Americans obtain their coverage is in the form of a benefit associated with their employment. Employers offer health insurance as part of a comprehensive set of benefits offered in exchange for the labor of their employees. Typically, the offered benefit also includes a means for the employee to obtain coverage for a spouse and/or children. It is important to note that there is enormous variation in the degree and manner of employer participation, including whether or not the benefit is offered at all; the amount of employer contribution to the premium; employer contributions to family premiums as distinct from the individual employee coverage; the number of plans offered; and the manner in which the employer negotiates with insurance carriers about specific coverage elements, prices, and other aspects of the insurance itself, such as co-pay amounts or deductibles. Despite these variations, the common denominator, for more than 50 years, has been a basic assumption that this mechanism of private group insurance, purchased in the private marketplace through collaboration between the employer and the employee, is our nation's preferred approach to

obtaining health insurance coverage. The ACA is explicit in its support of this fundamental assumption.

Historically, the role of employers in providing access to health insurance has been voluntary in the legal sense. However, with labor market influences, employers have sometimes found it necessary to provide health insurance benefits in order to successfully compete for and retain the best employees. In support of employer-sponsored health insurance, both state and federal laws have treated the employer cost of such benefits favorably for tax and other purposes. However, the ACA goes beyond encouragement—making the employer role and responsibility explicit.

The employer obligations vary depending on several factors, including employer size, whether or not the employer currently offers insurance, current state insurance regulations, employee wages, and employee health status. Small employers (fewer than 50 employees) have no new requirements but will have health insurance options that can save money for employees (Blumberg, 2013). Medium employers (50 – 100 employees) must pay a penalty if they do not provide health insurance coverage or if the coverage offered is insufficient, defined as not covering at least 60% of health-care services for a typical population or if the employee has to pay more than 9.5% of family income for coverage (Blumberg, 2013). Large employers (101+ employees) must offer and must enroll employees in a sufficient employer-sponsored plan or be levied fines (Blumberg, 2013). While some small employers have expressed concerns that the ACA will increase health-care costs and reduce coverage options, an analysis by McMorrow, Blumberg, and Buettgens (2011) found that small employers (firms with fewer than 50 employees) stand to gain the most from the ACA with employee participation in the Exchanges and tax credits for insurance coverage.

The Medicaid Expansion

The law recognizes that there is a limitation in our national preference for the employer-sponsored approach to health insurance. Very low wage earners, people working for modest-sized firms, or people without any individual or familial connection to the work place may simply be unable to obtain this form of health insurance. An individual's income or other circumstances may also make any consideration of purchasing an individual policy unrealistic. Despite this scenario, these individuals will be faced with the same mandate to obtain coverage.

The ACA's solution for the aforementioned situation is Medicaid expansion, accomplished by shifting from the traditional focus of categorical eligibility to an approach that makes anyone whose income is below 138% FPL eligible for Medicaid. This change removes the highly complex set of categorical eligibility standards that exists today, which have had the effect of making Medicaid a program largely focused on women and their children, as well as certain individuals with disabilities. With this change, the nation's Medicaid programs will increasingly cover working (low-wage) adults, including males. This change to a single, income-based eligibility standard will dramatically increase the number of newly eligible people in the Medicaid program by an estimated 15.1 million nationwide (Kenney, Dubay, Zuckerman, & Huntress, 2012).

In recognition of Medicaid's expense and the limited resources that states have to accomplish any expansion, the ACA commits federal funding in the amounts necessary to cover 100% of the cost of the required expansion for 2014–2016 and then a gradually reduced federal subsidy

down to 90% of the expansion costs (95% in 2017, 94% in 2018, 93% in 2019, and 90% in 2020 and future years) (The Henry J. Kaiser Family Foundation, 2010a).

Medicaid Expansion in Florida

Currently, Florida is not expected to expand its Medicaid program. Although Florida's Governor Rick Scott now supports Florida's Medicaid expansion, all bills to expand the program were unsuccessful during Florida's 2013 legislative session (Alvarez, 2013). Democrats in favor of Medicaid expansion have asked Governor Scott to call a special session, but this is unlikely unless Republicans lawmakers are willing to collaborate (Mitchell, 2013).

The journey towards Medicaid expansion in the Florida Legislature in 2013 involved three different bills, two of which made it to a vote in the other legislative body. Senate Bill 1816 (Healthy Florida) would have increased the eligibility level for Medicaid to those living below 133% FPL in unison with the plan under the ACA (Florida Center for Fiscal and Economic Policy, 2013). Healthy Florida would have then taken the \$50 billion in federal funds and used it to expand Healthy Kids, the state's CHIP program. Healthy Florida would have also helped enroll over a million low-income residents in private insurance plans as an alternative to the state's Medicaid program (Alvarez, 2013). House Bill 7169 (Florida Health Choices Plus+) would have taken \$237 million in state funds and offered about 115,000 working parents below 100% FPL about \$2,000 in stipends to buy health care for themselves (Deslatte, 2013). The House bill would have not used any federal funds (Florida Center for Fiscal and Economic Policy, 2013). Neither bill was passed.

If Medicaid expansion had occurred in Florida during the 2013 Florida legislative session, about 1.3 million additional Floridians would have become newly eligible for that form of coverage (Kenney et al., 2012)². The federal government would have assumed 100% of the costs of medical care for these new enrollees for the first three years starting in 2014, and then support would taper off until reaching 90% of costs in 2020 (Alker, Hoadley, & Prater, 2012). Florida would have received about \$51 billion over the next 10 years from the federal government for Medicaid expansion and would have expected to spend about \$1.2 billion in its own funds over the same 10-year period, an increase of 7.9% over a scenario in which there were no expansion (Holahan, Buettgens, Carroll, & Dorn, 2012).

The Exchanges

The establishment of health insurance Exchanges is another mechanism for providing health insurance coverage to individuals. The ACA envisioned the creation of health insurance marketplaces (Exchanges) in most states, as well as a federal Exchange to provide comparable services to residents of states that may choose to not establish their own Exchange. Modeled after the Massachusetts Health Care Connector, the Exchanges are intended to be "one-stop" shops in which employers, employees, or individuals can obtain information, make selections, and proceed with the purchase of health insurance coverage that meets their many and highly variable needs (The Henry J. Kaiser Family Foundation, 2013h).

² It is important to note that there are numerous and widely diverging estimates of the number of individuals who would become Medicaid enrollees if Florida chose to expand its Medicaid program. These estimates range from 1.0 million to 2.2 million people depending on the data sources, methodological differences, and assumptions underlying the calculations.

For the most part, Exchanges have been seen as electronic sites, although it is possible that some physical locations may emerge, particularly in larger states. They are required to be created and formally organized as non-governmental, not-for-profit entities. Health insurance companies would provide information about their various products in a manner allowing an individual or a business to consider the various options and prices as they select a health insurance product that meets their needs and preferences (Fernandez & Mach, 2013).

Further, the Exchanges are expected to function in a “no wrong door” modality. If a person visiting the Exchange is found to be eligible for Medicaid, they should be able to enroll in Medicaid. If they are not eligible for Medicaid, but have income circumstances that make them eligible for financial support toward the purchase of health insurance, the amount of that support can be calculated and the subsidy delivered directly to the insurance company whose product the consumer has selected. If the individual is sufficiently well off that there will be no subsidy, they can directly comparison shop for their own preferred coverage and make the purchase. Businesses can compare the products that are offered and make selections of one (or more) options they may choose to offer their employees (Fernandez & Mach, 2013).

As of May 2013, 27 states including Florida had “defaulted” to the federal Exchange, 17 states were planning on a state-based Exchange, and 7 states were planning a federal-state-based Exchange (The Henry J. Kaiser Family Foundation, 2013g).

New Rules for Health Insurance Companies

The ACA affects all parts of the country’s health-care system, including its payer organizations in the private sector. Under the ACA, health insurance companies will now have various new rules and regulations that will change key aspects of their business.

Some new rules under the ACA will directly affect customers or would-be customers. These regulations include the prohibition of pre-existing conditions clauses, the higher monetary amounts on annual and life-time limits, barring the retroactive cancellation or discontinuation of coverage based on an inadvertent misstatement of facts, and the extended period allowed for young adults to be on their parent’s health plans (The Henry J. Kaiser Family Foundation, 2009). An important change involving consumers is the new regulation regarding clarity of policy language. Under the ACA, insurance companies must give two uniform and key documents to their customers. One document is the Summary of Benefits and Coverage, which provides a common format for describing the benefits and coverage under the applicable plan. The second document is the Uniform Glossary, which provides definitions of terms commonly used in health insurance coverage (Pollitz, 2012).

Insurance companies must also now follow regulations regarding administrative simplification, adjusted community ratings, medical loss ratios, and rate review. The Administrative Simplification rules will adopt set standards for financial and administrative transactions (The Henry J. Kaiser Family Foundation, 2009). New rules on adjusted community ratings mandate single risk pools and bar variation on premiums charged except in four special cases including family size, geography, age, and tobacco use (The Henry J. Kaiser Family Foundation, 2013e). The ACA also implements new medical loss ratios, or the amount that insurance companies must spend on claims as opposed to administrative costs. Large group insurers must spend at

least 85% of their premium dollars on claims, while smaller group insurers must spend at least 80% (Centers for Medicare & Medicaid Services, 2011). Finally, insurance companies must undergo a federal rate review if their premiums rise more than 10% in a single year (Centers for Medicare & Medicaid Services, 2013b).

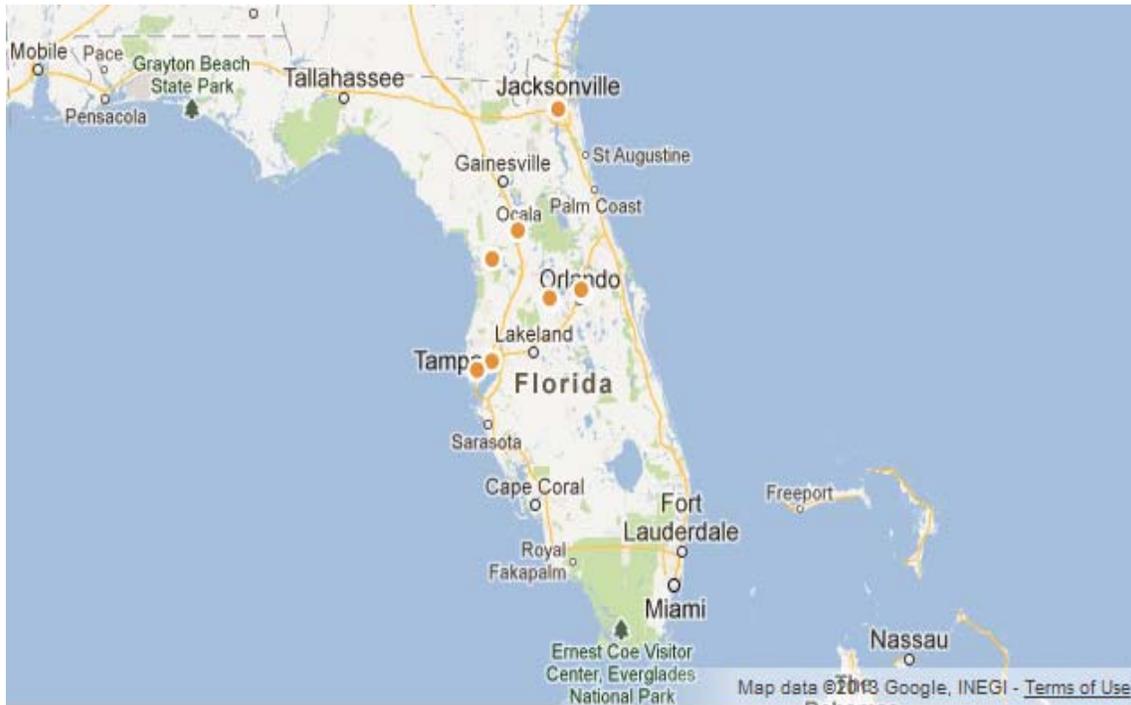
Health insurance companies will also face new fees under the ACA. One fee, called the Patient-Centered Outcomes Research Institute Fee, imposes a \$1 fee per covered life per year, starting in 2014, increasing to \$2 per covered life per year, and then adjusted annually thereafter until the fee ends in 2019. Another fee health insurers must pay, called the Insurer Fee, will be based on net written premiums beginning at \$8 billion in 2014, gradually increasing to \$14.3 billion in 2018, and adjusted thereafter (United HealthCare Services Inc, 2013).

New Approaches to Health-Care Delivery

The ACA recognizes that cost and quality concerns, while impacted by insurance coverage, must also be addressed in their own right. The law devises mechanisms and specific resources to support initiatives that may change the manner of health services delivery. For example, it establishes the Patient-Centered Outcomes Research Institute (PCORI) and charges that entity with the development of new research focused on issues of importance to patients and allowing direct comparison of the relative effectiveness of various alternative approaches to treatment, varying health system structures, or other issues.

One key element of the new approach to health-care delivery is the Medicare Accountable Care Organization (ACO). Health-care delivery has changed over time, mostly in response to the economic pressure of rising costs. Traditional fee for service that gave providers the capacity to directly bill for their services, gave way to health maintenance organizations (HMOs) and other aptly named managed care networks that attempted to control costs and deliver services more efficiently. The ACA offers the most current system, the ACO. ACOs are groups of doctors and hospitals that provide coordinated care to their Medicare patients. Several types of ACOs have emerged, and, as such, different methods of reimbursement have been established. Under the Shared Savings Program, ACOs are rewarded financially if they lower their growth in health-care costs while meeting certain quality and performance standards. Physician-based ACOs or ACOs that are rural providers participating in the Shared Savings Program may choose to participate in the Advanced Payment Model. Under this approach, these ACOs receive upfront and monthly payments, which can be used to invest in care coordination. Finally, there are Pioneer ACOs, organizations that are early adopters of coordinated care (Centers for Medicare & Medicaid Services, 2013a). In Florida, there are nine Advance Payment Model ACOs, located in Jacksonville (2), Clermont (2), Tampa, Winter Park, Beverly Hills, Maitland, and Ocala. The Pioneer ACO is located in St. Petersburg but also operates in Orlando, Tampa, and South Florida.

Figure 2: Accountable Care Organization (ACO) Penetration in Florida



Notes. The map illustrates the number and location of ACOs in Florida. Established ACOs in Florida include Primary Partners, LLC in Clermont; Accountable Care Partners ACO, LLC in Jacksonville; Reliance Healthcare Management Solutions in Tampa; Northeast Florida Accountable Care in Jacksonville; Central Florida Physicians Trust in Winter Park; Nature Coast ACO, LLC in Beverly Hills; Physicians Collaborative Trust ACO, LLC in Maitland; Primary Partners ACIP, LLC in Clermont; American Health Alliance in Ocala; and JSA Medical Group in St. Petersburg.
(Center for Medicare & Medicaid Services, n.d.)

Capacity and Systems Issues

Concerns have been expressed about the capacity of our nation's medical care delivery systems to handle the sudden increase in volume that may be precipitated by adding as many as 15 million people to those with private insurance and perhaps another 15 million to an expanded Medicaid program. Where and how will these people find doctors? What will be the impact on such routine processes as waiting times for an appointment? Is the system able to absorb such a dramatic change without serious disruption? These are questions that must be asked and dealt with seriously.

The ACA contains language and identifies resources to increase the number of primary care physician residency programs, a means to increase the number of new doctors entering primary care practice. It provides financial incentives such as improvements in loan repayment programs, expansion of the National Health Service Corps, and similar steps to encourage an increase in the number of primary care physicians and to encourage that they practice in locations with shortages of medical capacity. The ACA also funds increases in Medicaid reimbursement rates (to the Medicare levels) in hopes of making it more attractive for physicians to see Medicaid enrollees (Davis, Abrams, & Stremikis, 2011).

Beyond physician supply, the law encourages, by establishing demonstration projects as well as more direct interventions, expansion in the supply and the use of nurse practitioners, physician assistants, and other non-physician practitioners who might be of great value, particularly in the delivery of primary care services. It encourages organizational efficiencies through the device of ACOs that may also free up provider resources for the anticipated increase in demand.

The ACA also benefits primary care by increasing the amount given to Federally Qualified Health Centers (FQHCs) so that they might be able to serve 15 to 20 million more patients in the coming years (Abrams, Nuzum, Mika, & Lawlor, 2011). In Florida, Health Centers currently serve about one million people and, under the ACA, have received about \$161 million to support ongoing operations and to expand its services (U.S. Department of Health and Human Services, 2013).

Costs and Sources of Funding

The cost of the ACA is itself the subject of debate and controversy. Cost estimates vary widely, depending on the assumptions set forth as part of any estimation process and, in some cases, depending upon the “spin” used to describe or explain the estimates. Separating the costs that will be borne by the federal government from those that will be borne by states, employers, insurance companies, stockholders, and individuals is challenging. Important distinctions between long-term and short-term costs are frequently ignored. And almost none of the various approaches to considering the costs of the law take into account the costs associated with doing nothing. All that considered, it is clear that there will be significant costs and that these costs will be widely distributed among various segments of our economy. According to the Congressional Budget Office (CBO), implementing the Affordable Act will cost the federal government \$1.3 trillion over 10 years (2012–2023) (Congressional Budget Office, 2013b). Most of this cost would be in two areas—the transfer of funds to the states in support of the Medicaid expansion and the sliding scale subsidies targeted to assist in the purchase of individual insurance in and through the Exchanges.

According to the official health-care website, provisions in the law allow the ACA to be completely paid for and estimate that the law will reduce the federal deficit by over \$100 billion over the next 10 years (U.S. Department of Health and Human Services, n.d.). It will be paid for through savings from Medicare and Medicaid, as well as new taxes and fees. New taxes include an excise tax on high-cost insurance, which CBO estimates will raise \$32 billion over the next 10 years (The Henry J. Kaiser Family Foundation, 2010b). There will also be an increase in the tax for distributions from health savings accounts and Archer medical savings accounts for unqualified purposes, a pharmaceutical manufacturer fee, a medical device manufacturer fee, a health insurance provider fee, a tax on indoor tanning, and an additional hospital insurance tax for high-wage workers (Democratic Policy and Communications Committee, n.d.). CBO recently estimated that the ACA and the President’s 2014 budget proposal have the combined potential of lowering the federal deficit by \$1.1 trillion over the next 10 years (Congressional Budget Office, 2013a).

Additional Elements of the ACA

Beyond the more widely known and reported elements of the ACA, there are many additional provisions, some of which are detailed in Table 3 below. Perhaps most relevant to Florida are elements related to long-term care services and the emphasis on the provision of prevention

and wellness services. Within the proposed changes to Medicaid programs, the ACA provides mechanisms for improving access to long-term care services by providing additional federal funds and allowing for increased eligibility.

The ACA also provides opportunities for Medicare, states, and employer groups to emphasize prevention and wellness within their benefit structures.

Table 3: Additional Elements of the Affordable Care Act

Additional Elements of the Affordable Care Act	Description
Medicaid Long-Term Services	<i>Independence at Home</i> demonstration program: provides high-need Medicare beneficiaries with primary care services in their homes. Providers can share savings if programs result in reduced hospitalizations and readmissions and improved health outcomes.
	<i>State Balancing Incentive Program</i> : provides enhanced matching payments to support community-based long-term care services and attendant services.
	The expansion of financial eligibility for <i>Home and Community Based Services</i> : a new optional Medicaid eligibility group for individuals not otherwise eligible to receive full benefits in addition to state plan benefits. This will allow states to target waiver services to specific population groups.
	<i>Money Follows the Person Program</i> : monies for states to transition Medicaid beneficiaries out of institutions to communities.
Community Transformation Grants and National Focus on Prevention	Grants made to 61 communities and states to fight chronic diseases and their root causes. Establishment of a National Prevention, Health Promotion, and Public Health Council.
	Elimination of cost-sharing for certain Medicare-covered preventive services. Grants are available to states to offer incentives to Medicaid beneficiaries who participate in prevention and wellness programs. Grants to small employers that establish wellness programs—employers will be allowed to offer employees rewards up to 30% for participating in wellness programs. An established 10-state pilot program allows states to participate in developing wellness programs for the Exchanges.
Health Center Trust Fund and Primary Care	\$11 billion to support growth in community health centers.

(The Henry J. Kaiser Family Foundation, 2013b; Watts, Musumeci, & Reaves, 2013)

Section 3: Special Considerations for Florida

Florida has several characteristics that may make implementation of the ACA especially challenging. Furthermore, these characteristics are intertwined in complex ways. It has been well-documented for more than two decades that Florida ranks near the top (or bottom, depending on perspective) in both the number and the proportion of state residents who do not have health insurance (Duncan, Porter, Garvan, & Hall, 2005). At present, it is estimated that 3.8 million Floridians are without any form of health insurance coverage (The Henry J. Kaiser Family Foundation, 2013a). Thus, the sheer magnitude of the transition problem, including the potential volume of activity at an Exchange, will create major challenges. Similarly, Florida has historically been among those states known for limiting the size of its Medicaid program, in part by relatively stringent eligibility and enrollment constraints. So if Medicaid expansion does occur in Florida, it would be challenging simply from the perspective of numbers.

The source of Florida's atypically high rates of uninsurance can be partially found in the nature of the state's economic and employment structures. Tourism is one of Florida's primary industries, attracting more than 91.4 million visitors in 2012 who spent nearly \$72 billion (VISIT FLORIDA Research, 2013). A dominant component of the state's economy is composed of the attractions themselves, as well as the associated service firms (e.g., restaurants, hotels, t-shirt shops, etc.); tourism employed an estimated 1.1 million individuals in 2012 (VISIT FLORIDA Research, 2013). While significant variation has been documented, those elements of the service sector associated with tourism are among the employers least likely to offer and subsidize health insurance for their employees.

Florida is also a major agricultural center, producing 67% of the U.S. oranges and 40% of the world's orange juice supply; in addition, during positive economic periods, Florida can experience enormous growth with attendant construction activities (Stateofflorida.com, 2013). However, agriculture and construction are also among the industries that frequently do not offer health insurance to employees. These industries have also been employers of numerous migrant and seasonal workers. Therefore, even in the large construction companies and corporate farms where owners, managers, and permanent employees might have access to an insurance program, the labor force may not. It should be noted that Florida is one of over 20 states that have "right to work" policies in place, intended to make Florida more appealing to corporations but which may also have contributed to greater proportions of Floridians who are not insured and who work in jobs (often multiple) that are not sufficient to exceed poverty levels. Evidence indicates that workers in these states suffer depressions in wages and insurance coverage, a factor that is especially relevant to Florida due to the existing documented disparities in coverage offerings and availability common to ethnically and racially diverse workers (Ku, 2009; Minor, 2012; Stevans, 2009).

Over most of the past three or four decades, Florida has been a location to which people move in pursuit of their own dreams, which sometimes include the creation of a small business. For these people, health insurance for employees is commonly not the immediate objective. These economic and employment factors that help us understand why Florida currently has so many uninsured individuals are the exact factors that will make it difficult and unappealing for many of the state's firms, especially those seeking to grow beyond the level of 50 employees, to meet their responsibilities and obligations under ACA.

The size, complexity, and diversity of the state will also create challenges. Florida is home to nearly 19 million people, making it the fourth most populous state (United States Census Bureau, 2013). In addition to the population size, Florida hosts demographically, economically, and spatially diverse collections of communities. For example, the urban vibrancy and intensity of Miami-Dade County shares few commonalities with the rural communities in Florida's panhandle (64.5% of the population in Miami-Dade County is Latino compared to 10% in Gadsden County in Florida's panhandle which is comprised of 55.5% Blacks) (United States Census Bureau, 2013). How such diverse settings and people will adapt to a single new law is unpredictable.

Most health insurance products (either group or individual) are built around annual contract periods with fixed opportunities for change or enrollment. Part-year residents present special challenges that to date have not been explicitly addressed in the development of Exchanges, employer responsibilities, or other elements of the ACA.

In 2012, Florida received an estimated 91.4 million tourists (VISIT FLORIDA Research, 2013). Although few definitive estimates are available, it seems likely that most are insured. Although international visitors will not likely experience much (if any) impact from the ACA, tourists may experience health events that necessitate health care use, such as the cold or flu, motor vehicle accidents, and heart attacks. Such use certainly consumes health-care capacity that may very well be in short supply as the ACA is implemented. Therefore, perhaps more so than any other state, Florida's unique population and circumstances will pose challenges as the ACA is implemented.

It is expected that Florida will face a significant number and wide variety of challenges in adopting the ACA. Perhaps some of the most dramatic areas in which Florida's issues will differ from those in most other states are (a) the size and diversity of our state's Latino population and (b) the number of elders/Medicare enrollees.

Latinos

Latinos in the U.S.

Latinos are the major minority in the United States and currently make up about 16.4% of the U.S. population or 52 million individuals (United States Census Bureau, 2012). More than 50% of the total population growth in the U.S. in the last decade was due to the Latino population. By 2050 it is projected that 30% of the population, or one in every three U.S. residents, will be Latino (United States Census Bureau, 2012d).

Latinos in Florida

Florida is home to the third-largest Latino population in the U.S., estimated to be around 4.4 million people, meaning nearly one in four Floridians is Latino (Motel & Patten, 2013). Beyond its size, there are several demographic characteristics that distinguish Florida's Latino population from other major Latino population centers such as California, New York, and Texas, and from the non-Latino White Florida population. Differences include age, place of origin, migration status, insurance status, employment, education, and language status. Florida's Latinos are, on average, younger than non-Latino Whites (mean age of 33 years vs. 47, respectively) (Pew Hispanic Center, 2010). Florida Latinos are primarily comprised of Cubans (35%), Mexican (26%), and Puerto Ricans (23%) (Motel & Patten, 2013).

Latinos and Health Care Disparities

Although 76% of all Latinos and more than 90% of Latino children are U.S. citizens, Latinos face a litany of social and structural barriers to health care even when eligible to receive care (Kaiser Commission on Medicaid and the Uninsured, 2013; Nelson, Smedley, & Stith, 2002). Of the 4.4 million Latinos in Florida, about 1.4 million non-elderly residents are currently uninsured. Of those 1.4 million, 57% are below 138% FPL (The Henry J. Kaiser Family Foundation, 2013c).

According to the Agency for Healthcare Research and Quality, Hispanics received worse care than non-Hispanic Whites (Agency for Healthcare Research and Quality, 2012). While a majority of Florida Latinos are bilingual (85.0%) compared to all Floridians (27.3%), the percentage of individuals who speak English less than "very well" is considerably higher among Florida Latinos (40.2%), than other Florida residents (11.9%). This could present additional risk of adverse outcomes in terms of health-care quality and safety (United States Census Bureau, 2012a) (United States Census Bureau, 2012b).

Existing barriers to health care are exacerbated in Florida given the over-representation of low-wage employers that do not offer insurance to workers or do not permit full-time status to make them eligible. Even when employers do offer insurance, it may be unaffordable (Kaiser Commission on Medicaid and the Uninsured, 2013). While some low-wage workers are eligible for public insurance, based on their income, the lack of uptake in Florida may be indicative of the proportion of undocumented immigrants in the state, estimated to be between 850,000 and 1 million people (Passel & Cohn, 2011). The nature of Florida's "right to work" policies may further exacerbate disparities given the difference in coverage and worker wages (Merlis, 2011).

Latinos and the ACA

Latinos will have many benefits with the implementation of the ACA and its push to reduce the number of uninsured and reduce health-care disparities. Expanded insurance coverage will help cover 5.4 million Latinos by 2016 (Henderson, Robinson, & Finegold, 2012). This is especially important since Latinos make up more than 50% of the agriculture, service and construction workforce, where they are less likely to be insured under current rules (Kaiser Commission on Medicaid and the Uninsured, 2013; United States Census Bureau, 2012a). Given Florida's current decision to not expand Medicaid, it is likely that many Florida Latinos who would otherwise be eligible for Medicaid given their low incomes will remain uninsured.

Other improvements in access and delivery will also positively affect Latino communities. Preventive services provided by health plans will be covered under the ACA at little to no cost and ACOs will help improve chronic disease management. Also, access to Community Health Centers, which cater to rural and lower income populations, is expected to grow (Henderson et al., 2012). Latinos will also benefit from the ACA's support for increased health-care workforce diversity and improved cultural competency (Henderson et al., 2012).

About 46% of uninsured Latinos in the U.S are non-citizens (including lawfully present and undocumented immigrants) and according to estimates, about 3.7 million non-citizens reside in Florida, a majority of whom are Latino (Kaiser Commission on Medicaid and the Uninsured, 2013; Migration Policy Institute, 2013a). So, even with expansion, many non-citizen Latinos (lawfully present and undocumented immigrants) will still not be eligible for Medicaid and will continue to be uninsured and experience reduced access to care (Kaiser Commission on Medicaid and the Uninsured, 2013). Undocumented Latinos inevitably experience the same kinds of illnesses, accidents, and other circumstances that result in a need for health care. The likely recourse for undocumented persons is to delay treatment as long as possible and then present at the emergency room, where, after being stabilized, they may be left on their own to recover (Ortega, 2009).

Latinos, ACA, and Philanthropy

Florida continues to be the arrival point and, ultimately, residence location for a complex mix of foreign-born legal residents, naturalized citizens, and undocumented immigrants. Together these groups account for about 3.7 million people or 19.4% of Florida's population, with the majority (70%) from Latin America including South America, Central America, Mexico and the Caribbean (Migration Policy Institute, 2013b). It is noted that half of Florida's foreign-born population are U.S. citizens (1.8 million or 49.7%) (Migration Policy Institute, 2013b).

The implications of ACA for the Latino population of the United States are as complex and diverse as the Latinos that make up this demographic group. However, some consequences are quite clear. Positive outcomes from the individual mandate will benefit Latinos in terms of preventive services, higher quality of services, and coverage for children. The employer response is less clear.

Current policy conversations about immigration reform are under way, and research continues to contribute evidence to the non-health-care related determinants of health disparities. The circumstances of undocumented Floridians may change as a consequence, but it is not clear whether and how any immigration reform will impact health care. While the ACA does not

explicitly include reform for undocumented immigrants, their contribution to the Florida economy and health risks associated with reduced access to care make acknowledgement and consideration of this population a salient policy issue in our state.

The ACA gives philanthropy new opportunities to assist the rapidly growing Latino communities in Florida. First, understanding barriers to care such as economic and cultural issues using available data will enable philanthropic organizations to strategically develop and coordinate efforts (Diaz, 2013). According to the 2013 National Health Survey of Latino Adults, 52% of Latinos indicated they were uninformed about the ACA (Sanchez, 2013). Clearly, philanthropic organizations can contribute to enrollment efforts, outreach, and related initiatives targeted to the 1.4 million non-elderly uninsured Latinos in the state, with the help of community members who are culturally and linguistically competent. They can also focus on reducing language and literacy barriers when it comes to access to health care and facilitate the work of community-based safety-net providers, like local Community Health Centers (The Henry J. Kaiser Family Foundation, 2013c).

Elders

Elders in the U.S.

There are about 41.4 million elders in the United States, one in eight residents (Department of Health and Human Services, 2013). Older women outnumber older men, at 23.4 million versus 17.9 million, respectively, and more than a quarter (28%) of noninstitutionalized older persons live alone. According to the Agency on Aging, almost 3.6 million elderly persons (8.7%) were below the poverty level in 2011, and the median income of older persons during that same period was \$27,707 for males and \$15,362 for females (Department of Health and Human Services, 2013). As the population continues to age, the number of elders in the United States is expected to more than double, and the number of elders over 85 is expected to triple (Miller, 2012).

Elders in Florida

According to the Florida Department of Elder Affairs (DOEA), Florida has more than 4.45 million residents aged 60 years or older (Florida Department of Elder Affairs, 2012). In addition, Florida is also the premiere destination for snowbirds—residents who follow seasonal migration patterns and are often missed in population counts (Smith & House, 2006). Estimates conducted by the Bureau of Economic and Business Research indicate that during the peak of the winter season there are as many as 818,000 snowbirds in Florida, and around 119,000 during late summer (Smith & House, 2006). Snowbirds tend to be White and non-Latino, with higher incomes and more education than permanent elder Florida residents. Snowbirds also tend to be healthier than year-long Florida residents of a similar age (Smith & House, 2006).

Florida has the highest percentage of elder citizens in the entire United States, and, in 51 out of 67 counties, the percentage of the population over the age of 65 is higher than the national average (Florida Department of Elder Affairs, 2012). A Department of Elder Affairs list of the 10 counties with the highest number of persons over 60 includes, in order from highest number of elder residents to lowest, Miami-Dade, Palm Beach, Broward, Pinellas, Hillsborough, Lee, Sarasota, Brevard, Orange, and Duval (Florida Department of Elder Affairs, 2012). Florida's elders disproportionately live in the state's large, urban counties. But it should be noted that

some of the state's sparsely populated rural counties have the highest percentages of this population.

Elders and Health Care

Despite this population having near universal coverage under Medicare, elders still face considerable financial strain when it comes to the costs of health care. According to a report by researchers at Mount Sinai Medical School, UCLA and Dartmouth, elders' average out-of-pocket expenditures in the five years prior to death was \$38,688 for individuals and \$51,030 for couples in which one spouse dies. More than 75% of Medicare-eligible households spent at least \$10,000 out of pocket on health care while the remaining 25% spent over \$100,000 (Kelley et al., 2013).

Elders also face issues when it comes to access. According to a report by the Medicare Payment Advisory Commission, a survey revealed that among Medicare beneficiaries looking for a new primary care physician, 30% reported difficulties, with 17% reporting it was a "big" problem. This issue could exacerbate as the share of medical school graduates going into family care and primary care residency programs continues to diminish (Medicare Payment Advisory Commission, 2008).

Elders also face health disparities. A report by the CDC used 15 indicators from the Healthy People initiative to assess the health of adults 65 years or older. These indicators were divided into four categories, including Health Status, Health Behaviors, Preventive Care and Screening, and Injuries. According to the report, elders suffer from obesity, lack leisure physical activity, and fail to get certain vaccinations, including for the flu and for pneumonia (Centers for Disease Control and Prevention, n.d.).

Elders and the ACA

There are several key provisions of the ACA that will have an impact on elders in Florida, including long-term care, Medicare, and prescription drugs. Currently, there are 62,135 people over 65 years of age in nursing or skilled nursing facilities in Florida (Florida Legislative Office of Economic and Demographic Research, 2011) and the ACA has presented six new or expanded options for long-term care programs. The ACA provides additional funding to extend the "Money Follows the Person" (MFP) Rebalancing Demonstration Program, which is intended to help states reduce the number of elders and persons with disabilities in institutional care and instead transition them into receiving home- and community-based care (Watts et al., 2013). Home- and community-based care is less expensive than similar institutional care, and a Supreme Court decision affirmed that people with disabilities have the right to participate in home- or community-based care over institutional care, if they are able and willing to do so. Florida was eligible to receive a \$35.7 million grant from the federal government through the ACA to implement the MFP program but did not accept it (Shrieves, 2011).

Another important provision is the Independence at Home Demonstration project. The purpose of the project is to provide at-home primary care for Medicare beneficiaries with multiple chronic conditions, improving quality of care and lowering costs while allowing patients to remain in their homes. There are currently two demonstration sites in Florida: RMED, LLC in Jacksonville and Treasure Coast Healthcare, LLC in Stuart (Centers for Medicare & Medicaid Services, n.d.).

Another provision that will have an impact in Florida is the expanded funding of Aging and Disability Resource Centers (ADRCs). ADRCs serve as a single point for elders and their families to find information, available services, and support. Florida operates a streamlined hotline under ADRCs to help elders determine their eligibility for long-term care services (Florida Department of Elder Affairs, n.d.). ADRCs have the potential to serve as a focal point for rural elders and may help improve health outcomes by connecting them to caregivers and providers (National Advisory Committee on Rural Health and Human Services, 2011). Rural Florida residents, both elders and others, may also be affected by the 340B Drug Pricing Program. The program requires drug manufacturers to provide outpatient drugs to certain health-care organizations at reduced prices. Eligible organizations include FQHCs, Rural Referral Centers (RRCs), and Disproportionate Share Hospitals (DSHs)—organizations that traditionally serve rural populations (Health Resources and Services Administration, 2013).

Florida's elders may also be affected by the reduction in payments for both Medicare and Medicaid DSHs. Beginning October 1, 2013, DSHs will see a 75% reduction in payments (The Henry J. Kaiser Family Foundation, 2013d). Since the intention of the law was to severely reduce the number of uninsured, and thus the amount of uncompensated care, the loss of revenue from DSH payments would be made up by compensation for care. However, the Supreme Court ruled that Medicaid expansion is up to the states, and safety-net hospitals in states that choose not to expand their Medicaid programs could have financial issues since they will be receiving a huge cut in payments and face continued levels of uncompensated care (Graves, 2012). Florida is among the states currently debating whether or not to expand Medicaid, and though Governor Scott has declared his support for expansion, the Legislature has not followed suit (Gentry, 2013).

Elders, ACA, and Philanthropy

The ways in which philanthropic organizations can help elders in Florida in relation to the ACA are plentiful. For instance, the primary care health-care worker shortage is a big issue across the nation and especially here in Florida, with its large elderly population. In order to help with this shortage, funders could provide support for workforce recruitment programs with an emphasis on rural areas where the need is greatest.

Another way that foundations can help is by assisting local organizations in conducting needs assessments. By conducting these needs assessments, communities will have a better understanding of where they fall short when it comes to providing for their elderly populations, whether it be in primary health-care workers, mental health-care workers or any other area related to overall well-being.

Philanthropy should also consider collaborating with Aging and Disability Resource Centers. By providing outreach to the elderly, they can help this community navigate the sometimes confusing health-care system and its new rules and regulations under the ACA.

Section 4: Potential Role of Philanthropy

There are opportunities for philanthropic organizations to play important roles in the developing implementation processes associated with the ACA. In fact, there is every reason to anticipate that implementation will include subtleties and unexpected twists and turns, with great variation from one community to the next and from state to state. Foundations, especially those with strong community ties, are likely to be a key resource. However, it should be acknowledged that even this seemingly obvious opportunity has become a subject of controversy. Recent efforts to enlist the support of philanthropic organizations in outreach and enrollment activities have been characterized by some as an inappropriate effort to subvert the will of Congress, as manifested in its decision to not appropriate funding with which the federal government might itself pursue such initiatives (Morgan, 2013; Pear, 2013).

Certainly, foundations have a well-documented track record of success in an area of activity that could generally be termed outreach. Whether in the form of public education programs, fostering community leadership, enhancing participation, or dozens of other specific initiatives, local/regional foundations are uniquely positioned to assist their communities in adapting to the new realities created by the ACA.

The potential roles of foundations extend to virtually every element of the law. For example, issues regarding medical care capacity have been noted. Local/regional foundations could partner with community health centers or private practices to support some of the costs of recruitment and retention. Even for just one clinic in a community, a foundation's commitment to assist with educational loan repayment, relocation costs, salary support, spousal support, or similar contributions could make a huge difference in the ability to attract new physicians to a community practice.

With reference specifically to Florida and the previously noted characteristics of this state, the philanthropic opportunities in regards to elders and our state's Latino and other minority communities bear particular attention.

In particular, projects might support (1) educating the general public, policymakers, and other key stakeholders on the provisions of the law and regulatory and implementation activities as they unfold; (2) direct service activities relevant to aspects of the law, including patient education, navigating changing elements of health insurance and health care, and obtaining benefits; and (3) needs assessments and evaluations of specific elements of the law. Figure 3 below illustrates the range of possibilities for philanthropic involvement given the specificity of focus on the law, the populations served, and types of activities.

It also important to note that the ACA aligns itself with the values of responsible corporate citizenship. As such, there are plentiful opportunities for public-private partnerships. These mutually beneficial private sector partnerships can facilitate public health initiatives as the private market can help drive innovation and, in turn, help promote quality standards and eliminate onerous and outdated barriers in public health (Florida Blue Center for Health Policy, 2012).

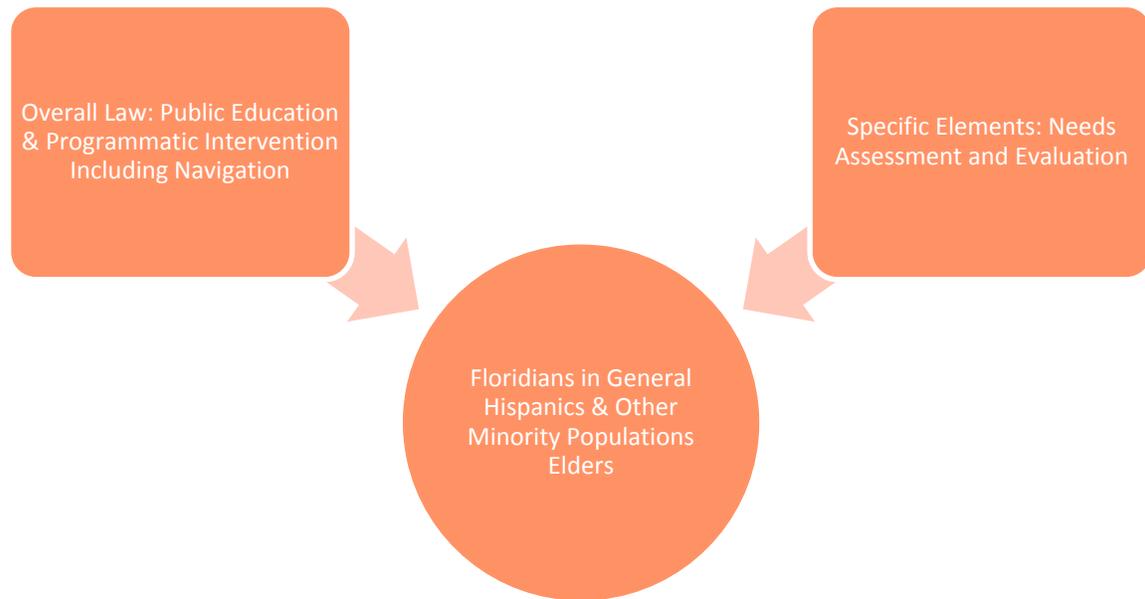
Philanthropic organizations have been highly involved with all aspects of the ACA (Masters & Rounsaville, 2010). Now that the ACA has been upheld by the Supreme Court, the task of

implementing it has become the focus, providing many opportunities for more than just health-centered organizations to get involved (Tallon, 2012, August 2). The predominant need seems to be for philanthropic organizations to provide education and clarification about the law and what it means for individuals and businesses (Philanthropy New York, 2013; Tallon, 2012, August 2). Grantmakers in Health (GIH) developed a comprehensive report on the role of philanthropic organizations and the ACA. GIH outlined six key activity categories based on interviews and discussions with a number of philanthropic organizations. The key activities include public education, partnering with government, advocacy, policy research, convening, and program innovation and reform (Masters & Rounsaville, 2010). GIH also gave examples of projects under each of the activity categories:

- Public education: educating grantees, funding a public education or social marketing campaign, establishing a centralized place for information and resources, conducting framing and messaging research, supporting media coverage, and conducting public opinion polling.
- Partnering with government: providing direct funding for a program or personnel, funding expert consultants to work for or with a state, supporting local or state efforts to apply for federal grants, supporting data collection and evaluation, and partnering on enrollment and eligibility simplification activities.
- Advocacy: supporting core operations, building capacity, supporting technical assistance to improve communication, funding consumer participation, and supporting grantee efforts to apply for federal grants.
- Policy research: conducting policy analysis, commissioning policy analyses, and funding independent centers or policy institutes.
- Convening: supporting grantee and partner strategy development and convening community leaders, public officials, and stakeholders.
- Program innovation and reform: exploring collaborative approaches with national and state-based foundations that have common interests.

GIH also suggests that for philanthropic organizations that have not previously been involved with health-care reform activities, a focused planning process should be developed. This includes meeting with state officials to learn about their priorities and capacity, putting together a stakeholder engagement process, conferring with experts, determining how the ACA intersects with the foundation's priorities and goals, and even sharing strategies with other foundations to prevent overlap of activities and enhance coordination (Masters & Rounsaville, 2010).

Figure 3: Framework for Considering Philanthropic Responses



Educating the General Public and Key Stakeholders. The health-care reform law is complex and will profoundly impact health-care delivery in this country. Yet the public, including policymakers and the key stakeholders, lack knowledge about specific reform elements and their potential impacts. Philanthropic activities in Florida could focus on engaging in educational activities (Figure 4). One idea of great potential could be a comprehensive effort that includes the development of a website that includes regulatory and legislative updates as they pertain to Florida, descriptions of related activities that could impact ACA implementation (e.g., the expansion of the Medicaid demonstration to all counties), and issue briefs and policy documents that outline specific aspects of the law. The website could be similar to that developed by the Kaiser Family Foundation (<http://healthreform.kff.org/>) but with a specific emphasis on our state.

Websites, issue briefs, and policy briefs will likely only appeal to advocates, stakeholders, and policymakers. Local/regional philanthropic organizations may want to target additional educational activities to the general public. This could include town hall meetings for certain groups such as Latinos, other minority populations and/or elder individuals. Presentations could be relatively simple and limited to descriptions of the legislation. Local/regional philanthropic organizations could also partner with news organizations to periodically update the public on key aspects of the legislation. Table 4 below highlights specific aspects of the law that might serve as topics for public education efforts. Particularly needed are educational activities focused on limited knowledge of the elements of the ACA such as long-term care services and Accountable Care Organizations.

Figure 4: Public and Stakeholder Education



Programmatic Interventions. Local/regional philanthropic organizations could work towards developing programs and interventions that complement and support the implementation of the ACA. One example is the need for navigational support to help consumers obtain the services they need (e.g., selection of health plans under the Exchanges, or Medicare Part D plans). With respect to certain minority populations, there is a documented need to translate information into Spanish, Creole and/or other languages. Other ideas include developing programs to sustain the safety net as it will remain vital to serving the remaining uninsured, working with local chambers of commerce to support small business participation on the Exchanges, or providing support for mounting credible grant applications for funding authorized under the legislation (see Table 4).

Two agencies within Florida have received Community Transformation Grants (CTGs). Funding for the CTGs was authorized under the ACA and managed by the Centers for Disease Control and Prevention (CDC). The Broward Health Planning Council and the Miami-Dade School Board received CTG funding. Florida philanthropic organizations could provide additional funds to support or enhance activities sponsored by the CTG (see Table 4).

Needs Assessments and Evaluations. If implemented as envisioned, the ACA will improve financial access to health care, mental health, and long-term care services. The impact of this legislation on existing delivery infrastructure is unclear. To facilitate planning and redesign of the delivery system, a critical assessment of the health, mental health, and long-term care workforce and access points is warranted. Local/regional philanthropic organizations could focus on conducting such assessments and disseminating the findings to appropriate partners and stakeholders.

Evaluations of the effectiveness of the ACA in addressing key policy goals may also be an important contribution made by Florida grantmakers. Evaluation efforts could focus on specific elements of the ACA that are relevant to target populations (e.g., the experiences of elders who are in an Accountable Care Organization) or focused on understanding how the ACA has improved access to health-care services for Floridians.

One approach to such an evaluation could be a new round of the Florida Health Insurance Survey, as the last time the survey was fielded was in 2004—at least six years before the ACA was passed into law. There are several national surveys that are fielded regularly and can provide statewide estimates overtime. However, these surveys cannot provide useful estimates of county uninsurance rates or rates that are specific to certain population groups, such as minority populations or individuals who work for small businesses. The advantage of developing and fielding statewide surveys is that questions and analyses can be tailored to the unique policy and programmatic needs of that state.

Table 4: Key Issues and Components of the Law and Potential Responses

Focus	Population Emphasized	Potential Philanthropic Opportunities	Examples of Current Philanthropic Activities
Uninsured			
<p>In Florida, the Legislature has decided not to push forward on Medicaid expansion efforts. Without Medicaid expansion, the state will continue to have about 4.1 million uninsured residents. With Medicaid expansion, the uninsured would be reduced by 869,000–2.1 million residents. However, significant numbers of people without health-care coverage will remain even in a best-case scenario.</p> <p>A recent study completed by the University of Minnesota State Health Access Data Assistance Center concluded that about 16% of low-income uninsured will be immigrants who will not qualify for the expanded Medicaid coverage even if it were to be enacted (State Health Access Data Assistance Center, 2013).</p> <p>Historically, the Latino population has had very high rates of uninsurance. Given workforce participation characteristics, Latino populations will likely continue to be at risk for high rates of uninsurance (Holahan et al., 2012).</p> <p>Floridians may also be affected by the reduction in payments for both Medicare and</p>	<p>Floridians, Latinos, Immigrants</p>	<p>Develop policy and position papers on how Florida can improve coverage within the context of the ACA.</p> <p>Fund and support the safety-net delivery system.</p>	<p>In Massachusetts, the state’s Blue Cross Blue Shield Foundation has been at the forefront in launching public education campaigns by running public service announcements and television advertisements about the individual mandate. The foundation also partnered with the state to fund community-based organizations in their mission to educate the public about their options in buying health insurance (Masters & Rounsaville, 2010).</p>

Focus	Population Emphasized	Potential Philanthropic Opportunities	Examples of Current Philanthropic Activities
<p>Medicaid Disproportionate Share Hospitals (DSHs). Beginning Oct. 1, 2013, DSHs will see a 75% reduction in payments (The Henry J. Kaiser Family Foundation, 2011b) (Kaiser Family Foundation, 2013). It was planned that the loss of revenue from DSH payments would be mitigated by compensation for care from Medicaid expansion. However, Florida is among the states currently debating Medicaid expansion (Gentry, 2013). Safety-net providers could still stand to lose DSH payments even if Medicaid is not expanded in the state.</p>			
<p>Public Awareness of the ACA</p>			
<p>According to the latest tracking poll from the Kaiser Family Foundation, most of the uninsured still are unaware of how the law will impact them (Altman, 2011). 47% believe the law will not significantly impact them and 14% think the law will be a disadvantage to them. In addition, the law is complicated, with many different components that will affect different population groups at different times. Individuals may not be aware of their rights and responsibilities under the law and the law's impact on their access to health care.</p>	<p>Floridians, Latinos, Other Minority Groups, Elders</p>	<p>Participate in public relations and community engagement activities (perhaps targeted at different population groups) to educate the public on relevant components of the law.</p>	<p>The Winter Park Health Foundation, in collaboration with the Jessie Ball duPont Fund, gave financial support to a series of four educational briefs that focused on the proposed changes to Florida's Medicaid program under the ACA. Authored by the Georgetown Health Policy Institute, the briefs were meant to help educate and inform consumers, stakeholders, and policymakers on the issues involved in Medicaid reform (Winter Park Health Foundation, 2013).</p>
<p>Workforce and Capacity Issues</p>			
<p>More people with health insurance could result in increased demand for primary care and specialty care providers. Current primary care capacity may not be sufficient to meet emerging demand for care.</p>	<p>Floridians</p>	<p>Conduct a needs assessment to determine projected workforce required to meet new demands in primary care and certain specialties.</p>	<p>The Institute for Healthcare Improvement, which is partly funded by the Commonwealth Fund, has launched a program called the State Action on Avoidable Rehospitalizations (STAAR). STAAR is meant to help teach</p>

Focus	Population Emphasized	Potential Philanthropic Opportunities	Examples of Current Philanthropic Activities
		Provide support for training new primary care clinicians, including nurse practitioners and physician assistants.	hospitals how to transition their discharged patients into other care settings if necessary and to help implement changes that cause fragmentation in care, like payment methods. The program currently works with both policymakers and other important stakeholders in Massachusetts, Michigan, and Washington (Institute for Healthcare Improvement, 2013).
The ACA created a five-year \$11 billion Health Center Trust Fund to support health center growth. Its intent is to provide greater access to primary care as coverage expands as well as to continue to serve the remaining uninsured (Shin, Sharac, Alvarez, Rosenbaum, & Paradise, 2013).	Floridians, Latinos, Other Minority Groups	Provide grant support for existing Federally Qualified Health Centers (FQHCs) and new organizations that will want to apply for grants to develop and expand community health centers. Consider targeting those FQHCs and grants that will improve access for Latino populations or other populations of particular interest in Florida.	The Florida Blue Foundation has given about \$3 million in the past year to 15 community-based organizations and health departments that provide important primary medical services to both children and adults. For instance, the Manatee County Rural Health Services received a 3-year grant to increase its mobile dental unit, while the nonprofit clinic, the Sundari Foundation, received funds to help its clinical operations for Lotus House, a homeless shelter for women and children in Miami-Dade County (The Blue Cross and Blue Shield of Florida Foundation, 2012, Oct. 22).
Patient Centered Outcomes Research Institute (PCORI)			
PCORI was established to help patients and individuals make informed decisions about their health and health care. Research projects funded by PCORI must include patient perspectives on the relevance of the research question and the health decisions that will be informed by the study. Additionally, patients, stakeholders, or their advocacy organizations must be engaged in all phases of the research process.	Floridians, Elders, Latinos, Other Minority Groups	Provide support for the engagement of patients and stakeholders in the design of grant applications that will be submitted to PCORI.	

Focus	Population Emphasized	Potential Philanthropic Opportunities	Examples of Current Philanthropic Activities
Exchanges			
<p>Key issues relevant to the establishment of Exchanges:</p> <ul style="list-style-type: none"> • Unclear whether Florida will be starting a state Exchange or whether a federally operated Exchange will be established. • Individuals with incomes between 139% and 400% FPL can enroll in Exchanges if Medicaid expansion is not available (The Henry J. Kaiser Family Foundation, 2011a). • Ensure plan participation in rural areas. • Ensure small business participation on the Exchange. 	<p>Floridians, Latinos, Other Minority Groups</p>	<p>Policy and position papers on how insurers can participate in Exchanges, especially in rural areas; support for information technology development; and types of consumer assistance needed to enroll in coverage, including the provision of standardized easy-to-read summary of benefits and coverage in Spanish, Creole and/or other languages.</p> <p>Engage Chambers of Commerce to facilitate small business participation on the Exchanges.</p>	<p>Enroll America is a nonpartisan, nonprofit organization that collaborates with other health-care stakeholders in order to ensure that all Americans are enrolled in and retain health coverage (Enroll America, n.d.). Enroll America does direct recruitment through grassroots door-to-door work and will launch a multimillion-dollar outreach campaign that will include targeted advertising on television and radio (Frisch, 2013).</p>
Community Transformation Grants			
<p><i>Broward Health Planning Council (BHPC) – Community Transformation Grants in Large Communities.</i> Funding to support efforts in tobacco-free living, active living, healthy eating, quality clinical and other preventive services, healthy and safe physical environments (Centers for Disease Control and Prevention, 2011b).</p>	<p>Floridians, Latinos, Other Minority Groups, Elders</p>	<p>Companion projects that replicate or sustain BHPC efforts in Broward and other parts of the state. Consider a specific focus on elderly, Latinos or other populations of particular interest in Florida.</p>	
<p>School Board of Miami-Dade County – <i>Community Transformation Grants in Small Communities.</i> Funding to support the implementation of the Play, Eat, Succeed project to impact the prevalence of childhood obesity for students with disabilities and the Head Start Program. The project focuses on improving nutritional habits, increasing</p>	<p>Floridians, Children</p>	<p>Companion projects that replicate or sustain School Board efforts in Miami-Dade or other parts of the state. Consider a specific focus on Latino populations or other populations of particular interest in Florida.</p>	

Focus	Population Emphasized	Potential Philanthropic Opportunities	Examples of Current Philanthropic Activities
physical activity, and achieving a healthy weight (Centers for Disease Control and Prevention, 2011a).			
Wellness and Prevention			
Medicare and new health plans are required to provide preventive health-care services with minimal or no cost sharing.	Floridians, Latinos, Other Minority Groups Elders	Outreach and educational projects aimed at encouraging Floridians to participate in prevention and wellness programs. Programs could be culturally and age specific.	The Health Foundation of South Florida gave a grant to the Haitian American Association Against Cancer program, which provides outreach, workshops and classes on breast and cervical cancer, and trains Haitian women located in this community to educate their fellow community members on these cancers and on the importance of screening measures like mammograms and Pap Smears. The program was translated to Creole and adapted to the Haitian culture (Health Foundation of South Florida, 2013).
Primary Care Medical Homes and Mental Health Care Services			
The establishment of health-care homes for individuals with co-occurring physical and mental health disorders (funding not appropriated in budget).		Track subsequent development of this component. Provide position or policy relevant papers.	The Palm Healthcare Foundation has given about \$700,000 in the last 10 years to different organizations involved in integrating mental health and primary health care, including the Mental Health Association of Palm Beach County and Alzheimer’s Community Care, Inc. (Palm Healthcare Foundation Inc, 2012).
Accountable Care Organizations			
The ACA supports the development of Medicare Accountable Care Organizations (ACOs). ACOs are groups of doctors, hospitals, or other providers who provide coordinated care for a defined group of patients. There are two types of ACOs. <u>The Medicare Shared</u>	Floridians, Elders, Latinos, Other Minority Groups	Support development of applications to CMS to form an ACO. Consider supporting applications from those organizations that are likely to serve elderly, Latinos or other populations of particular interest in Florida.	Blue Shield of California gave \$1 million to AltaMed Health Services Corp., which primarily serves Latino, multi-ethnic, and uninsured populations in L.A. and Orange County, to continue its work with its ACO hospital partners (Blue Shield of California, 2011).

Focus	Population Emphasized	Potential Philanthropic Opportunities	Examples of Current Philanthropic Activities
<p><u>Savings Program</u> helps a Medicare Fee-For-Service program become an ACO. The <u>Advanced Payment Model</u> provides additional incentives for selected participants in the shared savings program (Centers for Medicare and Medicaid Services, 2013). Florida has been active in ACO development in certain parts of the state. South Florida and the Panhandle seem to have relatively little ACO development.</p>			
<p>Medicare Part D</p>			
<p>Prescription drug benefits will continue to be provided through Part D plans. ACA reduces the amount enrollees are required to pay for their brand name and generic prescriptions when the enrollee reaches the coverage gap (the Donut Hole). Enrollees will continue to be required to select a Part D plan that best suits their financial and clinical needs.</p>	<p>Floridians, Latinos, Other Minority Groups</p>	<p>Provide assistance to Medicare enrollees in their Part D plan selection. Develop and disseminate materials that are specific to populations’ culture and/or language needs.</p>	
<p>Elderly who Live in the North During the Summer and Florida during the Winter</p>			
<p>Estimates indicate that during the peak of the winter season there are as many as 818,000 snowbirds in Florida and around 119,000 during late summer (Smith & House, 2006).</p>	<p>Elders</p>	<p>Conduct needs assessment of health needs of snowbirds in Florida.</p>	
<p>Issues Facing Rural Elders</p>			
<p>340B Drug Pricing Program requires drug manufacturers to provide outpatient drugs to eligible organizations, including Federally Qualified Health Centers (FQHCs), Rural Referral Centers (RRCs), and Disproportionate Share Hospitals (DSHs)—organizations that</p>	<p>Elders</p>	<p>Provide support for rural workforce recruitment programs.</p>	<p>Illinois Farm Bureau, in conjunction with Illinois State Medical Society, runs Rural Illinois Medical Student Assistance Program to provide loans to medical students in Illinois who agree to practice in an approved rural community (Illinois State Medical Society, 2013).</p>

Focus	Population Emphasized	Potential Philanthropic Opportunities	Examples of Current Philanthropic Activities
traditionally serve rural populations (Health Resources and Services Administration, 2013).			
<p>Primary Care Extension Program (PCEP) can help rural elders gain access to mental health services; there is a shortage of mental health professionals across the country, particularly in rural areas. PCEP can help educate and provide assistance to primary care providers serving as mental health providers (Russell, 2010). Provisions in the ACA to address health-care workforce needs may also help provide relief to the mental health professional workforce, especially for rural and underserved areas (Russell, 2010).</p>		<p>Conduct mental health workforce needs assessment.</p>	
Long-Term Care Issues			
<p>The ACA provides increased federal funding and expanded eligibility for the Money Follows the Person demonstration program (Watts et al., 2013). Although Florida was awarded a \$35.7 million grant to implement this program, it chose not to accept the grant funds (Shrieves, 2011).</p>	<p>Floridians</p>	<p>Support for outreach to potential enrollees.</p>	
<p>ACA expands financial eligibility for the Home and Community-Based Services (HCBS) waivers (Watts et al., 2013). The HCBS expansion is not mandatory, but there are financial incentives to encourage states to expand their eligibility.</p>		<p>Develop policy and position papers describing alternatives under the HCBS Waiver program.</p>	<p>TNational Senior Citizen Law Center, with support from the Commonwealth Fund, issued a series of briefs dealing with HCBS waivers and other federal and state Medicaid policies that have affected assisted living residents (National Senior Citizens Law Center, 2011).</p>
Aging and Disability Resource Centers (ADRCs)			
<p>Expanded funding for ADRCs to serve as centers for elders and their families who are</p>	<p>Elders</p>	<p>Collaborate with ADRCs in providing outreach to elderly in the provision of</p>	<p>The Weaver Family Foundation in Jacksonville gave \$1 million to ElderSource, the ADRC of</p>

Focus	Population Emphasized	Potential Philanthropic Opportunities	Examples of Current Philanthropic Activities
<p>seeking services and support. ADRCs have the potential to serve as a focal point for rural elders and help improve health outcomes by connecting them to caregivers and providers (National Advisory Committee on Rural Health and Human Services, 2011).</p>		<p>social services and navigating the health-care system.</p>	<p>Northeast Florida, to help it more effectively serve its 12,000 senior clients spread over seven counties, including the rural county of Baker (Cravey, 2013).</p>
Health-Care Access Survey			
<p>Last statewide insurance survey was in 2004. While there are other sources of data on population health estimates (e.g., the Census), these data lack specificity.</p>	<p>Floridians</p>	<p>Support new round of the Florida Health Insurance Survey.</p>	<p>In Harrisburg, PA, Holy Spirit Health System, Penn State Milton S. Hershey Medical Center, and PinnacleHealth System came together to perform a community health needs assessment that found economic and social barriers to health care, like poverty and unemployment, in the five-county area it serves (Cohen, 2013, February 6).</p>

Conclusion

Our nation's ongoing pursuit of an optimal balance in assuring access to high quality care at an acceptable level of cost is currently manifested in efforts to implement the ACA. The new Act has created an atmosphere of uncertainty among many regarding its intent and likely impact, its key elements, and the implementation process. As such, the ACA has created opportunities for philanthropic activities focused in the areas of public education, partnering with government, advocacy, policy research, convening, and program innovation and reform. Furthermore, Florida's unique population characteristics and economic/employment structure provide innumerable philanthropic opportunities that may be tailored toward specific populations, such as Latinos or other minority groups, elders, or other salient groups, such as small businesses, agriculture, tourism, or particular geographic portions of the state. Other opportunities may include public health initiatives either in the form of support for public health programs, or in support of health behaviors. And of course it will be valuable for Florida philanthropic organizations to continue their support of evaluation and related research to assess the impact of their programmatic interventions, as well as the timely and accessible dissemination of information about the impact of their work—both the success stories and the lessons learned from initiatives that do not produce the expected outcomes.

About FPN's Health Funders Group

Florida Philanthropic Network's Health Funders Group is comprised of FPN members who share an interest in supporting health issues, organizations and needs in Florida. Current HFG members include:

- Allegany Franciscan Ministries
- The Community Foundation for Northeast Florida
- Community Foundation for Palm Beach and Martin Counties
- Wallace H. Coulter Foundation
- Florida Blue Foundation
- Gulf Coast Community Foundation
- Health Foundation of South Florida
- Jessie Ball duPont Fund
- Dr. John T. Macdonald Foundation
- Palm Healthcare Foundation
- Quantum Foundation
- Winter Park Health Foundation

The viewpoints expressed in this paper do not necessarily represent the viewpoints of any individual FPN member.

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