SOLICITATION OF INTEREST

From

HEALTH CHOICES:
Florida's Insurance Marketplace

Florida Health Choices, Inc.
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I. INTRODUCTION

This solicitation of interest (SOI) is issued by Florida Health Choices, Inc. (Corporation) seeking information from potentially interested vendors eligible to participate in the marketplace. The goal of this request for information to it assist the Corporation in identifying potential vendors and the products or services they may choose to offer in the marketplace during the Quick Start phase. Vendors are encouraged to suggest alternative methods, products, services and program approaches, and to suggest products or solutions not identified by the Corporation.

The following table provides a very brief overview of the launch phases and proposed expansions of eligibility, vendors, products and services for each phase:

HEALTH CHOICES: FLORIDA'S INSURANCE MARKETPLACE					
Launch	Phase	Employer Options	Target Population	Vendor Offerings	Products/Services
2011	Quick Start	• Choice • Preferred	• Eligible Employers	• Risk-Bearing Health Offerings	Individual
2011/12	Mid-Term	• Choice • Preferred • Select • Plan	• Eligible Employers • Other Individuals	• Risk-Bearing Health, Dental & Vision Offerings • Employer Offerings	Individual Small Group
2012	Long-Term	• Choice • Preferred • Select • Plan • Network	• Eligible Employers • Other Individuals	• Risk-Bearing Health, Dental & Vision Offerings • Employer Offerings • Non-Risk-Bearing Offerings	Individual Small Group Service Contracts

II. DESIGNATED CONTACT

Lauren McCarthy
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Tallahassee, Florida 32301
Info@myfloridachoices.org

III. PROPOSED CALENDAR OF EVENTS

Quick Start Review and Interest Phase

Vendor Review Period:	April 14-28, 2011
Vendor Comments Accepted Through:	April 28, 2011
Quick Start Letter of Interest Due:	May 2, 2011
Establish Schedule of Vendor Conferences:	May 5, 2011
Vendor Set-Up Package Provided:	May 6, 2011
Vendor Discovery Conferences	May 17-20, 2011
Vendor Confirms Participation in Quick Start	May 27, 2011

Quick Start Technical Phase

Receive Vendor Detail	May 27, 2011
Loading Vendor Detail	2 Weeks
Testing and Vendor Approval	2 Weeks
Portal Update	1 Week

Proposed Calendar by Phase

Quick Start	
Interest Phase	May 2011
Technical Phase	June 2011
Launch	July 2011
Mid Term	
Interest Phase	October 2011
Technical Phase	November 2011
Launch	January 2012
Long Term	
Interest Phase	May 2012
Technical Phase	June 2012
Launch	July 2012

IV. BACKGROUND

A. State of Florida

The Florida Legislature created Florida Health Choices, Inc. during 2008 by enacting Section 408.910, Florida Statutes. Proposed revisions to current law are currently under consideration. Proposed changes include expanding the type of vendors and the products or services they may offer, streamlining the approval process by which vendors may enter the marketplace and conformance to the Insurance Code. Current law can be found in Exhibit A of this SOI. If approved, any changes to current law will likely take effect July 1, 2011.

In establishing the Corporation and the Florida Health Choices Program, the Florida Legislature found that a significant number of the residents of this state did not have adequate access to affordable, quality health care.

Specifically, the Florida Health Choices Program was established to:

- Expand opportunities for Floridians to purchase affordable health insurance and health services.
- Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.
- Enable individual choice in both the manner and amount of health care purchased.
- Provide for the purchase health care coverage.
- Disseminate information to consumers on the price and quality of health services.
- Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

The Corporation elects to implement the program in three phases which are detailed in a later section.

B. Potential Impact of Health Care Reform

Vendors are advised that Florida Health Choices, Inc. is not a State designated American Health Benefit Exchange (AHBE Exchange) for individuals or a Small Business Health Options Programs (SHOP Exchange) as defined by the Patient Protection and Affordable Care Act. Likewise, the program the Corporation will implement is not subject to federal approval.

V. ELIGIBLE VENDORS

A. Risk-Bearing Health Insurance Vendors

Vendors meeting all requirements of the Florida Insurance Code may offer risk-bearing policies, products or contracts approved by the Office of Insurance Regulation. Risk-bearing vendors include the following:

- Insurers
- Health Maintenance Organizations
- Pre-paid Limited Health Service Organizations
- Discount Medical Plans
- Prepaid Health Clinics

B. Non Risk-Bearing Health Service Vendors

Other health vendors may offer service contracts and arrangements for a specified amount and type of health service or treatment in compliance with applicable state laws and as approved by the Corporation. Non-risk-bearing health service vendors may include but are not limited to the following:

- Hospitals
- Licensed health facilities
- Health care clinics
- Licensed health professionals
- Pharmacies
- Licensed health care providers
- Provider organizations
- Service networks
- Group practices
- Professional associations
- Other incorporated organizations of providers
- Corporate entities

C. Other Vendors

Other vendors may offer service to support participating employers. Examples of other vendors may include but are not limited to the following:

- Payroll service providers
- Human resource compliance providers
- Individual benefit account managers
- Other insurers may offer business insurance products

VI. TARGET POPULATION

Florida law outlines the target population for enrollment in the Florida Health Choices Program. Participation is voluntary and, while not specifically limited to the following list of employers and individuals, the Corporation intends to target the organizations named in Section 408.910, Florida Statutes:

- Employees of enrolled employers that have 1 to 50 employees
- Employees of enrolled counties designated as fiscally constrained
- Employees of enrolled school districts in fiscally constrained counties
- Employees of enrolled municipalities having fewer than 50,000 residents
- Employees of enrolled statutory rural hospitals

Other individuals that may enroll include:

- Employees of the State of Florida not eligible for state health benefits
- Retirees of the State of Florida
- Medicaid reform participants who select the opt-out provision of Medicaid Reform

VII. PROGRAM OPTIONS

The Corporation proposes establishing a series of options for employers and vendors. Vendors may elect to participate in one or more of the option levels. Vendors are not required to provide offerings at all levels in order to participate.

The following employer options are under consideration:

- Choice Option: The enrolled employer provides eligible employees with access to the marketplace and employees may select coverage or services from among the offerings available at the choice level. This option will be available during the Quick Start Phase.

- Preferred Option: The enrolled employer provides eligible employees with access to the marketplace and the employer recommends up to four offerings. The employee may select from the recommended offerings or shop from all of the offerings at the preferred level. This option will be available during the Quick Start Phase.

- Select Option: The enrolled employer selects one insurer offering. The employee may elect to enroll with the insurer offering selected by the employer. It is anticipated this option will be available during the Mid-Term Phase.

- Plan Option: The enrolled employer selects 2-3 offerings and the employee shops from among the offerings designated. It is anticipated this option will be available during the Mid-Term Phase.

- Network Option: The enrolled employer selects a health benefit plan and the eligible employee shops from among actuarially equivalent health benefit plans. The feasibility of this option is currently under review and the phase during which it may be available has not been determined.

Exhibit B further describes the option levels under consideration.

VIII. OFFERINGS

The Corporation, through the centralized marketplace, will offer various products that enable employers and employees to pay for health care.

A. Health Offerings

The health offerings include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts.

Employee and individual health offerings may include but are not limited to:

- Health insurance and health maintenance contracts
- Dental, vision and other limited benefit plans
- Life insurance
- Flexible spending accounts
- Public programs
- Wellness programs

B. Employer Offerings

The program may also provide administrative services to participating employers which may include the following:

- Payroll services
- Human resource compliance
- Assistance in seeking approval of cafeteria plans
- Worker's Compensation and other business insurance products

IX. IMPLEMENTATION PHASES

The Corporation proposes to launch the program in three phases as described below:

The Quick Start Phase will support limited offerings. The Corporation proposes to support 3 to 9 offerings by statewide or regionally licensed vendors. The supported vendors during this initial phase will include risk-bearing health insurers, preferred provider organizations, exclusive provider organizations and health maintenance organizations. Vendors may offer individual policies or contracts that are regulated and approved by the Florida Office of Insurance Regulation. An employer's options for participation will include the Preferred Option and the Choice Option. A quick start launch is planned for the summer of 2011.

The Mid-Term Phase will expand the type and number of products offered through the program. The offerings during this phase will include other risk-bearing entities that are regulated by the Florida Office of Insurance Regulation. Examples include but are not limited to pre-paid limited health service organizations, discount medical plans and prepaid health clinic service providers. The mid-term phase may be launched early in 2012.

Also during this phase, the Corporation may accept group policies and contracts as offerings in the marketplace. When group policies and contracts are added to the list of offerings, the employer options will be expanded to include the Select Option and the Plan Option.

The Long-Range Phase provides an opportunity for non-risk-bearing vendors to enter the marketplace. Examples of allowable vendors and their offerings may include but are not limited to:

- Hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed care providers.
- Provider organizations including service networks, group practices, professional associations, and other incorporated organizations of providers.
- Corporate entities providing specific health services in accordance with applicable state law.

If determined to be feasible, the number of employer participation options may be expanded to include the Network Option during this phase. This phase may be implemented during the summer months of 2012.

X. THIRD PARTY ADMINISTRATION

The Corporation contracts with Ceridian Exchange Services, LLC (CES) to provider third party administration services. The range of services that will provided by CES include:

A. Web-Based Portal

In partnership with eHealth, CES is establishing and will maintain a web-based choice portal. CES will design and deploy the web-based choice portal with a wide range of functions. The functions will include:

- Provide information to interested persons about available offerings and vendors
- Facilitate eligibility and enrollment of:
  - Employers
  - Employees of enrolled employers
  - Health insurance agents
- Allow comparison of benefit, plan and service options utilizing a standardized presentation of information

Information about each product and service available through the program will be made available through this interactive website. The presentation of plan and service options will allow comparison when reasonable comparisons exist. The purpose is to allow the eligible participant to search through plan and service offerings, based on a variety of search criteria to identify the product or service that best fits their individual needs. The presentation options will permit the user to identify options available in their geographic area and may also organize the options using criteria selected by the user.

B. Eligibility Determination

CES will determine eligibility of employers, their employees and health insurance agents. Applications for enrollment will be accepted by the Administrator by electronic means through on-line applications or through paper applications. Upon determination of eligibility, the information collected during the eligibility process will generate an account for the applicant employer, employee or health insurance agent.

C. Enrollment Management

CES will maintain a comprehensive, automated, enrollment management system and the capabilities described below:

- Correspondence generation
- Account history maintenance
- Late/delinquent payment notification
- Outgoing correspondence
- Transmittal of participant data to participating plans and service providers
- Provide verifications to vendors
- Transfer enrollment to another insurer or service provider when a vendor withdraws from the program or when the participant elects a new choice
- Changes in contact information
- Account update due to change in family composition
- Process returned mail and update address changes received from the U.S. Postal Service
- Continuing eligibility verification
- Renewal processing

D. Financial Services

The Administrator will calculate and facilitate the collection of participant and third party contributions toward the cost of multiple program offerings.

CES is responsible for maintaining all financial activity on employer and participant accounts and provides the following financial services:

- **Premium Calculation –** Based upon information collected as to participant choice, and contribution amounts designated by the employer, CES will calculate the amount of funds due from each source for each participant. The Administrator will make the detail available to enrolled employers and aggregate the total amount due from the employer for the payroll frequency established by the employer.

- **Premium Collection -** Options for premium collection will include checks, automatic deductions from checking accounts, automatic deductions from credit card accounts and any other payment methods accepted by CES.

- **Remittance Processing -** At least twice monthly, CES will generate detailed reports the Corporation will use for remittance of premiums and other contributions to participating vendors.

E. Customer Contact Center

The Administrator provides customer service via a toll-free hotline, email and regular U.S. mail service. The Statewide Customer Contact Center (Center) is located in St. Petersburg, Florida and will:

- Assist employers with establishment and administration of cafeteria plans
- Disseminate information to consumers on the price and quality of services available
- Provide access to account information
- Assist individual participants with managing available resources
- Respond to inquiries from employers, employees and agents
- Distribute materials
- Provide general program information and answer inquiries about eligibility and enrollment
- Provide account payment and coverage verification
- Return calls left on voice mail
- Refer calls to a participating agents as appropriate
- Return calls requiring additional research

Professional, accurate, courteous customer service is a high priority for the Corporation. The Administrator is prepared to accurately and timely processing of all incoming correspondence, all outgoing correspondence, and all telephone or email inquiries.

The Center provides customer service days and hours of operation which are conducive to participant needs and include regular business hours on Monday through Friday, from 8:00 a.m. until 8:00 p.m., Eastern Standard Time, excluding approved holidays. The Center provides the option of a live call agent for all callers during these hours of operation. Note: the Corporation follows the holiday schedule designated by the State of Florida with the addition of Good Friday.

The Center will manage customer communications in a professional, culture and language sensitive manner. At a minimum, the Center will make sufficient numbers of English and Spanish speaking staff during all hours of Center operations.

The Administrator has the ability to communicate timely, accurately and efficiently with non-English speaking callers, and callers that are hearing impaired.

XI. MARKETING

Several sources of data have been identified that will be useful in designing and implementing marketing and outreach efforts to employers and potential participants. The Corporation proposes to establish partnerships with public and private agencies that may share information on businesses, professionals, corporations, and contractors licensed by, doing business with, or associated with the partner agency.

The Corporation intends to develop targeted marketing and outreach efforts for the purpose of educating potential participant employers and their employees about the Florida Health Choices Program. Marketing materials may be designed and distributed based on a variety of elements including county of residence, zip code, type or status of professional license, business type, association membership, etc.

A comprehensive approach to establish awareness of the program will be developed. A Marketing and Outreach Committee of the FHC has been established and will begin meeting in the coming weeks. Vendor input and suggestions on developing the marketing approach are solicited.

XII. PROPOSED PROGRAM RULES

A. Employer Enrollment

1. During initial registration, employers will elect program options and enrollment windows.

2. During Quick Start, employer options will include the Choice and Preferred participation options.

3. If the employer's window is "fixed" all employees will begin coverage on the same date determined by the employer and at the conclusion of the 60-day open enrollment period. If the employer's window is "rolling" employees of that employer may begin coverage on the first of a month during the 60 day enrollment period.

B. Open Enrollment Periods

1. An eligible employee may enroll in health coverage during the employer's established 60-day open enrollment period.

2. No retro-active coverage will occur.

3. New hires will be provided an enrollment window of 30 days.

4. Participants are locked into their plan selection for one year unless a life event qualifies them to make a change in plan selection.

C. Special Enrollment Periods

1. A qualifying life event will permit participants to change coverage during the plan year and will establish a special enrollment period for the qualified family or individual. (Proposed qualifying life events are listed in Exhibit C.)

2. If the reported change causes a change in the monthly premium, the system will calculate the new rate based on the rate that was in effect at the time the participant enrolled in the plan (grandfathered rate).

3. All changes with the exception of Drop Dependent due to eligibility in Medicare/Medicaid/SCHP must be reported within 30 days of the date that the change happened. Drop Dependent due to eligibility in Medicare/Medicaid/SCHP must be reported within 90 days of the eligibility date.

D. Timely Premium Payment

1. Participating employers must agree to payroll deduction of employee contributions.

2. Employers are required to make full payment of their invoice by the due date. The system will cancel employer accounts if full payment has not been received. Employees will not be billed directly.

3. Participants not associated with an employer must agree to make timely payment of premiums through a method other than payroll deduction. The system will cancel an independent participant account is full payment is not received timely.

4. Accounts on which a notice of insufficient funds are received, will be assessed a $25.00 non-sufficient fund fee.

5. Employees associated with an employer who is cancelled for non-payment will become independent participants and will be billed with payment terms of Net 30. Coverage for independent participants who are cancelled for non-payment will be cancelled.

E. Agents

1. Health Insurance Agents licensed by the State of Florida are eligible to register and participate in the marketplace.

2. The system will compare an agent's last name and Florida license number against data provided by the Florida Department of Financial Services. Confirmation of an agent's active license status will determine the agent's eligibility.

3. Continuing agent eligibility will be re-determined monthly.

XIII. PROPOSED VENDOR PROCESSES

Florida Health Choices is committed to a successful partnership with interested vendors throughout implementation and during ongoing program administration. The vendor implementation delivery model is structured using best-practices and industry standards for excellence within Florida's insurance marketplace.

The Corporation, working with CES and eHealth, offer the following processes for consideration by interested vendors. Vendor comments and suggestions for improving upon the initial recommendations are desired.

A. Plan Documentation

1. Interested vendors will be provided with a template that will be used to obtain the plan description/benefits, rates, rate rules (age, gender, location), eligibility rules (location), zip code tables, provider directory, billing rules, pre-existing exclusions and effective dates.

2. CES will work with the vendor to set the plan up in the system. The vendor will test and approve plan setup before it is released to production. The Corporation will also have access to review the plan information prior to it being released to production.

B. Shop And Compare

1. Employees will enter the program portal via the employer-specific URL or the general program URL.

2. Employees will click "Get Quote" then enter their date of birth, dependents' dates of birth, indicate whether they or any of their dependents are full-time college students, enter their zip code then click "Get Quote".

3. If the zip code entered spans multiple counties, the employee selects their county from a drop down list.

4. All program plans the employee is eligible for will immediately display.

6. The system will filter plans by plan type, office visit, company (carrier name), premium range, deductible range, and co-insurance range to aid in identifying the plan that best meets the employee's needs.

7. As criteria are entered, the number of plans meeting that criteria and the lowest plan rate is displayed. The lowest rate will display based on whether the employee is searching before or after employer contribution.

8. The system will allow the enrollee to select up to four (4) plans to display in a side-by-side comparison.

9. Monthly plan premiums displayed to the enrollee will show “Cost” (full monthly cost), “Employer Contribution”, and “My Cost” (employee's portion of the cost).

10. The system will provide a method for employees to search for a health insurance agent to assist with plan selection. Search criteria will be full zip code, county name, agent’s last name, first name and/or languages spoken.

11. The system will not allow an employee to enroll outside of the 60-day enrollment window.

C. Application

1. The Corporation proposes to develop a single standardized medical plan application to be used for all plans available through the program. However, the Corporation is committed to developing an approach to the application process that is acceptable to participating vendors.

2. During the application process, the enrollee will create an account.

3. The application will include a section for the enrollee to provide information about each dependent being enrolled into the plan. Employee's tier (individual, individual+1, family) will be based on the number of dependents entered on the census page.

4. The application may be configured to support additional questions if required by the vendor.

5. The application will include eSignature functionality for employees to certify that they agree to payroll deductions and to the lock-in of their plan selection for one year or the remainder of the plan year unless a life event qualifies them to make a change.

6. The application will include functionality for the enrollee to indicate which health insurance agent assisted the enrollee with plan selection. Identifying information of the associated agent will be transmitted to the vendor.

D. Enrollment Transmission

1. CES will work with the vendor to set up the file and processes used to transmit enrollments and changes to the vendor. Initially, the EDI-834 industry standard file will be the program's standard format used to transmit data to the vendors. However, CES will work with vendors who cannot accept the standard format to establish a format that will meet their needs.

2. Newly enrolled member information will be transmitted to the vendor on the first weekly file after the application has been approved by the employer.

3. Full population files will be sent weekly. The weekly system extract used to create the file for transmission to the carrier will include all active records (participants and dependents) and canceled records that have not previously been sent to the carrier (participants and dependents).

4. Participant account changes (address, etc.) will be sent to the vendor on the next file sent.

5. A health insurance agent's identifying information will be a data element on the file.

6. Vendors will be required to acknowledge receipt of the file and provide the number of records successfully loaded into their system.

E. Premium Management

1. When the enrollment is complete, the employer will be advised how much of the full premium is their responsibility and how much is their employee's. The employer will use payroll deduction to obtain the employee's portion.

2. The system will have the capability to house and maintain split family rate information where the vendor may have specific rates based on age. Split family means that some vendors may require a different rate for a dependent that is in a different age band than the primary enrollee. The system must display the premium based on the data entered by the enrollee and the plan's rate rules.

3. Monthly billing to employers for their enrolled employees will be run on or about the 23rd of the month to generate invoices for coverage that is effective the 1st of the second month (approx. 5 weeks out). For example on 4/23/11 the invoice will be generated for the coverage period 6/1/11 - 6/30/11.

4. Daily billing will occur to generate invoices for rebilling and for new enrollments with applicable coverage effective dates.

5. Independent participants will be invoiced for their full premium. Employees will not be invoiced directly.

6. Employers will be invoiced for the full premium for each of their active employees, aggregated into a single monthly invoice.

7. The system will set the employer invoice method automatically based on whether the employer has ACH set up. If ACH is set up, the employer will get electronic notification when their bill is ready to view and pay online. Paper invoices will be mailed to employers who do not have ACH set up. These employers may view their invoice detail online, but the Pay My Bill button will not display.

8. Online invoice detail will display the amount owed by the employee and the amount owed by the employer which, added together, will equal the total premium

9. Employers can recalculate their invoice by canceling employees via the Manage My Employees functionality.

F. Methods of Payment

1. Employers will have the option to pay by check or sign up for ACH.

a. The ACH option will require them to take action each billing period. Clients using the ACH option review their invoice online, update employee status to remove employees as applicable, and click the "Make Payment" link.
b. Employers that select the option to mail in a check each month will be provided with a paper invoice.

2. The system will pull the funds from the employers designated bank account and apply the payments to the employee accounts.

3. Independent participants will have the option to pay by check or Fiserv's CheckFree service. A link to the CheckFree service will be located on the participant's billing & payment screen.

G. Premium Disbursement to Vendors

1. The vendor disbursement process will be run on or around the 5th (for funds received by the 1st) and the 15th (for funds received by the 10th) of each month.

2. The disbursement process will generate a Premium Distribution Report indicating what funds should be disbursed to each vendor. The Corporation will transmit funds to the vendor.

XIV. PARTICIPATION AGREEMENT AND TERMS

The vendor will execute a participation agreement with the Corporation. The Corporation intends to develop a standard participation agreement for vendor consideration. Interested vendors are invited to suggest reasonable terms and conditions for consideration by the Corporation. At a minimum, vendors must agree:

- To ensure the availability of covered services and benefits to participating individuals for an enrollment year. Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract

- To submit required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product or service offered through the program

- To comply with grievance and other procedures established by the Corporation

- To participate in reporting and evaluation efforts

- To a prohibition on refusal to sell any offered non-risk-bearing product to a participant who elects to buy it

- To accept payment for enrolled participants from the Corporation.

The Corporation will assess all vendors a surcharge on products and service purchased through the marketplace. The maximum surcharge permissible in 408.910, F. S. is 2.5%. Therefore, the Corporation will remit a minimum of 97.5% of the premium or service amount collected.

Once collected, and based upon remittance reports generated by CES, the Corporation will distribute the appropriate amount to the recipient vendors.

Vendors will benefit from the marketing efforts of the Corporation and from the activities conducted by its Third Party Administrator. Vendors are not responsible for any payments to the Corporation's Third Party Administrator.

XV. SOLICITATION OF INTEREST

A. Comments and Questions in the Review Period

A two-week vendor review period has been established prior to finalizing this document. Based on any vendor comments, questions or suggestions, the content of this SOI may be revised before final publication. Please direct comments, questions or suggestions about this SOI to info@myfloridachoices.org as noted in the Designated Contacts section.

B. Vendor Input

In this SOI, the Corporation solicits input from interested vendors on several areas. While, the Corporation will consider any and all input from vendors, specific areas of interest include the following:

- General Comments
- Scheduling
- Program Options
- Offerings
- Phases
- Third Party Administration
- Marketing
- Proposed Program Rules
- Vendor Processes
- Participation Agreement and Terms
- Performance Standards
- Reporting and Evaluation

Please direct vendor input to info@myfloridachoices.org as noted in the Designated Contacts section. Vendor input will be accepted throughout the calendar established in this SOI.

C. Letter of Interest

Potential vendors are invited to submit a non-binding Letter of Interest. If choosing to submit a letter of interest for the quick start phase, please submit it by 5:00 p.m., Eastern Standard Time, May 2, 2010, and direct it to the address info@myfloridachoices.org as noted in Designated Contacts.

Please provide the formal name, title, type of insurer, business address, location of the vendor's principal offices, as well as any other name(s) under which the organization does business.

With the Letter of Interest, please provide evidence of appropriate licensure and indicate the Florida file numbers issued by the Office of Insurance Regulation, Life and Health Product Review unit, for each of the risk-bearing insurance products the vendor proposes to consider offering during the Quick Start Phase.

D. Discovery Conferences and Vendor Set-Up Packages

1. On or before May 5, the Corporation will establish a 1-2 hour block of time for each vendor requesting a discovery conference. Interested vendors eligible for the Quick Start phase will be invited to register for a discovery conference.

2. On or about May 6, the Corporation will provide interested eligible vendors with a vendor set-up package. The

3. Questions regarding plan detail set-up and implementation may be submitted prior to the vendor's scheduled discovery conference to the address info@myfloridachoices.org as noted in Designated Contacts.

4. Initial meetings with interested vendors are tentatively scheduled May 17-20 in St. Petersburg and Miami-Dade County.

5. Additional meeting locations are possible and may be added to the schedule.

6. Follow up meetings may also be scheduled when requested by the vendor.

E. Quick Start Technical Phase

After reviewing the vendor set-up package and participating in a discovery conference, eligible vendors will submit the information required for plan set-up using the template provided by the Corporation. Upon submission of the plan detail, it will be loaded into the test web-portal and prepared for vendor approval. Only after receiving vendor approval, and negotiation of the participation agreement, will the plan detail be loaded to www.floridahealthchoices.com.

XVI. GENERAL CONDITIONS

A. Corporation Furnished Property

No material, labor, or facilities will be furnished by the Corporation unless otherwise provided for in this SOI.

B. Special Note

The Corporation is a private, not-for-profit corporation, and is not subject to the bid requirements of the State of Florida. The Corporation is not a state agency.

C. Excluded Organizations

The Corporation will not consider, directly or indirectly, any vendor that is debarred, suspended, ineligible or voluntarily excluded from doing business with any state or federal agency.

Otherwise eligible vendors may be excluded from participating in the marketplace for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the Corporation.

D. Performance Standards

The Corporation places a high priority on customer service including the timely and accurate handling of all vendor functions. Please know that the Corporation is committed to negotiation of reasonable standards of performance.

E. Announcements

To ensure the accuracy of any public communication, the content of any announcement, press release or statement issued by a vendor concerning acceptance to or withdrawal from the Corporation's marketplace must be submitted to, and approved by, the Corporation prior to release.

XVII. EXHIBITS

EXHIBIT A

408.910 Florida Health Choices Program.--

(1) LEGISLATIVE INTENT.--The Legislature finds that a significant number of the residents of this state do not have adequate access to affordable, quality health care. The Legislature further finds that increasing access to affordable, quality health care can be best accomplished by establishing a competitive market for purchasing health insurance and health services. It is therefore the intent of the Legislature to create the Florida Health Choices Program to:

(a) Expand opportunities for Floridians to purchase affordable health insurance and health services.

(b) Preserve the benefits of employment-sponsored insurance while easing the administrative burden for employers who offer these benefits.

(c) Enable individual choice in both the manner and amount of health care purchased.

(d) Provide for the purchase of individual, portable health care coverage.

(e) Disseminate information to consumers on the price and quality of health services.

(f) Sponsor a competitive market that stimulates product innovation, quality improvement, and efficiency in the production and delivery of health services.

(2) DEFINITIONS.--As used in this section, the term:

(a) "Corporation" means the Florida Health Choices, Inc., established under this section.

(b) "Health insurance agent" means an agent licensed under part IV of chapter 626.

(c) "Insurer" means an entity licensed under chapter 624 which offers an individual health insurance policy or a group health insurance policy, a preferred provider organization as defined in s. 627.6471, or an exclusive provider organization as defined in s. 627.6472.

(d) "Program" means the Florida Health Choices Program established by this section.

(3) PROGRAM PURPOSE AND COMPONENTS.--The Florida Health Choices Program is created as a single, centralized market for the sale and purchase of various products that enable individuals to pay for health care. These products include, but are not limited to, health insurance plans, health maintenance organization plans, prepaid services, service contracts, and flexible spending accounts. The components of the program include:

(a) Enrollment of employers.

(b) Administrative services for participating employers, including:

1. Assistance in seeking federal approval of cafeteria plans.

2. Collection of premiums and other payments.

3. Management of individual benefit accounts.

4. Distribution of premiums to insurers and payments to other eligible vendors.

5. Assistance for participants in complying with reporting requirements.

(c) Services to individual participants, including:

1. Information about available products and participating vendors.

2. Assistance with assessing the benefits and limits of each product, including information necessary to distinguish between policies offering creditable coverage and other products available through the program.

3. Account information to assist individual participants with managing available resources.

4. Services that promote healthy behaviors.

(d) Recruitment of vendors, including insurers, health maintenance organizations, prepaid clinic service providers, provider service networks, and other providers.

(e) Certification of vendors to ensure capability, reliability, and validity of offerings.

(f) Collection of data, monitoring, assessment, and reporting of vendor performance.

(g) Information services for individuals and employers.

(h) Program evaluation.

(4) ELIGIBILITY AND PARTICIPATION.--Participation in the program is voluntary and shall be available to employers, individuals, vendors, and health insurance agents as specified in this subsection.

(a) Employers eligible to enroll in the program include:

1. Employers that have 1 to 50 employees.

2. Fiscally constrained counties described in s. 218.67.

3. Municipalities having populations of fewer than 50,000 residents.

4. School districts in fiscally constrained counties.

(b) Individuals eligible to participate in the program include:

1. Individual employees of enrolled employers.

2. State employees not eligible for state employee health benefits.

3. State retirees.

4. Medicaid reform participants who select the opt-out provision of reform.

5. Statutory rural hospitals.

(c) Employers who choose to participate in the program may enroll by complying with the procedures established by the corporation. The procedures must include, but are not limited to:

1. Submission of required information.

2. Compliance with federal tax requirements for the establishment of a cafeteria plan, pursuant to s. 125 of the Internal Revenue Code, including designation of the employer's plan as a premium payment plan, a salary reduction plan that has flexible spending arrangements, or a salary reduction plan that has a premium payment and flexible spending arrangements.

3. Determination of the employer's contribution, if any, per employee, provided that such contribution is equal for each eligible employee.

4. Establishment of payroll deduction procedures, subject to the agreement of each individual employee who voluntarily participates in the program.

5. Designation of the corporation as the third-party administrator for the employer's health benefit plan.

6. Identification of eligible employees.

7. Arrangement for periodic payments.

8. Employer notification to employees of the intent to transfer from an existing employee health plan to the program at least 90 days before the transition.

(d) Eligible vendors and the products and services that the vendors are permitted to sell are as follows:

1. Insurers licensed under chapter 624 may sell health insurance policies, limited benefit policies, other risk-bearing coverage, and other products or services.

2. Health maintenance organizations licensed under part I of chapter 641 may sell health insurance policies, limited benefit policies, other risk-bearing products, and other products or services.

3. Prepaid health clinic service providers licensed under part II of chapter 641 may sell prepaid service contracts and other arrangements for a specified amount and type of health services or treatments.

4. Health care providers, including hospitals and other licensed health facilities, health care clinics, licensed health professionals, pharmacies, and other licensed health care providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

5. Provider organizations, including service networks, group practices, professional associations, and other incorporated organizations of providers, may sell service contracts and arrangements for a specified amount and type of health services or treatments.

6. Corporate entities providing specific health services in accordance with applicable state law may sell service contracts and arrangements for a specified amount and type of health services or treatments.

A vendor described in subparagraphs 3.-6. may not sell products that provide risk-bearing coverage unless that vendor is authorized under a certificate of authority issued by the Office of Insurance Regulation under the provisions of the Florida Insurance Code. Otherwise eligible vendors may be excluded from participating in the program for deceptive or predatory practices, financial insolvency, or failure to comply with the terms of the participation agreement or other standards set by the corporation.

(e) Eligible individuals may voluntarily continue participation in the program regardless of subsequent changes in job status or Medicaid eligibility. Individuals who join the program may participate by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information.

2. Authorization for payroll deduction.

3. Compliance with federal tax requirements.

4. Arrangements for payment in the event of job changes.

5. Selection of products and services.

(f) Vendors who choose to participate in the program may enroll by complying with the procedures established by the corporation. These procedures must include, but are not limited to:

1. Submission of required information, including a complete description of the coverage, services, provider network, payment restrictions, and other requirements of each product offered through the program.

2. Execution of an agreement to make all risk-bearing products offered through the program guaranteed-issue policies, subject to preexisting condition exclusions established by the corporation.

3. Execution of an agreement that prohibits refusal to sell any offered non-risk-bearing product to a participant who elects to buy it.

4. Establishment of product prices based on age, gender, and location of the individual participant.

5. Arrangements for receiving payment for enrolled participants.

6. Participation in ongoing reporting processes established by the corporation.

7. Compliance with grievance procedures established by the corporation.

(g) Health insurance agents licensed under part IV of chapter 626 are eligible to voluntarily participate as buyers' representatives. A buyer's representative acts on behalf of an individual purchasing health insurance and health services through the program by providing information about products and services available through the program and assisting the individual with both the decision and the procedure of selecting specific products. Serving as a buyer's representative does not constitute a conflict of interest with continuing responsibilities as a health insurance agent if the relationship between each agent and any participating vendor is disclosed before advising an individual participant about the products and services available through the program. In order to participate, a health insurance agent shall comply with the procedures established by the corporation, including:

1. Completion of training requirements.

2. Execution of a participation agreement specifying the terms and conditions of participation.

3. Disclosure of any appointments to solicit insurance or procure applications for vendors participating in the program.

4. Arrangements to receive payment from the corporation for services as a buyer's representative.

(5) PRODUCTS.--

(a) The products that may be made available for purchase through the program include, but are not limited to:

1. Health insurance policies.

2. Limited benefit plans.

3. Prepaid clinic services.

4. Service contracts.

5. Arrangements for purchase of specific amounts and types of health services and treatments.

6. Flexible spending accounts.

(b) Health insurance policies, limited benefit plans, prepaid service contracts, and other contracts for services must ensure the availability of covered services and benefits to participating individuals for at least 1 full enrollment year.

(c) Products may be offered for multiyear periods provided the price of the product is specified for the entire period or for each separately priced segment of the policy or contract.

(d) The corporation shall provide a disclosure form for consumers to acknowledge their understanding of the nature of, and any limitations to, the benefits provided by the products and services being purchased by the consumer.

(6) PRICING.--Prices for the products sold through the program must be transparent to participants and established by the vendors based on age, gender, and location of participants. The corporation shall develop a methodology for evaluating the actuarial soundness of products offered through the program. The methodology shall be reviewed by the Office of Insurance Regulation prior to use by the corporation. Before making the product available to individual participants, the corporation shall use the methodology to compare the expected health care costs for the covered services and benefits to the vendor's price for that coverage. The results shall be reported to individuals participating in the program. Once established, the price set by the vendor must remain in force for at least 1 year and may only be redetermined by the vendor at the next annual enrollment period. The corporation shall annually assess a

surcharge for each premium or price set by a participating vendor. The surcharge may not be more than 2.5 percent of the price and shall be used to generate funding for administrative services provided by the corporation and payments to buyers' representatives.

(7) EXCHANGE PROCESS.--The program shall provide a single, centralized market for purchase of health insurance and health services. Purchases may be made by participating individuals over the Internet or through the services of a participating health insurance agent. Information about each product and service available through the program shall be made available through printed material and an interactive Internet website. A participant needing personal assistance to select products and services shall be referred to a participating agent in his or her area.

(a) Participation in the program may begin at any time during a year after the employer completes enrollment and meets the requirements specified by the corporation pursuant to paragraph (4)(c).

(b) Initial selection of products and services must be made by an individual participant within 60 days after the date the individual's employer qualified for participation. An individual who fails to enroll in products and services by the end of this period is limited to participation in flexible spending account services until the next annual enrollment period.

(c) Initial enrollment periods for each product selected by an individual participant must last at least 12 months, unless the individual participant specifically agrees to a different enrollment period.

(d) If an individual has selected one or more products and enrolled in those products for at least 12 months or any other period specifically agreed to by the individual participant, changes in selected products and services may only be made during the annual enrollment period established by the corporation.

(e) The limits established in paragraphs (b)-(d) apply to any risk-bearing product that promises future payment or coverage for a variable amount of benefits or services. The limits do not apply to initiation of flexible spending plans if those plans are not associated with specific high-deductible insurance policies or the use of spending accounts for any products offering individual participants specific amounts and types of health services and treatments at a contracted price.

(8) CONSUMER INFORMATION.--The corporation shall establish a secure website to facilitate the purchase of products and services by participating individuals. The website must provide information about each product or service available through the program.

(a) Prior to making a risk-bearing product available through the program, the corporation shall provide information regarding the product to the Office of Insurance Regulation. The office shall review the product information and provide consumer information and a

recommendation on the risk-bearing product to the corporation within 30 days after receiving the product information.

1. Upon receiving a recommendation that a risk-bearing product should be made available in the marketplace, the corporation may include the product on its website. If the consumer information and recommendation is not received within 30 days, the corporation may make the risk-bearing product available on the website without consumer information from the office.

2. Upon receiving a recommendation that a risk-bearing product should not be made available in the marketplace, the risk-bearing product may be included as an eligible product in the marketplace and on its website only if a majority of the board of directors vote to include the product.

(b) If a risk-bearing product is made available on the website, the corporation shall make the consumer information and office recommendation available on the website and in print format. The corporation shall make late-submitted and ongoing updates to consumer information available on the website and in print format.

(9) RISK POOLING.--The program shall utilize methods for pooling the risk of individual participants and preventing selection bias. These methods shall include, but are not limited to, a postenrollment risk adjustment of the premium payments to the vendors. The corporation shall establish a methodology for assessing the risk of enrolled individual participants based on data reported by the vendors about their enrollees. Monthly distributions of payments to the vendors shall be adjusted based on the assessed relative risk profile of the enrollees in each risk-bearing product for the most recent period for which data is available.

(10) EXEMPTIONS.--

(a) Policies sold as part of the program are not subject to the licensing requirements of the Florida Insurance Code, chapter 641, or the mandated offerings or coverages established in part VI of chapter 627 and chapter 641.

(b) The corporation may act as an administrator as defined in s. 626.88 but is not required to be certified pursuant to part VII of chapter 626. However, a third party administrator used by the corporation must be certified under part VII of chapter 626.

(11) CORPORATION.--There is created the Florida Health Choices, Inc., which shall be registered, incorporated, organized, and operated in compliance with part III of chapter 112 and chapters 119, 286, and 617. The purpose of the corporation is to administer the program created in this section and to conduct such other business as may further the administration of the program.

(a) The corporation shall be governed by a 15-member board of directors consisting of:

1. Three ex officio, nonvoting members to include:

a. The Secretary of Health Care Administration or a designee with expertise in health care services.

b. The Secretary of Management Services or a designee with expertise in state employee benefits.

c. The commissioner of the Office of Insurance Regulation or a designee with expertise in insurance regulation.

2. Four members appointed by and serving at the pleasure of the Governor.

3. Four members appointed by and serving at the pleasure of the President of the Senate.

4. Four members appointed by and serving at the pleasure of the Speaker of the House of Representatives.

5. Board members may not include insurers, health insurance agents or brokers, health care providers, health maintenance organizations, prepaid service providers, or any other entity, affiliate or subsidiary of eligible vendors.

(b) Members shall be appointed for terms of up to 3 years. Any member is eligible for reappointment. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment.

(c) The board shall select a chief executive officer for the corporation who shall be responsible for the selection of such other staff as may be authorized by the corporation's operating budget as adopted by the board.

(d) Board members are entitled to receive, from funds of the corporation, reimbursement for per diem and travel expenses as provided by s. 112.061. No other compensation is authorized.

(e) There is no liability on the part of, and no cause of action shall arise against, any member of the board or its employees or agents for any action taken by them in the performance of their powers and duties under this section.

(f) The board shall develop and adopt bylaws and other corporate procedures as necessary for the operation of the corporation and carrying out the purposes of this section. The bylaws shall:

1. Specify procedures for selection of officers and qualifications for reappointment, provided that no board member shall serve more than 9 consecutive years.

2. Require an annual membership meeting that provides an opportunity for input and interaction with individual participants in the program.

3. Specify policies and procedures regarding conflicts of interest, including the provisions of part III of chapter 112, which prohibit a member from participating in any decision that would inure to the benefit of the member or the organization that employs the member. The policies and procedures shall also require public disclosure of the interest that prevents the member from participating in a decision on a particular matter.

(g) The corporation may exercise all powers granted to it under chapter 617 necessary to carry out the purposes of this section, including, but not limited to, the power to receive and accept grants, loans, or advances of funds from any public or private agency and to receive and accept from any source contributions of money, property, labor, or any other thing of value to be held, used, and applied for the purposes of this section.

(h) The corporation may establish technical advisory panels consisting of interested parties, including consumers, health care providers, individuals with expertise in insurance regulation, and insurers.

(i) The corporation shall:

1. Determine eligibility of employers, vendors, individuals, and agents in accordance with subsection (4).

2. Establish procedures necessary for the operation of the program, including, but not limited to, procedures for application, enrollment, risk assessment, risk adjustment, plan administration, performance monitoring, and consumer education.

3. Arrange for collection of contributions from participating employers and individuals.

4. Arrange for payment of premiums and other appropriate disbursements based on the selections of products and services by the individual participants.

5. Establish criteria for disenrollment of participating individuals based on failure to pay the individual's share of any contribution required to maintain enrollment in selected products.

6. Establish criteria for exclusion of vendors pursuant to paragraph (4)(d).

7. Develop and implement a plan for promoting public awareness of and participation in the program.

8. Secure staff and consultant services necessary to the operation of the program.

9. Establish policies and procedures regarding participation in the program for individuals, vendors, health insurance agents, and employers.

10. Develop a plan, in coordination with the Department of Revenue, to establish tax credits or refunds for employers that participate in the program. The corporation shall submit the plan to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 1, 2009.

(12) REPORT.--Beginning in the 2009-2010 fiscal year, submit by February 1 an annual report to the Governor, the President of the Senate, and the Speaker of the House of Representatives documenting the corporation's activities in compliance with the duties delineated in this section.

(13) PROGRAM INTEGRITY.--To ensure program integrity and to safeguard the financial transactions made under the auspices of the program, the corporation is authorized to establish qualifying criteria and certification procedures for vendors, require performance bonds or other guarantees of ability to complete contractual obligations, monitor the performance of vendors, and enforce the agreements of the program through financial penalty or disqualification from the program.

History.--s. 4, ch. 2008-32.

EXHIBIT B

FLORIDA HEALTH CHOICES, INC.

Draft Program Options for Small Employers

Eligible Small Employer	Employer Program Option		Eligible Persons	Shopping Experience	Suggested Elements#
-Principal place of business in Florida -Average 1-50 employees during preceding year -If an employer was not in existence throughout the preceding calendar year, the average number of employees reasonably expected to be employed during the current year averages 1-50 -If a participating employer exceeds 50 employees after initial enrollment it may continue to be treated as a small employer	Select Option	Employer selects one insurer and one health benefit plan offered by the selected insurer	-Eligible Employee as determined by the employer -Spouse or child of an eligible employee -Participates in payroll deduction	Employee may elect to enroll with the insurer and health benefit plan selected by employer	Type: Small Group Insurance or HMO Contract Holder: Group Sponsored Contract Year: Plan Year Open Enrollment: Annual Rating Method: Community Rating Employer Contribution: Minimum 50% Employee Participation: Minimum 75% Pre-existing Conditions: TBD Medical Underwriting: -10% to +15% Guarantees: Guarantee Issue Continuation: COBRA
	Plan Option	Employer selects one insurer and 2-3 health benefit plans offered by that insurer		Employee shops from among the designated benefit plans offered by the designated insurer	
	Network Option	Employer selects a health benefit plan		Employee shops from among the insurers that offer actuarially equivalent health benefit plans	*Note: Research on actuarially equivalent health benefit plans is pending*
	Preferred Option	Employer recommends up to 4 insurers or health benefit plan		Employee notified of employer recommendations with ability to shop from available insurers and benefit plans	Type: Individual Insurance or HMO Contract Holder: Individual Contract Year: Product Date or 12 months Open Enrollment: Annual Rating Method: Medical Underwriting Employer Contribution: 0-100% Employee Participation: 0-100% Pre-existing Conditions: TBD Medical Underwriting: -10% - +15% Guarantees: No Guarantee Issue Continuation: Portable
	Choice Option	Employer does not select or recommend insurer or health benefit plan		Employee shops from available insurers and benefit plans	

FLORIDA HEALTH CHOICES, INC.

Draft Programs Options for Other Employers >50

Eligible Other Employer >50	Employer Program Option		Eligible Persons	Shopping Experience	Suggested Elements#
-Fiscally constrained counties and schools - Municipality less than 50,000 residents -Statutory rural hospital -State of Florida	Select Option	Employer selects one insurer and one health benefit plan offered by the selected insurer	-Eligible Employee as determined by the employer -State employees not eligible for state employee health benefits -Spouse or child of one of the above -Participates in payroll deduction	Employee may elect to enroll with the insurer and health benefit plan selected by employer	Type: Large Group Insurance or HMO Contract Holder: Group Sponsored Contract Year: Plan Year Open Enrollment: Annual Rating Method: Experience Rated Employer Contribution: Minimum 50% Employee Participation: Minimum 75% Pre-existing Conditions: TBD Guarantees: Guarantee Issue Continuation: COBRA
	Plan Option	Employer selects one insurer and 2-3 health benefit plans offered by that insurer		Employee shops from among the designated benefit plans offered by the designated insurer	
	Network Option	Employer selects a health benefit plan		Employee shops from among the insurers that offer actuarially equivalent health benefit plans	*Note: Research on actuarially equivalent health benefit plans is pending*
	Preferred Option	Employer recommends up to 4 insurers or health benefit plan		Employee notified of employer recommendations with ability to shop from all available insurers and benefit plans	Type: Individual Insurance or HMO Contract Holder: Individual Contract Year: Product Date or 12 months Open Enrollment: Annual Rating Method: Medical Underwriting Employer Contribution: 0-100% Employee Participation: 0-100% Pre-existing Conditions: TBD Medical Underwriting: -10% - +15% Guarantees: No Guarantee Issue Continuation: Portable
	Choice Option	Employer does not select or recommend insurer or health benefit plan		Employee shops from all available insurers and benefit plans	

FLORIDA HEALTH CHOICES, INC.

Draft Program Level for Individuals

Eligible Individuals	Individual Program Option	Eligible Persons	Shopping	Suggested Elements
-Unaffiliated Individual: A person or family who participates in the program but is not eligible for payroll deduction through a participating employer	Choice Option	-State of Florida retiree -Medicaid participants who select the opt-out provisions -Participating employees when 18 months of COBRA ends -Participating employees who separate from employer with no COBRA option -Makes premium payments through a method other than payroll deduction	Unaffiliated Individual shops from available insurers and benefit plans	Type: Individual Insurance or HMO Contract Holder: Individual Contract Year: Product Date or 12 months Open Enrollment: Annual Rating Method: Medical Underwriting Pre-existing Conditions: TBD Medical Underwriting: -10% - +15% Guarantees: No Guarantee Issue Continuation: Portable

EXHIBIT C

Qualifying Life Events (For Discussion)

Event	Example	Action	If Removed
Employee Events			
Employee gains dependent	Marriage Birth Adoption	Add dependent	
Employee loses dependent	Death Divorce Placed for adoption	Remove dependent	Add independent
Employee becomes eligible	New hire Job status change	Add employee/family	
Employee loses eligibility	Employment ends Job status change		Add independent
Employee loses eligibility in dependent plan	Dependent employment ends Divorce Dependent job status change	Add employee/family	
Employee moves out of service area	Relocation by employer Residence address change	Remove employee/family	Add independent
Eligible employee moves to new service area	Relocation by employer Residence address change	Add employee/family	
Employee enrolls in public coverage	Enrolls in Medicare Enrolls in Medicaid/SCHIP	Remove employee/family	Add independent
Eligible employee loses public coverage	Public coverage canceled due to ineligibility.	Add employee/family	
Dependent Events			
Dependent enrolls in another plan	Enrolls in employer's plan	Remove dependent	Add independent
Dependent loses eligibility in another plan	Dependent employment ends Job status change	Add dependent	
Dependent become ineligible	Overage dependent	Remove dependent	Add independent
Dependent moves out of service area	Out of service area college student	Remove dependent	Add independent
Dependent moves to service area	Returning college student	Add dependent	
Dependent enrolled in public coverage	Enrolls in Medicare Enrolls in	Remove dependent	Add independent

	Medicaid/SCHIP		
Eligible dependent loses public coverage	Public coverage canceled due to ineligibility.	Add dependent	
Judgment, decree or order to add	Court order requiring coverage for employee's dependent	Add dependent	
Judgment, decree or order to release	Court order releasing required coverage for employee's dependent	Remove dependent	Add independent