

**MEMORANDUM OF UNDERSTANDING
BETWEEN
THE OFFICE OF POLICY AND MANAGEMENT
AND
THE CONNECTICUT HEALTH INSURANCE EXCHANGE**

This Memorandum of Understanding ("MOU") is entered into by the Office of Policy and Management ("OPM") and the Connecticut Health Insurance Exchange ("CT HIX") for the purpose of transferring funds from OPM to CT HIX to support the establishment of a state-operated Health Insurance Exchange in Connecticut. This MOU shall take effect April 1, 2012 and may be modified by amendments or superseded in its entirety at any time by mutual written agreement of both signatories.

WHEREAS, OPM is the recipient of Grant Award HBEIE110070-01-00 ("Grant Award") from the U.S. Department of Health and Human Services in the amount of \$6,687,933, covering the period from August 15, 2011 through August 14, 2012, to support the establishment of a state-operated Health Insurance Exchange in Connecticut in accordance with the Affordable Care Act;

WHEREAS, OPM has hired staff and consultants, and has purchased other goods and services to support the establishment of a Health Insurance Exchange in Connecticut;

WHEREAS, in accordance with Public Act 11-53, the Connecticut General Assembly established CT HIX;

WHEREAS, in accordance with Public Act 11-53, the goals of CT HIX shall be to reduce the number of individuals without health insurance in this state and assist individuals and small employers in the procurement of health insurance by, among other services, offering easily comparable and understandable information about health insurance options;

WHEREAS, in accordance with Public Act 11-53, CT HIX shall take measures necessary and convenient to carry out the purposes of CT HIX, provided measures shall not conflict with the provisions of the Affordable Care Act, regulations adopted thereunder or federal guidance issued pursuant to the Affordable Care Act; and

WHEREAS, both OPM and CT HIX recognize the need for a coordinated effort to implement the requirements of the Affordable Care Act and the establishment of a state-operated Health Insurance Exchange.

THEREFORE, the parties mutually agree as follows:

- 1.) CT HIX shall implement the requirements of the Grant Award including but not limited to the approved scope of service as described in the project narrative included herein as Appendix A and as outlined below:
 - Establishment of administrative structure, hiring of staff and procurement of office space and equipment;
 - Identification of business operations and definition of IT systems requirements; and
 - Assessment of customer assistance and support.

- 2.) OPM shall transfer funds in an amount not to exceed \$6,197,916.78 from the Grant Award to CT HIX to implement the requirements of the Grant Award and to fund expenditures for the receipt of goods and/or services from the effective date of the Grant Award through August 14, 2012.

OPM shall transfer funds to CT HIX after OPM's receipt and approval of a cash request supported by a cash flow projection prepared by CT HIX in a mutually agreeable electronic format in accordance with the following schedule and approved budget categories of the Grant Award. Failure by CT HIX to submit to OPM other required reports in accordance with this MOU may delay the transfer of funds from OPM to CT HIX.

Cash Request/Cash Flow Projection Due Date	Months Covered
April 1, 2012	April 1, 2012 through June 30, 2012
July 1, 2012	July 1, 2012 through August 14, 2012

Approved Budget Categories:

- Salaries and Wages, Fringe Benefits, and Indirect
- Administrative Structure Development
- Business Operations/IT Systems Development
- Customer Assistance Program Assessment
- Office Space
- Equipment
- Office Supplies
- Travel
- Professional Services

- 3.) CT HIX shall provide to OPM financial reports utilizing the spreadsheet included herein as Appendix B reflecting Grant Award expenditures in accordance with the following schedule:

Financial Report Due Date	Months Covered
Interim report due May 15, 2012	April 1, 2012 through April 30, 2012
Interim report due June 15, 2012	May 1, 2012 through May 31, 2012
Interim report due July 15, 2012	June 1, 2012 through June 30, 2012
Interim report due August 15, 2012	July 1, 2012 through July 31, 2012
Interim report due August 30, 2012	August 1, 2012 through August 14, 2012
Final report due October 31, 2012	April 1, 2012 through August 14, 2012

- 4.) OPM shall use the financial reports from CT HIX to complete and submit form 425 to the U.S. Department of Health and Human Services – Centers for Medicare and Medicaid Services and to draw down funds from the Payment Management System.

- 5.) CT HIX shall provide to OPM progress reports in a mutually agreeable electronic format in accordance with the following schedule:

Progress Report Due Date	Months Covered
Interim report due June 15, 2012	April 1, 2012 through May 31, 2012
Interim report due August 15, 2012	June 1, 2012 through July 31, 2012
Interim report due August 30, 2012	August 1, 2012 through August 14, 2012
Final report due October 31, 2012	April 1, 2012 through August 14, 2012

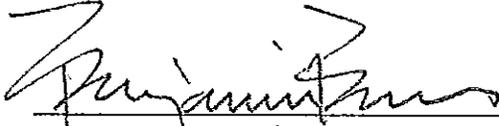
The progress reports shall include the status of the following activities and functionalities:

- Administrative structure, staffing, and office space/equipment procurement including but not limited to the following:
 - 1.) Development of by-laws and a plan for the board's operation encompassing the hiring, dismissing, promoting and compensating of employees, an affirmative action policy and general employment rules;
 - 2.) Preparation of the necessary documentation to establish the CT HIX business entity, including tax identification numbers and the tax status of CT HIX;
 - 3.) Necessary financial, legal or other professional services, including a requirement for a competitive procurement process;
 - 4.) Legal advice and guidance on compliance with applicable state and federal law in the operation of CT HIX;
 - 5.) Staff hiring and contract negotiations as necessary; and
 - 6.) Purchase of equipment including computers, laptops, printer, copier, and office furniture.
 - Business operations including but not limited to the following:
 - 1.) Business process requirements;
 - 2.) IT requirements; and
 - 3.) Option selection and preliminary cost estimate.
 - Customer assistance and support including but not limited to the following:
 - 1.) Assessment and leveraging of existing capabilities;
 - 2.) Development of requirements for achieving an integrated customer approach; and
 - 3.) Development of business processes, enhancements and procurement strategy.
- 6.) OPM and CT HIX representatives shall meet to decide which, if any, current OPM contracts relating to the implementation of CT HIX shall be assigned from OPM to CT HIX.
- 7.) CT HIX agrees to return to OPM any unexpended funds no later than October 31, 2012.
- 8.) This MOU does not supersede the agreement reached between OPM and CT HIX in the Memorandum of Understanding, dated January 25, 2012, included herein as Appendix C.

9.) The term of this agreement shall be from April 1, 2012 until the close out of the Grant Award by the U.S. Department of Health and Human Services.

ACCEPTANCE AND APPROVALS

THE OFFICE OF POLICY AND MANAGEMENT

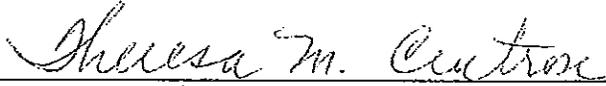


Benjamin Baines, Secretary

4/2/2012

Date

CONNECTICUT HEALTH INSURANCE EXCHANGE



Theresa Cintron, Acting Chief Executive Officer

3/30/12

Date

Appendix A

State of Connecticut Level One Establishment Grant Application; ID-HBE-11-004/CFDA: 93.525

Level One Establishment Grant: Project Narrative

Demonstration of Past Progress in Exchange Planning Core Areas

Since passage of the Affordable Care Act (ACA), Connecticut has worked to assess the impact of federal health reform, including the Exchange, and to prepare for its implementation. This commitment has been strengthened under the administration of Governor Dannel Malloy, and Connecticut is now taking steps to fully realize the potential of health reform within the state.

In January, the Governor appointed a cabinet-level health reform lead and during the 2011 legislative session the administration worked with the legislature to create an Office of Health Reform and Innovation (the Office) and a Healthcare Cabinet, both within the Lieutenant Governor's office. The Office will be responsible for coordinating and implementing health reform and ensuring that the structures of state government are working in concert. The Office will work with the Cabinet-comprised of officials from several State agencies, along with individuals appointed from the community- to shape and direct both state and federal health reform initiatives.

In addition, in June 2011 Connecticut's General Assembly enacted into law Public Act 11-53, creating the Connecticut Health Insurance Exchange, a quasi-public entity. Please see more information on this legislation in the State Legislative/Regulatory Action and Governance sections. This structure represents Connecticut's commitment to meaningful reform that increases access to health insurance while also developing policies to improve individual and community health, reduce health care costs, and achieve long-term system sustainability. A key responsibility for the Office will be to ensure coordination between the Exchange, Medicaid, and overall state policy.

Connecticut is making steady progress in the Exchange planning core areas, with the goal of providing the citizens of Connecticut a fully operational health insurance exchange by January 1, 2014. Much of this work is being funded by the Establishment Planning Grant that was awarded to Connecticut on September 29, 2010. Below is a discussion of Connecticut's progress in each of the core areas.

A. BACKGROUND RESEARCH

Key to establishing policy direction and implementation strategy for Connecticut's Exchange is to establish a baseline understanding of the advantages and disadvantages of allowing individuals and small firms to access coverage that is portable, choice-based and tax advantaged. Understanding the variables and complexities in organizing a new health insurance marketplace as well as the dynamics of driving system affordability and improving the quality of health care delivery systems is vital to Connecticut's Exchange planning processes. To this end, the State of Connecticut has contracted with Mercer Health and Benefits, LLC to obtain the necessary research and analysis to answer these significant policy questions:

- Should Connecticut develop two Exchanges—one for the individual market and one for the small employer market?
- What would be the impact if one Exchange is developed that merges the individual and small employer markets and what are the advantages and disadvantages of this approach? What impact will this decision have on coverage and costs across the entire market and how will it affect enrollment in coverage through the Exchange?

- What are the advantages and disadvantages to redefining the small group market Exchange from its current 50 employees up to 100 employees?
- Should Connecticut consider participation in a multi-state Exchange; and what are the advantages and disadvantages?
- Should the existing high risk pools be integrated in the non-group market Exchange or maintained separately?
- What will be the impact on enrollment and costs for the Medicaid Program?
- What is the impact to the Exchange if the Basic Health Plan option is considered for Connecticut?
- What will be the projected percent of population with health insurance?
- What would be the potential effect if the large employer market seeks participation in the Exchange?

Specifically, the planning grant research deliverables are due to the State in September, 2011 and include the following:

1. An assessment of the State's uninsured and underinsured population under the various types of coverage, including government sponsored coverage.
2. A survey of the health insurance carriers that offer coverage to Connecticut residents. This data should include, at a minimum, plan designs being sold, premium levels and the number of enrollees in each market segment.
3. A survey of the small employer market to identify current and anticipated future benefit design needs and other issues. This research must project the possible impact that certain policy decisions may or may not have for the small employer. It may include tax credit and hiring decision impacts and whether employers will offer coverage and whether they will purchase it in or out of the Exchange.
4. Economic and actuarial modeling and analyses to project trends such as the number of newly insured, the impact of certain market changes on premium levels and the implications of different policy questions.
5. Analysis of the effect if the large employer market seeks participation in the Exchange in 2017.
6. Analysis of the impact of the Exchange in regards to interaction with other health system initiatives in Connecticut.
7. A financial model for the Exchange to understand the administrative charges necessary to be financially self-sustaining by January 2015 and offer recommendations regarding the options to receive such charges.
8. An assessment of technical requirements and development of specifications for accounting and financial system functions for the Exchange.
9. An assessment of the existing Medicaid eligibility system and identification of interface issues and necessary requirements for integration with the Exchange information technology infrastructure.
10. An impact study of the Medicaid program on the Exchange.
11. Analysis of the advantages and disadvantages of a Connecticut statewide Exchange versus a multi-state Exchange.

B. STAKEHOLDER CONSULTATION

Consultation with stakeholders is an important component of Exchange planning and development for Connecticut. Public Act 11-53, Connecticut's recently enacted legislation establishing an Exchange, requires consultation with stakeholders relevant to carrying out Exchange activities including, but not limited to, stakeholders who are knowledgeable about health care systems, have background or

experience in making informed decisions regarding health, medical and scientific matters and are enrollees in qualified health plans. Our initial efforts, specifically pertaining to the planning grant research, include the following:

An Exchange Planning Committee was assembled in November 2010 to provide guidance, insight and review of planning grant processes. The Planning Committee consists of State agencies and industry organizations that include:

- Grant Staff
 - Special Advisor to the Governor for Healthcare Reform
 - Project Manager
- State Agencies
 - Office of Policy and Management
 - Department of Social Services
 - Insurance Department
 - Department of Public Health
 - Department of Information Technology
 - Department of Economic and Community Development
- Insurers
 - Aetna
 - Anthem Blue Cross Blue Shield
 - ConnectiCare
- Consumer Advocates
 - Office of the Healthcare Advocate
 - Permanent Commission on the Status of Women
- Provider Organizations
 - Connecticut Hospital Association
 - Community Health Center, Inc.
 - Connecticut State Medical Society
 - Community Health Center Association of Connecticut
 - Cornell Scott-Hill Health Corporation
- Insurance Brokers
 - Connecticut Association of Health Insurance Underwriters
- Small Business
 - Greater New Haven Chamber of Commerce
 - Middlesex Chamber of Commerce

The focus of the initial public engagement outreach was to build a foundation of understanding regarding Exchanges as well as collect insight from a wide range of individuals, community groups and industry organizations for consideration and integration in Connecticut's planning efforts. A two-tiered engagement approach was taken consisting of public forums and stakeholder meetings.

Public Forums - Evening forums throughout the state informing the public about HIX and soliciting feedback. Meetings held April-June 2011.			
Locations	Sites	Outreach	Agenda
<ul style="list-style-type: none"> o Hartford o New London o New Haven o Bridgeport o Danbury o Windham 	<ul style="list-style-type: none"> o Public schools o Town halls o Libraries 	<ul style="list-style-type: none"> o Websites o Existing distribution lists o Print/Electronic media o Non-Profits/Churches o Consumer Groups o Health care providers o Local government o Legislators 	<ul style="list-style-type: none"> o Introductions o Inform (w/handouts) <ul style="list-style-type: none"> o Overview of HIX background o Identify state options o Explain activity and next steps o Solicit Feedback <ul style="list-style-type: none"> o Listen to verbal testimony
Stakeholder Meetings - Held with stakeholders by professional category. Meetings were held May 2011.			
Location	Organizations	Outreach	Agenda
Onsite at OPM	<ul style="list-style-type: none"> o Small business o Providers o Trade associations o Hospitals o Community health centers o Insurance companies o Insurance agents/brokers o Consumer advocacy groups o Conference of Churches o Nonprofit safety net o Government o Tribal Nations 	<ul style="list-style-type: none"> o Associations o Trade Groups o Coalitions o Response to Inquiry o Websites o Other outreach as appropriate 	<ul style="list-style-type: none"> o Introductions o Inform (w/slides & handouts) <ul style="list-style-type: none"> o Overview of HIX background o Identify state options o Explain activity and next steps o Solicit Feedback <ul style="list-style-type: none"> o Identify how info will be used o Questions by topic o Survey on forum effectiveness
Public Hearings		Stakeholder Meetings	
Background materials were provided through outreach vehicles. Transcription service enabled record of verbal comments. Information will be summarized and reported to Governor and General Assembly for Exchange policy and planning.		Materials were made available in advance of meetings to enable thoughtful responses and discussion during event. After the meeting, feedback was summarized and sent back to primary group contact to ensure accuracy of recording. Stakeholder feedback will be summarized and reported to the Governor and General Assembly for Exchange policy and planning.	

Six public forums were held throughout the state and provided initial outreach to the community. The purpose of the forums was to provide basic information on how the State is beginning to plan for an Exchange, to provide information on planning activities to date and to solicit feedback about how Connecticut's citizens would like to see the Exchange develop. The meetings were conducted using a power point presentation with the majority of the time provided for public testimony. These meetings

were professionally facilitated, a translator was present, and they were recorded and transcribed. The key issues during each meeting included:

Danbury, CT: April 25, 2011

- Concern about affordability, controlling costs, pricing of plans, and transparency in pricing
- Question about how the Exchange will impact Medicare and Medicaid
- Interest from small employers and consumers
- Exchange Board should have consumers and small employer representation, advisory groups, and provisions against conflict of interest
- Exchange should make comparative information more accessible

New London, CT: April 27, 2011

- Question about tie-in between Sustinet and the Exchange
- Concern about affordability
- Concern about how the Exchange will be funded
- Consider the role of the agent in assisting small employers select insurance
- Good insurance plans need good provider networks

New Haven, CT: May 5, 2011

- Question about how the Exchange will impact HUSKY and Charter Oak
- Exchange Board should have consumer and small employers representation
- Importance of quality, affordability, and access to providers
- Questions about how the Exchange will be paid for and whether it will include advertising
- Concern that rising costs and physician shortage will be difficult to address with the Exchange
- Include medical nutrition therapy in benefits
- Consider the importance of the agent
- Ensure Navigators are properly licensed and insured
- Hope that Sustinet will be part of the Exchange

Hartford, CT: May 9, 2011

- Remember the role and expertise of agents and brokers and ensure Navigators do not take that role
- Cover nutrition services in benefits package
- Concern about costs for persons identified as having pre-existing conditions
- Hope that Sustinet will be part of the Exchange
- Insurance companies should not be on the Exchange Board
- Ensure Navigators are well trained and have a consistent message
- Concerned about cost of health care
- Think regionally about the parts of Connecticut and their different needs
- Consider quality in addition to affordability and accessibility
- Do not create big new government entities
- Importance of community health centers

Windham, CT: May 17, 2011

- Need to have consumers represented on the Exchange Board and not insurance companies
- Support for a public option
- Support for medical homes, accountable care organizations, and other reimbursement structures
- Question about whether the Exchange would impact people on Medicare
- Concern about very high costs currently in the individual market
- Be careful with catastrophic coverage

Bridgeport, CT: June 15, 2011

- Exchange Board should not include insurance brokers
- Community Advisory Committee should be created
- Exchange should be easily accessible to those without access to computers or the internet
- Written material as well as phone support should be in multiple languages
- A non-profit public option should be offered as one of the choices on the Exchange
- Question on how insurance marketplace will be different under Exchange in relation to the expense associated with the cost of insurance plans
- Question on how the Exchange is going to create competition within the insurance marketplace
- Question about whether or not there are subsidies for small businesses buying into the Exchange

Along with the public forums nine stakeholder meetings were held and organized by professional category. Each organization was sent a questionnaire that included pertinent Exchange topics. They were asked to disseminate this questionnaire to the appropriate individuals and to provide the State their comments prior to their scheduled meeting. Comments received were spread sheeted and outlined in a power point presentation which provided the structure and framework for the meeting. This process ensured productive discussions and provided valuable insight. Each stakeholder meeting was professionally facilitated, recorded and transcribed so that a summary of each will be represented in the final planning grant report. Key points made in the meetings were integrated into the original comment submissions and provide the State a summary of stakeholder feedback for Exchange policy development.

The organizations that were invited to meet with Connecticut included:

<p><u>Consumer Advocates Group #1</u> Connecticut Health Policy Project National Multiple Sclerosis Society National Alliance on Mental Illness Family Support Network Legal Assistance Resource Center of CT Office of the Health Care Advocate Advocacy for Patients with Chronic Illness Connecticut Voices for Children Child Health and Development Institute Medical Resources Management Mental Health Association of CT Hispanic Health Council CT Association for Home Care and Hospice</p> <p><u>Brokers and Agents</u> CT Association of Health Underwriters CT Benefit Brokers</p> <p><u>Small Employers</u> CT Business and Industry Association National Federation of Independent Businesses Chamber of Commerce of Eastern Connecticut Greater New Haven Chamber of Commerce Northwest CT Chamber of Commerce Bridgeport Regional Business Council Middlesex County Chamber of Commerce Greater Danbury Chamber of Commerce Central Connecticut Chambers of Commerce MetroHartford Alliance Greater Waterbury Regional Chamber of Commerce The Business Council of Fairfield County Spanish American Merchants Association</p>	<p><u>Consumer Advocates #2</u> New Haven Legal Assistance Association Universal Health care Foundation Connecticut Conference of Churches Connecticut Health Foundation Community Renewal Team Connecticut AIDS Resource Coalition NAACP-CT AARP-CT Connecticut Area Health Education Center The Connecticut Multicultural Health Partnership Asian Pacific American Affairs Commission African-American Affairs Commission Latino and Puerto Rican Affairs Commission CT Commission on Health Equity Urban league Realtors Association</p> <p><u>Providers</u> Connecticut Hospital Association CT Association of Health Care Facilities CT Association of Not-for-Profit Providers for the Aged Radiological Society of Connecticut Connecticut Alliance of Subacute Care Facilities Sharon Hospital CT Academy of Physicians Assistants CT Community Providers Association</p>	<p><u>Providers</u> CT State Medical Society CT State Medical Society IPA CT Medical Management CT Nurses Association CT State Dental Association CT Pharmacists Association Federally Qualified Health Centers</p> <p><u>Insurers</u> Anthem Aetna Cigna Community Health Network ConnectiCare United Health Group Wellcare of CT Celtic American Republic Golden Rule John Alden Trustmark Life Trustmark Time</p> <p><u>Providers</u> CT Naturopathic Physicians Association CT Podiatric Medical Association CT Association of Optometrists CT Dental Hygienists Association CT Chiropractic Association CT Society for Respiratory Care Community Health Center, Inc.</p> <p><u>Tribal Nations</u> Mohegan Tribe Mashantucket Pequot Tribe</p>
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Materials developed for the public engagement outreach efforts include the following and are posted to our Exchange website: www.ct.gov/opm/exchange/grant.

- Public Engagement Strategy Overview
- Stakeholder Topic Questions
- Public Forum power point presentation
- Public Forum leave behind (English and Spanish)
- Public Forum survey
- Public Forum press release
- Public Forum Feedback Summaries
- Stakeholder meetings (attendees and comment documents)

C. STATE LEGISLATIVE/REGULATORY ACTION

When Connecticut's General Assembly enacted Public Act 11-53 (the Act) in June 2011, the Connecticut Health Insurance Exchange was established, which has the necessary legal authority to establish and operate an Exchange in Connecticut that complies with existing Federal requirements. This effort has spanned two Administrations with the participation of both the executive and legislative branches of government and a range of consumers and stakeholders.

Throughout the deliberations among stakeholders convened under both the previous Administration of Governor Rell and the current Administration of Governor Malloy, and within the General Assembly during the 2011 legislative session, there was consensus on establishing a state Exchange as a quasi-public authority. This model provides for governmental oversight, while allowing for a more nimble organization to respond to the demanding timelines established under the ACA.

In February 2011, under the direction of Governor Malloy, the Office of Policy and Management submitted a legislative proposal establishing the Connecticut Health Insurance Exchange (Senate Bill 921). In order to be as responsive as possible to the requirements of the ACA, this bill largely reflected the model legislation developed by the National Association of Insurance Commissioners (NAIC). Two other Exchange bills were raised: one by House Speaker Christopher Donovan (House Bill 6323) and one by Senator Pro Tempore Donald Williams (Senate Bill 1204). Although divergent with regard to several policy issues related to governance and operation, all three bills proposed a quasi-public authority, established a Governance structure, and provided for the necessary legal authority to establish and operate an ACA compliant Exchange. All three bills received public hearings in February and March of 2011. Through a long negotiating process between Governor Malloy's Administration and legislative leadership for the House and Senate, as well as with stakeholder involvement, a single Exchange bill was agreed upon and passed. *Link:* <http://www.cga.ct.gov/2011/ACT/PA/2011PA-00053-R00SB-00921-PA.htm>.

The Act establishes a quasi-public entity that is Governed by an 11 member Board of Directors (see the Governance section for details on Board appointments). The Board may convene stakeholder advisory committees to address such issues as customer service needs and insurance producer concerns. As stated in the Act, the purpose of the Exchange is "to reduce the number of individuals without health insurance in this state and assist individuals and small employers in the procurement of health insurance by, among other services, offering easily comparable and understandable information about health insurance options." The Act includes much of the ACA conforming language provided by the NAIC.

In addition to the establishment of the Exchange Authority, an additional piece of legislation was enacted by Connecticut's General Assembly in June 2011 to support state efforts to implement federal health care reform. Public Act 11-58 establishes an Office of Health Reform and Innovation within the Office of the Lieutenant Governor to oversee the statewide implementation of federal health care reform. This office will be led by the Special Advisor to the Governor on Healthcare Reform who was appointed by Governor Malloy in January 2011. In addition, the bill establishes, also within the Office of the Lieutenant Governor, a 28 member Sustinet Health Care Cabinet to advise the Governor and the Office of Health Reform and Innovation on development of an integrated health care system for Connecticut and other health care reform issues.

D. GOVERNANCE

As discussed above, under the State Regulatory/Legislative Action section, Connecticut has established a quasi-public insurance Exchange and governance structure with the passage of Public Act 11-53.

The Exchange Board of Directors composition is modeled on the California Exchange, which does not appoint any representatives of the insurance industry or of health care providers to avoid any conflicts of interest. The Act contains clear conflict of interest language in Section 2(b)(2) prohibiting Board members from involvement in the health insurance industry or health care providers. Transparency of operation and decision making and public accountability are required of the Exchange as it is in all Connecticut quasi-public entities.

Voting members consist of individuals appointed by either the Governor or legislative leadership with expertise in the area of:

- Individual health insurance coverage
- Issues relating to small employer health insurance coverage
- Health care finance
- Health care benefits plan administration
- Health care delivery systems
- Health care economics
- Health care access issues faced by self-employed individuals
- Barriers to individual health care coverage

Ex-Officio voting members consist of the Commissioner of Social Services (Medicaid), the Special Advisor to the Governor on Healthcare Reform, and the Secretary of the Office of Policy and Management. Ex-officio non-voting members consist of the Commissioners of Insurance and Public Health and the Healthcare Advocate.

Board members must be appointed no later than July 1, 2011 and must have their first meeting by August 1, 2011. With respect to hiring the initial Chief Executive Officer, the Board will nominate three candidates for the Governor to select from. Future Chief Executive Officers will be hired by the Board. All Exchange staff are exempt from state classified service, allowing for a more rapid hiring process and ability to attract staff with high levels of expertise and experience.

A number of policy questions related to the structure and operation of the Exchange are currently being researched under Connecticut's Exchange Planning Grant and a final report is due in September 2011. In an effort to avoid premature decisions on these issues and base policy decisions on sound data and information produced under the Planning Grant, the Exchange is required to submit a report on a plan to establish a health insurance Exchange in the state by January 1, 2012 (Section 12 of the Act). Issues to be considered include: whether to establish two separate exchanges, one for individuals and one for the small employer; whether to merge the individual and small employer health insurance markets; and whether to require qualified health plans to provide only the essential health benefits package or to include additional State mandated insurance benefits.

E. PROGRAM INTEGRATION

Connecticut is using the Exchange Planning Committee as an initial vehicle for program integration and communication between State agencies and stakeholders. Interagency work groups are being formed with the Department of Social Services and Connecticut's Insurance Department as well as others to ensure that current capabilities and future plans are effectively assessed, utilized and leveraged. Roles

and responsibilities of the work groups are currently under development and will parallel the needed resources and next steps in planning processes. Specifically, these work groups will begin taking the information from the planning research and will support implementation efforts.

In addition, the involvement of Jeannette DeJesús, who is currently the Principal Investigator for Connecticut's Health Insurance Exchange Planning Grant and will also serve as the Principal Investigator for this Level One Establishment Grant, assures that Exchange development activities will be integrated with other state health reform efforts. As Special Advisor to the Governor on Healthcare Reform, Ms. DeJesús is responsible for overseeing all the administration's efforts to implement federal health care reform in the State. In addition, as of July 1, 2011, an Office of Health Reform and Innovation will be established within the Lieutenant Governor's Office under Ms. DeJesús' leadership. Ms. DeJesús is also named as a Director on the Board of the Connecticut Health Insurance Exchange Authority established by Public Act 11-53 in June 2011. All this activity reinforces Connecticut's commitment to a well integrated, transparent, and inclusive process to design and develop a Health Insurance Exchange in Connecticut.

F. EXCHANGE IT SYSTEMS

One of the key planning grant deliverables is a comprehensive assessment of the operational processes between the Exchange and Medicaid to ensure a streamlined, integrated approach for determining eligibility that screens and refers individuals to the appropriate program, communicates health plan choices and benefits to applicants, and enrolls individuals in health plans. The federal guidance published to date will be considered in the assessment including, but not limited to:

- CMS Eligibility and Enrollment Blueprint-Exchange Business Architecture Supplement versions 1.0
- CCIIO Guidance for Exchange and Medicaid Information Technology Systems Versions 1.0 and 2.0
- CMS Harmonized Security and Privacy Framework-Exchange TRA supplement Version .95
- CMS Exchange Reference Architecture: Foundation Guide version .99
- Section 1561 Enrollment HIT Standards to facilitate enrollment and systems
- CCIIO Agreement to Support Innovative Exchange IT Systems grant opportunity
- CMS Notice of Proposed Rule Making

The planning grant IT Gap analysis project components, currently being conducted by Mercer Health and Benefits, are outlined below and will include an assessment, evaluation and consideration of the following:

1. Identify interface issues and requirements for integration between the State's Department of Social Service's Eligibility Management System (EMS) and Exchange IT Infrastructure

Eligibility for federal tax subsidies will be based on income reported on an individual's most recent completed tax return. Although there will be mechanisms to account for changed circumstances, such as an increase or decrease in income or a relevant change in family size or composition. Connecticut will have several options to comply with the streamlined eligibility processes. For example, some states will modify existing Medicaid systems to perform this function, while others will create mechanisms to accept applications for all state health subsidy programs through a web portal and establish back-end interfaces to create a seamless application and enrollment process.

One of the responsibilities of the Exchange is to inform consumers of the requirements of the Medicaid and CHIP programs and, if eligible, to enroll them. The Department of Social Services (DSS) maintains the Medicaid eligibility system, called the Eligibility Management System (EMS), which is used to determine which Medicaid coverage group a family may qualify for and to enroll the participants in managed care,

if appropriate. Affiliated Computer Services (ACS), under contract with DSS, maintains the CHIP eligibility system, called ConneXion. This system is used by ACS staff to screen consumers for Medicaid eligibility and referral of application to DSS, as well as to determine eligibility for CHIP and set the premium level. Key to the successful operation of the Exchange will be the development of a seamless interface between the Exchange web portal and the logic of the Medicaid and CHIP eligibility systems. Providing consumers with the ability to enter information through the Exchange portal which automatically applies determination logic for State-sponsored eligibility is essential. Not only is this a key element of a successful Exchange, it is also one of the most challenging technical tasks of Exchange implementation.

2. The Eligibility Management System (EMS) – Medicaid Eligibility

EMS is a legacy mainframe system developed in the late 1980's. The system supports eligibility for other public assistance programs as well as Medicaid, such as SNAP (formerly Food Stamps), and cash assistance programs. Medicaid eligibility in EMS is extremely complicated – within "tracks," applicants "trickle" from one possible coverage group to another, finally lodging in one for which they qualify, or ending in denial. Notices are generated by the system to inform the applicants of the result of the eligibility determination. DSS workers enter client information into EMS to enable the system to calculate the correct eligibility decision. Apart from standard basic demographic and financial information, these entries include such data as relationship codes for the various household members and setting up the "assistance unit" under the category, or "track" for which eligibility should be considered. EMS currently handles eligibility for approximately 40 separate Medicaid coverage groups.

3. Modernization Project

Under its Modernization Project, DSS is currently planning a new web-based front end to EMS which will enable customers to apply for Medicaid, check their status, report changes and initiate their annual redetermination of eligibility. Under current plans, this front-end will have a real-time interface with the EMS eligibility logic, enabling information to flow immediately between the two applications. The details of how this will work and the timing of implementation are yet to be defined.

4. Enhanced Match for Medicaid System Modifications

The Centers for Medicare and Medicaid Services (CMS) has issued a Proposed Rule in the Federal Register that will essentially provide enhanced federal funding for new or modified Medicaid eligibility systems that coordinate and integrate with the Exchange IT infrastructure. The enhanced funding includes up to 90 percent Federal Financial Participation (FFP) for design, development and installation or enhancement of Medicaid eligibility systems and 75 percent FFP for maintenance and operation of the system. The enhanced funding is available for only a limited period of time, with the expectation that states will work immediately to modify or replace their existing Medicaid systems. The expectation of CMS in the Proposed Rule is "...systems transformations should be undertaken in full partnership with Exchanges, in order to meet coverage goals, minimize duplication, ensure effective reuse of infrastructure and applications, produce seamless enrollment for consumers, and ensure accuracy of program placements. Extensive coordination and collaboration would be required between Exchanges and Medicaid, including an oversight and evaluation of the interoperability of the Exchange and Medicaid systems."

5. The ConneXion System – CHIP Eligibility

CHIP eligibility is performed in ConneXion, a separate system maintained by ACS as part of support services provided to DSS. ConneXion is a web-based system developed in 2003 to support eligibility and enrollment of Connecticut's CHIP population, HUSKY B. Using data entered by ACS staff, ConneXion first

calculates potential eligibility for HUSKY A and, for children not being referred to DSS, determines HUSKY B eligibility and premium level. ACS staff then use ConneXion to enroll the HUSKY B eligible children in the health plan of their choice. ConneXion creates letters to notify families of the outcome of the eligibility determination and enrollment choice. Overnight, the system creates a file of enrollees that is used by the health plans, DSS and the provider of behavioral health services to update their records with accurate enrollment information.

6. The Assessment Process

For Connecticut, the beginning of the coordination and collaboration between the Exchange and Medicaid expected by CMS is the assessment of the Medicaid eligibility system and the identification of interface issues and requirements for integration with the Exchange IT infrastructure. To perform this assessment, Mercer will provide the State a comprehensive, fully-documented, step-by-step approach, incorporating the CHIP system assessment as follows:

Step 1 -- Identify Key Stakeholders and Subject Matter Experts

Mercer is working with OPM, other State agencies and ACS' Connecticut operations to identify the individuals who understand the structure and processes of EMS and ConneXion and the planned structure of the Exchange system, as well as subject matter experts in Medicaid and CHIP eligibility and enrollment processing.

Step 2 -- Obtain and Analyze Existing System Documentation

From any documentation available on EMS and ConneXion and design documents for the new Exchange system, the structure, data elements, workflows and logic to gain a comprehensive base understanding of the way each system works to support consumer eligibility will be analyzed. This background will prepare the foundation to conduct efficient and effective meetings with the stakeholders and subject matter experts.

Step 3 -- Conduct Requirements Sessions

Using the understanding already gained to organize the discussion, requirement sessions will be conducted with the previously identified stakeholders and subject matter experts to gain a deeper knowledge of the systems, identify options, and gather requirements for integration. This will guide the discussions through a set of organized questions designed to help the group determine the requirements for successful integration of the systems and to uncover any specific issues to be addressed.

Step 4 -- Document Interface Issues and Requirements

Throughout the process, the system structures, data elements, workflows and logic necessary to achieve successful integration will be documented. During the requirements sessions, interface issues and requirements will be recorded in order to develop a final report providing viable options for integration between EMS, ConneXion and the Exchange IT infrastructure. Policy makers will be able to use these findings to choose the method of integration that will best complement the overall organization of the Exchange operation and provide customers with seamless access to Medicaid and CHIP eligibility and enrollment through the Exchange web portal.

7. Interface Challenges

Since EMS was developed over 20 years ago, it uses programming language no longer used in today's web-based environment. Although quite advanced for its time, EMS is not as flexible and easy to change as newer web-based systems. However, in spite of these challenges, DSS IT staff members have created successful interfaces with other systems, including ACS systems, to improve the accuracy of the HUSKY A enrollment process.

Some of the questions to explore in identifying the interface issues and requirements for integration include the following:

- What is the timing of the Modernization Project and what bearing will the development of that website and on-line application tool have on the Exchange system and interface with EMS?
- Will DSS be seeking the enhanced funding from CMS to modify or replace EMS? If so, what will be the timing of the design and development of the new system or system modifications? Would creating a new Medicaid eligibility system within the Exchange IT structure (thus separating it from the rest of public assistance eligibility) be considered?
- How will the Medicaid eligibility determination take place—automatically upon the entry of information by the consumer, or following worker intervention?
- Would the interface between the Exchange system and EMS or ConneXion be “real-time,” that is, instantaneous, or by the use of overnight batch processes?
- Which system will be used to provide official notification to the consumer? Are traditional written notices sent by mail required if the system provides a confirmation screen and email?
- Would the interface between ConneXion and the Exchange system include processing eligibility determinations for individuals eligible for the Charter Oak program for uninsured adults? Or will this program be eliminated in the overall Exchange marketplace?

Through assessment of the existing EMS and ConneXion systems these and other critical questions will be answered and will provide the State with the structure for Exchange implementation planning.

8. Early Innovator Grant Project

Additionally, Connecticut is participating in the Early Innovator grant project through the New England States Collaborative Insurance Exchange Systems (NESCIES) and will leverage relevant information and findings from that initiative in the design and planning efforts of Connecticut's Exchange IT system. For example, a gap analysis is being conducted through this grant assessing the Massachusetts Exchange as compared to how the states' Exchanges are meant to operate under the ACA. This analysis will be shared with the collaborating states for their use. In addition, the vendor will also render a “reusability scorecard” on the components in the current Exchange. Their final deliverable will be a detailed design review (DDR) artifact that is required by the federal government pursuant to our Innovator grant.

G. FINANCIAL MANAGEMENT

Connecticut acknowledges that the financial model of the Exchange is critical to sustainability. The development of a financial model for a self-sustaining Exchange in Connecticut is one of the core research deliverables in the planning grant.

The key components involved in analysis include project planning, identifying specifications, designing and building the model, testing the financial model and providing documentation. The model will include projected operating costs and identifying revenue to offset those costs, including representing cash flow and suggesting appropriate reserves to ensure the Exchange is self-sustaining beginning in January 2015. In addition to categorizing and estimating operating costs and providing projections based on a range of scenarios, potential revenue sources also analyzed will include an evaluation of studies of the effect of various options on the operating financial model itself and on the broader marketplace.

The benefit of these studies and calculations for Connecticut is to test the viability and sustainability of the Exchange under various scenarios. Approaches that create differences between the market inside the Exchange and outside will be scrutinized carefully to ensure that they do not inappropriately distort the market and cause adverse selection against the Exchange. A cost/benefit analysis of options will inform the opinions for financial policy decisions. Additionally, operational elements that equally influence cost assessment will be integrated and analyzed across the planning grant project research deliverables to ensure that different scenarios are developed and considered and that the model will be structured to cover a range of potential enrollment and premium-level scenarios.

H. PROGRAM INTEGRITY

An important deliverable in the planning grant research is assessment of the technical requirements and development of the specifications for accounting and financial systems function for the Exchange. The issues associated with the finance-related functions such as developing accounting and auditing standards; collecting premiums; controlling waste, fraud, and abuse; creating transparency and reporting mechanisms for the public; and developing the technical infrastructure to comply with federal reporting requirements are being analyzed in the planning research process.

A baseline will be established of existing accounting and auditing standards for current State programs to identify consistency, redundancy and fundamental compliance with Federal and State standards. Along with this, existing systems of premium collection in Connecticut are being considered and assessed for relativity and participation in the Exchange. Any ACA requirements specific to identifying improprieties and recommending corrective action will be assessed and synthesized. Another component to ensure program integrity is analysis and research of the consideration, design and testing of financial functionalities and reports to ensure Exchange accountability that is transparent and relevant to all stakeholders. Through the planning research, key financial control and system challenges and potential solutions associated with premium aggregation are being assessed, to inform policy makers as they determine whether the Exchange should take on this important function.

I. HEALTH INSURANCE MARKET REFORMS

State Legislation

In June 2011, two pieces of legislation were passed that address insurance market reforms that assures Connecticut's conformance with the provisions described under Subtitles A and C of the federal ACA. Together they implement ACA conforming health insurance market reforms and mandate that the Connecticut Health Insurance Exchange Authority develop a plan to make changes to the health insurance market.

Public Act 11-58: *An Act Establishing the Connecticut Healthcare Partnership (Act)* changes various health insurance statutes to conform to the ACA:

- Dependents to age 26. Under the federal ACA, children may stay on a parent's health insurance plan until age 26. The Act revises various insurance statutes to comply with this requirement. Current state law restricts a child's coverage based on his or her marriage or residency status.
- Pre-existing conditions. Under the ACA, insurers cannot impose a pre-existing condition limitation that excludes coverage for children under age 19. The Act revises various insurance statutes to comply with this requirement. The Act specifies that no insurer can refuse to issue an individual health insurance plan or arrangement to children under age 19 solely on the basis that he or she has a pre-existing condition.
- Lifetime limits. Under the ACA, health benefit plans cannot impose lifetime limits on the dollar value of essential health benefits which will be defined by HHS. To conform to the federal requirement, the Act prohibits individual and group comprehensive health care plans from imposing such a lifetime limit. It specifies that a plan may include a lifetime limit of at least \$1 million on benefits that are not essential health care benefits as defined by the ACA and related regulations.
- Continuation of coverage. As under current law, the Act requires health insurers to provide continuation of coverage to individuals under specified circumstances.
- Rescissions. The ACA limits policy rescissions (e. g., retrospective policy cancellations) to instances of fraud and intentional material misrepresentation. Under state law, an insurer or HMO must obtain the Insurance Commissioner's approval for a policy rescission, cancellation, or limitation. The Act requires the Commissioner to approve a request for rescission or limitation when the insured or the insured's representative (1) submitted fraudulent (rather than false) information on an insurance application, (2) intentionally (rather than knowingly) misrepresented material information on the application, or (3) intentionally (rather than knowingly) omitted material information from the application. He must approve a cancellation in accordance with federal law, which requires prior notification to the insured.
- Medical Loss Ratio. The Insurance Department publishes an annual Consumer Report Card on Health Insurance Carriers in Connecticut. By law, the report card must include each insurer's and HMO's medical loss ratio. The Act refers to that medical loss ratio as the "state medical loss ratio" and specifies that the report card also include the federal medical loss ratio, as defined in the ACA. "Medical loss ratio" is generally the percentage of premium dollars that an insurer or HMO spends on providing health care and health care quality improvement activities, versus how much is spent on administrative and overhead costs. By law, an insurer or HMO must include a written notice with each application for individual or group health insurance coverage that discloses the medical loss ratio. The Act requires that both the state and federal medical loss ratios be disclosed. The Act requires a managed care organization to report both medical loss ratios to (1) the insurance Commissioner and (2) enrollees.
- ACA Compliance and Regulations. The Act requires insurers to comply with the ACA. It authorizes the Insurance Commissioner to adopt regulations. It specifies that state law provisions concerning

the ACA are not to be construed to supersede any state law that provides greater protection to an insured, unless it prevents the application of the ACA.

- The Act also revises the health insurance utilization review, grievance, and external appeal statutes to comply with the ACA.

Also in Public Act 11-58, Section 14 mandates that the Sustinet Health Care Cabinet, which is located within the Lieutenant Governor's Office, jointly evaluate, with the Chief Executive Officer of the Connecticut Health Insurance Exchange, the feasibility of implementing a basic health program option allowed under the ACA.

A second law, creating the Connecticut Health Insurance Exchange, also addresses the development of market reforms necessary to the operation of the Exchange. In Section 12 of Public Act 11-53: *An Act Establishing a State Health Insurance Exchange*, the Connecticut Health Insurance Exchange Authority is mandated to provide the Governor and General Assembly a plan to establish the details of the Exchange which includes various changes to the health insurance market. The Plan must include the information below, much of which will be informed by the market research currently being conducted under Connecticut's Exchange Establishment Planning grant:

- Whether to establish two separate exchanges, one for the individual health insurance market and one for the small employer health insurance market, or to establish a single exchange.

J. PROVIDING ASSISTANCE TO INDIVIDUALS AND SMALL BUSINESSES, COVERAGE APPEALS, AND COMPLAINTS:

Effective integration and leveraging of existing capabilities is a priority for the State in providing assistance to individuals and small employers. Currently the State's Office of the Healthcare Advocate (OHA), an independent State consumer assistance agency, provides Connecticut consumers with health care issues assistance through outreach programs, the provision of direct services, and communications related to consumer rights and responsibilities. OHA assists consumers in making informed decisions when selecting a health plan; assists consumers in resolving problems with their health insurance plans; and identifies issues, trends and problems that may require executive, regulator or legislative intervention. OHA became the State's designated consumer assistance program under the Affordable Care Act when it received a Consumer Assistance Program grant in October 2010 to enhance core service delivery through hiring additional staff to provide health insurance consumer outreach and education, direct services and systemic advocacy to additional Connecticut residents.

Since 2002, OHA has assisted nearly 9,000 health insurance consumers in determining whether they should appeal a denial of treatment or service by their insurer and provides assistance to any Connecticut resident who requests help with an insurance issue. OHA routinely accepts cases from individuals and families affected by denials in coverage, treatment, or services from private health insurers, group health plans, the federal employee benefits health plan, public programs (Medicaid and CHIP), Connecticut's high risk pool (HRA) and other public health coverage.

OHA received a federal Consumer Assistance Grant (CAP) to enhance core service delivery through hiring additional staff to provide health insurance consumer outreach and education, direct services and systemic advocacy to additional Connecticut Residents. It is the State's intent to work collaboratively with OHA in developing and integrating existing services in Exchange development and ensuring that the

outcomes and capabilities realized in the CAP grant are leveraged appropriately. The State recognizes the value of having OHA as an integral partner in Exchange customer assistance delivery.

Along with OHA, the Connecticut Insurance Department (CID) also provides customer support through their Customer Assistance Unit (CAU). Currently, CAU performs the following functions:

- Informs consumers about the complaint filing and appeals processes
- Reviews complaints including claim denials and billing disputes to determine if statutory and contractual obligations have been met
- Records data on complaints, including instances where violations have occurred
- Where patterns of violations have occurred, referrals are made to the Market Conduct or Investigations Units
- Provides assistance to consumers in understanding their rights and protections under the law
- When appropriate, makes referrals to other State and federal agencies (including regulatory agencies in other states)
- Provides information on available health insurance options (public and private); based on consumer responses to screening questions to determine what social programs or group coverage (if self-employed) they may be eligible for
- Answers questions on internal and external appeals
- Educates the Public on insurance issues by presenting at local organizations' meetings through the Department's Speakers Bureau

Currently, CID fields many inquiries from consumers who are currently uninsured or are coming to the end of their COBRA benefits. Examiners within the Consumer Affairs Unit routinely spend time educating consumers on their options in obtaining health insurance coverage including directing callers to specific information on CID's website for companies licensed to do business in the state. CID has a data collection system that tracks intake and closure and reports by insurer, coverage type, subject matter and outcome. They also monitor patterns of complaints and insurer conduct, and recommend legislative changes, where needed. With these systems in place, the CID has recovered \$6,911,212 in health benefits alone and \$17,288,044 across all lines of business for consumers in the past 5 years. These recovered funds are the direct result of consumer complaints that have been handled by CAU and include money recovered for consumers who may not have complained to CID, but have been identified as being harmed by a global error on the part of the insurance carrier. In the most recent budget year CAU handled 6,915 complaints and inquiries, as well as almost 25,000 phone calls across all lines of business.

As with OHA, it is Connecticut's intent to assess and leverage current capabilities within the CAU unit to ensure appropriate programs and systems are in place to effectively provide superior customer assistance for Exchange participants.

K. EXCHANGE FUNCTIONS

The planning grant research will provide some analysis of certain functional areas. However, Connecticut has considered these operational functionalities best suited for design after legislation was enacted and planning research complete. Therefore, the next steps in Connecticut's Exchange functional development will be addressed in the following Project Two scope of work described in the following section.

Project Narrative:

Proposal to Meet Program Requirements

Planning grant research will be completed in the Fall of 2011 and will provide Connecticut with the critical foundation for Exchange design, development and implementation policy planning. However, there are other issues that must be resolved in order for Connecticut to successfully build a State Exchange and apply for Level Two Establishment funding. There are a number of core area components that Connecticut needs to address while completing planning research efforts. Level One grant funding will enable Connecticut to focus on three necessary projects with a coordinated purchasing strategy including written requests for proposals for implementing the technical systems identified. These projects include: (1.) Administrative structure, leadership staffing and office space procurement, (2.) Business operations, and (3.) Consumer support program assessment and design.

	Project	Core Areas	Key Components
1.	Administrative Structure, Leadership Staffing, and Office Space Planning and Procurement	Governance	<ul style="list-style-type: none"> • Establish Administrative Structure for the Exchange • Hire key Exchange Staff • Procure space
2.	Business Operations	Exchange IT Systems Business Operations Exchange Functions	Develop: <ul style="list-style-type: none"> • Eligibility Determination • Enrollment Process • Exemptions from individual responsibility requirement and payment • Premium Tax Credit and Cost Sharing Reduction Administration • Notification and appeals of employer liability • Information reporting to IRS and Enrollee • Free Choice Vouchers • SHOP specific functions • Website and Calculator • Program Integration
3.	Consumer Assistance	Providing Assistance to Individuals and Small Businesses, Coverage Appeals and Complaints	Assessment of capabilities and development of operational plan: <ul style="list-style-type: none"> • Eligibility Assistance • Grievance and Appeal Filings • Consumer Protections • Problem Resolution • Data Collection • Business process documentation and mapping

PROJECT ONE: Administrative Structure, Exchange Leadership, and Office Space Procurement

An overview of the necessary administrative infrastructure and policies and procedures needed for the Exchange are outlined in this Project One scope of work. There will be three areas of focus within this key planning area. The first includes a development of the administrative and legal functionalities of "starting up" a quasi-public entity; the second will include recruitment and hiring of Exchange leadership; the third is planning and procurement of Exchange office space.

Projected Timeline:

Project scope	2011					2012							
	8	9	10	11	12	1	2	3	4	5	6	7	8
Establish Administrative Structure													
Leadership Recruitment and Staffing <i>The goal is for the CEO to be hired Fall 2011 and have all initial leadership hired by May, 2012.</i>													
Office Space Assessment and Procurement													

Project 1a.) Administrative Structure

The Level One grant will support the development of the necessary administrative structure for the Exchange. The first stage in this organizational area is the development of policy and procedures. Connecticut will secure the services of a law firm to provide the guidance needed in the formation and establishment of administrative, legal, financial and tax functions for the Exchange to begin operations. Services provided will include, but not be limited to:

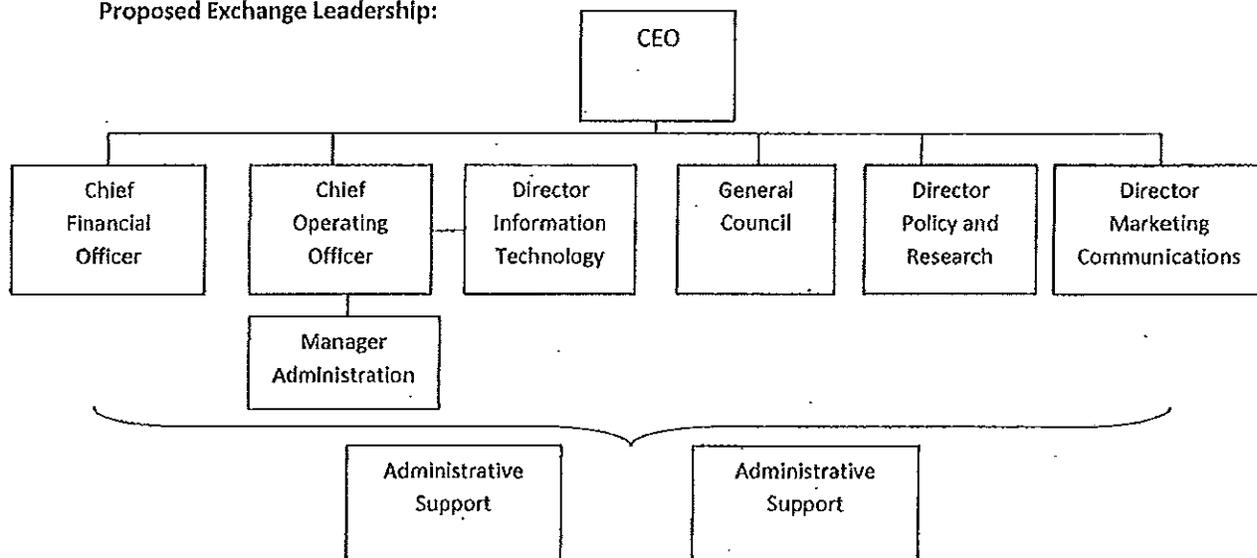
- 1.) Development of by-laws and a plan for the board's operation encompassing the hiring, dismissing, promoting and compensating of employees, an affirmative action policy and general employment rules;
- 2.) Preparation of the necessary documentation to establish the Exchange business entity, including tax identification numbers and the tax status of the Exchange;
- 3.) Legal advice and guidance on compliance with applicable State and federal law in the operation of the Exchange;
- 4.) Preparation of personnel policies and/or an employee handbook encompassing the hiring, dismissing, promoting and compensating of employees, an affirmative action policy and general work and employment rules;
- 5.) Draft boilerplate contracts for use by the Exchange in contracting for necessary financial, legal or other professional services, including a requirement for a competitive procurement process;
- 6.) Negotiation of lease for office space to house the staff of the Exchange; and
- 7.) Negotiation of employment contracts for senior/key employees of the Exchange.

These services will be procured through Connecticut's Request for Proposals processes, coordinated with the Level One grant staff, Attorney General's office, the Office of Policy and Management and with the Exchange Board of Directors.

Project 1b.) Exchange Leadership

Level One Grant funding will need to support the initial leadership staff for the Exchange Authority in order to meet federal implementation deadlines. The first position to be hired will be the Chief Executive Officer (CEO). Exchange staff are exempt from State classified service which will allow for a more rapid hiring process and the ability to attract staff with high levels of expertise and experience. Recruitment proceedings will be coordinated with Exchange Board of Directors and from the support of the Level One grant staff. Per Public Act 11-53, the Governor will choose the Exchange CEO based on three recommendations provided to him from the Board of Directors. After the CEO is selected, he/she will lead the recruitment efforts of the remaining initial leadership team in collaboration and coordination with the Exchange Board. These positions will be hired on a staggered basis as needed, but all positions will be filled by May 2012 at the latest. The positions proposed in the organizational chart below are considered critical to initial implementation. Compensation for Exchange staff will be based on comparable positions within other quasi-public entities in Connecticut.

Proposed Exchange Leadership:



It is important to note that when the Exchange CEO is hired, the Level One grant staff and grant administrative duties will transition from the Office of Policy and Management to the Exchange under the leadership and direction of the CEO and Board of Directors. As mentioned previously, this timing is anticipated for Fall 2011.

The key Exchange leadership team will include the position summaries outlined below. Full descriptions and qualifications for each position are described in the Budget Narrative section. These positions, and the full staffing plan, will need to be finalized and approved by the Exchange Board of Directors. CCEO will be notified once a final staffing plan is approved by the Board of Directors.

Chief Executive Officer

The Chief Executive Officer oversees the entirety of the Exchange activities, working closely with the organization's senior managers, staff and Board of Directors to define and execute its mission in light of its statutory responsibilities and the health insurance needs of individuals and small businesses.

Chief Financial Officer

Reporting to the Chief Executive Officer (CEO), the Chief Financial Officer (CFO) is responsible for management oversight and the strategic direction of the financial operation. The CFO works directly with the CEO on key strategic initiatives. The CFO also works closely with the COO, the General Counsel, the Board of Directors, as well as other members of the senior management team to develop and implement strategy for Exchange programs.

Chief Operating Officer

The Chief Operating Officer plays a leading role in establishing Exchange strategic and programmatic priorities and managing the organization to ensure that it achieves its mission. Reporting to the Chief Executive Officer, the Chief Operating Officer's (COO) position is key, and the primary responsibilities include assisting the CEO in setting strategic priorities for the Exchange in consultation with its Board of Directors and staff, including national and state cost containment initiatives; and other opportunities to add value for the Exchange. The COO leads the management of the organization to ensure that it achieves its strategic priorities and day-to-day activities.

General Counsel

The General Counsel works closely with the Board, CEO, and CFO and will work closely with other members of management of the Exchange and affiliated entities and outside counsel to ensure management of all legal matters. Sets direction for the Exchange on legal, statutory, governance & compliance matters within the strategic plan developed by the CEO.

Director of Information Technology

The Director of Information Technology shall be responsible for all information technology functions throughout the organization, including both long-term planning of technology initiatives and arranging to meet the near-term requirements of a functioning agency and a public, high traffic web site.

Director of Policy and Research

The Director of Policy and Research serves as one of the Exchange's senior management team responsible for shaping organizational strategy and long term planning. The position reports directly to the CEO and is responsible for identifying the implications of national and state health reform for the Authority and developing strategy to move to compliance.

Director, Marketing and Communications

The Director of Marketing and Communications is responsible for developing and managing all internal and external marketing and communications initiatives including ensuring that all efforts are coordinated across the appropriate State agencies and Office of Healthcare Reform and Innovation.

Manager, Administration

The Manager, Administration manages human resources functions and reports to the COO on proactively managing and resolving issues. General responsibilities for this position include: interprets policies and procedures and communicates to employees both proactively and in response to questions; administers office policies and procedures; maintains accurate files and employment records; administers the recruiting process for new hires, including searching and screening candidates, tracking applicants, checking references and producing offer letters; coordinates all training for associates; manages additional staff where appropriate; ensures regulatory and legal compliance for all employment-related matters

Administration Support (2)

Reports to the Administration Manager of the Exchange. General responsibilities include performing a variety of specialized administrative assignments to support Exchange management staff efforts. Assist in the production of reports, presentations, proposals, and general communications. Performs ancillary support functions such as scheduling meetings, maintaining files, and coordinating travel.

Project 1c.) Office Space Procurement

The third component of Project One is assessment of office space needs and procurement of an appropriate location to house the Exchange staff. We will use the expertise of a contractor to help Connecticut perform these necessary tasks in a timely and economic fashion. To ensure that there is sufficient space both initially and in the long term, this assessment will provide the necessary information for effective decision making. Forecasting both the initial and long term needs for space is an important component to ensure effective Exchange implementation and operations. This effort will be coordinated and supported by the Exchange Board, Exchange Level One grant staff and necessary real estate professionals.

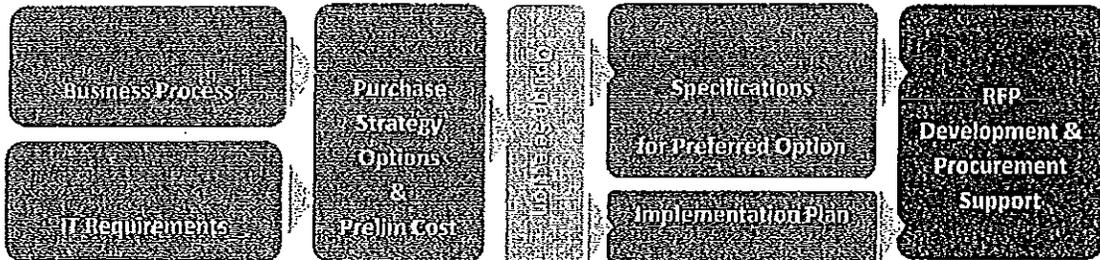
PROJECT TWO: Business and IT Operations

A preliminary description of our proposed activities for Project Two: Business and IT Operations in the Level One grant funding period is provided in this section. Please note that the final scope for Project Two will be developed based on the specific outputs of our Planning Grant research activities and IT Gap Analysis, now ongoing.

Overview and Approach

Overall, our Project Two activities in the Level One grant funding will be supported through procurement of an external technical assistance vendor to assist us with the iterative process of moving from planning through procurement and implementation activities. This interdisciplinary vendor team will focus on both business process functions and related IT systems, and will follow best practice methodologies for phasing and documenting all concept definition, planning, and requirements development activities, using practices such as CMS' *Integrated IT Investment & System Life Cycle Framework*.

Top-Level Phasing of Technical Assistance Vendor Scope of Work



Project Two activities begin with two task areas that run in parallel: *Business Process Requirements* and *IT Requirements*. The business process requirements phase is a classic requirements development process in which business functions and flow diagrams describe the workflow and relationships among the various functional activities within the Exchange. Many, if not most of, business requirements drive specific IT needs, which are captured as an IT requirement. *Note: typically, business requirements are identified first, followed by IT requirements, but we are running these in parallel in order to accommodate the compressed time schedule inherent in HHS' goals.* We expect a rolling integration between these two task areas. We have planned to have two separate consultant teams working in a closely-coordinated parallel effort, using an 'agile' process of requirements and IT development. The end result of these two phases produce documents that should allow a business person to easily follow "a day in the life" of any particular consumer interaction or financial transaction.

In the next task area, *Purchase Strategy Options & Preliminary Cost Estimate*, we will work with our vendor to develop multiple reasonable options for implementing the Exchange, such as "Who will operate the Exchange?" (e.g., vendor or public entity or consortium partner) and "How will we acquire the necessary technical and software tools?" (e.g., build, enhance existing, procure via operational

outsourcing, etc.). Each option is evaluated in a matrix indicating the risks and opportunities for that option, as well as an overall cost, expressed as a life cycle cost. (Life cycle costs consider the total cost of ownership over a period of time, including initial cost to develop or buy, plus the cost to maintain and keep current over the ownership period, and the related inherent risks in the above.)

In the next task area, called *Option Selection*, we select a preferred option based on cost/benefit and stakeholder input. After this selection, our vendor proceeds to develop detailed technical specifications and/or vendor requirements under the task area called *Specifications for Preferred Option*. These specifications form the body of a Request for Proposals (RFP) or other procurement-related document or documents necessary for the implementation phase. While developing specifications, we have arranged for a vendor team to simultaneously help us develop the next (detailed) iteration of an implementation roadmap and schedule (*Implementation Plan* task area).

In a final task area, *RFP Development and Procurement Support*, we will ask our vendor to assist us in creation of an RFP document and the many tasks related to managing a complex procurement.

Additional detail on each of these task areas is presented in the table below.

Project Two: Preliminary SOW for Technical Assistance Vendor	
Task Area 1.0 Business Process & IT Design, Definition & Requirements	<p><u>Business Operations Components</u></p> <p>The following task areas and deliverables are included:</p> <ul style="list-style-type: none"> ▪ Business processes, maps and flow diagrams ▪ Business rules ▪ Functional Requirements ▪ Use Cases and/or Vignettes ▪ Ecosystem Interfaces - Touch points with external state and non-state entities ▪ Re-cap/update of IT Existing Conditions from prior phase ▪ Re-cap/update of both IT Gap and Business Process Fit/Gap analysis from prior phase ▪ Deliverable: Requirements document <p><u>IT Systems Components</u></p> <p>This task will develop an IT architectural model for the Exchange, through technical requirements and risk assessment. The functional areas will include:</p> <ul style="list-style-type: none"> ▪ Portals (Web, Mobile) ▪ User-facing tools (Calculators) ▪ Business Rules Engine ▪ Workflow Engine and Customer Relationship Management ▪ Data Interoperability – external interfaces ▪ Data Warehouse, ▪ Document Generation & Management ▪ Business Intelligence and Reporting ▪ IT Service Levels ▪ Security and Reliability Standards <p>The IT requirements will be defined throughout this project as Discrete Exchange Modules (in order to allow for component re-use by others):</p> <ul style="list-style-type: none"> ▪ Eligibility ▪ Enrollment ▪ Premium tax credit administration ▪ Cost sharing assistance ▪ Qualified health Plan certification ▪ Payment management system for Free Choice Vouchers

Project Two: Preliminary SOW for Technical Assistance Vendor (Con't)	
Task Area 2.0 Procurement Strategy Options & Preliminary Cost Estimate	<p>This task area articulates a handful of purchasing strategy options and high level "concept" cost estimates for each. Each option analysis will contain pros/cons, opportunities/constraints, risk profile, and a life-cycle cost estimate.</p> <p>Options will include but are not limited to:</p> <ul style="list-style-type: none"> ▪ Operations Model – Vendor Operated/Outsourcing ▪ Operations Model - Self Operated ▪ IT – Buy Commercial Off The Shelf (COTS) components available for purchase; ▪ IT – Build (and related) ▪ IT – Re-use platforms or components from Early Innovator States ▪ IT – Enhance existing ▪ Hybrids, joint ventures and/or combinations of above ▪ Recommended Procurement approach
Task Area 3.0 Specifications and for Preferred Option(s)	<p>This task area starts with the preferred option or options from Task Area 2.0, and develops these to specifications at the appropriate level of detail required to be compliant with the SDLC approach. The level of detail and type of specifications are highly dependent on decisions regarding buying or building IT, and subsequently decisions regarding self-operating versus selecting a vendor-operated approach. Under the most likely scenario, these specifications will be largely "functional specifications" by nature, and will be directly inserted into the RFP documents used for selection of implementation vendors in Task 5.0.</p>
Task Area 4.0 Implementation Plan for Executing the Preferred Option	<p>This task area starts with the preferred option or options from Task Area 2.0, and develops these into a detailed implementation plan that will be used by the Connecticut Exchange leadership team to manage the overall implementation from this phase through testing and go-live.</p>
Task Area 5.0 RFP Development and Procurement Support	<p>This task area assists the Connecticut Exchange toward procuring the next phase of implementation of systems, technologies and/or vendors. Task include:</p> <ul style="list-style-type: none"> ▪ RFI/RFP development, including publishing of Functional and other Specifications (level of detail depends on the selected procurement approach) ▪ Publish Procurement Library ▪ Pre-proposal Bidder's Conference and responses to Contractor questions ▪ Proposal Evaluation Criteria & evaluation process ▪ Post-award support for contracting and project startup ▪ Knowledge transfer activities

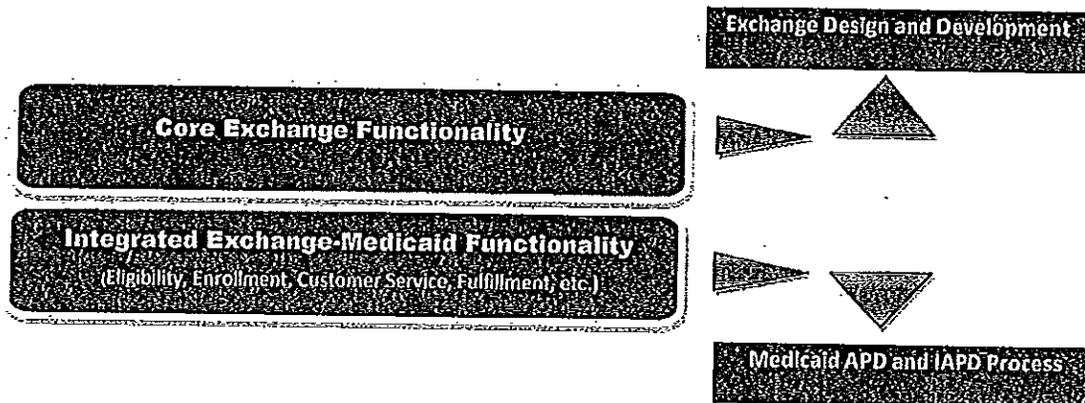
Phasing the Project, and Interface with Medicaid System Modernization

The Connecticut Exchange is dedicated to exploring a "single front door" approach to customer service and access to the wide variety of State-supported health benefit programs, including the Exchange products, Medicaid, CHIP and other health and human service programs.

This approach will likely take the form of a unified portal experience. It may or may not also include a unified approach to eligibility and enrollment operations, customer service and fulfillment. For example, inbound calls from a Connecticut resident looking for health insurance, whether he or she is ultimately destined for a Medicaid program or an Exchange product, could be handled by a unified customer service center.

To accommodate these planning goals, on a preliminary basis we propose to organize a portion of Project Two into two major parallel activity areas or "Tracks" that will be run as separate but coordinated sub-activities under a single vendor contract illustrated in the diagram below. Each track will cover all of the scope of work areas described above.

Project Two Activity Tracks:



Project Track 1: Exchange Operations

This parallel track covers the subject matter of the typical core health insurance Exchange functionality, with the exception of certain eligibility/enrollment functions, which we have carved out as described below. This track covers business processes that can more or less be separated from Medicaid-related functions. Areas of significant potential overlap with Connecticut Medicaid operations are marked with an asterisk (*).

- Certification, recertification, and decertification of qualified health plans
- Quality rating system
- Customer Service Call Center*
- Exchange Website*
- Outreach and education*
- Navigator Program on-line and technical support*
- Enrollment process, applications and notices; individual responsibility determinations; subsidy administration, premium billing and payment*
- Premium tax credit and cost-sharing reduction calculator
- Administration of premium tax credits and cost-sharing reductions
- Notification and appeals of employer liability
- Information reporting to IRS and enrollees
- Free Choice Vouchers
- Risk adjustment and transitional reinsurance
- SHOP Exchange-specific functions (tax credit eligibility, rating engine, facilitating choice of health plan, enrollment, appeals).

Project Track 2: Eligibility Determination, Enrollment and Fulfillment Operations

The second track runs in parallel to Track 1 and is focused on eligibility/enrollment, and potentially a joint approach to customer service and fulfillment:

- Seamless eligibility and enrollment process with Medicaid and other State health subsidy programs
- Eligibility determinations for Exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid
- Adjudication of appeals of eligibility determinations

We have organized the project into two tracks for several reasons:

- 1) The two areas are comprised of different industry functional content (health insurance brokerage and public subsidy eligibility, respectively) and require reasonably different subject matter teams;
- 2) The two areas have implementation paths with widely different contingent dependencies. That is, the E/E Track must interface with the Medicaid APD and IAPD process, and with the overall State Modernization project, as the core Exchange development has a different set of external contingencies; and
- 3) All activities related to the Exchange-Medicaid interface need to be closely tracked in order to maintain separate expense and activity accounting for federal cost allocation purposes. Our prospective cost allocation plan includes procedures to identify, record, allocate, and report direct and indirect costs, partially and fully attributable to each system project.

Use of System Development Life Cycle Methodology and Interface with HHS Reviews

As we plan, design and procure our Exchange IT systems, all vendor and state staff activities and deliverables will be designed to interface with the emerging HHS review methodology, including *Integrated IT Investment & System Life Cycle Framework, CMS Requirements Writer's Guide* (Department of Health and Human Services, Centers for Medicare & Medicaid Services, Version 4.11, August 31, 2009). *An example of Best-Practice Ingredients, using SDLC approach:*

- Project Startup Checklist: Concept of Operations, Scope, Charter
- Project Architecture: Business Process Models, Requirements Document, Architectural diagrams
- Project Baseline: Risk Assessment, Project Management Plan, Project Schedule,
- Preliminary & Detailed Design: Test Plans, Logical Data Model, Data Use Agreement, Technical Architecture Diagrams (SW, HW, MW, network, security)
- Pre-Operational Readiness: Inter/Intra-agency Agreements, End-to-End Testing Plan and Cases, Implementation Plan, User Manuals, Operations & Maintenance Manual, Training Plan
- Operational Readiness: Defect & Remediation

Compliance with Federal Standards Development Organizations IT Interoperability, Reusability, Security, Privacy and Accessibility Standards

Our IT project planning staff and vendors will be compliant with current and emerging standards related to both Exchanges and overall Federal requirements, such as:

- Service Oriented Architecture and other interoperability standards that support Shared Pool and Cloud utilization

- Reusability standard: Development of reusable components that may be used by other States and Consortia
- MITA Architecture and other CMS Capability Maturity Models
- NIST Federal Information Processing Standards (FIPS)
- HIPAA and HITECH
- Accessibility for Individuals with Disabilities: Section 508(b) of the Rehabilitation Act of 1973 and user-centered design (UCD) methods
- National Information Exchange Model (NIEM) (<http://release.niem.gov/niem/2.1/>)
- ACA Section 1561 ONC – Core data, business rules, verification interfaces, transmission of enrollment information using X12 EDI, and security and privacy using FIPS

Timeline, Schedule and Key Dependencies

The overall timeline for vendor activities in Project Two is approximately nine months, from commencement of the vendor contract to the execution of procurement for the next phase of implementation under Level 2 Establishment.

Project Two ideally commences immediately after substantial completion of our current planning grant activities and its deliverables. The specific deliverables from the planning grant that will be used as important inputs into Project Two are as follows: (a) IT Gap Analysis, (b) comprehensive assessment of the operational processes between the Exchange and Medicaid, (c) technical requirements and specifications for Exchange accounting and financial system functions, (d) assessment of the existing Medicaid eligibility system, interface issues and necessary requirements for integration with the Exchange IT infrastructure, (e) impact study of the Medicaid program specifically addressing the areas of enrollment change and associated costs, analysis of the federal poverty level increase, and impact to the Children's Health Insurance Program, and (f) advantages and disadvantages of a Connecticut statewide Exchange versus a multi-state Exchange.

Pre-Project Finalize Scope of Work; Procurement of Project Two Technical Assistance Vendor Team

Project Month 0-3 Business Process Operations and IT Requirements

Project Month 4 Procurement Strategy and Option Selection

Project Month 5-8 Specifications and Implementation/Work Plan

Project Month 9 RFP Development and Procurement Support

As with most Exchange projects nationally, our establishment effort is likely contingent on APD and IAPD project schedules related to modernization of our Medicaid eligibility and enrollment systems.

PROJECT THREE: Consumer Assistance and Support

Customer experience and satisfaction are critical organizing principles governing the development of Connecticut's Exchange and are directly related to effective consumer assistance and support services. To ensure that Connecticut provides comprehensive support for Exchange participants, Project Three will be focused on assessment of all current programs and services in the State so to enable accurate planning in terms of leveraging capabilities as well as building appropriate capacities to ensure excellent support is provided. Project Three components will be conducted through a contractor with a specialized multidisciplinary team to enable us to define and execute assistance planning against our customer-oriented objectives. This team will also assure sensitivity to the needs and diversity of Connecticut citizens.

Project Three will commence immediately upon kick-off of our Level One grant activities and is intended to be completed in time to produce specifications that can be directly integrated with overall business process and IT implementation activities.

Scope and Phasing

The scope of this project will cover the consumer assistance components of each of the Eleven Exchange Establishment Core Areas, as detailed in ACA Sections 1311(d)(4), 1413 and other sections. In particular:

Areas of Focus:

- General information assistance, advisory and navigation, call center, self-help, toll-free telephone hotline, etc.
- Eligibility and enrollment process
- Consumer protections
- Grievance and Appeal (coverage, eligibility, etc.)
- Problem Resolution
- Performance Transparency and Reporting on the above, including related data collection

Phase 1. Assessment of Existing Conditions and Strategy for Leverage of Existing Capabilities

Effective integration and leveraging of existing capabilities is a priority for the State in providing assistance to individuals and small businesses. Several State entities and vendors are already providing certain aspects of customer assistance and support, and these need to be woven together to produce a unified consumer experience. For example, the Office of the Healthcare Advocate (OHA) is the independent State consumer assistance agency and Connecticut's designated Consumer Assistance Program under the ACA, Consumer Assistance Program (CAP) grant (October 2010). Connecticut is dedicated to on-going collaboration, integration, and leveraging of the CAP grant program services. Connecticut's Insurance Department (CID) also provides customer support through their Customer Assistance Unit (CAU). In addition, there are existing State Medicaid consumer support programs and the underlying Customer Relation Management systems (CRM) that support these.

Phase 2. Requirements for Achieving an Integrated Consumer Experience; and Performance Metrics Methodology

This phase will define the business requirements, using workflow and mappings at the level of detail specified in Project Two. The focus is on new business activities beyond existing capabilities established in Phase 1. This phase would specify the methodology, which includes the necessary data to be

collected, the expected target levels of quality, and the performance results. It would also provide methodology to ensure transparency to stakeholders in terms of reporting through a quality dashboard or similar public posting.

Phase 3. Business Process Changes, Enhancements and Implementation/Procurement Strategy

This phase will integrate the new and the existing customer assistance and support functions into one to ensure that Connecticut Exchange participants have a robust support system to depend on. It will describe what current capabilities need to be consolidated or changed, and how the new activities will be delivered—for example, whether through a contracted vendor, State staff, an interagency agreement and/or other outside entity.

Phase 4. Technical Requirements and Contract Specifications

This phase, if necessary, creates technical requirements and contract specifications for inclusion in the next phase of implementation.

Timeline, Schedule and Key Dependencies

Project Three is a three month effort, running in parallel to the first three months of Project Two, and with important coordination activity with Project Two. Project Three ideally commences immediately after our grant award and runs concurrent to the "Business Process Operations and IT Requirements" phase of Project Two.

Pre-Project	Finalize Scope of Work; Procurement of Project Three Consumer Assistance and Support vendor
Project Month 1:	Phase 1. Existing Conditions & Strategy for Leverage of Existing Capabilities
Project Month 2:	Phase 2. Requirements for Achieving an Integrated Consumer Experience
Project Month 3:	Phase 3. Business Process Changes, Enhancements and Implementation/Procurement Strategy
	Option: Phase 4. Technical Requirements & Contract Specifications

III. Summary of Exchange IT Gap Analysis

The IT Gap Analysis is a significant deliverable under the planning grant. The scope for this assessment is discussed in the above Progress Overview section F.

IV. Evaluation Plan

The Level One project areas are focused on staffing and space procurement, business operations and consumer support. The evaluation plan will measure each of these areas to ensure that objectives are successfully met.

The Principal Investigator, who also leads the Office of Health Reform and Innovation within the Lieutenant Governor's Office and is a Board member of the Connecticut Health Insurance Exchange Authority, will provide a broad view to the evaluation plan, assuring that the goals and timelines are being met, the process is well integrated with other health reform efforts and that the process is an inclusive one.

Key Indicators to be Measured

The goal of the evaluation plan is to ensure that quality standards are adhered to as the Exchange continues to develop under the Level One funding period and begins establishing its business operations. Key indicators to be measured are derived from the principal tasks and milestones to be completed and achieved within each Core Area. The status and performance of key indicators will be reported on in the required quarterly reports to CCIIO. Additionally, general quality indicators are an essential component of Connecticut's continual project evaluation and include consultant/program integrity assessment and monitoring.

The review process and hiring of consultants adheres to strict guidelines established and enforced by the State. Prior to a consultant working with Connecticut, a thorough evaluation is completed and is approved by the Attorney General. At the outset of any new task or project, the goals and objectives are outlined and a work plan agreed upon. Recognizing that work products may evolve throughout the contractual periods, language is included to address these possible variances while respecting the original quality and timelines of the required outcome delivered to the State. Superior project management is an essential component of Connecticut's vendor relationships. To ensure project integrity, continual assessment of work quality is conducted through interim milestone/deliverable review and reporting, interagency work groups and routine meetings and conference calls.

Baseline Data for each Indicator

A deliverable of the Level One project scope will include the identification of the baseline data indicators that will provide value to Connecticut's Exchange development process. The selected contractor(s) will identify the specific framework for these baseline data and reporting elements. In general, they will fall under the categories of eligibility, enrollment, consumer support, staffing, and space procurement. The reporting components will encompass the identification and design of technical specifications, mapping, program integration as well as purchasing strategy.

Methods and their Efficacy to Monitor Progress and Evaluate the Achievement of Program Goals

The deliverables identified in the scope of work for each of the Level One projects will be monitored and evaluated through a number of avenues. Each deliverable will be detailed and broken down by task category. The Project Director, along with a multi-disciplinary project team, will provide oversight and assume responsibility for monitoring each component in terms of project progress and goals, timeline adherence, and status reporting. Additionally, internal work groups will be accountable for effective and timely communications and progress report updates and project team weekly meetings will be reported on as appropriate and in accordance with relevant work plan processes. Quarterly reports will also be submitted with project status to CCIIO as required.

Inclusion of plans for timely interventions when targets are not met or unexpected obstacles delay plans

Typically the effect of a delay on project scope is assessed for relative impact on a situational basis. Connecticut will use this approach for Level One project work. Usually, the mitigation strategy is handled contractually through the direct and defined relationship between required task and financial accountability thus ensuring that timelines are adhered to and/or the adjusted outcome is mutually agreed to by both parties.

Inclusion of a plan for ongoing evaluation of Exchange functioning once it is operational

Once the Exchange has established the Board of Directors, an expanded and enhanced evaluation plan will be formalized leveraging current capabilities and processes while incorporating the larger scale Exchange operations.

Appendix C

MEMORANDUM OF UNDERSTANDING
BETWEEN THE OFFICE OF POLICY AND MANAGEMENT
AND THE
CONNECTICUT HEALTH INSURANCE EXCHANGE

WHEREAS, pursuant to the federal Patient Protection and Affordable Care Act (ACA) each state, by January 2014, will establish an Exchange to help individuals and small employers obtain health insurance coverage;

WHEREAS, the State of Connecticut through the Office of Policy and Management (OPM) has applied for planning grant and the level one grant funds through the federal Health and Human Services agency for the establishment of the Exchange;

WHEREAS, the Connecticut General Assembly adopted and the Governor signed Public Act 11-53 which established the Connecticut Health Insurance Exchange (CHIE);

WHEREAS, the CHIE Board of Directors has been appointed and the Exchange has begun the work required to fully establish and implement the provisions of the ACA;

WHEREAS, the grant funds are currently held by OPM and administered by OPM in accordance with the grant award for the benefit of the CHIE;

WHEREAS, the CHIE Board of Directors is authorized to enter into contracts and authorize expenditures on behalf of CHIE;

WHEREAS, the CHIE Board of Directors has approved a budget for the expenditure of the level one grant funds; and

WHEREAS, the CHIE has not become fully staffed, has not opened a banking account and does not yet have procedures in place to provide for the authorization of payments or an accounting system for the expenditure of funds.

NOW THEREFORE, OPM and the CHIE mutually agree to the following:

- A. OPM will charge previously approved planning grant expenditures to Account 22440 and level one grant funds to Account 22482 in accordance with the budget (attached hereto) and based upon authorization from the Board of Directors of CHIE or the Chief Executive Officer including the Acting Chief Executive Officer;
- B. CHIE may designate one or more staff people to authorize expenditures below \$5,000.00;
- C. In order to simplify the payment of bills, CHIE hereby authorizes OPM to directly charge accounts 22440 and 22482 as necessary and appropriate to pay the expenses of the CHIE and to fund the salary, benefits and indirect costs of OPM staff assigned to work with the CHIE as specified in the federal grant award;

D. CHIE delegates to OPM the authority to act as the CHIE's paying agent to make direct payments for contracts to which OPM is not a signatory and upon approval of invoices by the designated CHIE authority including but not limited to the following:

1. Legal Services
2. Consumer Outreach
3. Executive Search Firm
4. Business Operations, IT, and Consumer Assistance
5. Contracts assigned by OPM to the Exchange (HES Advisors Inc., and Mercer)

E. OPM shall provide the CHIE space in its building at 450 Capitol Avenue, Hartford, Connecticut until the CHIE obtains other adequate space or December 31, 2013 whichever comes first, unless extended by mutual agreement. The State of Connecticut reserves the right to charge rent to CHIE on or after July 1, 2013;

F. OPM will permit CHIE to utilize available desktop computers, associated software and telephones for a period of time not to exceed three months while CHIE is located at 450 Capitol Avenue, but in no event shall CHIE be permitted to remove or otherwise obtain an ownership interest in such equipment. OPM will assist CHIE in determining what services, including network hardware, it can utilize through the existing infrastructure and assist in any communications with DAS/BEST;

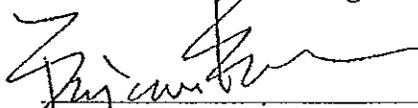
G. CHIE shall take action to identify and acquire peripherals to provide the CHIE print, copy and scanning functions not later than sixty days from the date of this MOU;

H. CHIE shall identify and acquire technology services including but not limited to file servers, print services, email and internet access, and on-going desktop support services; and

I. CHIE shall be responsible for the payment of any cost associated with work of DAS/BEST staff, any equipment repairs, rental of equipment specifically and exclusively for the use of staff supporting CHIE, copies, office supplies, telephone bills for any lines utilized by staff supporting the CHIE and the cost associated with any configuration or reconfiguration of space at 450 Capitol Avenue for staff.

The memorandum of understanding may be terminated by either party upon thirty (30) days written notice to the signatory below or such other person designated in writing by the Secretary of OPM or the Chair of the CHIE.

Office of Policy and Management


Benjamin Barnes
Secretary

Connecticut Health Insurance Exchange


Theresa Cintron
Acting CEO

1-25-12
Date

1-25-12
Date

January 19, 2012

To: Board of Directors, Connecticut Health Insurance Exchange

From: Tia Cintron, Acting CEO

Re: Level One Establishment Budget

Recommendation:

Reallocate \$1,210,000 of Level One Establishment award to procure necessary professional services to support consumer outreach research, advisory committee research and policy recommendations, executive recruitment efforts, and general Exchange program development.

Reference	Budget Line Item	Amount Awarded (July 2011)	Reallocation (January 2012)
1	Salaries and Wages, includes Fringe and Indirect	\$2,396,886	\$400,000
2	Exchange Administrative Structure Development	\$153,500	
3	Business Operations/IT Systems Development	\$3,554,063	\$600,000
4	Customer Assistance Program Assessment	\$265,782	
5	Office Space	\$230,000	\$200,000
6	Equipment	\$38,002	
7	Office Supplies	\$3,100	
8	Travel	\$46,601	\$10,000
	Total	\$6,687,934	\$1,210,000

Notes:

Professional Services

- Consumer Outreach Research: Mintz & Hoke
- Advisory Committee Research support: To be determined
- Executive Search Recruitment: Fitzgerald Associates
- General Exchange development consultation: HES Advisors Inc.