Grant Application Package

Opportunity Title:	"Grants to States for Health Insurance Premium Review-C
Offering Agency:	Ofc of Consumer Information & Insurance Oversight
CFDA Number:	93.511
CFDA Description:	Affordable Care Act (ACA) Grants to States for Health I
Opportunity Number:	RFA-FD-10-999
Competition ID:	ADOBE-FORMS-B
Opportunity Open Date:	06/07/2010
Opportunity Close Date:	07/07/2010
Agency Contact:	Gladys Melendez-Bohler Grant Specialist E-mail: Gladys.Melendez-Bohler@fda.hhs.gov Phone: 301-827-7168

This electronic grants application is intended to be used to apply for the specific Federal funding opportunity referenced here.

If the Federal funding opportunity listed is not the opportunity for which you want to apply, close this application package by clicking on the "Cancel" button at the top of this screen. You will then need to locate the correct Federal funding opportunity, download its application and then apply.

This opportunity is only open to organizations, applicants who are submitting grant applications on behalf of a company, state, local or tribal government, academia, or other type of organization.

*** Application Filing Name:** CT Health Insurance Premium Review Grant

Mandatory Documents

Move Form to Complete

Move Form to Delete

Mandatory Documents for Submission

- Budget Narrative Attachment Form
- Key Contacts
- Project/Performance Site Location(s)
- Assurances for Non-Construction Programs (SF-42
- Disclosure of Lobbying Activities (SF-LLL)
- Attachments

Optional Documents

- Basic Work Plan
- Project Abstract Summary
- Other Attachments Form

Move Form to Submission List

Move Form to Delete

Optional Documents for Submission

Instructions

1 **Enter a name for the application in the Application Filing Name field.**

- This application can be completed in its entirety offline; however, you will need to login to the Grants.gov website during the submission process.
- You can save your application at any time by clicking the "Save" button at the top of your screen.
- The "Save & Submit" button will not be functional until all required data fields in the application are completed and you clicked on the "Check Package for Errors" button and confirmed all data required data fields are completed.

2 **Open and complete all of the documents listed in the "Mandatory Documents" box. Complete the SF-424 form first.**

- It is recommended that the SF-424 form be the first form completed for the application package. Data entered on the SF-424 will populate data fields in other mandatory and optional forms and the user cannot enter data in these fields.

- The forms listed in the "Mandatory Documents" box and "Optional Documents" may be predefined forms, such as SF-424, forms where a document needs to be attached, such as the Project Narrative or a combination of both. "Mandatory Documents" are required for this application. "Optional Documents" can be used to provide additional support for this application or may be required for specific types of grant activity. Reference the application package instructions for more information regarding "Optional Documents".

- To open and complete a form, simply click on the form's name to select the item and then click on the => button. This will move the document to the appropriate "Documents for Submission" box and the form will be automatically added to your application package. To view the form, scroll down the screen or select the form name and click on the "Open Form" button to begin completing the required data fields. To remove a form/document from the "Documents for Submission" box, click the document name to select it, and then click the <= button. This will return the form/document to the "Mandatory Documents" or "Optional Documents" box.

- All documents listed in the "Mandatory Documents" box must be moved to the "Mandatory Documents for Submission" box. When you open a required form, the fields which must be completed are highlighted in yellow with a red border. Optional fields and completed fields are displayed in white. If you enter invalid or incomplete information in a field, you will receive an error message.

3 **Click the "Save & Submit" button to submit your application to Grants.gov.**

- Once you have properly completed all required documents and attached any required or optional documentation, save the completed application by clicking on the "Save" button.
- Click on the "Check Package for Errors" button to ensure that you have completed all required data fields. Correct any errors or if none are found, save the application package.
- The "Save & Submit" button will become active; click on the "Save & Submit" button to begin the application submission process.
- You will be taken to the applicant login page to enter your Grants.gov username and password. Follow all onscreen instructions for submission.

OMB Number: 4040-0004
Expiration Date: 03/31/2012

Application for Federal Assistance SF-424

* 1. Type of Submission:
- [ ] Preapplication
- [x] Application
- [ ] Changed/Corrected Application

* 2. Type of Application:
- [x] New
- [ ] Continuation
- [ ] Revision

* If Revision, select appropriate letter(s):

* Other (Specify):

* 3. Date Received: Completed by Grants.gov upon submission.

4. Applicant Identifier:

5a. Federal Entity Identifier:

5b. Federal Award Identifier:

State Use Only:

6. Date Received by State:

7. State Application Identifier:

8. APPLICANT INFORMATION:

* a. Legal Name: State of Connecticut

* b. Employer/Taxpayer Identification Number (EIN/TIN): 066000798

* c. Organizational DUNS: 0130566550000

d. Address:

* Street1: 153 Market Street
Street2:
* City: Hartford
County/Parish:
* State: CT: Connecticut
Province:
* Country: USA: UNITED STATES
* Zip / Postal Code: 06103-1300

e. Organizational Unit:

Department Name: CT Insurance Department

Division Name: Life & Health Division

f. Name and contact information of person to be contacted on matters involving this application:

Prefix: Ms.
* First Name: Mary Ellen
Middle Name:
* Last Name: Breault
Suffix:

Title: Director, Life & Health Division

Organizational Affiliation:

* Telephone Number: 860-297-3857
Fax Number: 860-566-7410

* Email: maryellen.breault@ct.gov

Application for Federal Assistance SF-424

*** 9. Type of Applicant 1: Select Applicant Type:**

A: State Government

Type of Applicant 2: Select Applicant Type:

Type of Applicant 3: Select Applicant Type:

* Other (specify):

*** 10. Name of Federal Agency:**

Ofc of Consumer Information & Insurance Oversight

11. Catalog of Federal Domestic Assistance Number:

93.511

CFDA Title:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

*** 12. Funding Opportunity Number:**

RFA-FD-10-999

* Title:

"Grants to States for Health Insurance Premium Review-Cycle I" Office of Consumer Information and Insurance Oversight (OCIIO)

13. Competition Identification Number:

ADOBE-FORMS-B

Title:

14. Areas Affected by Project (Cities, Counties, States, etc.):

Add Attachment | Delete Attachment | View Attachment

*** 15. Descriptive Title of Applicant's Project:**

Enhancements to Rate Review Process and Transparency

Attach supporting documents as specified in agency instructions.

Add Attachments | Delete Attachments | View Attachments

Application for Federal Assistance SF-424

16. Congressional Districts Of:

* a. Applicant: CT-all

b. Program/Project: CT-all

Attach an additional list of Program/Project Congressional Districts if needed.

Add Attachment | Delete Attachment | View Attachment

17. Proposed Project:

* a. Start Date: 08/09/2010

* b. End Date: 09/30/2011

18. Estimated Funding ($):

* a. Federal	1,000,000.00
* b. Applicant	0.00
* c. State	300,000.00
* d. Local	0.00
* e. Other	0.00
* f. Program Income	0.00
* g. TOTAL	1,300,000.00

*** 19. Is Application Subject to Review By State Under Executive Order 12372 Process?**

☐ a. This application was made available to the State under the Executive Order 12372 Process for review on .

☐ b. Program is subject to E.O. 12372 but has not been selected by the State for review.

☒ c. Program is not covered by E.O. 12372.

*** 20. Is the Applicant Delinquent On Any Federal Debt? (If "Yes," provide explanation in attachment.)**

☐ Yes ☒ No

If "Yes", provide explanation and attach

Add Attachment | Delete Attachment | View Attachment

21. *By signing this application, I certify (1) to the statements contained in the list of certifications and (2) that the statements herein are true, complete and accurate to the best of my knowledge. I also provide the required assurances** and agree to comply with any resulting terms if I accept an award. I am aware that any false, fictitious, or fraudulent statements or claims may subject me to criminal, civil, or administrative penalties. (U.S. Code, Title 218, Section 1001)**

☒ ** I AGREE

** The list of certifications and assurances, or an internet site where you may obtain this list, is contained in the announcement or agency specific instructions.

Authorized Representative:

Prefix: Ms.

* First Name: Mary Ellen

Middle Name:

* Last Name: Breault

Suffix:

* Title: Director, Life & Health Division

* Telephone Number: 860-297-3857

Fax Number: 860-566-7410

* Email: maryellen.breault@ct.gov

* Signature of Authorized Representative: Completed by Grants.gov upon submission.

* Date Signed: Completed by Grants.gov upon submission.

OMB Number: 4040-0003
Expiration Date: 7/30/2011

Key Contacts Form

*** Applicant Organization Name:**

State of Connecticut

Enter the individual's role on the project (e.g., project manager, fiscal contact).

*** Contact 1 Project Role:** Project Manager

Prefix: Ms.

* First Name: Mary Ellen

Middle Name:

* Last Name: Breault

Suffix:

Title: Director, Life & Health Division

Organizational Affiliation:

CT Insurance Department

* Street1: 153 Market Street

Street2:

* City: Hartford

County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* Zip / Postal Code: 06103-1300

* Telephone Number: 860-297-3857

Fax: 860-566-7410

* Email: maryellen.breault@ct.gov

Delete Entry

Next Person

OMB Number: 4040-0010
Expiration Date: 08/31/2011

Project/Performance Site Location(s)

Project/Performance Site Primary Location ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name: Connecticut Insurance Department

DUNS Number: 0130566550000

* Street1: 153 Market Street

Street2:

* City: Hartford County:

* State: CT: Connecticut

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: 06103-1300 * Project/ Performance Site Congressional District: CT-all

Project/Performance Site Location 1 ☐ I am submitting an application as an individual, and not on behalf of a company, state, local or tribal government, academia, or other type of organization.

Organization Name:

DUNS Number:

* Street1:

Street2:

* City: County:

* State:

Province:

* Country: USA: UNITED STATES

* ZIP / Postal Code: * Project/ Performance Site Congressional District:

Additional Location(s) Add Attachment Delete Attachment View Attachment

ATTACHMENTS FORM

Instructions: On this form, you will attach the various files that make up your grant application. Please consult with the appropriate Agency Guidelines for more information about each needed file. Please remember that any files you attach must be in the document format and named as specified in the Guidelines.

Important: Please attach your files in the proper sequence. See the appropriate Agency Guidelines for details.

1) Please attach Attachment 1	A4-HIPR-CT statutes.pdf	Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2	A5-HIPR-CT Organization chart	Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3	A6-HIPR-CT Department staff t	Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4	A7-HIPR-CT Job descriptions.p	Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5	A8-SSA_Additional Assurances	Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

Project:

Enhancements to Rate Review Process and Transparency

* Year:	* Funding Agency Goal:
1	The goal is to ensure that consumers get value for their dollars

* Objective:

The objective of this grant project is to improve the rate review process in CT by providing more tools, developing more transparency and developing an expanded data capture, analysis and reporting capability.

* Results or Benefits Expected:

Expect to perform a more rigorous actuarial review of health rate filings, with more transparency to the consumers and provide Insurance Department with the appropriate data reporting capabilities to help provide consumers with value

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours
Purchase multiple commercial actuarial health pricing models for both the group and individual market. Train staff to use the pricing models in the most effective manner	Actuary	08/09/2010	09/30/2011	1,080
Programming that would allow the loading of activities related to the rate filings onto the CT Insurance Department website; create ability for consumers to post comments on rate filings	IT Consultants overseen by Department Computer Support Staff	08/09/2010	09/30/2011	750
Coordinate with the National Association of Insurance Commissioners for SERFF application enhancements to collect rate filing data for reporting purposes and additional information that may be useful to load on the CT Insurance Dept website	IT Consultants overseen by Department Computer Support Staff	08/09/2010	09/30/2011	675
Assist in development of rate review process and transparency enhancements; support rate hearings as needed held at the discretion of the Commissioner	Legal Consultant overseen by Department Legal staff	08/09/2010	09/30/2011	525

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

* Activities	* Position Responsible	* Time Period Begin	* Time Period End	* Non-Salary Personnel Hours

* Criteria for Evaluating Results or Benefits Expected:

By using the pricing models to perform a more rigorous actuarial review, this will help to reduce any perception of bias in the rate review process. As more information is provided to the public through the process of transparency, the public will be able to provide comment directly to the Department and make more informed health care purchases. Through enhanced data reporting capabilities the Department will be able to provide all the necessary reports to HHS.

OMB Number: 0980-0204
Expiration Date: 12/31/2009

Objective Work Plan

You may attach up to 17 additional Objective Work Plan forms here. To extract, fill and attach each additional form, follow these steps:

- Select the "Select to Extract the Objective Work Plan Attachment" button below.

- Save the file using a descriptive name to help you remember the content of the supplemental form that you are creating. When assigning a name to the file, please remember to give it the extension ".pdf" (for example, "Objective_1.pdf"). If you do not name your file with the ".pdf" extension you will be unable to open it later, using Adobe Reader.

- Use the "Open Form" tool on Adobe Reader to open the new form you just saved.

- Enter your additional Objective information in this supplemental form, similar to the Objective Work Plan form that you see in the main body of your application.

- When you have completed entering information in the supplemental form, save and close it.

- Return to this page and attach the saved supplemental form you just filled in, to one of the blocks provided on this "attachments" form.

Important: Attach additional Objective Work Plan forms, using the blocks below. Please remember that the files you attach must be Objective Work Plan PDF forms that were previously extracted using the process outlined above. Attaching any other type of file may result in the inability to submit your application to Grants.gov. Note: It is important to attach completed forms only. Attach ONLY PDF (.pdf) forms where ALL required fields are filled out. Incomplete or missing data will cause your application to be rejected.

Select to extract the Objective Work Plan Attachment

1) Please attach Attachment 1		Add Attachment	Delete Attachment	View Attachment
2) Please attach Attachment 2		Add Attachment	Delete Attachment	View Attachment
3) Please attach Attachment 3		Add Attachment	Delete Attachment	View Attachment
4) Please attach Attachment 4		Add Attachment	Delete Attachment	View Attachment
5) Please attach Attachment 5		Add Attachment	Delete Attachment	View Attachment
6) Please attach Attachment 6		Add Attachment	Delete Attachment	View Attachment
7) Please attach Attachment 7		Add Attachment	Delete Attachment	View Attachment
8) Please attach Attachment 8		Add Attachment	Delete Attachment	View Attachment
9) Please attach Attachment 9		Add Attachment	Delete Attachment	View Attachment
10) Please attach Attachment 10		Add Attachment	Delete Attachment	View Attachment
11) Please attach Attachment 11		Add Attachment	Delete Attachment	View Attachment
12) Please attach Attachment 12		Add Attachment	Delete Attachment	View Attachment
13) Please attach Attachment 13		Add Attachment	Delete Attachment	View Attachment
14) Please attach Attachment 14		Add Attachment	Delete Attachment	View Attachment
15) Please attach Attachment 15		Add Attachment	Delete Attachment	View Attachment
16) Please attach Attachment 16		Add Attachment	Delete Attachment	View Attachment
17) Please attach Attachment 17		Add Attachment	Delete Attachment	View Attachment

OMB Number: 4040-0003
Expiration Date: 09/30/2011

Project Abstract

The Project Abstract must not exceed one page and must contain a summary of the proposed activity suitable for dissemination to the public. It should be a self-contained description of the project and should contain a statement of objectives and methods to be employed. It should be informative to other persons working in the same or related fields and insofar as possible understandable to a technically literate lay reader. This Abstract must not include any proprietary/confidential information.

* Please click the add attachment button to complete this entry.

Add Attachment | Delete Attachment | View Attachment

Project Abstract.pdf

Project Narrative File(s)

*** Mandatory Project Narrative File Filename:** Project Narrative final.pdf

Add Mandatory Project Narrative File | Delete Mandatory Project Narrative File | View Mandatory Project Narrative File

To add more Project Narrative File attachments, please use the attachment buttons below.

Add Optional Project Narrative File | Delete Optional Project Narrative File | View Optional Project Narrative File

Budget Narrative File(s)

*** Mandatory Budget Narrative Filename:** Budget Narrative for Rate Review Grant-final.pdf

Add Mandatory Budget Narrative | Delete Mandatory Budget Narrative | View Mandatory Budget Narrative

To add more Budget Narrative attachments, please use the attachment buttons below.

Add Optional Budget Narrative | Delete Optional Budget Narrative | View Optional Budget Narrative

BUDGET INFORMATION - Non-Construction Programs

OMB Approval No. 4040-0006
Expiration Date 07/30/2010

SECTION A - BUDGET SUMMARY

Grant Program Function or Activity (a)	Catalog of Federal Domestic Assistance Number (b)	Estimated Unobligated Funds		New or Revised Budget		
		Federal (c)	Non-Federal (d)	Federal (e)	Non-Federal (f)	Total (g)
1. Rate Enhancement Tools		$	$	$ 226,480.08	$ 100,000.00	$ 326,480.08
2. Transparency				708,250.00	100,000.00	808,250.00
3. Data Collection and Reporting Enhancements				46,125.00	100,000.00	146,125.00
4. SERFF Enhancements - Contribution to NAIC enhancements				18,808.00		18,808.00
5. Totals		$	$	$ 999,663.08	$ 300,000.00	$ 1,299,663.08

SECTION B - BUDGET CATEGORIES

6. Object Class Categories	GRANT PROGRAM, FUNCTION OR ACTIVITY				Total
	(1) Rate Enhancement Tools	(2) Transparency	(3) Data Collection and Reporting Enhancements	(4) SERFF Enhancements - Contribution to NAIC enhancements	(5)
a. Personnel	$	$	$	$	$
b. Fringe Benefits					
c. Travel					
d. Equipment					
e. Supplies					
f. Contractual		708,250.00	46,125.00	18,808.00	773,183.00
g. Construction					
h. Other	226,480.08				226,480.08
i. Total Direct Charges (sum of 6a-6h)	226,480.08	708,250.00	46,125.00	18,808.00	$ 999,663.08
j. Indirect Charges					$
k. TOTALS (sum of 6i and 6j)	$ 226,480.08	$ 708,250.00	$ 46,125.00	$ 18,808.00	$ 999,663.08
7. Program Income	$	$	$	$	$

SECTION C - NON-FEDERAL RESOURCES

(a) Grant Program	(b) Applicant	(c) State	(d) Other Sources	(e)TOTALS
8. Rate Review Enhancement Tools	$	$ 100,000.00	$	$ 100,000.00
9. Transparency		100,000.00		100,000.00
10. Data Collection and Reporting Enhancements		100,000.00		100,000.00
11. SERFF Enhancements - Contribution to NAIC enhancements				
12. TOTAL (sum of lines 8-11)	$	$ 300,000.00	$	$ 300,000.00

SECTION D - FORECASTED CASH NEEDS

	Total for 1st Year	1st Quarter	2nd Quarter	3rd Quarter	4th Quarter
13. Federal	$ 999,663.08	$ 349,261.50	$ 296,276.58	$ 177,062.50	$ 177,062.50
14. Non-Federal	$ 300,000.00	100,000.00	75,000.00	75,000.00	50,000.00
15. TOTAL (sum of lines 13 and 14)	$ 1,299,663.08	$ 449,261.50	$ 371,276.58	$ 252,062.50	$ 227,062.50

SECTION E - BUDGET ESTIMATES OF FEDERAL FUNDS NEEDED FOR BALANCE OF THE PROJECT

(a) Grant Program	FUTURE FUNDING PERIODS (YEARS) (b)First	(c) Second	(d) Third	(e) Fourth
16. Rate Review Enhancement Tools	$ 89,350.00	$ 92,030.50	$ 94,791.42	$ 97,635.17
17. Transparency	160,000.00	160,000.00	160,000.00	160,000.00
18. Data Collection and Reporting Enhancements	30,000.00	30,000.00	30,000.00	30,000.00
19. SERFF Enhancements - Contribution to NAIC enhancements	0.00	0.00	0.00	0.00
20. TOTAL (sum of lines 16 - 19)	$ 279,350.00	$ 282,030.50	$ 284,791.42	$ 287,635.17

SECTION F - OTHER BUDGET INFORMATION

21. Direct Charges:

22. Indirect Charges:

23. Remarks:

OMB Approval No.: 4040-0007
Expiration Date: 07/30/2010

ASSURANCES - NON-CONSTRUCTION PROGRAMS

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

NOTE: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant, I certify that the applicant:

1. Has the legal authority to apply for Federal assistance and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project cost) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States and, if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standards or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standards for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C.§§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U. S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee- 3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to nondiscrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and, (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Titles II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally-assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally-assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetlands pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clean Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended (P.L. 93-523); and, (h) protection of endangered species under the Endangered Species Act of 1973, as amended (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead-based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations, and policies governing this program.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	Director, Life & Health Division
* APPLICANT ORGANIZATION	* DATE SUBMITTED
State of Connecticut	Completed on submission to Grants.gov

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C.1352

Approved by OMB
0348-0046

1. * Type of Federal Action:
- [ ] a. contract
- [x] b. grant
- [ ] c. cooperative agreement
- [ ] d. loan
- [ ] e. loan guarantee
- [ ] f. loan insurance

2. * Status of Federal Action:
- [ ] a. bid/offer/application
- [x] b. initial award
- [ ] c. post-award

3. * Report Type:
- [x] a. initial filing
- [ ] b. material change

4. Name and Address of Reporting Entity:

[x] Prime [ ] SubAwardee

** Name:* State of Connecticut Insurance Department

** Street 1:* 153 Market Street *Street 2:*

** City:* Hartford *State:* CT: Connecticut *Zip:* 06103-1300

Congressional District, if known: CT-all

5. If Reporting Entity in No.4 is Subawardee, Enter Name and Address of Prime:

6. * Federal Department/Agency:

HHS - OCIIO

7. * Federal Program Name/Description:

Affordable Care Act (ACA) Grants to States for Health Insurance Premium Review

CFDA Number, *if applicable:* 93.511

8. Federal Action Number, *if known:*

RFA-FD-10-999

9. Award Amount, *if known:*

$

10. a. Name and Address of Lobbying Registrant:

Prefix: ** First Name:* n/a *Middle Name:*

** Last Name:* N\A *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

b. Individual Performing Services (including address if different from No. 10a)

Prefix: ** First Name:* n/a *Middle Name:*

** Last Name:* N\A *Suffix:*

** Street 1:* *Street 2:*

** City:* *State:* *Zip:*

11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when the transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

*** Signature:** Completed on submission to Grants.gov

***Name:** *Prefix:* Ms. ** First Name:* Mary Ellen *Middle Name:*

** Last Name:* Breault *Suffix:*

Title: Director, Life & Health Division **Telephone No.:** 860-297-3857 **Date:** Completed on submission to Grants.gov

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Standard Form - LLL (Rev. 7-97)

Attachment 1

APPLICATION COVER SHEET AND CHECK-OFF LIST

Indentifying Information:

Grant Opportunity: **HHS Health Insurance Rate Review Grants-Cycle I**

DUNS #: 0130566550000 Grant Award: $1 million

Applicant: Connecticut Insurance Department

Primary Contact Person, Name: Mary Ellen Breault

Telephone Number: 860-297-3857 Fax number: 860-297-3941

Email address: maryellen.breault@ct.gov

APPLICATION COVER SHEET AND CHECK-OFF LIST

REQUIRED CONTENTS

A complete proposal consists of the following material organized in the sequence below: Please ensure that the project narrative is page-numbered. The sequence is:

- ☐ Cover Sheet
- ☐ Forms/Mandatory Documents (Grants.gov).

  The following forms must be completed with an original signature and enclosed as part of the proposal:

- ☐ SF-424: Application for Federal Assistance
- ☐ SF-424A: Budget Information
- ☐ SF-424B: Assurances-Non-Construction Programs
- ☐ SF-LLL: Disclosure of Lobbying Activities
- ☐ Additional Assurance Certifications
- ☐ Required Letter of support and Memorandum of Agreement
- ☐ Applicant's Application Cover Letter
- ☐ Project Abstract
- ☐ Project Narrative
- ☐ Work plan and Time Line
- ☐ Proposed Budget (Narrative/Justifications)
- ☐ Required Appendices
- ☐ Resume/Job Description for Project Director and Assistant Director

M. Jodi Rell
GOVERNOR
STATE OF CONNECTICUT

June 28, 2010

The Honorable Kathleen Sebelius
Secretary of Health and Human Services
The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Letter of Support for Grant Application by Connecticut for Rate Review Enhancements

Dear Secretary Sebelius,

The State of Connecticut ("the State") is pleased to submit an application for a grant made available through the Patient Protection and Affordable Care Act to expand the State's rate review process for health insurance premiums. I am extremely concerned with the increasing cost of health insurance and applaud the goals of this grant to provide the opportunity to enhance the Connecticut Insurance Department's existing rate review oversight.

The proposal outlines how the grant will allow a more rigorous actuarial review to enhance consumer protections and allow Connecticut to develop the reporting capabilities required by the Patient Protection and Affordable Care Act. I am excited that the grant will also provide the State with resources to post rate filings and other important information on the Insurance Department website that will be available to consumers and employers.

I appreciate your willingness to work with my Administration to help make private insurance more accessible and affordable and increase the transparency of the health insurance system. I look forward to future joint efforts on issues related to the implementation of the Patient Protection and Affordability Care Act.

Sincerely,

M. Jodi Rell
Governor

EXECUTIVE CHAMBERS • STATE CAPITOL
210 CAPITOL AVENUE, HARTFORD, CONNECTICUT 06106
TEL (860) 566-4840 • FAX (860)524-7396 • WWW.CT.GOV
GOVERNOR.RELL@CT.GOV

Certification of Maintenance of Effort by the State of Connecticut

I certify that the Health Insurance Premium Review grant funds (grant 93.511) provided in accordance with the Patient Protection and Affordable Care Act of 2010 (PPACA) will only be used to enhance the state's existing rate review efforts and not as a substitute for funding the existing rate review processes. Current Connecticut Insurance Department staff will continue to perform the rate reviews in accordance with existing law and the state will continue to fund these positions and activities. The grant will be used to hire consultants and actuarial models to enhance the existing rate review process, to expand the Insurance Department website to provide greater transparency for consumers, and to develop systems for data collection and reporting that is required by PPACA.

I certify that the funds will not be used for the following prohibited uses of grants funds:

1. To cover the costs to provide direct services to individuals.
2. To match any other Federal funds.
3. To provide services, equipment, or supports that are the legal responsibility of another party under Federal or State law (e.g. vocation rehabilitation or education services) or under any civil rights laws. Such legal responsibilities include, but are not limited to, modifications of a workplace or other reasonable accommodations that are a specific obligation of the employer or other party.
4. To supplant existing State, local, or private funding of infrastructure or services such as staff salaries, etc.

M. Jodi Rell
Governor

June 28, 2010
(Date)

PROJECT ABSTRACT

Under existing laws, the Connecticut Insurance Department ("CID") has rate review authority for individual health insurance rates and individual and group health rates for HMOs .CID's proposed Health Insurance Premium Review Grant ("Grant") application, consistent with the goals of the Affordable Care Act, is to ensure that consumers receive value for their premium dollars by enhancing existing CID rate review capabilities through investments in rate review tools and technology upgrades and development which will support transparency, data collection and reporting in our rate review processes. The total amount sought by CID in its Grant application is $1million. With this Grant, CID will make investments to enhance the current rate review process by funding the following overlapping project activities.

1. **Rate Review Enhancement Tools:** The proposed budget includes $226,480.08 to initially purchase, and renew for one year, commercial rating manuals and software packages offered by Towers/Watson and Milliman. These tools will enable CID actuarial staff to augment current in-depth review of individual and HMO proposed rate increases by testing and validating proposed rates and rate assumptions submitted by regulated entities using state of the art actuarial tools that are universally recognized and accepted. For all other health rate filings that the Department does not have statutory rate review authority over, which is primarily group non-HMO rate increases, the Department will perform for those increases that are determined by HHS to be unreasonable, the same level of rigorous review as mentioned above using the commercial health rate models.

2. **Transparency:** The proposed budget includes $708,250 for process development, application and hardware enhancements and resource expenditures related to transparency. There are three primary groupings of expenditures – information technology ("IT"); actuarial, and legal. The allocation for IT expenditures is budgeted for $166,000 for an estimated 830 hours of IT consulting to be used to design and implement CID website modifications to enable the CID to post all rate filings for public review and comment. The actuarial allocation is $336,000, designated to provide 1120 hours of actuarial consulting to be used to design and implement modifications to the current rate review process to strengthen the rigor of the review through rate review modeling, to work with the IT consultants in developing system changes to support the more expansive filings and the website modifications and to design and develop expanded data capture, reporting and analysis capabilities. The legal allocation totals $206250, with $75,000 to be used for expenses such as independent hearing officers and court reporters associated with rate hearings for rate requests determined to be unreasonable and unresolved through the rate review process and the balance of $131,250 to be used to provide 525 hours of legal consulting to support the actuarial and IT enhancements.

3. **Data Collection and Reporting and Data Center:** The proposed budget has allocated a total of $64,933 for data related initiatives to include Connecticut's contribution of $18, 808 to the NAIC SERFF modifications and 615 hours of IT consulting time to design and develop a more robust data reporting capability, to enable CID to track and analyze trends, patterns of rate increases, and fulfill reporting requirements to HHS.

STATE OF CONNECTICUT

INSURANCE DEPARTMENT

July 1, 2010

The Honorable Kathleen Sebelius
Secretary, Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201

Re: Grants to States for Health Insurance Premium Review-Cycle I

Dear Secretary Sebelius,

The State of Connecticut, through the Connecticut Insurance Department ("Department"), is the applicant for the Grants to States for Health Insurance Premium Review-Cycle I. The Connecticut Insurance Department is the state entity that has the statutory and regulatory authority over private health insurance in the State of Connecticut.

Connecticut General Statute section 38a-8(a) provides in part:

> *The commissioner shall see that all laws respecting insurance companies and health care centers are faithfully executed and shall administer and enforce the provisions of this title. The commissioner has all powers specifically granted, and all further powers that are reasonable and necessary to enable the commissioner to protect the public interest in accordance with the duties imposed by this title...."*

In addition to the broad, general authority above, the Connecticut Insurance Department has rate review authority for individual health insurance rates under section 38a-481 of the Connecticut General Statutes. Furthermore, the Department has authority to approve both individual and group health rates for Health Care Centers under section 38a-183 of the Connecticut General Statutes. "Health Care Center" is a term used by Connecticut, whereas most other states utilize the term "health maintenance organization" or "HMO".

The Connecticut Insurance Department has authority under the statutes cited above to oversee and coordinate the activities proposed under this grant application. I have been designated as the Project Director. In addition to myself as Project Director, the Department has additional actuarial and other staff who will oversee and participate in the proposed activities.

Sincerely,

Mary Ellen Breault

Mary Ellen Breault
Director, Life and Health Division
153 Market Street
Hartford, CT 06103-1300
Phone 860-297-3857 Fax 860-297-3941
maryellen.breault@ct.gov

Project Narrative

A. Current Rate Review Process

1. General health insurance rate regulation information

Health care centers (HMOs) and health insurance companies must be licensed by the Connecticut Insurance Department (CID) to offer products in this state. Forms for all health insurance products must be filed for prior approval by CID for both entities. Rates must be filed for prior approval by CID for all products offered by HMOs in both the group and individual market. Rates must be filed for prior approval by CID for all individual products offered by health insurance companies. The Insurance Commissioner may at his or her discretion hold a public hearing on any rate application. Health insurance companies are not required to file rates for group products. In the small employer market, there are statutory rate limitations (community rating with allowable adjustment for specified classes). Although only HMOs must file these rates for prior approval, both HMOs and health insurance companies must file with CID an annual actuarial certification that they are in compliance with the rating restrictions in the small employer market.

Individual health insurance products are generally medically underwritten. Current rates typically vary by age, gender and location. Carriers may offer substandard rates based on health conditions or use smoker/nonsmoker adjustments. Individual health insurers may opt to offer a loss ratio guarantee. Filed rates are deemed approved if loss ratio guarantee is filed. An annual independent audit is filed with Commissioner and refunds are payable if the loss ratio is not met. To date only one carrier has filed a loss ratio guarantee.

The small employer market is defined as 1-50. All products are guaranteed issue for groups of 2-50, and a statutory plan is available on a guaranteed issue basis for self-employed groups of one. Rates are required to be community rated, but currently may be adjusted for age, gender, geographic location, industry, family composition and group size, but not for health conditions or claims experience.

The large employer market is defined as over 50. Rates filed for approval by HMOs are community rated and adjustments are currently allowed for age, gender, geographic location, industry and family composition. HMOs may use prospective experience rating, but the methodology must be filed with CID for prior approval and used consistently in the large group market.

2. Health insurance rate review and filing requirements

CID does not require a standard format but does require the following components to be included in the rate filings:

- Historical claim experience since inception for both Connecticut and nationwide
- Development of base premium rates
- Adjustment factors (age, gender, geographic location, etc.)
- Development of trend assumptions
- Experience rating methodology (group market only)
- Development of expense charge
- Enrollment data by plan
- Benefit descriptions
- Benefit relativities
- Actuarial certification signed by a Member of the American Academy of Actuaries

Description of rate review process:

There is one staff actuary in the Life and Health Division of CID that currently reviews all rate filings. The Life and Health Division Director is also an actuary and may review complex filings with the staff actuary and has acted as hearing officer at one public hearing called by the Commissioner on a rate application. The Department does not currently contract with consultants and does not have any commercial pricing models available to use in the rate review process. The statutory standard is that rates are approved if they are not inadequate, excessive nor unfairly discriminatory. A thorough analysis is completed by the CID actuary to ensure that the rates are actuarially justified in accordance with the Actuarial Standard of Practice No. 8 of the Actuarial Standards Board of the American Academy of Actuaries. Rates may be approved, modified or disapproved. Rate changes are implemented on a prospective basis.

All HMO products and individual health insurance products are required by statute to have rates filed for prior approval. The CID actuary completes a thorough review of past experience from inception of the policy form to current time including earned premium, incurred claims and the resulting actual loss ratio. The actual loss ratio is compared to the expected loss ratio for each year of experience. The actuary also compares the requested rate increases, claims data and average premium rates for Connecticut to the nationwide data for the same or similar policy forms. Connecticut only experience may need to be weighted by nationwide experience if the Connecticut experience is not sufficient, or credible, to stand on its own

The CID actuary also analyzes recent historical claim experience to evaluate trend assumptions used to project current claims to the rating period in the filing. The components of trend include the unit cost trend for medical inflation, utilization trend, changes in the mix or intensity of

services used by consumers, cost-sharing leveraging to account for fixed deductibles or copayments having a decreasing effect on lowering premiums as medical costs rise, and medical technology. Claim lag triangles are reviewed to test the estimates of incurred claims for the most recent calendar year of experience and the projected year and to identify any possible seasonality in claims(where the volume of claims may vary by time of year). The analysis also includes a review of other adjustments for actuarial soundness including changes in the membership, aging factor of population, changes in gender mix, the cost of any new benefit mandates and any potential new health impacts (e.g. H1N1 virus).

The retention charge or expense component includes administrative expenses, commissions, premium taxes and any margin or profit component. The retention charge used in the rate development is compared to the actual expenses reported in the most recently filed statutory financial statement for that regulated entity.

The current process does not include any verification of cost or utilization data for specific benefits. The rate filings provide relativity factors for various benefit designs. These values are reviewed for overall reasonableness, but are basically accepted as filed. These values cannot be verified since CID does not have any systems in place, data or sufficient staff to review cost data, utilization data, negotiated discounts, fee schedules or levels of reasonable and customary charges. With the grant, CID proposes to enhance the current actuarial rate review to better evaluate these items. These are detailed in the proposed rate review enhancements section.

The Market Conduct Division of CID conducts periodic examinations or targeted examinations in instances where issues of non-compliance have been discovered or complaints have been filed

with CID. Rates may be adjusted retroactively if it is determined that rates were implemented that were not approved or not applied consistently in accordance with the approved rate filing.

3. Current level of resources and capacity for reviewing health insurance rates:

Information Technology (IT) and systems capacity

CID has minimal IT systems that support the rate review process. Electronic filings are made via SERFF, and there is an in-house tracking system for all form and rate filings. Both systems can be accessed by the public to view filings, but only if the individual comes to the Department. With the grant, CID is proposing to implement systems to expand the actuarial review of costs of services, transparency of filings for consumers and data collection and reporting. These are detailed in the proposed rate review enhancements section.

Budget and Staffing

The current annual Connecticut Insurance Department budget is approximately $25 million. Total revenues deposited by the Insurance Department for this fiscal year will be approximately $100 million with $25 million deposited into the Insurance Fund, and $75 million into the State of Connecticut General Fund.

The budgetary breakdown for resources allocated to rate review currently are at the following:

1 full time staff actuary = $200,000 for salary and fringe

10% of Life and Health Division Director and 10% Legal staff support = $100,000 for salary and fringe

There is one staff actuary in the Life and Health Division of CID that currently reviews all rate filings who has been with CID for 14 years. The actuary received a degree in actuarial science

from the University of Connecticut and is an Associate of the Society of Actuaries and a member of the American Academy of Actuaries. Prior to joining CID, the actuary worked at an insurance company for 9 years, 8 of which consisted of health pricing. The Life and Health Division Director may review complex filings with the actuary and has acted as hearing officer at one public hearing called by the Commissioner on a rate application. The director has a degree in mathematics and economics from Trinity College and is also an Associate of the Society of Actuaries and a member of the American Academy of Actuaries. The director has been with CID for 18 years and had previously worked as a health pricing actuary at an insurance company. CID does not currently contract with consultants and does not have any pricing models used in the rate review process. There are two staff attorneys that provide support regarding rate review issues including public rate hearings. The Department frequently needs a Department attorney to assist the Department actuaries in the rate review process to address legal issues and statutory interpretation as well as to participate in optional hearings, as determined by the Commissioner. A Department attorney needs to have a Juris Doctor (JD) degree beyond a Bachelor's degree (BA or BS) and be a member of the Connecticut Bar. In addition the attorney needs to have extensive background and experience in both insurance law and health law. There are 2 Department attorneys today working on health issues. One has 30+ years experience in the insurance and managed care industry with experience in product development, customer service operation and strategic marketing. This individual has been a lawyer for 7 years with one year experience at the Connecticut legislature working on complex legislation and 6 years as counsel at the Insurance Department focused on health issues. This lawyer has a JD degree with a health law certificate issued by the Quinnipiac University School of Law. The second attorney has over 30 years of legal experience, primarily in insurance and health law, and has worked at managed care companies for over 25 years, specializing in federal laws such as ERISA that impact health benefits, and contract negotiation with Fortune 500 companies for administration of their health

plans. This attorney has been serving as counsel at the Connecticut Insurance Department for just under 4 years and has a JD degree from the University of Connecticut School of Law.

Not every health insurance company in the individual market currently files rates annually for all products. There are five HMOs that file rates at least annually for both group and individual products. In 2009, there were 77 rate filings submitted for review. One submission generally encompasses multiple product forms and variations of each form. On average the reviews are completed within three to four weeks. With the grant, CID is proposing to contract with a consulting actuary to assist in the expanded review of unreasonable group rates that are not currently subject to the Department's authority. Since group rates are not currently required to be filed, the actual number of filings is not known. There are 19 carriers actively marketing in the small group market and approximately 475 companies with the authority to write health insurance. This will be detailed in the proposed rate review enhancements section.

4. Consumer protections

Rate filings are available for public inspection at CID. Public terminals are available to access electronic records and paper filings are also available. Filings are not currently posted on the website. Under the Freedom of Information laws, carriers may request that trade secret information that is not required to be filed be held confidential. Carriers are currently required to submit a public copy with the confidential data removed. Summaries of rate changes are not currently compiled or made available to the public. Public comment is not currently solicited during the rate review process. Notices to consumers of rate increases are governed by contractual notice requirements. Hearings are not currently required, but the Insurance Commissioner may at his or her discretion hold a public hearing on any rate application.

For the two year period from June 2008 through June 2010, there were 140 complaints regarding rate increases. The primary complaint was the level of the rate increase seemed excessive or unjustified.

With the grant, CID will contract with a consultant to expand information available on our website to enhance transparency for consumers. This is detailed in the proposed rate review enhancements section.

5. Examination and Oversight

There have been no actions taken against any HMO or insurance company over the past two years regarding health insurance rates. CID has worked with carriers over the past several years to ensure rate filings are complete and accurate when submitted. Very few rates are disapproved in their entirety as CID works with the companies to modify rates that are not justified.

A formal public hearing was held in July 2009 regarding the Anthem Blue Cross and Blue Shield application for increases on several individual products. The Commissioner called the hearing to provide a forum to receive public input on the filing since Anthem Blue Cross and Blue Shield is one of the largest carriers in the state and requested substantial rate increases. CID lowered the requested rate increases significantly as the rates were found to be excessive and not actuarially justified. In addition, the effective date of the rate increases were delayed for 3 months. A copy of the order (Docket Number 09-51) is available on the CID website, www.ct.gov/cid.

B. Proposed rate review enhancements for health insurance

1. Expanding the Scope of Current Review and Approval Activities

As required by PPACA, when a rate increase is determined to be unreasonable, a thorough review of the rate increase will be performed to determine whether or not the rate increase request is justified.

Currently, the CID has rate review approval authority over individual and HMO rate increase requests. A thorough analysis of these rate filings exists today, but will be significantly enhanced through the purchase of commercial health rating models. This will allow the Department to provide more in-depth actuarial reviews of all rate filings to determine whether or not the rate increase is justified.

For all other health rate filings that the Department does not have statutory rate review authority over, which is primarily group non-HMO rate increases, the Department will perform the same level of rigorous review as mentioned above using the commercial health rate models, for those increases that are determined by HHS to be unreasonable.

2. Improving Rate Filing Requirements

The CID will be developing a thorough set of rate filing requirements to be documented in a bulletin published by the Insurance Department and posted on our website, which are consistent with, and in some cases more expansive than, what we currently use for the rate review process of products and market segments for which we currently have rate review authority. These rate filings requirements will include but not be limited to the following:

- Historical experience from inception-to-date, this includes earned premium, incurred claims and the resulting loss ratio (both Connecticut and nationwide separately)
- Expected loss ratios for each year of experience

- Unit cost trend (medical inflation and net impact of provider contracts)
- Utilization trend (change in # of services used)
- Mix/Intensity of services trend (change in types of services used by consumers)
- Cost-sharing Leverage (impact of fixed $ cost sharing)
- Medical Technology trend
- Benefit buy-downs and the resulting impact on trend
- Change in membership and the make-up of that change if any
- Cost of any new mandates
- Any potential new health impacts
- Retention charge or expense component
- Components of the retention charge such as administrative expenses, commissions, premium tax and profit/margin
- Compare the retention charge used in rate filing to the most recently filed statutory financial statement for that regulated entity
- Claim lag triangles – a multi period report that provides for each incurral period the paid amount
- The components of the numerator and denominator for purposes of the MLR calculation for rebating purposes.
- Actuarial certification signed by a Member of the American Academy of Actuaries

3. Enhancing rate review process-Staffing

In anticipation of more rigorous reviews of current rate filings where the Department has approval authority and additional rate reviews of unreasonable rate increases for products the Department does not have approval authority of, we will be contracting with temporary actuarial

consultants that we estimate to provide 1120 hours of actuarial support. The cost for this temporary actuarial support is budgeted at $336,000.00. These temporary consultants will have lengthy experience in the pricing of health care products in Connecticut and will meet the qualification standards of the Society of Actuaries. These consultants will be in addition to the current actuarial staff at the CID, which includes an actuary and a Division Director that is also an actuary.

Along with the aforementioned actuarial consultants, the Department will be contracting with temporary I\T support consultants in order to provide rate review database enhancements for our website as well as any system enhancements that are necessary to provide data elements and reporting capabilities and work with the NAIC SERFF staff to coordinate data collection from electronic rate filings. This will help the Department provide more transparency to the health care consumers of Connecticut and provide HHS and the public with any necessary reports. The estimated number of temporary I\T consultant hours for the website enhancement as well as the rate review database enhancements, both of which will provide more transparency, is 830 hours. The cost for this is budgeted at $166,000.00. The estimated number of I\T hours for the data collection and reporting requirements is 615. The cost for this temporary I\T consulting is budgeted at $46,125.00.

The Department will also be contracting with temporary legal consultants to help provide legal support for any public rate hearings that may be held. This would include but not be limited to hearing officers, transcripts, and general legal support to the CID. The cost for all legal services is budgeted at $206,250.00.

The timeline for the hiring of all temporary consultants, as described above, is 8/9/2010 through 9/30/2011.

4. Enhancing rate review process-IT capacity

The Insurance Department currently utilizes the experience of existing actuarial staff in order to provide an actuarial review of rate increases that are submitted for individual and HMO rate filings. In order to enhance this actuarial review process, the Department will purchase multiple pricing models that provide, not only medical, but dental and prescription drug pricing manuals. These manuals and the models they support can be used by the Departments actuarial staff to review individual health product rate filings as well as small group and large group rate filings. One of the models includes a mandated benefits model that can provide valuable information related to state specific mandates. Medical simulation software can be used to verify a specific small group or large group case and provide a comparison to the overall database that is provided in the larger pricing model. Age 65 and older and Medicare supplement software can be used to determine individual pricing since HIPAA requires the guarantee renewability of individual health policies past the age of 64. The purchase price of the Towers Watson pricing model is $34, 720.00, while the first year renewal cost is $23, 262.40, for a total of $57,982.40. The purchase price of the Milliman pricing model is $105,012.50 and the first year renewal is $63,485.18 for a total of $168,497.68. The timeline for the purchase and renewal of both models and any training that is necessary is 8/9/10 through 1/31/11.

More than one pricing model from multiple sources will provide the Department with the ability to verify assumptions used in the rate filings more thoroughly as the multiple models can be used as a source of checks and balances and will mitigate any inherent bias that might be contained in one pricing model versus another pricing model.

New software will need to be downloaded in conjunction with new computer hardware in order to run the pricing models. The Department staff including any additional temporary actuarial consultants will need to be trained in the use of these pricing models in order for the Department to fully utilize all the capabilities the pricing models have to offer.

The CID I\T staff and any additional temporary I\T consultants will work with the National Association of Insurance Commissioners SERFF team in order to develop data exchange capabilities for the purposes of satisfying the enhanced data reporting requirements that will be part of future HHS regulatory requirements. They will also work to provide this same type of reporting capability to the Departments website so that health care consumers can access the necessary information they need to make informed decisions. They will also work towards enhancing the approval process by posting the rate filing and all correspondence on the Departments website for public viewing.

5. Enhancing consumer protection standards

Currently the rate filings and all of the actuarial material provided are considered to be to exempt from public inspection. Only the actual rates themselves are available in a hard copy format or on the SERFF system for the public. The Insurance Department will be publishing a bulletin that will contain all of the filing requirements of any health rate filing that is submitted. This will need to also be posted on our website and incorporated into the SERFF process as required elements of a rate filing. The rate filing will then be posted to our website for the public in order to create more transparency in the rate process. Any correspondence between the filing company and Insurance Department staff will also be posted, along with a final determination. The public will also have an opportunity to provide comment and those comments will also be posted to the website for consumers to view.

In addition, if there are any rate hearings, the notice of the rate hearing as well as the full process will be posted to the website prior to the rate hearing date.

C. Reporting to the Secretary on Rate Increase Patterns

CID attests that it will comply with the reporting requirements outlined in the Patient Protection and Affordable Care Act of 2010. CID does not currently compile the data outlined for filed rate increases. Although most of the data that has been outlined pending final reporting requirements is contained in current rate filings, CID will need to revise its existing rate filing requirements to add any additional required elements. This includes but is not limited to disaggregated trends by benefit category, changes in member cost-sharing, and changes in member benefits. The grant will be used to contract with an IT consultant and the NAIC to develop data exchange capabilities to capture and report the required data.

Appendix

Statute Requiring Licensure to do Insurance Business

Sec. 38a-41. (Formerly Sec. 38-20). Authority to do business. Licensure. Revocation or refusal to renew license. Fines. Company owned by a state or foreign nation or company controlled by insureds not to be licensed. Appeals. Plan of operations. Type of business to be conducted. (a) No insurance company or health care center shall do any insurance business or health care center business within this state until and except while it is permitted to do so under the terms of a license issued by the commissioner. Any such company desiring to obtain such a license shall make application to the commissioner, setting forth the line or lines of business which it is seeking authorization to write. It shall file with the commissioner a certified copy of its charter or articles of association and evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, a statement of its financial condition in such form as is required by the commissioner, together with such evidence of its correctness as the commissioner requires and evidence of good management in such form as is required by the commissioner. Applicant companies licensed in and operated from administrative offices in one state but domiciled in another state, as permitted by the applicable state law, shall provide justification of such arrangement, satisfactory to the commissioner, which shall demonstrate that regulatory influence of the domiciliary supervisory official has not been diminished as a result of such arrangement. An applicant shall demonstrate an orderly pattern of growth in its marketing territories in the geographic region, with the exception of a newly formed health care center, and an expertise in marketing and servicing the lines of insurance or the health care center business it desires to write. It shall submit evidence of its ability to provide continuant and timely claims settlement. If the information furnished is satisfactory to the commissioner and if all other requirements of law have been complied with, he may issue to such company a license permitting it to do business in this state. Each such license shall expire on the first day of May succeeding the date of its issuance, but may be renewed without any formalities except as required by the commissioner. Failure of a licensed company to exercise its authority to write a particular line or lines of business in this state for two consecutive calendar years may constitute sufficient cause for revocation of the company's authority to write those lines of business.

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 specifying the information and evidence that an insurance company or health care center desiring to obtain or renew a license to do an insurance business or health care center business shall submit and the requirements with which it shall comply.

(c) The commissioner may, at any time, for cause, suspend, revoke or refuse to renew any such license or in lieu of or in addition to suspension or revocation of such license the commissioner, after reasonable notice to and hearing of any holder of such license, may impose a fine not to exceed fifty thousand dollars. Such hearings may be

held by the commissioner or any person designated by the commissioner. Whenever a person other than the commissioner acts as the hearing officer, the person shall submit to the commissioner a memorandum of the person's findings and recommendations upon which the commissioner may base a decision. The commissioner may, if the commissioner deems it in the interest of the public, publish in one or more newspapers of the state a statement that, under the provisions of this section, the commissioner has suspended or revoked the license of any insurance company or health care center to do business in this state.

(d) No license to do an insurance business within this state shall be issued to a foreign insurance company owned or financially controlled by another state of the United States or to an alien insurance company owned or financially controlled by a foreign nation or any state or province thereof.

(e) No license to do an insurance business within this state shall be issued to any company which insures or plans to insure the separate risks of the employees of an employer that directly or indirectly controls the insurer by stock ownership or otherwise or exercises control of the operations of the insurer where the premiums written annually by the insurer on the separate risks of such employees exceed or will exceed ten per cent of the total premiums which the insurer writes or will write annually or where the commissions payable, if any, on premiums covering the risks of such employees written by the insurer annually exceed or will exceed ten per cent of the total commissions to agents which are or will be paid annually by the insurer.

(f) Any company aggrieved by the action of the commissioner in revoking, suspending or refusing to renew a license or in imposing a fine may appeal therefrom, in accordance with the provisions of section 4-183, except venue for such appeal shall be in the judicial district of New Britain. Appeals under this section shall be privileged in respect to the order of trial assignment.

(g) Except as provided in section 38a-92*l* an insurer shall be required to be licensed to transact financial guaranty insurance in this state, as defined in subdivision (1) of section 38a-92a. Prior to the issuance of a license to transact financial guaranty insurance business, an insurer shall submit for the approval of the commissioner a plan of operation detailing the types and projected diversification of guaranties that will be issued, the underwriting procedures that will be followed, managerial oversight methods, investment policies and other matters as may be prescribed by the commissioner. An insurer licensed to transact the business of financial guaranty insurance may also be licensed to transact the business of surety, credit and residual value insurance, but may not be licensed to transact any other lines of insurance in this state.

Statutes Requiring Health Care Centers (HMOs) to File Forms and Rates

Sec. 38a-182. (Formerly Sec. 33-179j). Agreements with subscribers. Agreement requirements. Evidence of coverage. (a) An agreement issued by a health care center governed by sections 38a-175 to 38a-192, inclusive, may be issued for health care or the costs thereof to a subscriber, to a subscriber and spouse, to a subscriber and family, to a subscriber and dependent or dependents related by blood, marriage or adoption or to a subscriber and ward. Such agreement or evidence of coverage document shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate.

(b) Each such agreement shall contain the following provisions: (1) Name and address of the health care center; (2) eligibility requirements; (3) a statement of copayments, deductibles or other out-of-pocket expenses payment payable by the subscriber; (4) a statement of the nature of the health care services or benefits to be furnished and the period during which they will be furnished, and, if there are any services or benefits to be excepted, a detailed statement of such exceptions provided that such services or benefits to be furnished conform at a minimum to the requirements of the Federal Health Maintenance Organization Act; (5) a statement of terms and conditions upon which the agreement may be cancelled or otherwise terminated at the option of either party; (6) claims procedures; (7) enrollee grievance procedures; (8) continuation of coverage; (9) conversion; (10) extension of benefits, if any; (11) subrogation, if any; (12) description of the service area, out-of-area benefits and services, if any; (13) a statement of the amount payable to the health care center by the subscriber and by others on his behalf and the manner in which such amount is payable; (14) a statement that the agreement includes the endorsement thereon and attached papers, if any, and contains the entire agreement; (15) a statement that no statement by the subscriber in his application for an agreement shall void the agreement or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such agreement; and (16) a statement of the period of grace which will be allowed the subscriber for making any payment due under the agreement, which period shall not be less than ten days.

(c) Every subscriber shall receive an evidence of coverage from the group contract holder or the health care center. The evidence of coverage shall not contain provisions or statements which are unfair, inequitable, misleading, deceptive or which encourage misrepresentation. The evidence of coverage shall contain a clear statement of the provisions set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section.

Sec. 38a-183. (Formerly Sec. 33-179k). Approval by commissioner of amounts to be paid subscribers and agreements. Component of rate. Capital reserve fund. Methods of protecting members from liability for uncovered expenditures. (a) A health care center governed by sections 38a-175 to 38a-192, inclusive, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the

commissioner's approval thereof. The commissioner may refuse such approval if he finds such amounts to be excessive, inadequate or discriminatory. Each such health care center shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a copy of such agreement or agreements, including all riders and endorsements thereon, and until the commissioner's approval thereof has been obtained. The commissioner shall, within a reasonable time after the filing of any request for an approval of the amounts to be paid, any agreement or any form, notify the health care center of either his approval or disapproval thereof.

(b) A health care center may establish rates of payment by any method permitted by the Federal Health Maintenance Organization Act and the regulations adopted thereunder from time to time unless otherwise determined by the commissioner by regulation.

(c) Each such health care center may include as a component of its rate a sum up to ten per cent of such rate to be used for the objects and purposes set forth in section 38a-184. An amount not exceeding ten per cent of the annual net premium income of such center may be set aside annually as a capital reserve fund and may be accumulated from year to year by such health care center, to be expended for the objects and purposes as set forth and in accordance with said section.

Statutes Providing Form and Rate Authority of Insurance Department

Sec. 38a-481. (Formerly Sec. 38-165). Approval of individual health application, policy form and rates. Medicare supplement policies and certificates: Age, gender, previous claim or medical history rating prohibited. Loss ratios. Optional life insurance riders. Underwriting classifications, claim experience and health status. Exceptions. Regulations. Certain refunds to be donated to The University of Connecticut Health Center. (a) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. The commissioner shall adopt regulations, in accordance with chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer which has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

(b) No rate filed under the provisions of subsection (a) of this section shall be effective until the expiration of thirty days after it has been filed or unless sooner approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to insure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

(c) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(d) Rates on a particular policy form will not be deemed excessive if the insurer has filed a loss ratio guarantee with the Insurance Commissioner which meets the

requirements of subsection (e) of this section provided (1) the form of such loss ratio guarantee has been explicitly approved by the Insurance Commissioner, and (2) the current expected lifetime loss ratio is not more than five per cent less than the filed lifetime loss ratio as certified by an actuary. The insurer shall withdraw the policy form if the commissioner determines that the lifetime loss ratio will not be met. Rates also will not be deemed excessive if the insurer complies with the terms of the loss ratio guarantee. The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to assure that the use of a loss ratio guarantee does not constitute an unfair practice.

(e) Premium rates shall be deemed approved upon filing with the Insurance Commissioner if the filing is accompanied by a loss ratio guarantee. The loss ratio guarantee shall be in writing, signed by an officer of the insurer, and shall contain as a minimum the following:

(1) A recitation of the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(2) A guarantee that the actual Connecticut loss ratios for the experience period in which the new rates take effect and for each experience period thereafter until any new rates are filed will meet or exceed the loss ratios referred to in subdivision (1) of this subsection. If the annual earned premium volume in Connecticut under the particular policy form is less than one million dollars and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nation-wide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars, the experience period will be extended until the end of the calendar year in which one million dollars of earned premium is attained;

(3) A guarantee that the actual Connecticut or nation-wide loss ratio results, as the case may be, for the experience period at issue will be independently audited by a certified public accountant or a member of the American Academy of Actuaries at the insurer's expense. The audit shall be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Insurance Commissioner not later than June thirtieth following the end of the experience period;

(4) A guarantee that affected Connecticut policyholders will be issued a proportional refund, which will be based on the premiums earned, of the amount necessary to bring the actual loss ratio up to the anticipated loss ratio referred to in subdivision (1) of this subsection. If nation-wide loss ratios are used, the total amount refunded in Connecticut shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned from all Connecticut policyholders who will receive refunds and divided by the total premium earned in all states on the policy form. The refund shall be made to all Connecticut policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal two dollars or more. The refund shall include interest, at six per cent, from the end of the experience period until the date of payment. Payment shall be made during the third

quarter of the year following the experience period for which a refund is determined to be due;

(5) A guarantee that refunds less than two dollars will be aggregated by the insurer. The insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center;

(6) A guarantee that the insurer, if directed by the Insurance Commissioner, shall withdraw the policy form and cease the issuance of new policies under the form in this state if the applicable loss ratio exceeds the durational target loss ratio for the experience period by more than twenty per cent, provided the calculations are based on at least two thousand policyholder-years of experience either in Connecticut or nation-wide.

(f) For the purposes of this section:

(1) "Loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations; and

(2) "Experience period" means the calendar year for which a loss ratio guarantee is calculated.

(g) Nothing in this chapter shall preclude the issuance of an individual health insurance policy which includes an optional life insurance rider, provided the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

(h) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers, issues for delivery, amends, renews or continues an individual health insurance policy in this state on or after October 1, 2003, may (1) move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; or (2) increase premium rates due to the claim experience or health status of an individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a whole.

Sec. 38a-513. Approval of group health insurance policies and certificates. Medicare supplement policies and certificates: Age, gender, previous claim or medical history rating prohibited. Exceptions. Optional life insurance riders. Regulations. Group specified disease policies. (a) No group health insurance policy, as defined by the commissioner, or certificate shall be issued or delivered in this state unless a copy of the

form for such policy or certificate has been submitted to and approved by the commissioner under the regulations adopted pursuant to this section. The commissioner shall adopt regulations, in accordance with chapter 54, concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for reviewing such policies and certificates. If the commissioner issues an order disapproving the use of such form, the provisions of section 38a-19 shall apply to such order.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(c) Nothing in this chapter shall preclude the issuance of a group health insurance policy which includes an optional life insurance rider, provided the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

(d) Not later than January 1, 2009, the commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits in group specified disease policies, certificates, riders, endorsements and benefits.

Regulation Regarding Hearings

Special Provisions:
Hearings of Applications and Petitions

Sec. 38a-8-47. General provisions.

(a) The Commissioner shall hold a hearing on any application or petition where required by law and may in his or her discretion hold a hearing on any application or petition presented to the Commissioner where he or she deems a hearing to be necessary for a complete consideration of the matter.

(b) In addition to the general provisions of this article governing hearings, the following special provisions, sections 38a-8-48 to 38a-8-53, inclusive, of the Regulations of Connecticut State Agencies shall apply to all hearings on applications and petitions filed with the Commissioner.

Statute Requiring Public Access of Records

Sec. 1-210. (Formerly Sec. 1-19). Access to public records. Exempt records. (a) Except as otherwise provided by any federal law or state statute, all records maintained or kept on file by any public agency, whether or not such records are required by any law or by any rule or regulation, shall be public records and every person shall have the right to (1) inspect such records promptly during regular office or business hours, (2) copy such records in accordance with subsection (g) of section 1-212, or (3) receive a copy of such records in accordance with section 1-212. Any agency rule or regulation, or part thereof, that conflicts with the provisions of this subsection or diminishes or curtails in any way the rights granted by this subsection shall be void. Each such agency shall keep and maintain all public records in its custody at its regular office or place of business in an accessible place and, if there is no such office or place of business, the public records pertaining to such agency shall be kept in the office of the clerk of the political subdivision in which such public agency is located or of the Secretary of the State, as the case may be. Any certified record hereunder attested as a true copy by the clerk, chief or deputy of such agency or by such other person designated or empowered by law to so act, shall be competent evidence in any court of this state of the facts contained therein.

(b) Nothing in the Freedom of Information Act shall be construed to require disclosure of:

(1) Preliminary drafts or notes provided the public agency has determined that the public interest in withholding such documents clearly outweighs the public interest in disclosure;

(2) Personnel or medical files and similar files the disclosure of which would constitute an invasion of personal privacy;

(3) Records of law enforcement agencies not otherwise available to the public which records were compiled in connection with the detection or investigation of crime, if the disclosure of said records would not be in the public interest because it would result in the disclosure of (A) the identity of informants not otherwise known or the identity of witnesses not otherwise known whose safety would be endangered or who would be subject to threat or intimidation if their identity was made known, (B) signed statements of witnesses, (C) information to be used in a prospective law enforcement action if prejudicial to such action, (D) investigatory techniques not otherwise known to the general public, (E) arrest records of a juvenile, which shall also include any investigatory files, concerning the arrest of such juvenile, compiled for law enforcement purposes, (F) the name and address of the victim of a sexual assault under section 53a-70, 53a-70a, 53a-71, 53a-72a, 53a-72b or 53a-73a, or injury or risk of injury, or impairing of morals under section 53-21, or of an attempt thereof, or (G) uncorroborated allegations subject to destruction pursuant to section 1-216;

(4) Records pertaining to strategy and negotiations with respect to pending claims or pending litigation to which the public agency is a party until such litigation or claim has been finally adjudicated or otherwise settled;

(5) (A) Trade secrets, which for purposes of the Freedom of Information Act, are defined as information, including formulas, patterns, compilations, programs, devices, methods, techniques, processes, drawings, cost data, customer lists, film or television scripts or detailed production budgets that (i) derive independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and (ii) are the subject of efforts that are reasonable under the circumstances to maintain secrecy; and

(B) Commercial or financial information given in confidence, not required by statute;

(6) Test questions, scoring keys and other examination data used to administer a licensing examination, examination for employment or academic examinations;

(7) The contents of real estate appraisals, engineering or feasibility estimates and evaluations made for or by an agency relative to the acquisition of property or to prospective public supply and construction contracts, until such time as all of the property has been acquired or all proceedings or transactions have been terminated or abandoned, provided the law of eminent domain shall not be affected by this provision;

(8) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with such licensing agency to establish the applicant's personal qualification for the license, certificate or permit applied for;

(9) Records, reports and statements of strategy or negotiations with respect to collective bargaining;

(10) Records, tax returns, reports and statements exempted by federal law or state statutes or communications privileged by the attorney-client relationship;

(11) Names or addresses of students enrolled in any public school or college without the consent of each student whose name or address is to be disclosed who is eighteen years of age or older and a parent or guardian of each such student who is younger than eighteen years of age, provided this subdivision shall not be construed as prohibiting the disclosure of the names or addresses of students enrolled in any public school in a regional school district to the board of selectmen or town board of finance, as the case may be, of the town wherein the student resides for the purpose of verifying tuition payments made to such school;

(12) Any information obtained by the use of illegal means;

(13) Records of an investigation or the name of an employee providing information under the provisions of section 4-61dd;

(14) Adoption records and information provided for in sections 45a-746, 45a-750 and 45a-751;

(15) Any page of a primary petition, nominating petition, referendum petition or petition for a town meeting submitted under any provision of the general statutes or of any special act, municipal charter or ordinance, until the required processing and certification of such page has been completed by the official or officials charged with such duty after which time disclosure of such page shall be required;

(16) Records of complaints, including information compiled in the investigation thereof, brought to a municipal health authority pursuant to chapter 368e or a district department of health pursuant to chapter 368f, until such time as the investigation is concluded or thirty days from the date of receipt of the complaint, whichever occurs first;

(17) Educational records which are not subject to disclosure under the Family Educational Rights and Privacy Act, 20 USC 1232g;

(18) Records, the disclosure of which the Commissioner of Correction, or as it applies to Whiting Forensic Division facilities of the Connecticut Valley Hospital, the Commissioner of Mental Health and Addiction Services, has reasonable grounds to believe may result in a safety risk, including the risk of harm to any person or the risk of an escape from, or a disorder in, a correctional institution or facility under the supervision of the Department of Correction or Whiting Forensic Division facilities. Such records shall include, but are not limited to:

(A) Security manuals, including emergency plans contained or referred to in such security manuals;

(B) Engineering and architectural drawings of correctional institutions or facilities or Whiting Forensic Division facilities;

(C) Operational specifications of security systems utilized by the Department of Correction at any correctional institution or facility or Whiting Forensic Division facilities, except that a general description of any such security system and the cost and quality of such system may be disclosed;

(D) Training manuals prepared for correctional institutions and facilities or Whiting Forensic Division facilities that describe, in any manner, security procedures, emergency plans or security equipment;

(E) Internal security audits of correctional institutions and facilities or Whiting Forensic Division facilities;

(F) Minutes or recordings of staff meetings of the Department of Correction or Whiting Forensic Division facilities, or portions of such minutes or recordings, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;

(G) Logs or other documents that contain information on the movement or assignment of inmates or staff at correctional institutions or facilities; and

(H) Records that contain information on contacts between inmates, as defined in section 18-84, and law enforcement officers;

(19) Records when there are reasonable grounds to believe disclosure may result in a safety risk, including the risk of harm to any person, any government-owned or leased institution or facility or any fixture or appurtenance and equipment attached to, or contained in, such institution or facility, except that such records shall be disclosed to a law enforcement agency upon the request of the law enforcement agency. Such reasonable grounds shall be determined (A) (i) by the Commissioner of Public Works, after consultation with the chief executive officer of an executive branch state agency, with respect to records concerning such agency; and (ii) by the Commissioner of Emergency Management and Homeland Security, after consultation with the chief executive officer of a municipal, district or regional agency, with respect to records concerning such agency; (B) by the Chief Court Administrator with respect to records concerning the Judicial Department; and (C) by the executive director of the Joint Committee on Legislative Management, with respect to records concerning the Legislative Department. As used in this section, "government-owned or leased institution or facility" includes, but is not limited to, an institution or facility owned or leased by a public service company, as defined in section 16-1, a certified telecommunications provider, as defined in section 16-1, a water company, as defined in section 25-32a, or a municipal utility that furnishes electric, gas or water service, but does not include an institution or facility owned or leased by the federal government, and "chief executive officer" includes, but is not limited to, an agency head, department head, executive director or chief executive officer. Such records include, but are not limited to:

(i) Security manuals or reports;

(ii) Engineering and architectural drawings of government-owned or leased institutions or facilities;

(iii) Operational specifications of security systems utilized at any government-owned or leased institution or facility, except that a general description of any such security system and the cost and quality of such system, may be disclosed;

(iv) Training manuals prepared for government-owned or leased institutions or facilities that describe, in any manner, security procedures, emergency plans or security

equipment;

(v) Internal security audits of government-owned or leased institutions or facilities;

(vi) Minutes or records of meetings, or portions of such minutes or records, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;

(vii) Logs or other documents that contain information on the movement or assignment of security personnel;

(viii) Emergency plans and emergency preparedness, response, recovery and mitigation plans, including plans provided by a person to a state agency or a local emergency management agency or official; and

(ix) With respect to a water company, as defined in section 25-32a, that provides water service: Vulnerability assessments and risk management plans, operational plans, portions of water supply plans submitted pursuant to section 25-32d that contain or reveal information the disclosure of which may result in a security risk to a water company, inspection reports, technical specifications and other materials that depict or specifically describe critical water company operating facilities, collection and distribution systems or sources of supply;

(20) Records of standards, procedures, processes, software and codes, not otherwise available to the public, the disclosure of which would compromise the security or integrity of an information technology system;

(21) The residential, work or school address of any participant in the address confidentiality program established pursuant to sections 54-240 to 54-240o, inclusive;

(22) The electronic mail address of any person that is obtained by the Department of Transportation in connection with the implementation or administration of any plan to inform individuals about significant highway or railway incidents;

(23) The name or address of any minor enrolled in any parks and recreation program administered or sponsored by any public agency;

(24) Responses to any request for proposals or bid solicitation issued by a public agency or any record or file made by a public agency in connection with the contract award process, until such contract is executed or negotiations for the award of such contract have ended, whichever occurs earlier, provided the chief executive officer of such public agency certifies that the public interest in the disclosure of such responses, record or file is outweighed by the public interest in the confidentiality of such responses, record or file.

(c) Whenever a public agency receives a request from any person confined in a

correctional institution or facility or a Whiting Forensic Division facility, for disclosure of any public record under the Freedom of Information Act, the public agency shall promptly notify the Commissioner of Correction or the Commissioner of Mental Health and Addiction Services in the case of a person confined in a Whiting Forensic Division facility of such request, in the manner prescribed by the commissioner, before complying with the request as required by the Freedom of Information Act. If the commissioner believes the requested record is exempt from disclosure pursuant to subdivision (18) of subsection (b) of this section, the commissioner may withhold such record from such person when the record is delivered to the person's correctional institution or facility or Whiting Forensic Division facility.

(d) Whenever a public agency, except the Judicial Department or Legislative Department, receives a request from any person for disclosure of any records described in subdivision (19) of subsection (b) of this section under the Freedom of Information Act, the public agency shall promptly notify the Commissioner of Public Works or the Commissioner of Emergency Management and Homeland Security, as applicable, of such request, in the manner prescribed by such commissioner, before complying with the request as required by the Freedom of Information Act and for information related to a water company, as defined in section 25-32a, the public agency shall promptly notify the water company before complying with the request as required by the Freedom of Information Act. If the commissioner, after consultation with the chief executive officer of the applicable agency or after consultation with the chief executive officer of the applicable water company for information related to a water company, as defined in section 25-32a, believes the requested record is exempt from disclosure pursuant to subdivision (19) of subsection (b) of this section, the commissioner may direct the agency to withhold such record from such person. In any appeal brought under the provisions of section 1-206 of the Freedom of Information Act for denial of access to records for any of the reasons described in subdivision (19) of subsection (b) of this section, such appeal shall be against the chief executive officer of the executive branch state agency or the municipal, district or regional agency that issued the directive to withhold such record pursuant to subdivision (19) of subsection (b) of this section, exclusively, or, in the case of records concerning Judicial Department facilities, the Chief Court Administrator or, in the case of records concerning the Legislative Department, the executive director of the Joint Committee on Legislative Management.

(e) Notwithstanding the provisions of subdivisions (1) and (16) of subsection (b) of this section, disclosure shall be required of:

(1) Interagency or intra-agency memoranda or letters, advisory opinions, recommendations or any report comprising part of the process by which governmental decisions and policies are formulated, except disclosure shall not be required of a preliminary draft of a memorandum, prepared by a member of the staff of a public agency, which is subject to revision prior to submission to or discussion among the members of such agency;

(2) All records of investigation conducted with respect to any tenement house,

lodging house or boarding house as defined in section 19a-355, or any nursing home, residential care home or rest home, as defined in section 19a-490, by any municipal building department or housing code inspection department, any local or district health department, or any other department charged with the enforcement of ordinances or laws regulating the erection, construction, alteration, maintenance, sanitation, ventilation or occupancy of such buildings; and

(3) The names of firms obtaining bid documents from any state agency.

Appendix

Statute Requiring Licensure to do Insurance Business

Sec. 38a-41. (Formerly Sec. 38-20). Authority to do business. Licensure. Revocation or refusal to renew license. Fines. Company owned by a state or foreign nation or company controlled by insureds not to be licensed. Appeals. Plan of operations. Type of business to be conducted. (a) No insurance company or health care center shall do any insurance business or health care center business within this state until and except while it is permitted to do so under the terms of a license issued by the commissioner. Any such company desiring to obtain such a license shall make application to the commissioner, setting forth the line or lines of business which it is seeking authorization to write. It shall file with the commissioner a certified copy of its charter or articles of association and evidence satisfactory to the commissioner that it has complied with the laws of the jurisdiction under which it is organized, a statement of its financial condition in such form as is required by the commissioner, together with such evidence of its correctness as the commissioner requires and evidence of good management in such form as is required by the commissioner. Applicant companies licensed in and operated from administrative offices in one state but domiciled in another state, as permitted by the applicable state law, shall provide justification of such arrangement, satisfactory to the commissioner, which shall demonstrate that regulatory influence of the domiciliary supervisory official has not been diminished as a result of such arrangement. An applicant shall demonstrate an orderly pattern of growth in its marketing territories in the geographic region, with the exception of a newly formed health care center, and an expertise in marketing and servicing the lines of insurance or the health care center business it desires to write. It shall submit evidence of its ability to provide continuant and timely claims settlement. If the information furnished is satisfactory to the commissioner and if all other requirements of law have been complied with, he may issue to such company a license permitting it to do business in this state. Each such license shall expire on the first day of May succeeding the date of its issuance, but may be renewed without any formalities except as required by the commissioner. Failure of a licensed company to exercise its authority to write a particular line or lines of business in this state for two consecutive calendar years may constitute sufficient cause for revocation of the company's authority to write those lines of business.

(b) The commissioner shall adopt regulations in accordance with the provisions of chapter 54 specifying the information and evidence that an insurance company or health care center desiring to obtain or renew a license to do an insurance business or health care center business shall submit and the requirements with which it shall comply.

(c) The commissioner may, at any time, for cause, suspend, revoke or refuse to renew any such license or in lieu of or in addition to suspension or revocation of such license the commissioner, after reasonable notice to and hearing of any holder of such license, may impose a fine not to exceed fifty thousand dollars. Such hearings may be

held by the commissioner or any person designated by the commissioner. Whenever a person other than the commissioner acts as the hearing officer, the person shall submit to the commissioner a memorandum of the person's findings and recommendations upon which the commissioner may base a decision. The commissioner may, if the commissioner deems it in the interest of the public, publish in one or more newspapers of the state a statement that, under the provisions of this section, the commissioner has suspended or revoked the license of any insurance company or health care center to do business in this state.

(d) No license to do an insurance business within this state shall be issued to a foreign insurance company owned or financially controlled by another state of the United States or to an alien insurance company owned or financially controlled by a foreign nation or any state or province thereof.

(e) No license to do an insurance business within this state shall be issued to any company which insures or plans to insure the separate risks of the employees of an employer that directly or indirectly controls the insurer by stock ownership or otherwise or exercises control of the operations of the insurer where the premiums written annually by the insurer on the separate risks of such employees exceed or will exceed ten per cent of the total premiums which the insurer writes or will write annually or where the commissions payable, if any, on premiums covering the risks of such employees written by the insurer annually exceed or will exceed ten per cent of the total commissions to agents which are or will be paid annually by the insurer.

(f) Any company aggrieved by the action of the commissioner in revoking, suspending or refusing to renew a license or in imposing a fine may appeal therefrom, in accordance with the provisions of section 4-183, except venue for such appeal shall be in the judicial district of New Britain. Appeals under this section shall be privileged in respect to the order of trial assignment.

(g) Except as provided in section 38a-92*l* an insurer shall be required to be licensed to transact financial guaranty insurance in this state, as defined in subdivision (1) of section 38a-92a. Prior to the issuance of a license to transact financial guaranty insurance business, an insurer shall submit for the approval of the commissioner a plan of operation detailing the types and projected diversification of guaranties that will be issued, the underwriting procedures that will be followed, managerial oversight methods, investment policies and other matters as may be prescribed by the commissioner. An insurer licensed to transact the business of financial guaranty insurance may also be licensed to transact the business of surety, credit and residual value insurance, but may not be licensed to transact any other lines of insurance in this state.

Statutes Requiring Health Care Centers (HMOs) to File Forms and Rates

Sec. 38a-182. (Formerly Sec. 33-179j). Agreements with subscribers. Agreement requirements. Evidence of coverage. (a) An agreement issued by a health care center governed by sections 38a-175 to 38a-192, inclusive, may be issued for health care or the costs thereof to a subscriber, to a subscriber and spouse, to a subscriber and family, to a subscriber and dependent or dependents related by blood, marriage or adoption or to a subscriber and ward. Such agreement or evidence of coverage document shall be in writing and a copy thereof furnished to the group contract holder or individual contract holder, as appropriate.

(b) Each such agreement shall contain the following provisions: (1) Name and address of the health care center; (2) eligibility requirements; (3) a statement of copayments, deductibles or other out-of-pocket expenses payment payable by the subscriber; (4) a statement of the nature of the health care services or benefits to be furnished and the period during which they will be furnished, and, if there are any services or benefits to be excepted, a detailed statement of such exceptions provided that such services or benefits to be furnished conform at a minimum to the requirements of the Federal Health Maintenance Organization Act; (5) a statement of terms and conditions upon which the agreement may be cancelled or otherwise terminated at the option of either party; (6) claims procedures; (7) enrollee grievance procedures; (8) continuation of coverage; (9) conversion; (10) extension of benefits, if any; (11) subrogation, if any; (12) description of the service area, out-of-area benefits and services, if any; (13) a statement of the amount payable to the health care center by the subscriber and by others on his behalf and the manner in which such amount is payable; (14) a statement that the agreement includes the endorsement thereon and attached papers, if any, and contains the entire agreement; (15) a statement that no statement by the subscriber in his application for an agreement shall void the agreement or be used in any legal proceeding thereunder, unless such application or an exact copy thereof is included in or attached to such agreement; and (16) a statement of the period of grace which will be allowed the subscriber for making any payment due under the agreement, which period shall not be less than ten days.

(c) Every subscriber shall receive an evidence of coverage from the group contract holder or the health care center. The evidence of coverage shall not contain provisions or statements which are unfair, inequitable, misleading, deceptive or which encourage misrepresentation. The evidence of coverage shall contain a clear statement of the provisions set forth in subdivisions (1) to (12), inclusive, of subsection (b) of this section.

Sec. 38a-183. (Formerly Sec. 33-179k). Approval by commissioner of amounts to be paid subscribers and agreements. Component of rate. Capital reserve fund. Methods of protecting members from liability for uncovered expenditures. (a) A health care center governed by sections 38a-175 to 38a-192, inclusive, shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a full schedule of the amounts to be paid by the subscribers and has obtained the

commissioner's approval thereof. The commissioner may refuse such approval if he finds such amounts to be excessive, inadequate or discriminatory. Each such health care center shall not enter into any agreement with subscribers unless and until it has filed with the commissioner a copy of such agreement or agreements, including all riders and endorsements thereon, and until the commissioner's approval thereof has been obtained. The commissioner shall, within a reasonable time after the filing of any request for an approval of the amounts to be paid, any agreement or any form, notify the health care center of either his approval or disapproval thereof.

(b) A health care center may establish rates of payment by any method permitted by the Federal Health Maintenance Organization Act and the regulations adopted thereunder from time to time unless otherwise determined by the commissioner by regulation.

(c) Each such health care center may include as a component of its rate a sum up to ten per cent of such rate to be used for the objects and purposes set forth in section 38a-184. An amount not exceeding ten per cent of the annual net premium income of such center may be set aside annually as a capital reserve fund and may be accumulated from year to year by such health care center, to be expended for the objects and purposes as set forth and in accordance with said section.

Statutes Providing Form and Rate Authority of Insurance Department

Sec. 38a-481. (Formerly Sec. 38-165). Approval of individual health application, policy form and rates. Medicare supplement policies and certificates: Age, gender, previous claim or medical history rating prohibited. Loss ratios. Optional life insurance riders. Underwriting classifications, claim experience and health status. Exceptions. Regulations. Certain refunds to be donated to The University of Connecticut Health Center. (a) No individual health insurance policy shall be delivered or issued for delivery to any person in this state, nor shall any application, rider or endorsement be used in connection with such policy, until a copy of the form thereof and of the classification of risks and the premium rates have been filed with the commissioner. The commissioner shall adopt regulations, in accordance with chapter 54, to establish a procedure for reviewing such policies. The commissioner shall disapprove the use of such form at any time if it does not comply with the requirements of law, or if it contains a provision or provisions which are unfair or deceptive or which encourage misrepresentation of the policy. The commissioner shall notify, in writing, the insurer which has filed any such form of the commissioner's disapproval, specifying the reasons for disapproval, and ordering that no such insurer shall deliver or issue for delivery to any person in this state a policy on or containing such form. The provisions of section 38a-19 shall apply to such orders.

(b) No rate filed under the provisions of subsection (a) of this section shall be effective until the expiration of thirty days after it has been filed or unless sooner approved by the commissioner in accordance with regulations adopted pursuant to this subsection. The commissioner shall adopt regulations, in accordance with chapter 54, to prescribe standards to insure that such rates shall not be excessive, inadequate or unfairly discriminatory. The commissioner may disapprove such rate within thirty days after it has been filed if it fails to comply with such standards, except that no rate filed under the provisions of subsection (a) of this section for any Medicare supplement policy shall be effective unless approved in accordance with section 38a-474.

(c) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(d) Rates on a particular policy form will not be deemed excessive if the insurer has filed a loss ratio guarantee with the Insurance Commissioner which meets the

requirements of subsection (e) of this section provided (1) the form of such loss ratio guarantee has been explicitly approved by the Insurance Commissioner, and (2) the current expected lifetime loss ratio is not more than five per cent less than the filed lifetime loss ratio as certified by an actuary. The insurer shall withdraw the policy form if the commissioner determines that the lifetime loss ratio will not be met. Rates also will not be deemed excessive if the insurer complies with the terms of the loss ratio guarantee. The Insurance Commissioner may adopt regulations, in accordance with chapter 54, to assure that the use of a loss ratio guarantee does not constitute an unfair practice.

(e) Premium rates shall be deemed approved upon filing with the Insurance Commissioner if the filing is accompanied by a loss ratio guarantee. The loss ratio guarantee shall be in writing, signed by an officer of the insurer, and shall contain as a minimum the following:

(1) A recitation of the anticipated lifetime and durational target loss ratios contained in the original actuarial memorandum filed with the policy form when it was originally approved;

(2) A guarantee that the actual Connecticut loss ratios for the experience period in which the new rates take effect and for each experience period thereafter until any new rates are filed will meet or exceed the loss ratios referred to in subdivision (1) of this subsection. If the annual earned premium volume in Connecticut under the particular policy form is less than one million dollars and therefore not actuarially credible, the loss ratio guarantee will be based on the actual nation-wide loss ratio for the policy form. If the aggregate earned premium for all states is less than one million dollars, the experience period will be extended until the end of the calendar year in which one million dollars of earned premium is attained;

(3) A guarantee that the actual Connecticut or nation-wide loss ratio results, as the case may be, for the experience period at issue will be independently audited by a certified public accountant or a member of the American Academy of Actuaries at the insurer's expense. The audit shall be done in the second quarter of the year following the end of the experience period and the audited results must be reported to the Insurance Commissioner not later than June thirtieth following the end of the experience period;

(4) A guarantee that affected Connecticut policyholders will be issued a proportional refund, which will be based on the premiums earned, of the amount necessary to bring the actual loss ratio up to the anticipated loss ratio referred to in subdivision (1) of this subsection. If nation-wide loss ratios are used, the total amount refunded in Connecticut shall equal the dollar amount necessary to achieve the loss ratio standards multiplied by the total premium earned from all Connecticut policyholders who will receive refunds and divided by the total premium earned in all states on the policy form. The refund shall be made to all Connecticut policyholders who are insured under the applicable policy form as of the last day of the experience period and whose refund would equal two dollars or more. The refund shall include interest, at six per cent, from the end of the experience period until the date of payment. Payment shall be made during the third

quarter of the year following the experience period for which a refund is determined to be due;

(5) A guarantee that refunds less than two dollars will be aggregated by the insurer. The insurer shall deposit such amount in a separate interest-bearing account in which all such amounts shall be deposited. At the end of each calendar year each such insurer shall donate such amount to The University of Connecticut Health Center;

(6) A guarantee that the insurer, if directed by the Insurance Commissioner, shall withdraw the policy form and cease the issuance of new policies under the form in this state if the applicable loss ratio exceeds the durational target loss ratio for the experience period by more than twenty per cent, provided the calculations are based on at least two thousand policyholder-years of experience either in Connecticut or nation-wide.

(f) For the purposes of this section:

(1) "Loss ratio" means the ratio of incurred claims to earned premiums by the number of years of policy duration for all combined durations; and

(2) "Experience period" means the calendar year for which a loss ratio guarantee is calculated.

(g) Nothing in this chapter shall preclude the issuance of an individual health insurance policy which includes an optional life insurance rider, provided the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

(h) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers, issues for delivery, amends, renews or continues an individual health insurance policy in this state on or after October 1, 2003, may (1) move an insured individual from a standard underwriting classification to a substandard underwriting classification after the policy is issued; or (2) increase premium rates due to the claim experience or health status of an individual who is insured under the policy, except that the entity may increase premium rates for all individuals in an underwriting classification due to the claim experience or health status of the underwriting classification as a whole.

Sec. 38a-513. Approval of group health insurance policies and certificates. Medicare supplement policies and certificates: Age, gender, previous claim or medical history rating prohibited. Exceptions. Optional life insurance riders. Regulations. Group specified disease policies. (a) No group health insurance policy, as defined by the commissioner, or certificate shall be issued or delivered in this state unless a copy of the

form for such policy or certificate has been submitted to and approved by the commissioner under the regulations adopted pursuant to this section. The commissioner shall adopt regulations, in accordance with chapter 54, concerning the provisions, submission and approval of such policies and certificates and establishing a procedure for reviewing such policies and certificates. If the commissioner issues an order disapproving the use of such form, the provisions of section 38a-19 shall apply to such order.

(b) No insurance company, fraternal benefit society, hospital service corporation, medical service corporation, health care center or other entity which delivers or issues for delivery in this state any Medicare supplement policies or certificates shall incorporate in its rates or determinations to grant coverage for Medicare supplement insurance policies or certificates any factors or values based on the age, gender, previous claims history or the medical condition of any person covered by such policy or certificate, except for plans "H" to "J", inclusive, as provided in section 38a-495b. In plans "H" to "J", inclusive, previous claims history and the medical condition of the applicant may be used in determinations to grant coverage under Medicare supplement policies and certificates issued prior to January 1, 2006.

(c) Nothing in this chapter shall preclude the issuance of a group health insurance policy which includes an optional life insurance rider, provided the optional life insurance rider must be filed with and approved by the Insurance Commissioner pursuant to section 38a-430. Any company offering such policies for sale in this state shall be licensed to sell life insurance in this state pursuant to the provisions of section 38a-41.

(d) Not later than January 1, 2009, the commissioner shall adopt regulations, in accordance with chapter 54, to establish minimum standards for benefits in group specified disease policies, certificates, riders, endorsements and benefits.

Regulation Regarding Hearings

Special Provisions:
Hearings of Applications and Petitions

Sec. 38a-8-47. General provisions.

(a) The Commissioner shall hold a hearing on any application or petition where required by law and may in his or her discretion hold a hearing on any application or petition presented to the Commissioner where he or she deems a hearing to be necessary for a complete consideration of the matter.

(b) In addition to the general provisions of this article governing hearings, the following special provisions, sections 38a-8-48 to 38a-8-53, inclusive, of the Regulations of Connecticut State Agencies shall apply to all hearings on applications and petitions filed with the Commissioner.

Statute Requiring Public Access of Records

Sec. 1-210. (Formerly Sec. 1-19). Access to public records. Exempt records. (a) Except as otherwise provided by any federal law or state statute, all records maintained or kept on file by any public agency, whether or not such records are required by any law or by any rule or regulation, shall be public records and every person shall have the right to (1) inspect such records promptly during regular office or business hours, (2) copy such records in accordance with subsection (g) of section 1-212, or (3) receive a copy of such records in accordance with section 1-212. Any agency rule or regulation, or part thereof, that conflicts with the provisions of this subsection or diminishes or curtails in any way the rights granted by this subsection shall be void. Each such agency shall keep and maintain all public records in its custody at its regular office or place of business in an accessible place and, if there is no such office or place of business, the public records pertaining to such agency shall be kept in the office of the clerk of the political subdivision in which such public agency is located or of the Secretary of the State, as the case may be. Any certified record hereunder attested as a true copy by the clerk, chief or deputy of such agency or by such other person designated or empowered by law to so act, shall be competent evidence in any court of this state of the facts contained therein.

(b) Nothing in the Freedom of Information Act shall be construed to require disclosure of:

(1) Preliminary drafts or notes provided the public agency has determined that the public interest in withholding such documents clearly outweighs the public interest in disclosure;

(2) Personnel or medical files and similar files the disclosure of which would constitute an invasion of personal privacy;

(3) Records of law enforcement agencies not otherwise available to the public which records were compiled in connection with the detection or investigation of crime, if the disclosure of said records would not be in the public interest because it would result in the disclosure of (A) the identity of informants not otherwise known or the identity of witnesses not otherwise known whose safety would be endangered or who would be subject to threat or intimidation if their identity was made known, (B) signed statements of witnesses, (C) information to be used in a prospective law enforcement action if prejudicial to such action, (D) investigatory techniques not otherwise known to the general public, (E) arrest records of a juvenile, which shall also include any investigatory files, concerning the arrest of such juvenile, compiled for law enforcement purposes, (F) the name and address of the victim of a sexual assault under section 53a-70, 53a-70a, 53a-71, 53a-72a, 53a-72b or 53a-73a, or injury or risk of injury, or impairing of morals under section 53-21, or of an attempt thereof, or (G) uncorroborated allegations subject to destruction pursuant to section 1-216;

(4) Records pertaining to strategy and negotiations with respect to pending claims or pending litigation to which the public agency is a party until such litigation or claim has been finally adjudicated or otherwise settled;

(5) (A) Trade secrets, which for purposes of the Freedom of Information Act, are defined as information, including formulas, patterns, compilations, programs, devices, methods, techniques, processes, drawings, cost data, customer lists, film or television scripts or detailed production budgets that (i) derive independent economic value, actual or potential, from not being generally known to, and not being readily ascertainable by proper means by, other persons who can obtain economic value from their disclosure or use, and (ii) are the subject of efforts that are reasonable under the circumstances to maintain secrecy; and

(B) Commercial or financial information given in confidence, not required by statute;

(6) Test questions, scoring keys and other examination data used to administer a licensing examination, examination for employment or academic examinations;

(7) The contents of real estate appraisals, engineering or feasibility estimates and evaluations made for or by an agency relative to the acquisition of property or to prospective public supply and construction contracts, until such time as all of the property has been acquired or all proceedings or transactions have been terminated or abandoned, provided the law of eminent domain shall not be affected by this provision;

(8) Statements of personal worth or personal financial data required by a licensing agency and filed by an applicant with such licensing agency to establish the applicant's personal qualification for the license, certificate or permit applied for;

(9) Records, reports and statements of strategy or negotiations with respect to collective bargaining;

(10) Records, tax returns, reports and statements exempted by federal law or state statutes or communications privileged by the attorney-client relationship;

(11) Names or addresses of students enrolled in any public school or college without the consent of each student whose name or address is to be disclosed who is eighteen years of age or older and a parent or guardian of each such student who is younger than eighteen years of age, provided this subdivision shall not be construed as prohibiting the disclosure of the names or addresses of students enrolled in any public school in a regional school district to the board of selectmen or town board of finance, as the case may be, of the town wherein the student resides for the purpose of verifying tuition payments made to such school;

(12) Any information obtained by the use of illegal means;

(13) Records of an investigation or the name of an employee providing information under the provisions of section 4-61dd;

(14) Adoption records and information provided for in sections 45a-746, 45a-750 and 45a-751;

(15) Any page of a primary petition, nominating petition, referendum petition or petition for a town meeting submitted under any provision of the general statutes or of any special act, municipal charter or ordinance, until the required processing and certification of such page has been completed by the official or officials charged with such duty after which time disclosure of such page shall be required;

(16) Records of complaints, including information compiled in the investigation thereof, brought to a municipal health authority pursuant to chapter 368e or a district department of health pursuant to chapter 368f, until such time as the investigation is concluded or thirty days from the date of receipt of the complaint, whichever occurs first;

(17) Educational records which are not subject to disclosure under the Family Educational Rights and Privacy Act, 20 USC 1232g;

(18) Records, the disclosure of which the Commissioner of Correction, or as it applies to Whiting Forensic Division facilities of the Connecticut Valley Hospital, the Commissioner of Mental Health and Addiction Services, has reasonable grounds to believe may result in a safety risk, including the risk of harm to any person or the risk of an escape from, or a disorder in, a correctional institution or facility under the supervision of the Department of Correction or Whiting Forensic Division facilities. Such records shall include, but are not limited to:

(A) Security manuals, including emergency plans contained or referred to in such security manuals;

(B) Engineering and architectural drawings of correctional institutions or facilities or Whiting Forensic Division facilities;

(C) Operational specifications of security systems utilized by the Department of Correction at any correctional institution or facility or Whiting Forensic Division facilities, except that a general description of any such security system and the cost and quality of such system may be disclosed;

(D) Training manuals prepared for correctional institutions and facilities or Whiting Forensic Division facilities that describe, in any manner, security procedures, emergency plans or security equipment;

(E) Internal security audits of correctional institutions and facilities or Whiting Forensic Division facilities;

(F) Minutes or recordings of staff meetings of the Department of Correction or Whiting Forensic Division facilities, or portions of such minutes or recordings, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;

(G) Logs or other documents that contain information on the movement or assignment of inmates or staff at correctional institutions or facilities; and

(H) Records that contain information on contacts between inmates, as defined in section 18-84, and law enforcement officers;

(19) Records when there are reasonable grounds to believe disclosure may result in a safety risk, including the risk of harm to any person, any government-owned or leased institution or facility or any fixture or appurtenance and equipment attached to, or contained in, such institution or facility, except that such records shall be disclosed to a law enforcement agency upon the request of the law enforcement agency. Such reasonable grounds shall be determined (A) (i) by the Commissioner of Public Works, after consultation with the chief executive officer of an executive branch state agency, with respect to records concerning such agency; and (ii) by the Commissioner of Emergency Management and Homeland Security, after consultation with the chief executive officer of a municipal, district or regional agency, with respect to records concerning such agency; (B) by the Chief Court Administrator with respect to records concerning the Judicial Department; and (C) by the executive director of the Joint Committee on Legislative Management, with respect to records concerning the Legislative Department. As used in this section, "government-owned or leased institution or facility" includes, but is not limited to, an institution or facility owned or leased by a public service company, as defined in section 16-1, a certified telecommunications provider, as defined in section 16-1, a water company, as defined in section 25-32a, or a municipal utility that furnishes electric, gas or water service, but does not include an institution or facility owned or leased by the federal government, and "chief executive officer" includes, but is not limited to, an agency head, department head, executive director or chief executive officer. Such records include, but are not limited to:

(i) Security manuals or reports;

(ii) Engineering and architectural drawings of government-owned or leased institutions or facilities;

(iii) Operational specifications of security systems utilized at any government-owned or leased institution or facility, except that a general description of any such security system and the cost and quality of such system, may be disclosed;

(iv) Training manuals prepared for government-owned or leased institutions or facilities that describe, in any manner, security procedures, emergency plans or security

equipment;

(v) Internal security audits of government-owned or leased institutions or facilities;

(vi) Minutes or records of meetings, or portions of such minutes or records, that contain or reveal information relating to security or other records otherwise exempt from disclosure under this subdivision;

(vii) Logs or other documents that contain information on the movement or assignment of security personnel;

(viii) Emergency plans and emergency preparedness, response, recovery and mitigation plans, including plans provided by a person to a state agency or a local emergency management agency or official; and

(ix) With respect to a water company, as defined in section 25-32a, that provides water service: Vulnerability assessments and risk management plans, operational plans, portions of water supply plans submitted pursuant to section 25-32d that contain or reveal information the disclosure of which may result in a security risk to a water company, inspection reports, technical specifications and other materials that depict or specifically describe critical water company operating facilities, collection and distribution systems or sources of supply;

(20) Records of standards, procedures, processes, software and codes, not otherwise available to the public, the disclosure of which would compromise the security or integrity of an information technology system;

(21) The residential, work or school address of any participant in the address confidentiality program established pursuant to sections 54-240 to 54-240o, inclusive;

(22) The electronic mail address of any person that is obtained by the Department of Transportation in connection with the implementation or administration of any plan to inform individuals about significant highway or railway incidents;

(23) The name or address of any minor enrolled in any parks and recreation program administered or sponsored by any public agency;

(24) Responses to any request for proposals or bid solicitation issued by a public agency or any record or file made by a public agency in connection with the contract award process, until such contract is executed or negotiations for the award of such contract have ended, whichever occurs earlier, provided the chief executive officer of such public agency certifies that the public interest in the disclosure of such responses, record or file is outweighed by the public interest in the confidentiality of such responses, record or file.

(c) Whenever a public agency receives a request from any person confined in a

correctional institution or facility or a Whiting Forensic Division facility, for disclosure of any public record under the Freedom of Information Act, the public agency shall promptly notify the Commissioner of Correction or the Commissioner of Mental Health and Addiction Services in the case of a person confined in a Whiting Forensic Division facility of such request, in the manner prescribed by the commissioner, before complying with the request as required by the Freedom of Information Act. If the commissioner believes the requested record is exempt from disclosure pursuant to subdivision (18) of subsection (b) of this section, the commissioner may withhold such record from such person when the record is delivered to the person's correctional institution or facility or Whiting Forensic Division facility.

(d) Whenever a public agency, except the Judicial Department or Legislative Department, receives a request from any person for disclosure of any records described in subdivision (19) of subsection (b) of this section under the Freedom of Information Act, the public agency shall promptly notify the Commissioner of Public Works or the Commissioner of Emergency Management and Homeland Security, as applicable, of such request, in the manner prescribed by such commissioner, before complying with the request as required by the Freedom of Information Act and for information related to a water company, as defined in section 25-32a, the public agency shall promptly notify the water company before complying with the request as required by the Freedom of Information Act. If the commissioner, after consultation with the chief executive officer of the applicable agency or after consultation with the chief executive officer of the applicable water company for information related to a water company, as defined in section 25-32a, believes the requested record is exempt from disclosure pursuant to subdivision (19) of subsection (b) of this section, the commissioner may direct the agency to withhold such record from such person. In any appeal brought under the provisions of section 1-206 of the Freedom of Information Act for denial of access to records for any of the reasons described in subdivision (19) of subsection (b) of this section, such appeal shall be against the chief executive officer of the executive branch state agency or the municipal, district or regional agency that issued the directive to withhold such record pursuant to subdivision (19) of subsection (b) of this section, exclusively, or, in the case of records concerning Judicial Department facilities, the Chief Court Administrator or, in the case of records concerning the Legislative Department, the executive director of the Joint Committee on Legislative Management.

(e) Notwithstanding the provisions of subdivisions (1) and (16) of subsection (b) of this section, disclosure shall be required of:

(1) Interagency or intra-agency memoranda or letters, advisory opinions, recommendations or any report comprising part of the process by which governmental decisions and policies are formulated, except disclosure shall not be required of a preliminary draft of a memorandum, prepared by a member of the staff of a public agency, which is subject to revision prior to submission to or discussion among the members of such agency;

(2) All records of investigation conducted with respect to any tenement house,

lodging house or boarding house as defined in section 19a-355, or any nursing home, residential care home or rest home, as defined in section 19a-490, by any municipal building department or housing code inspection department, any local or district health department, or any other department charged with the enforcement of ordinances or laws regulating the erection, construction, alteration, maintenance, sanitation, ventilation or occupancy of such buildings; and

(3) The names of firms obtaining bid documents from any state agency.

ADDITIONAL ASSURANCES

CERTIFICATIONS

1. CERTIFICATION REGARDING DRUG-FREE WORK-PLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with the Drug-Free Workplace Act of 1988, 45 CFR Part 76, subpart F. The certification set out below is a material representation of fact upon which reliance will be placed when SSA determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, SSA, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants or government wide suspension or debarment.

The grantee certifies that it will or will not continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--

(1) The dangers of drug abuse in the workplace;

(2) The grantee's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency within ten calendar days after receiving notice under subparagraph (d)(2), above, from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices.

Notices shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), above, with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f), above.

The grantee certifies that, as a condition of the grant, it will not engage in the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance in conducting any activity with the grant.

2. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(a) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(b) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(c) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure."

3. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

NOTE: In accordance with 45 CFR Part 76, amended June 26, 1995, any debarment, suspension, proposed debarment or other government wide exclusion initiated under the Federal Acquisition Regulation (FAR) on or after August 25, 1995, shall be recognized by and effective for Executive Branch agencies and participants as an exclusion under 45 CFR Part 76.

(a) Primary Covered Transactions

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(2) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(3) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (a)(2) of this certification; and

(4) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed under the assurances page in the application package.

(b) Lower Tier Covered Transactions

The applicant agrees by submitting this proposal that it will include, without modification, **the following clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transaction"** (Appendix B to 45 CFR Part 76) in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions:

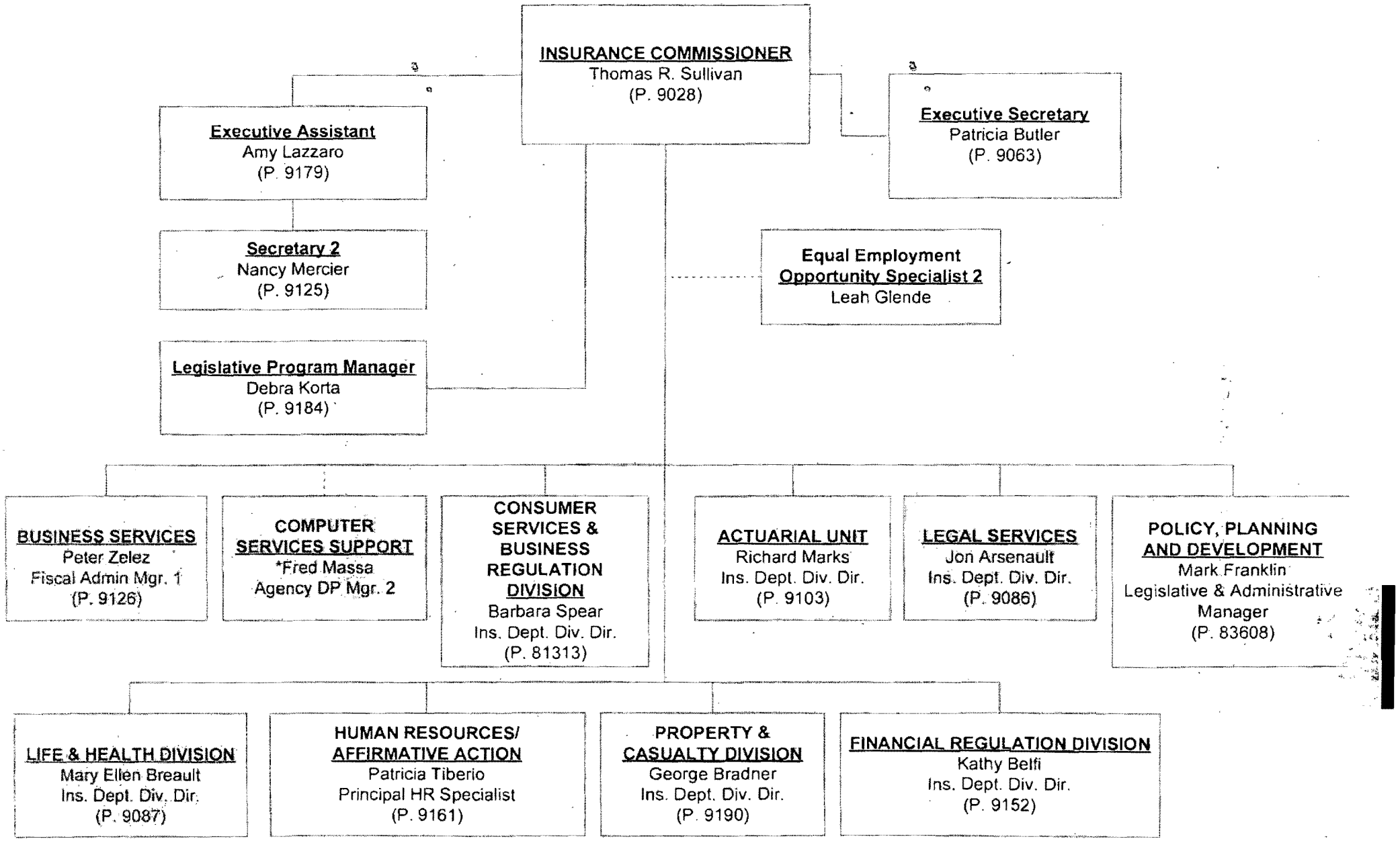
Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	* TITLE
Completed on submission to Grants.gov	
* APPLICANT ORGANIZATION	* DATE SUBMITTED
	Completed on submission to Grants.gov

STATE OF CONNECTICUT INSURANCE DEPARTMENT

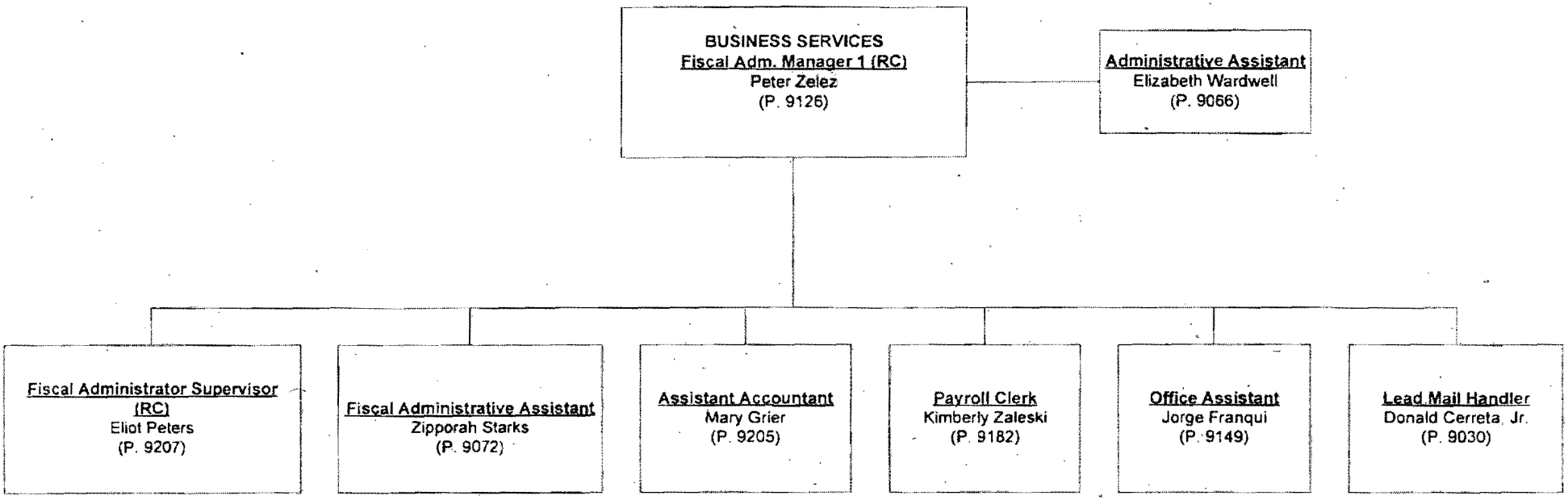


* Fred Massa, assigned to DOIT

Based on operational needs, this is subject to change

updated 01/27/10

ADMINISTRATION DIVISION
BUSINESS SERVICES



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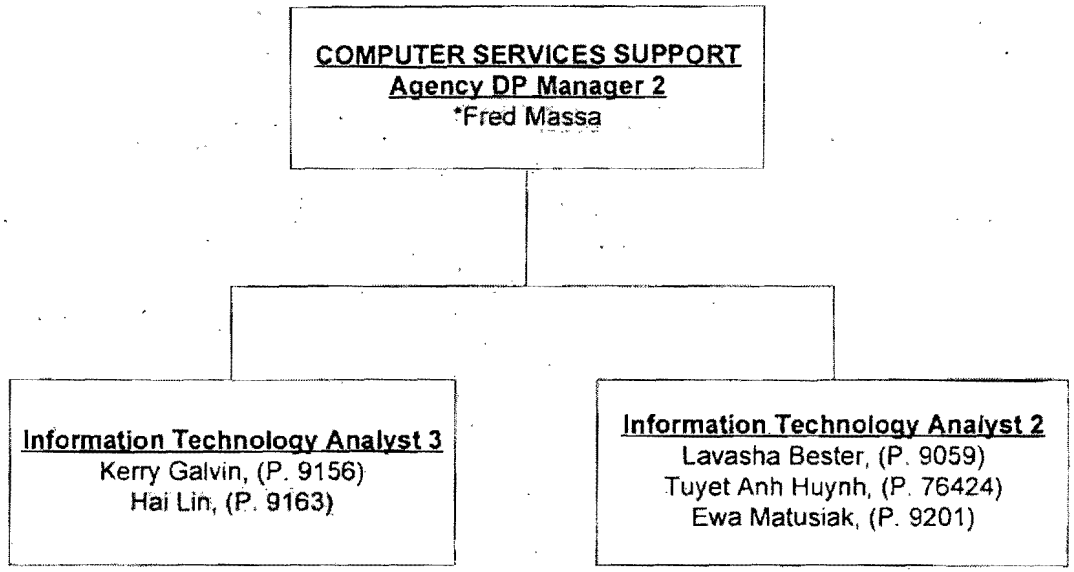
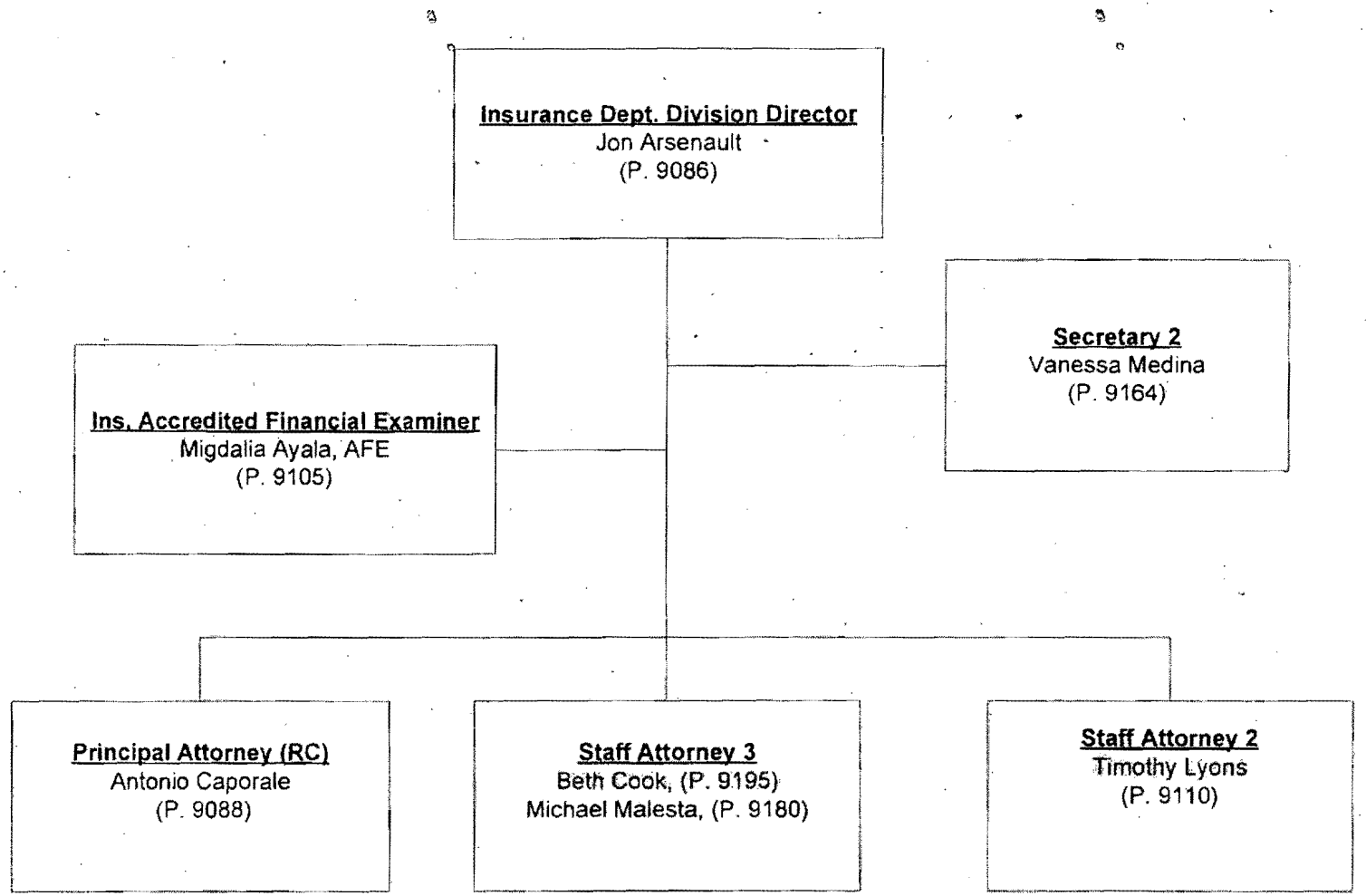
ADMINISTRATION DIVISION
COMPUTER SERVICES SUPPORT



updated 01/27/10

*DOIT Employee

ADMINISTRATION DIVISION
LEGAL



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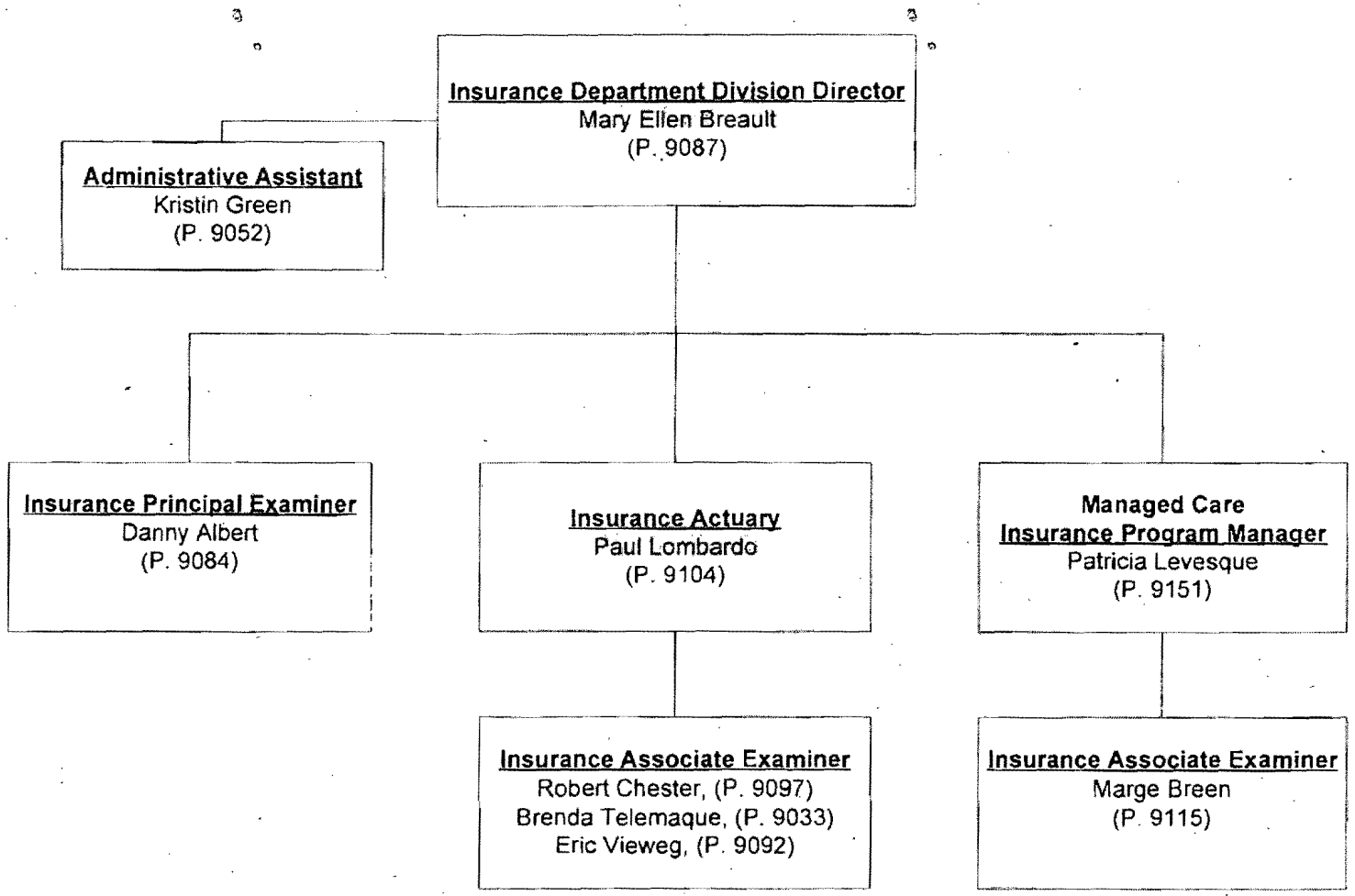
LIFE AND HEALTH DIVISION



updated 01/27/09

BUDGET NARRATIVE

The mission of the Connecticut Insurance Department ("CID") is to serve consumers in a professional and timely manner by providing assistance and information to the public and to policy makers, regulating the insurance industry in a fair and efficient manner which promotes a competitive and financially sound insurance market for consumers, and enforcing the insurance laws to ensure that consumers are treated fairly and are protected from unfair practices. The CID proposed budget for the Health Insurance Premium Review Grant ("Grant"), consistent with the goals of the Affordable Care Act, is to ensure that consumers receive value for their premium dollars by enhancing the existing CID rate review capabilities through investments in rate review tools, technology upgrades and development which will support transparency, data collection and reporting in our rate review processes. The CID FY2010-2011 budget allocates approximately $300,000 for rate review expenditures, all of which is associated with actuarial and legal staffing.

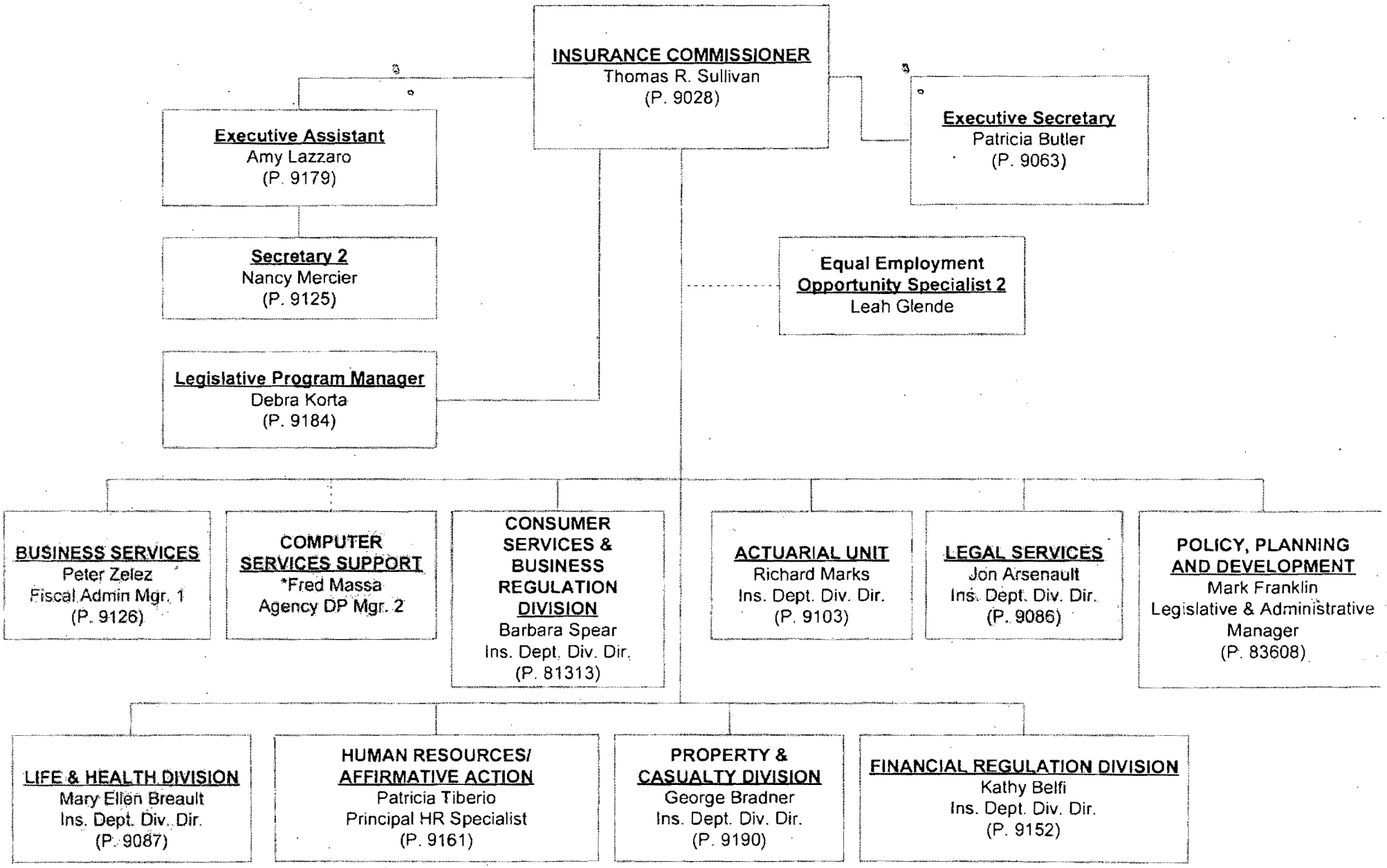
With this grant, CID sees an opportunity to make investments in the current rate review process which are unable to be funded under current State of Connecticut budget restraints. The proposed budget will fund integrated project activities:

1. **Rate Review Enhancement Tools** - The proposed budget includes $226,480.08 to initially purchase, and initially renew, commercial rating manuals and software packages offered by Towers/Watson and Milliman. These tools will enable CID actuarial staff to augment its current in-depth review of individual and HMO proposed rate increases by testing and validating proposed rates and rate assumptions submitted by the regulated entities using state of the art actuarial tools that are universally recognized. For all other health rate filings that the Department does not have statutory rate review authority over, which is primarily group non-HMO rate increases, the Department will perform the same level of rigorous review as mentioned above using these tools.
2. **Transparency** - The proposed budget includes $708,250 for process development, application and hardware enhancements and resource expenditures related to transparency in 3 primary

groupings of expenditures – information technology ("IT"); actuarial, and legal. The IT allocation is budgeted for $166,000 for an estimated 830 hours of IT consulting to design and implement CID website application modifications to enable the CID to post all rate filings for public review and comment. The actuarial allocation is $336,000 for 1120 hours of actuarial consulting to design and implement modifications to the current rate review process to strengthen the rigor of the review through rate review modeling, to work with the IT consultants in developing system changes to support the more expansive filings and the website modifications and to design and develop expanded data capture, reporting and analysis capabilities. The legal allocation totals $206,250, with $75,000 for expenses such as independent hearing officers and court reporters associated with rate hearings for rate requests determined to be unreasonable and unresolved through the rate review process; the balance of $131,250 is for 525 hours of legal consulting to support the actuarial and IT process, transparency and system enhancements.

3. **Data Collection and Reporting** - The proposed budget has allocated a total of $64,933 for data related initiatives of which$18,808 will be used for Connecticut's contribution to the NAIC SERFF modifications and 615 hours of IT consulting time to design and develop a more robust data reporting capability, to enable CID to track and analyze trends, patterns of rate increases, and fulfill reporting requirements to HHS. In the event that the Fair Health database is not fully established and we are unable to proceed with the projected plan with Fair Health, we will devote that funding allocation to creating greater reporting capabilities.

STATE OF CONNECTICUT INSURANCE DEPARTMENT

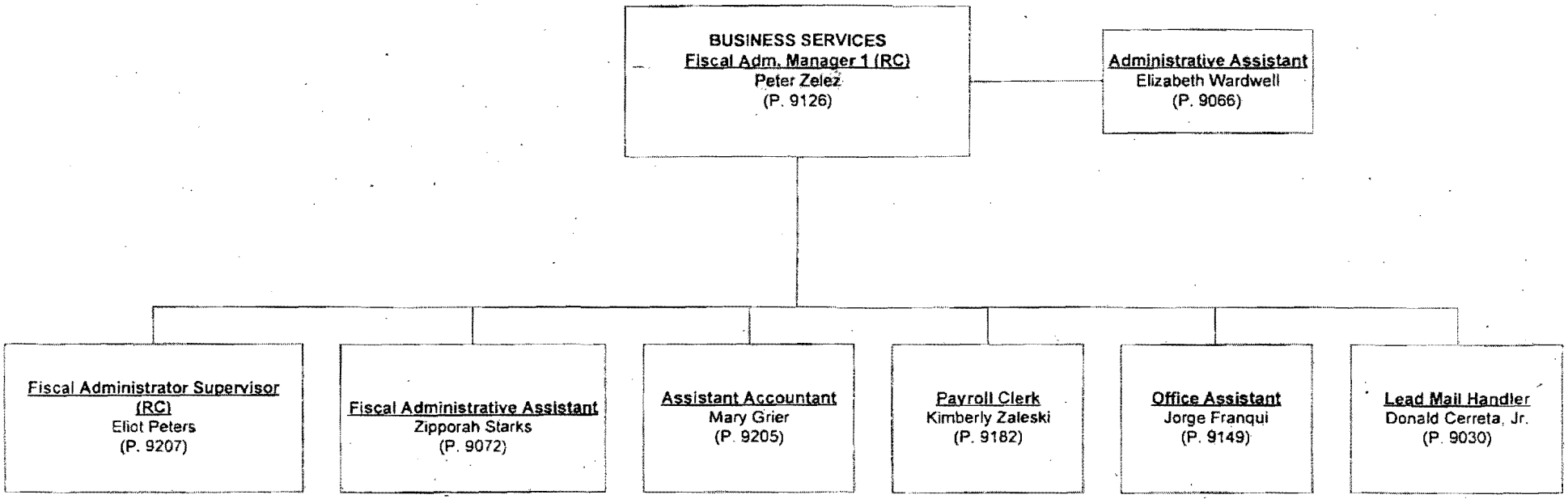


* Fred Massa, assigned to DOIT

Based on operational needs, this is subject to change

updated 01/27/10

ADMINISTRATION DIVISION
BUSINESS SERVICES



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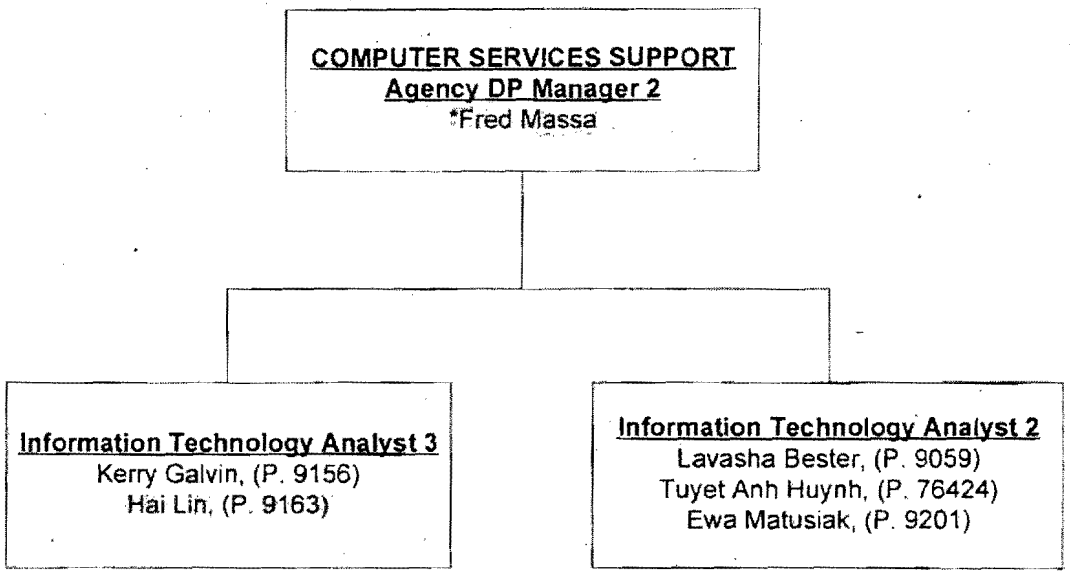
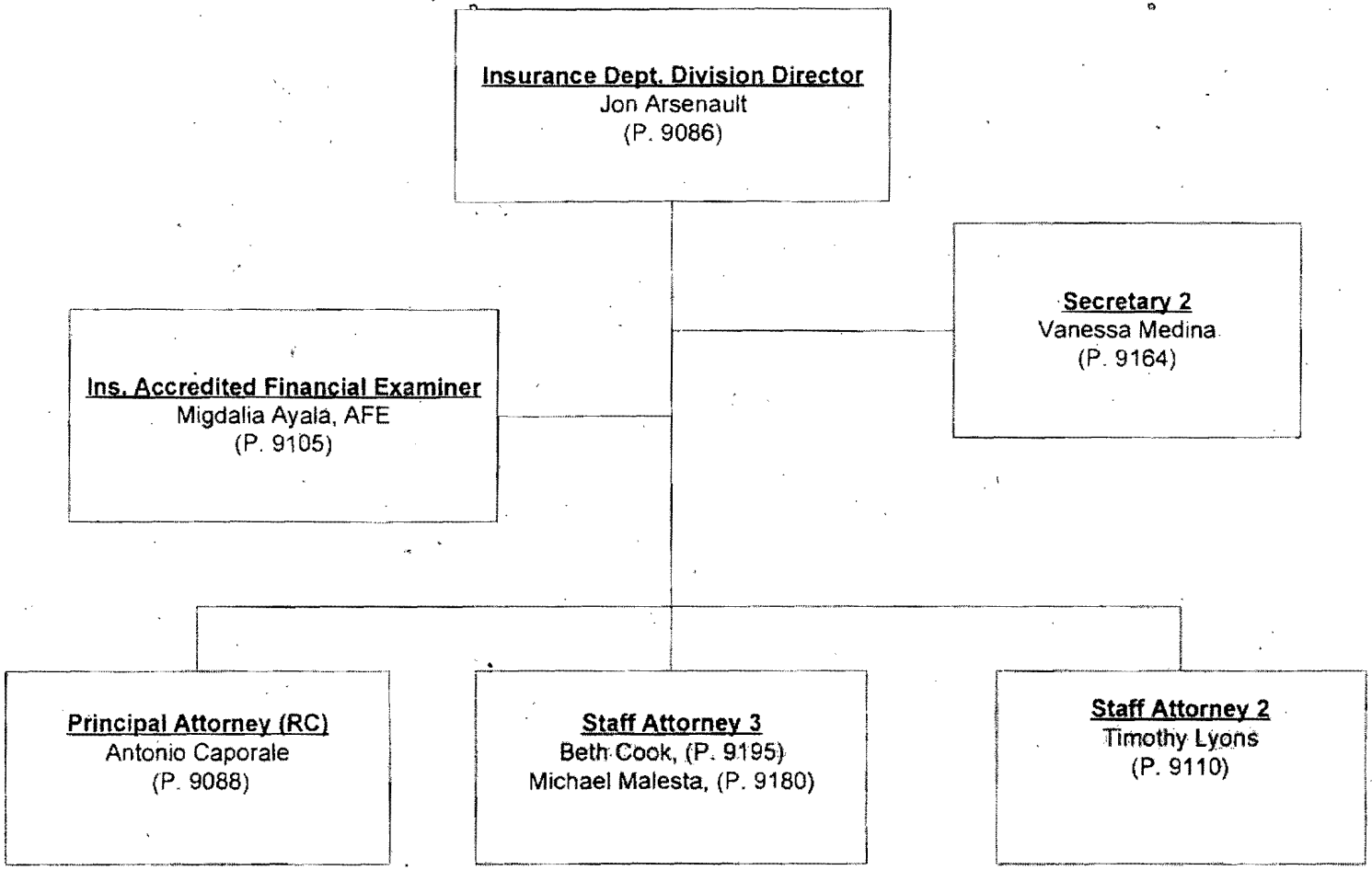
ADMINISTRATION DIVISION
COMPUTER SERVICES SUPPORT



updated 01/27/10

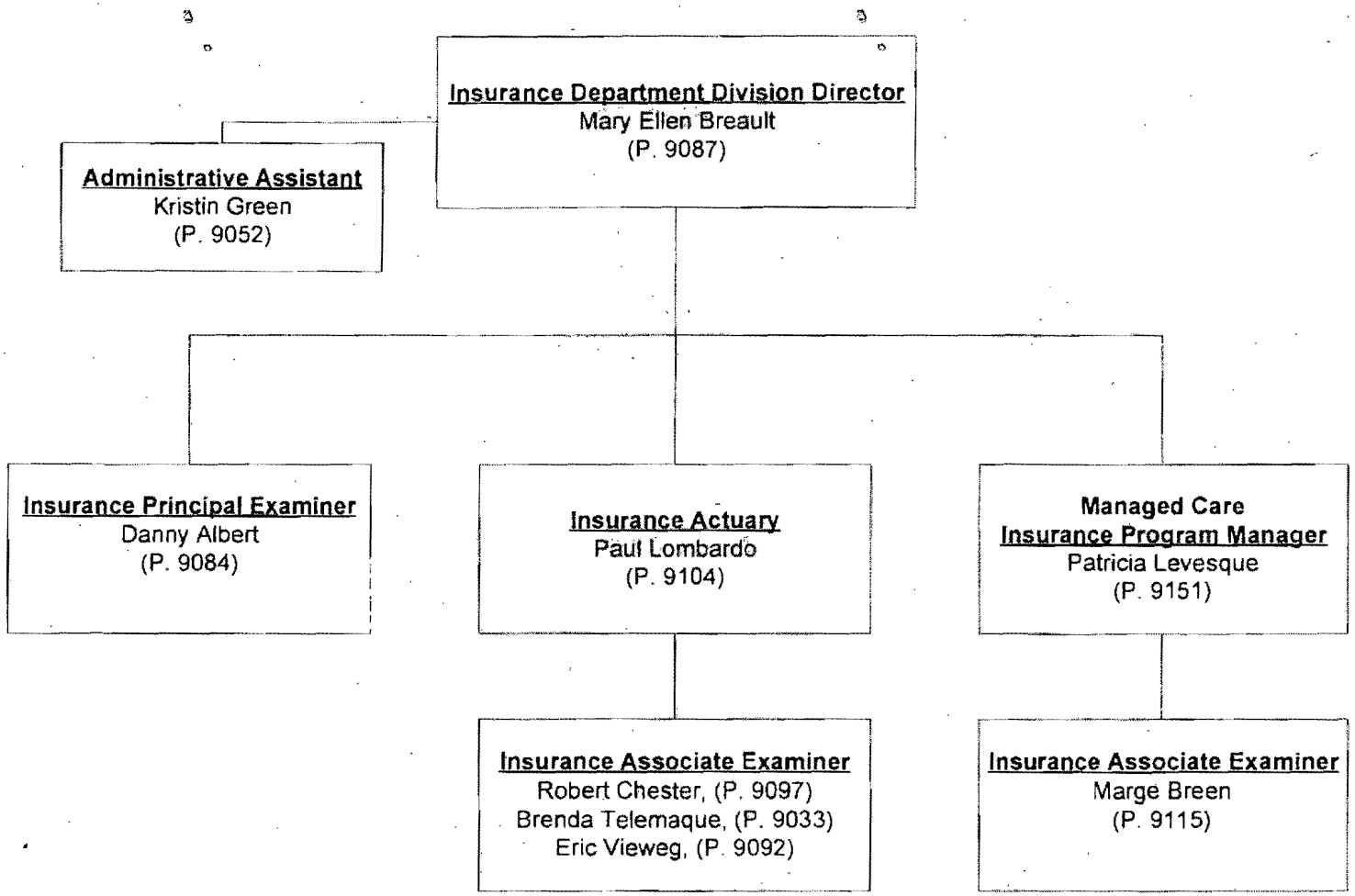
*DOIT Employee

ADMINISTRATION DIVISION
LEGAL



updated 01/27/10

LIFE AND HEALTH DIVISION



updated 01/27/09

Insurance Department Staff Department

Department staff that will be involved with the project are from the Life and Health, Legal, Business Services and Computer Services Support Divisions. The organizational chart for the Insurance Department and divisions involved as well as the job descriptions for staff are attached.

The Project Director is Mary Ellen Breault, the Director of the Life and Health Division at the Connecticut Insurance Department. The Assistant Director is Paul Lombardo, Actuary of the Life and Health Division at the Connecticut Insurance Department. It is expected that the Project Director will spend 90% of time on duties outside of the grant activities. Virtually 100% of the Assistant Director's time will be spend on activities related to the grant. It is estimated that other staff will spend approximately 10% of their time on grant activities. With the grant funds, consultants will be hired to help implement the plan for rate review enhancements.

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Department staff that will be involved with the project are from the Life and Health, Legal, Business Services and Computer Services Support Divisions. The organizational chart for the Insurance Department and divisions involved as well as the job descriptions for staff are attached.

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DAS

Class Specification

Classified/Competitive		
Class Code	Pay Plan	Class Title
2857	VR - 99	INSURANCE DEPARTMENT DIVISION DIRECTOR

PURPOSE OF CLASS:

In the Insurance Department this class is accountable for directing the programs and activities of a division.

SUPERVISION RECEIVED:

Receives executive direction from the Commissioner or other administrative official of higher grade; consults with Office of the Attorney General regarding legal matters.

SUPERVISION EXERCISED:

Directs staff of the division.

EXAMPLES OF DUTIES:

Directs staff and operations of division; coordinates, plans and manages division activities; formulates program goals and objectives; develops or assists in development of related policy; interprets and administers pertinent laws; evaluates staff; prepares or assists in preparation of division budget; maintains contacts with individuals within and outside of division who might impact on policy or program activities; represents department on various boards, commissions and task forces dealing with public policy issues; prepares and delivers testimony before legislative committees; may manage activities relating to insurance receiverships, guaranty fund administration, NAIC and legislative functions and delivery of legal service within department; may direct regulation of life and health insurance or property and casualty insurance products including but not limited to evaluation of insurance companies' financial strength and analyzing policy filings, rates and coverages; may direct conduct of financial analysis, field audit or market conduct of insurers, fraternal benefit societies, hospital and medical service corporations and health maintenance organizations; may develop and execute programs involving examination, mediation and resolution of complaints concerning all lines of insurance, insurance products, practices, procedures, operations, laws or regulations and licensees or non-licensees of department engaged in or acting as an insurance business; may direct programs and operations related to licensing of persons to perform insurance activities in Connecticut including but not limited to developing and maintaining up-to-date educational standards and licensing examinations; performs related duties as required.

MINIMUM QUALIFICATIONS REQUIRED KNOWLEDGE, SKILL AND ABILITY:

Considerable knowledge of and ability to apply management principles and techniques; considerable knowledge of relevant state and federal laws, statutes and regulations; considerable knowledge of principles, practices and modern methods of business organization and management, insurance policies, contracts and reinsurance agreements; considerable knowledge of insurance policy terminology, forms, organization, practice and procedures; considerable knowledge of methods used by other states in regulation of insurance companies; considerable interpersonal skills; considerable oral and written communication skills.

EXPERIENCE AND TRAINING:

General Experience:

Ten (10) years of experience in the regulation of insurance companies OR in policyholder services, sales, claims settlement, loss control, actuarial, contract development, investment, underwriting administration or audit services in the insurance industry.

Special Experience:

Two (2) years of the General Experience must have been in a supervisory capacity over professional staff.

Note: For state employees the Special Experience is interpreted at the level of Insurance Principal Examiner.

Substitutions Allowed:

1. College training in accounting, business, insurance, finance, economics or actuarial science may be substituted for the General Experience on the basis of fifteen (15) semester hours equalling one-half (1/2) year of experience to a maximum of four (4) years for a Bachelor's degree.
2. A Master's degree in accounting, business, insurance, finance, economics or actuarial science may be substituted for one (1) additional year of the General Experience.
3. A designation of a Certified Public Accountant (CPA) and/or Certified Financial Examiner (CFE) may be substituted for one (1) additional year of the General Experience.
4. Graduation from an accredited law school may be substituted for two (2) additional years of the General Experience.

SPECIAL REQUIREMENTS:

1. Incumbents in this class may be required to possess special qualifications, credentials or requirements depending upon the specific division and/or functional area being filled. Examples include but are not limited to membership in the Connecticut Bar Association, associate or full membership in a particular actuarial society or possession of a CPA certification.
2. Incumbents in this class may be required to travel.

COMPENSATION GUIDELINES:

1. The established salary range for this class is from the minimum of Salary Group MP 70 to the maximum of Salary Group MP 72.
2. The compensation of each position in this class shall be based on the skills and qualifications of the individual and the nature of the assigned duties but may not exceed the midpoint of the salary range except under exceptional circumstances and not without the approval of the Department of Administrative Services, Bureau of Human Resources.
3. Additional compensation may be authorized by the Bureau of Human Resources in the form of stipends, hiring rates or recruitment premiums over and beyond the above salary minimum, midpoint or maximum. These additional forms of compensation shall be based upon documented market compensation indicators.
4. The above stated salary minimum, midpoint and maximum shall be changed in accordance with MP pay plan adjustments as duly authorized by the Department of Administrative Services.
5. Incumbents in this class may receive performance assessment and recognition system bonuses or incentive pay without regard to the above referenced midpoint limitation.
6. Longevity payments shall be awarded as follows:

   Incumbents in this class who are at a compensation level below the midpoint shall be awarded a longevity payment in accordance with Salary Group MP 70.

   Incumbents in this class who are at a compensation level at midpoint or higher shall be awarded a longevity payment in accordance with Salary Group MP 72.

Note: The Compensation Benchmark Schedule for individual position slotting is located in the Class History File.

This replaces the existing specification for the same class in the same Salary Group VR 99 approved effective February 14, 1997. (Revised to modify Compensation Benchmark Schedule)

2857A 7/14/98 pzd

CC	Final#	Occup. Group	Bargaining Unit	EEO	Eff. Date
2857	468	(15)-Insurance Programs and Control	(02)-MANAGERIAL	(1)-Officials And Administrators	Jul 10, 1998

Print

DAS

Class Specification

Classified/Non-Examined		
Class Code	Pay Plan	Class Title
0051	MP - 70	INSURANCE ACTUARY

PURPOSE OF CLASS:

In the Department of Insurance, this class is accountable for directing and/ or conducting actuarial work involving casualty or life and health insurance, and conducting research and special studies.

SUPERVISION RECEIVED:

Receives direction from the Insurance Commissioner or Deputy Commissioner or other administrative official of higher grade.

SUPERVISION EXERCISED:

May direct the actuarial staff and technical and clerical employees as assigned.

EXAMPLES OF DUTIES:

Conducts analytical studies of insurance and health care center rate filings, rating plans and various special programs (such as experience rating, retrospective rating, and participating programs) and recommends action; conducts and reviews periodical examinations of rating organizations; may review an insurer's loss experience; reviews rates, rating plans, and self-insurance program; provides consulting service with respect to the approval or disapproval of requests made by insurance companies and rating organizations for changes in rates and rating plans; initiates recommendations with respect to improvements in rating plans and techniques; participates in Department hearings in connection with appeals of insureds regarding classifications and other rating matters; reviews insurance and health care reserves including cash flow testing of liabilities and asset adequacy testing; reviews reinsurance agreements; supervises the handling of complaints and inquiries concerning rates and related matters from the public, insurance companies, agents, brokers and rating organizations; serves as advisor on actuarial and related matters; prepares accurate and comprehensive reports containing findings, conclusions and recommendations; may act on behalf of the Commissioner at technical and professional conferences; performs related duties as required.

MINIMUM QUALIFICATIONS REQUIRED KNOWLEDGE, SKILL AND ABILITY:

Considerable knowledge of the relevant federal and state laws and regulations pertaining to insurance companies; considerable knowledge of actuarial principles, standards and methods; considerable knowledge of statistical methods and computer models as they relate to insurance rates and rating procedures; knowledge of the operation of relevant insurance programs; knowledge of the methods used by other states in the regulation of insurance companies; knowledge of relevant insurance coverages, rates, rating plans and special programs; knowledge of insurance company financial statements; considerable interpersonal skills; considerable oral and written communication skills; supervisory ability.

EXPERIENCE AND TRAINING:

General Experience:

Ten (10) years of experience as an actuary with an insurance company, an insurance regulatory agency, or in a consulting actuary's office performing actuarial insurance work.

Special Experience:

Two (2) years of the General Experience must have included experience setting insurance rates and/or

reserves for insurance companies or health care centers.

Substitutions Allowed:

1. College training in mathematics or statistics may be substituted for the General Experience on the basis of fifteen (15) semester hours equalling one-half (1/2) year of experience to a maximum of four (4) years.
2. A Master's degree in Mathematics or Statistics may be substituted for one (1) additional year of the General Experience.

SPECIAL REQUIREMENT:

An Associate membership, by examination, in a relevant actuarial society. For Property and Casualty, membership in the Casualty Actuarial Society is required. For Life and Health area, membership in the Society of Actuaries is required.

Note: Non-Examined refers to Section 5-219 of the Connecticut General Statutes which permits appointment of candidates to competitive positions without formal examination when a professional license, professional degree, accreditation or certificate is a mandatory requirement for appointment to a class.

This replaces the existing specification for the same class in the same Salary Group MP 70 approved effective September 23, 1996.

0051A 9/1/99 pzd

CC	Final#	Occup. Group	Bargaining Unit	EEO	Eff. Date
0051	255	(15)-Insurance Programs and Control	(02)-MANAGERIAL	(1)-Officials And Administrators	Sep 1, 1999

Print

DAS

Class Specification

Classified/Competitive		
Class Code	Pay Plan	Class Title
0126	MP - 66	FISCAL/ADMINISTRATIVE MANAGER 1
Unclassified		
Class Code	Pay Plan	Class Title
0410	MP - 66	FISCAL/ADMINISTRATIVE MANAGER 1 (UNCLASSIFIED)

PURPOSE OF CLASS:

In a state agency, facility or institution this class is accountable for directing a variety of complex, professional fiscal and administrative functions with a major emphasis on fiscal administration.

GUIDELINES FOR CLASS USE:

This is a managerial level class directly supervising a minimum of three (3) professional level staff over a combination of Fiscal/Administrative functions at least one (1) of which must be an accounting or budgeting function and meets a minimum of two (2) of the following criteria:

1. Manages six (6) or more fiscal/administrative functions (e.g., accounting, accounts examining, budget management, grant administration, human resources, purchasing)
2. Fiscal responsibility of $20 million or more. This is defined as monitoring control and decision making impact of dollars.
3. Directly supervises professional full time staff of six (6) or more and/or total full time staff of twelve (12) or more or acts as the assistant to a Fiscal/Administrative Manager 2 over the entire range of functions and staff.

Descriptions of these fiscal/administrative functions are attached.

SUPERVISION RECEIVED:

Receives administrative direction from a fiscal/administrative employee of higher grade or agency head.

SUPERVISION EXERCISED:

Directs professional and paraprofessional fiscal/administrative classes and other support staff.

EXAMPLES OF DUTIES:

Directs staff and operations of fiscal/administrative office; coordinates, plans and manages activities; formulates program goals and objectives; develops or assists in development of related policy; interprets and administers pertinent laws; evaluates staff; maintains contacts with individuals both within and outside of unit who might impact on program activities; coordinates fiscal management functions including budget preparation and management, accounting and financial reporting and analysis; assists in planning and implementation of financial aspects of EDP systems; utilizes EDP systems for financial records, reports and analyses; prepares programmatic fiscal/administrative analysis and impact statements on proposed regulations and legislation; directs and coordinates a variety of administrative functions such as grant administration, personnel, payroll, purchasing and contract administration; in addition to managing fiscal/administrative functions may manage support services such as maintenance, duplicating services, switchboard, mailroom, food services, security and housekeeping; in a facility or institution, in addition to the above, may insure conformance with related standards of JCAH, OSHA, Environmental Protection and other regulatory agencies; performs related duties as required.

MINIMUM QUALIFICATIONS REQUIRED

KNOWLEDGE, SKILL AND ABILITY:

Considerable knowledge of principles and practices of public administration with special reference to governmental budget management and governmental accounting; knowledge of and ability to apply management principles and techniques; knowledge of principles and procedures of personnel, payroll, purchasing, grant administration and contract administration; considerable interpersonal skills; considerable oral and written communication skills; considerable ability to understand and apply relevant state and federal laws, statutes and regulations; considerable ability in preparation and analysis of financial and statistical reports; ability to analyze budgetary and related problems; ability to utilize EDP systems for financial management.

EXPERIENCE AND TRAINING:

General Experience:

Nine (9) years of experience in a combination of fiscal/administrative functions (e.g., accounting, accounts examining, budget management, grants administration, personnel, payroll, purchasing) at least one (1) of which must be an accounting function. Descriptions of these fiscal/administrative functions are attached.

Special Experience:

One (1) year of the General Experience must have been supervising professional level staff.

Note: For state employees this is the level of Fiscal/Administrative Supervisor.

Substitutions Allowed:

1. College training may be substituted for the General Experience on the basis of fifteen (15) semester hours equalling one-half (1/2) year of experience to a maximum of four (4) years for a Bachelor's degree.
2. A Master's degree in public administration, business administration, or accounting may be substituted for one (1) additional year of the General Experience.

NOTE ON UNCLASSIFIED APPOINTMENTS:

Appointments to Unclassified positions will be made in accordance with sections of the Connecticut General Statutes related to the specific positions.

This replaces the existing specification for the same class in Salary Group MP 66 approved effective January 24, 1992. (Revised to modify Addendum)

0126A 1/4/08 cm

CC	Final#	Occup. Group	Bargaining Unit	EEO	Eff. Date
0126	1290	(04)-Business Management	(02)-MANAGERIAL	(2)-Professional	Jan 4, 2008
0410	1290	(04)-Business Management	(02)-MANAGERIAL	(2)-Professional	Jan 4, 2008

ADDENDUM TO FISCAL/ADMINISTRATIVE SERIES

FISCAL AND ADMINISTRATIVE FUNCTIONS

Distinction will be made between accountability for and participation in these functions. Fiscal/administrative supervisors, managers and chiefs must be accountable for (or supervise) the function if it is to be considered under the Guidelines for Class Use. The descriptions of each functional heading are not meant to be all inclusive. Their purpose is to provide a sampling of tasks in each functional area.

Those areas with an asterisk [*] must consume a significant amount of professional staff hours to be considered additional functions under the Guidelines. As a rule of thumb a significant amount of time will be considered a minimum of ten percent of total professional staff time or supervision of one full time professional position, whichever is smaller.

1. BUDGETING

Accountability for budget preparation and management for agency or facility; at higher levels includes participation in planning and policy decisions.

2. GENERAL FUND APPROPRIATION ACCOUNTING

Supervision of the agency's or facility's general fund accounting; includes maintenance of accounts (EDP or manual); Comptroller reconciliations; internal reconciliations; subsidiary accounts; payment lists; financial statements and reports; petty cash.

3. GRANT ADMINISTRATION (a&b ARE SEPARATE FUNCTIONS)

a. GRANT ACCOUNTING*

Supervision of the maintenance of accounting records, reconciliations, financial statements for grant funds, etc.

b. GRANT MONITORING* (non-programmatic)

Accountable for monitoring (or supervising monitoring) of grantees to ensure that funds are accounted for and expended properly. This can include pre- or post-audit of payments, review and analysis of budgets and financial statements, review of accounting procedures. It may include field work such as assistance with setting up financial records and may include (or consist mainly of) auditing grantees.

4. OTHER ACCOUNTING FUNCTIONS*

Accountability for or supervision of any additional professional accounting or accounts examining work which may be unique to an agency.

5. PURCHASING

Accountability for or supervision of the purchasing of supplies, equipment and contractual services including preparation and revision of specifications, selecting sources of supply, obtaining and evaluating formal written bids, issuing purchase orders, analyzing price trends.

6. CONTRACT ADMINISTRATION

Accountability for or supervision of contract preparation and monitoring including preparation of requests for proposals to obtain consulting or contractual services, determination of evaluation criteria, evaluation of proposals, preparation and monitoring of personal services agreements, point of service contracts and memoranda of understanding.

7. HUMAN RESOURCES

Accountability for and/or supervision of the agency or facility human resources function. This includes recruitment, human resources records, classification issues, grievances and other labor relations issues, worker's compensation, career and benefits counseling, preparation of agency or facility affirmative action goals, affirmative action recruitment, reporting, counseling and other aspects of implementation of affirmative action goals.

8. PAYROLL

Supervision of the payroll function.

9. SUPPORT SERVICES

Each additional support service supervised (e.g., stores, inventory/asset management, facilities/equipment security, facilities/equipment maintenance, mailroom, food service, phone system coordination) having a minimum of three (3) full-time positions or part-time equivalent) or taking a minimum of 10% of total fiscal/administrative staff time can be considered one (1) additional function.

10. INFORMATION TECHNOLOGY*

Supervision of an information technology operation including professional information technology staff (i.e., Information Technology Analyst 1 or above).

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Class Specification

Classified/Non-Examined		
Class Code	Pay Plan	Class Title
0088	AR - 28	STAFF ATTORNEY 2
0089	AR - 32	STAFF ATTORNEY 3

PURPOSE OF CLASS:

In a state agency this class is accountable for independently performing a full range of tasks in the legal work of the agency.

SUPERVISION RECEIVED:

Receives general supervision from an employee of a higher grade.

SUPERVISION EXERCISED:

May lead staff as assigned.

EXAMPLES OF DUTIES:

Performs advanced and complex legal work of an agency; researches, interprets, analyzes and applies complex and conflicting laws and regulations, case law and legal principles; acts as hearing officer or represents agency in formal administrative and public proceedings on a full range of cases involving complex legal and technical issues; negotiates and drafts settlement agreements; drafts advisory opinions, rulings, decisions, recommendations, findings, legislation, statutes, regulations, publications and other related legal documents; assists in the preparation and presentation of trials and appeals; consults with the Office of the Attorney General on legal issues; researches complex legal issues; conducts investigations and enforcement proceedings; prepares comprehensive reports for use in administrative and court proceedings; prepares pleadings and other court papers; interprets and applies complex or conflicting laws and regulations, case law and legal principles; participates in the conduct of various educational activities; provides legal guidance when duly authorized; provides input into policy formation; may testify at or monitor legislative proceedings; may represent agency in court when authorized; reviews court decisions, new and proposed laws and regulations to determine impact on agency operations; prepares and maintains precedent manuals; reviews legal and other related documents for legal sufficiency; performs related duties as required.

MINIMUM QUALIFICATIONS REQUIRED KNOWLEDGE, SKILL AND ABILITY:

Considerable knowledge of legal principles, practices and procedures in Connecticut; considerable knowledge of legal research techniques; considerable knowledge of the Uniform Administrative Procedures Act; considerable knowledge of and the ability to interpret and apply relevant state and federal laws, statutes, regulations and legislation; considerable knowledge of relevant agency policies and procedures; knowledge of the rules of evidence; knowledge of criminal and constitutional law and legislative process; considerable interpersonal skills; considerable oral and written communication skills; considerable ability to apply judicial decisions to the interpretation of statues; considerable ability to comprehend, analyze and organize technical data and coordinate elements of legal cases.

EXPERIENCE AND TRAINING:

General Experience:

STAFF ATTORNEY 2: Two (2) years of experience in the practice of law.

STAFF ATTORNEY 3: Three (3) years of experience in the practice of law at the level of Staff Attorney 2 in

the same state agency.

SPECIAL REQUIREMENTS:

1. Must be admitted to practice law in the State of Connecticut.
2. May be required to travel.

CAREER PROGRESSION:

After completion of three (3) years of successful and satisfactory performance as a Staff Attorney 2 in the same agency, an incumbent will be moved to the Staff Attorney 3 classification (on the first pay period following the completion of the three (3) year requirement).

NOTES:

1. Any incumbent having attained status in the class of Staff Attorney 3 who transfers to another state agency shall be reclassified back to and compensated at the level of Staff Attorney 2 (AR 28) until such time that the incumbent has been employed as a Staff Attorney 2 at the new agency for a period of two (2) years. (Reclassification to Staff Attorney 3 will be on the first pay period following the completion of the two (2) year requirement).
2. Non-Examined refers to Section 5-219 of the Connecticut General Statutes which permits appointment of candidates to competitive positions without formal examination when a professional license, professional degree, accreditation or certificate is a mandatory requirement for appointment to a class

This replaces the existing specification for the class of Staff Attorney 2 in Salary Group AR 28 approved effective December 9, 2005. (Revised to implement Memorandum of Understanding involving the creation of the new class title Staff Attorney 3 in Salary Group AR 32 and the genericization and consolidation of existing P-5 working level attorney classes into Staff Attorney 2)

0088A 6/6/06 cm

CC	Item#	Occup. Group	Bargaining Unit	EEO	Eff. Date
0088	1044	(18)-Legal	(16)-ADMIN & RESID (P-5)	(2)-Professional	Jun 9, 2006
0089	1044	(18)-Legal	(16)-ADMIN & RESID (P-5)	(2)-Professional	Jun 9, 2006

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DAS

Class Specification

Classified/Non-Competitive		
Class Code	Pay Plan	Class Title
2321	MP - 67	AGENCY INFORMATION TECHNOLOGY MANAGER

PURPOSE OF CLASS:

In a constitutional office this class is accountable for the management and direction of all agency information technology systems, applications development, systems maintenance and related functions.

SUPERVISION RECEIVED:

Receives administrative direction from an administrative official of higher grade.

SUPERVISION EXERCISED:

Directs the staff of the information technology division.

EXAMPLES OF DUTIES:

Directs staff and operations of an agency information technology system; coordinates, plans and manages division activities; formulates program goals and objectives; develops or assists in development of related policy; interprets and administers pertinent laws; evaluates staff; prepares or assists in preparation of division budget; maintains contacts with individuals both within and outside of division who might impact on program activities; establishes priorities for systems development and information technology projects in accordance with agency requirements; develops plans for future utilization information technology services in overall agency program; ensures development of high quality, low-cost technology solutions aligned with needs of agency; aligns information technology planning with business strategy; leads and influences development of standards and decisions regarding changes to systems/applications; stays abreast of local, regional and national industry trends; coordinates use of key people, resources, technologies, processes and capabilities to reach strategic goals; plans and supports information technology staff development; leverages technological solutions to meet business needs; performs related duties as required.

MINIMUM QUALIFICATIONS REQUIRED KNOWLEDGE, SKILL AND ABILITY:

Considerable knowledge of and ability to apply management principles and techniques; considerable knowledge of relevant state and federal laws, statutues and regulations; considerable knowledge of information technology methods, techniques and equipment; considerable interpersonal skills; considerable oral and written communication skills; considerable ability to analyze information technology system problems and implement effective solutions.

EXPERIENCE AND TRAINING:

General Experience:

Ten (10) years of experience in computer or network operations, systems development, information technology analysis and planning.

Special Experience:

Three (3) years of the General Experience must have been in a lead capacity.

NOTE: For State Employees this is interpreted at the level of an Information Technology Analyst 3.

Substitutions Allowed:

1. College training in management information systems, computer science or information technology related area may be substituted for the General Experience on the basis of fifteen (15) semester hours equalling one half (1/2) year of experience to a maximum of four (4) years for a Bachelor's degree.
2. A Master's degree in management information systems, computer science or electrical engineering may be substituted for one (1) additional year of the General Experience.

This replaces the existing specification for the same class in the same Salary Group MP 67 approved effective May 8, 2009. (Revised to modify Special Experience)

2321A 9/17/09 cm

CC	Final#	Occup Group	Bargaining Unit	EEO	Eff. Date
2321	1497	(07)-Information Technology	(02)-MANAGERIAL	(1)-Officials And Administrators	Sep 25, 2009

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Class Specification

Classified/Competitive		
Class Code	**Pay Plan**	**Class Title**
7605	EU - 30	INFORMATION TECHNOLOGY ANALYST 3

PURPOSE OF CLASS:

In a state agency Information Technology (IT) environment, this class is accountable for performing the most complex and technical support work and/or acting as a working supervisor of Information Technology Analysts engaged in information systems development or technical support.

GUIDELINES FOR CLASS USE:

1. All incumbents in this class perform tasks of the most complex nature in at least one of the following functional areas:
   Systems Programming: Performs services in planning, analyzing, modifying, designing, selecting, installing and implementing information systems.
   Software Development: Performs services related to leading application analysis, development and modification to support complex agency application and business needs.
   Database Administration: Performs services related to data acquisition, designing and modifying database systems.
   Network Support: Performs services in planning, designing, organizing and managing of network systems.
   IT Security: Perform functions and support projects aligned with protecting the confidentiality, integrity and availability of State data.
2. This class shall be used in one or both of the following capacities:

   Incumbents serving as a working supervisor must lead at least 50% of the time three (3) or more Information Technology Analysts engaged in a large information systems development project requiring application design, development, and programming, and/or network and system infrastructure work. Projects must be of a complex nature having inter-agency or enterprise wide impact and require specialized knowledge across multiple technical environments and disciplines.

   OR

   Incumbents serving in the advanced working level must perform the most complex tasks within a unit. The work must clearly exceed the norm and include a concentration of highly advanced functions within assigned disciplines. Class use is on a limited or exceptional basis.

NOTES:

1. For definitions of infrastructure and application complexity refer to the Addendum.
2. Incumbents are responsible for performing lower level duties as outlined in the Information Technology Analyst 2 specification. However, the primary focus of the incumbent's work shall be consistent with the duties illustrated below.
3. The Examples of Duties listed in this class specification are not necessarily descriptive of any one position in the class. The omission of specific statements does not preclude management from assigning specific duties not listed. The intent of the listed examples is to give a general indication of the level of difficulty and the responsibility common to all positions in the class.

SUPERVISION RECEIVED:

Works under the general supervision of an Information Technology Supervisor or an employee of higher grade.

SUPERVISION EXERCISED:

Supervises staff as assigned or acts as a project team leader.

EXAMPLES OF DUTIES:

All Functional Areas: Diagnoses host system problems and develops and coordinates resolutions; manages planning, analysis, design, selection, installation and implementation of new technologies; evaluates new technologies; tests and evaluates new hardware and/or software; makes recommendations for hardware and/or software purchases; determines interface and utility requirements and creates design specifications; acts as liaison to hardware and/or software vendors, system developers, programmers and management; develops and implements network and system security guidelines; makes recommendations for migration and upgrade directions; trains operators, systems developers and users on new procedures; conducts system performance analysis, tuning or storage management; conducts technical training programs for IT staff; acts as project coordinator overseeing other technical staff and support personnel; plans, coordinates and directs multiple projects of assigned staff; reviews work of assigned personnel; calculates project time and cost estimates; prepares necessary procedural specifications to meet design requirements; arranges necessary hardware and software availability; oversees hardware and software vendors; manages project budgets and schedules; reviews work of assigned Information Technology Analysts and serves as consultant and/or troubleshooter; reviews documentation work of assigned staff; communicates with business owners and management; facilitates meetings; assists in development of information technology policies, procedures and standards; participates in Request for Proposal (RFP) process; implements disaster recovery plans, assists in determining critical applications and personnel, or ensures offsite backups; defines data flow; performs related duties as required.

Working Supervisor Use: Plans unit workflow and determines priorities; schedules, assigns, oversees, and reviews work; establishes and maintains unit procedures; provides staff training and assistance; conducts or assists in conducting performance evaluations; acts as liaison with operating units, agencies, and outside officials regarding unit policies and procedures; make recommendations on policies or standards; prepare reports and correspondence; performs related duties as required.

Systems Programming: Performs the most complex duties related to application development; develops and implements system programming standards; configures and installs host-based application packages; maintains host operating systems; installs and upgrades host and/or Front End Processor (FEP) operating system software; performs other related duties as required.

Software Development: Configures and installs host-based application packages; analyzes upgrades for complex applications to determine functionality and necessary software customization; writes program specifications and systems specifications; designs forms, screens and reports; performs related duties as required.

Database Administration: Provides advanced level database support and troubleshooting; designs, installs, tunes and maintains integrity of major host-based database; leads integration efforts, transitioning applications to new technology; performs related duties as required.

Network Support: Designs and implements complex communications networks; diagnoses and resolves problems using network management systems and utilities; performs related duties as required.

IT Security: Develops, tests and maintains agency disaster recovery plans designed to restore IT system operability; develops process and procedures in support of IT Business Continuity Planning; conducts platform recoverability assessments and Business Impact Analysis (BIA) to determine and assess the impacts associated with disruptions to business functions; conduct risk analysis of IT environments by assessing administrative, technical and physical safeguards; performs IT investigations to include maintaining chain of custody procedures; performs forensics and documents detailed reports of findings;

performs related duties as required.

MINIMUM QUALIFICATIONS REQUIRED
KNOWLEDGE, SKILL AND ABILITY:

Considerable knowledge of principles and techniques of systems analysis, design, development, and computer programming; considerable knowledge of principles of information systems; considerable knowledge of principles and theories of business and planning functions; considerable knowledge of programming languages; considerable knowledge of project management principles and techniques; considerable knowledge of principles, problems and techniques of data processing and data communication operations; considerable knowledge of data processing and data communications equipment and diagnostic tools; considerable knowledge of methods and procedures used to conduct detailed analysis and design of computer systems; considerable knowledge of principles of complex computer operating systems; knowledge of principles and techniques of business information systems re-engineering; knowledge of network protocols and architecture; knowledge of practices and issues of systems security and disaster recovery; knowledge of applications systems development principles and techniques; knowledge of principles and practices of data base management; considerable interpersonal skills; considerable oral and written communication skills; considerable problem solving skills; considerable technical problem solving skills; considerable analytical skills; considerable ability to prepare correspondence, manuals, reports and documentation; considerable ability to analyze and resolve operational and communications problems; considerable ability to analyze and debug complex software programs; considerable ability to identify, analyze and resolve complex business and technical problems; some supervisory ability.

General Experience:

Seven (7) years of experience in information technology (IT) operations, programming, systems/software development or another IT related field.

Special Experience:

One (1) year of the General Experience must have been at the full professional working level with responsibility for performing a full range of complex technical support functions in one of the following areas:

1. Assisting in the design, implementation and management of a major communications network.
2. Providing technical and administrative support for a wide area network (WAN) or mini-computer system.
3. Assisting in the installation and maintenance of major sub-systems or installing and maintaining other host and/or network software.
4. Participating in the design and development of system applications.
5. Serving as a project coordinator responsible for coordinating the design, development, programming and implementation of moderately complex information systems projects.

NOTE: For state employees this is interpreted at the level of Information Technology Analyst 2.

Substitutions Allowed:

1. College training in management information systems, computer science or information technology related area may be substituted for the General Experience on the basis of fifteen (15) semester hours equaling six (6) months of experience to a maximum of four (4) years for a Bachelor's degree.
2. A Master's degree in management information systems, computer science or electrical engineering may be substituted for one (1) additional year of the General Experience.

New Class

7605A 7/2/07 cm

CC	Item#	Occup. Group	Bargaining Unit	EEO	Eff. Date
7605	1203	(07)-Information Technology	(15)-ENG, SCIEN, TECH P-4	(2)-Professional	Jun 22, 2007

ADDENDUM

Industry Job Titles

For the purposes of recruitment, examples of typical industry titles may be utilized in advertisements and postings as illustrated below. Incumbent's official title with the State of Connecticut will be Information Technology Analyst 3.

Functional Area	Industry Title
Systems Programming	Operating Systems Analyst, Application Systems Developer, Systems Developer, Mainframe Programmer, Midrange Programmer
Software Development	Software Developer, Software Development Analyst, Application Developer, Software Designer
Database Management	Database Analyst. Data Architect, Database Administrator
Network Management	Network Consultant, Network Specialist, Network Technician, Network Analyst

Definitions

Infrastructure Complexity
Routine:
An infrastructure that relies on intranet, local storage and dedicated server(s) to provide computing support.

Moderately complex:
An infrastructure that relies on intranet, SAN storage and shared servers to provide computing support.

Complex: An infrastructure that relies on Internet, IT security, application integration to provide computing support.

Highly complex:
An infrastructure that relies on integration with all of the following IT functional areas: networking, systems development, systems programming, IT security and database administration.

Application Complexity
Routine:
Executable application program, module, or subroutine using an operating-system or machine-interfacing language that reads programmed files, structured databases, or computer registers, and performs object processing involving graphic (algebraic), spatial (geometric) or computational (arithmetic) operations, character search or sorting, and creates a human or machine-readable output.

Moderately Complex:
Integrated set of multiple user written programs using compiled language that reads from multiple files or Data Base Management System (DBMS) based data base; processes intermediate files using arithmetic functions, character manipulation, and sorting; writes the processed data to one of several output files based

on processing results; and produces multiple outputs.

Complex:
Highly integrated set of programs with the following: each program using compiled language may read multiple files or a DBMS based data base; process intermediate files using the full range of software functions available; write the processed data to multiple output files based on processing results; update the master files, if any, with a capability for full error recovery; and produce multiple output.

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ADDITIONAL ASSURANCES

CERTIFICATIONS

1. CERTIFICATION REGARDING DRUG-FREE WORK-PLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that it will provide a drug-free workplace in accordance with the Drug-Free Workplace Act of 1988, 45 CFR Part 76, subpart F. The certification set out below is a material representation of fact upon which reliance will be placed when SSA determines to award the grant. If it is later determined that the grantee knowingly rendered a false certification, or otherwise violates the requirements of the Drug-Free Workplace Act, SSA, in addition to any other remedies available to the Federal Government, may take action authorized under the Drug-Free Workplace Act. False certification or violation of the certification shall be grounds for suspension of payments, suspension or termination of grants or government wide suspension or debarment.

The grantee certifies that it will or will not continue to provide a drug-free workplace by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about--

(1) The dangers of drug abuse in the workplace;

(2) The grantee's policy of maintaining a drug-free workplace;

(3) Any available drug counseling, rehabilitation, and employee assistance programs; and

(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that as a condition of employment under the grant, the employee will:

(1) Abide by the terms of the statement; and

(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency within ten calendar days after receiving notice under subparagraph (d)(2), above, from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices.

Notices shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 days of receiving notice under subparagraph (d)(2), above, with respect to any employee who is so convicted--

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f), above.

The grantee certifies that, as a condition of the grant, it will not engage in the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance in conducting any activity with the grant.

2. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(a) No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(b) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(c) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans, and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by section 1352, title 31, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure."

3. CERTIFICATION REGARDING DEBARMENT, SUSPENSION, AND OTHER RESPONSIBILITY MATTERS

NOTE: In accordance with 45 CFR Part 76, amended June 26, 1995, any debarment, suspension, proposed debarment or other government wide exclusion initiated under the Federal Acquisition Regulation (FAR) on or after August 25, 1995, shall be recognized by and effective for Executive Branch agencies and participants as an exclusion under 45 CFR Part 76.

(a) Primary Covered Transactions

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(1) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded by any Federal department or agency;

(2) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(3) are not presently indicted for or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (a)(2) of this certification; and

(4) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed under the assurances page in the application package.

(b) Lower Tier Covered Transactions

The applicant agrees by submitting this proposal that it will include, without modification, **the following clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transaction"** (Appendix B to 45 CFR Part 76) in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions:

Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion -- Lower Tier Covered Transactions

(1) The prospective lower tier participant certifies by submission of this proposal, that neither it nor its principals is presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participation in this transaction by any Federal department or agency.

(2) Where the prospective lower tier participant is unable to certify to any of the statements in this certification, such prospective participant shall attach an explanation to this proposal.

* SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	
Completed on submission to Grants.gov Mary Ellen Breault	Director, Life and Health Division
	* DATE SUBMITTED
State of Connecticut Insurance Dept	Completed on submission to Grants.gov